Care Quality Commission

Monitoring the Mental Health Act in 2022/23

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Foreword

Many of the issues discussed in this year's Monitoring the Mental Health Act Annual Report are all too familiar for people with lived experience of being detained, their friends and family, and mental health staff. We have seen examples of good practice, with staff doing their best in difficult circumstances to provide people with safe and effective care. However, there are still many people struggling to access care, not being involved in planning their care or being put at risk of experiencing restrictive practices that are not proportionate, justified or in line with their human rights.

The golden thread linking many of these issues is the ongoing pressures on limited workforce which, as we highlighted in our 2022/23 State of Care report, have continued to rise over the last year.

Throughout this report, we describe how workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, and highlight the effect this is having on the quality of care and the safety of both patients and staff. This is a particular problem for patients detained in the 3 high secure hospitals, where we have seen examples of inadequate staffing numbers and issues leading to patients being kept in their rooms during the day, and spending longer in their rooms at night. Staffing difficulties are also significantly restricting patients' access to therapies and activities, and patients have told us about the impact this had on their care, treatment and recovery.

We are pleased to see steps being taken to tackle the systemic issues around the NHS workforce. We welcome commitments to increasing nursing staff numbers in the NHS Long Term Workforce Plan, and are encouraged that there are now 50,000 more nurses in post than in 2019. However, as the majority of these new posts are not specifically for mental health care, we are concerned that the current shortfall in the mental health workforce is not being sufficiently addressed.

Nowhere is the impact of this shortfall more profound than for children and young people. As demand for children and young people's mental health services continues, staff shortages mean more and more children and young people are having to wait too long for mental health support, care and treatment. As at November 2023, nearly half a million children and young people were undergoing or waiting for mental health care.

This cannot continue. As well as the devasting impact on individuals, not providing children and young people with the care they need early enough presents a real risk to the future sustainability of NHS mental health services.

Without this early intervention, too many children and young people are reaching crisis point – in some cases this includes attempting suicide – before they can get the help they so desperately need. However, the lack of specialist beds then means that many of those in most need are ending up in inappropriate settings and/or in hospitals far away from home. As an organisation, we are committed to understanding why this is continuing to happen and working with stakeholders to design and implement solutions for now and the future.

Integrated care boards and integrated care systems will play a key role in bringing services together to provide care, at the right time, that meet the needs of their local population. But they will also be crucial in ensuring that services are joined up so people who are well can be discharged from hospital into the community in a timely way, with the support they need. As part of our new powers, we will be assessing how well systems are working to provide services that meet the needs of their local populations.

The draft Mental Health Bill also included important amends to the Mental Health Act 1983, which aimed to increase the safeguards for people who are detained. Despite this recognition of the need for change, we are disappointed that the bill was not mentioned in the King's speech as a priority, and that people continue to be denied improved safeguards. But legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential in improving mental health care and better outcomes for patients.

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 during 2022/23 from our engagement with people who are subject to the MHA as well as a review of services registered to assess, treat and care for people detained using the MHA.

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 who are currently detained in hospital under the MHA, and we require providers to take action when we become aware of concerns 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 complaints relating to use of the MHA
- make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also highlight practices that could lead to a breach of human rights standards during our MHA visits, and we make recommendations for action to improve. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM regularly visits places of detention to prevent torture, inhuman or degrading treatment. See Appendix B for more information on our role.

Evidence used in this report

This report is based on the findings from 860 monitoring visits carried out during 2022/23. This involved speaking with 4,515 patients (3,410 in private interviews and 1,105 in more informal situations) and 1,200 carers. We also spoke with advocates and ward staff. We have quoted from feedback letters issued following these monitoring reviews and have not identified the services concerned, apart from some exceptions when we are describing good practice.

This year, alongside speaking with people during our monitoring visits, we also carried out a series of interviews with people who have lived experience of being detained under the MHA or of caring for someone who has been detained. Their experiences illustrate the effect of detention on patients and their loved ones, and other issues highlighted in this report. We have used pseudonyms to maintain their anonymity.

Our other work that has informed this report includes:

- engaging at a policy level with a range of stakeholders in the use of the MHA
- handling information from 2,759 cases received through CQC's complaint system in 2022/23
- participating in 87 Independent Care Education and Treatment Reviews (IC(E)TRs, a process that the Department of Health and Social Care has asked us to take a lead on for the next 2 years.

We thank 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 draws on quantitative analysis of statutory notifications submitted by registered providers, and complaints and/or concerns submitted to us about the way providers use their powers or carry out their duties under the Act. We also use information from activity carried out through our second opinion appointed doctor (SOAD) service. This 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 carried out in preparing the data for publication, this data can change over time as it is taken from a live system.

The report also draws on data from NHS England's Mental Health Services Data Set (MHSDS), with both the annual figures from 2022/23 and monthly performance statistics files used. Figures used in the report relate to the specific data files referenced and were correct at the time of writing.

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 points

Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.

In June 2023, NHS England set out its plans to grow the number and proportion of NHS staff working in mental health, primary care and community care by 73% by 2036/37. While this is encouraging, we are concerned that this is not enough to address the current shortfall and the problems this creates both for patients and staff.

Through our monitoring activity, we have seen how the shortage of doctors and nursing staff continues to have an impact on the quality and safety of care for people detained under the MHA. Increased use of agency staff

to fill vacancies makes it difficult for staff to build meaningful therapeutic relationships and provide personalised care to patients who they are not familiar with. Staffing issues are also continuing to take a toll on the mental health and wellbeing of permanent staff.

Furthermore, staffing challenges are not only affecting frontline workers. A lack of agreed long-term funding for the second opinion appointed doctor (SOAD) service is creating problems with resourcing of the service. These issues mean the service is not keeping pace with demand, creating a safeguarding issue for people whose rights are restricted under the MHA.

Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of Black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.

While we have seen examples of NHS trusts making progress in tackling inequality, data from NHS England continues to show that detention rates for Black or Black British people are over 3 and a half times higher than for people in White ethnic groups. We welcome the rollout of the Patient and Carer Race Equalities Framework (PCREF) – the first anti-racism framework for mental health trusts and providers – and we plan to incorporate assessment of the PCREF into our MHA monitoring activity as we develop our approach.

We remain concerned about ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability. This can lead to them being inappropriately detained in hospital, which can have a devastating impact. Too often, people find themselves in the wrong setting for their needs, ending up in seclusion and segregation for long periods.

Although we have seen positive examples of staff celebrating and understanding diverse cultural perspectives, we are concerned that people may be at risk of direct or indirect discrimination in services where staff do not recognise and respect people’s protected characteristics as defined by the Equality Act 2010.

Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds means they continue to be cared for in inappropriate environments.

In 2021/22, the average waiting time between referral and the start of treatment for children and young people was 40 days. NHS data shows that in November 2023, there was a record 496,897 open referrals to children and young people’s mental health services. Delays in accessing care and treatment increase the risk that the symptoms in children and young people will worsen; YoungMinds found that more than half of young people reported that their mental health got worse while waiting for support.

When children and young people with mental health needs are admitted to hospital, a lack of specialist beds means that we continue to see them being treated on adult wards or general children's wards – often for extended periods and in locations far away from home. We are concerned that care on these wards is compromised by the fact that they are not designed for children and young people who have mental health needs, and that this can pose serious risks for them.

This lack of designated inpatient beds for children and young people has also led to problems with inappropriate ward layouts, as services attempt to accommodate people with differing mental health needs. We are concerned that this, combined with the workforce issues highlighted above, are leading to the use of blanket restrictions.

We expect care to be person centred and are committed to helping services promote positive cultures. While we have seen improvements in some areas, there is still significant work to be done to reduce restrictive practices.

We recognise that the use of restrictive practices may be appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights. But our expectations are clear: everyone working in health and care has a role to play in reducing the use of restrictive practices.

Over the last year, we have seen some positive examples of people being involved in their care and supported as an individual. This has helped to keep them safe and reduce unnecessary restraint.

However, there is a lot more work to do. For example, we remain concerned about the disproportionate use of force against some groups of people, including people from ethnic minority groups, autistic people and people with a learning disability.

It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

Many of the concerns we raise in this report are inherent risk factors and potential warning signs of when a closed culture could be developing.

We have seen examples of good practice, where patients have been involved in decisions around their care and treatment, demonstrating the benefits of an open and inclusive culture. Wider awareness of closed cultures has led to concerns being raised with us directly, allowing us to act quickly and ensure issues are appropriately escalated.

However, this is not common practice. We, along with providers and staff, need to continue to be vigilant to risks and warning signs so that people are not put at risk of deliberate or unintentional harm.

Workforce and staff wellbeing

Workforce and staff wellbeing

Key points

- Yet again, workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, with 1 in 5 mental health nursing posts vacant in the first 3 months of 2022/23.
- The shortage of doctors and nursing staff continues to have an impact on the quality and safety of care for people detained under the MHA. While steps are being taken to tackle issues around the mental health nursing workforce, we are concerned that this is not enough to address the current shortfall.
- To fill vacancies, many providers are turning to agency and bank staff. This increases the risk to people using services as it can be difficult for agency staff to build meaningful therapeutic relationships and provide personalised care to patients they are not familiar with.
- Rising demand, coupled with low staffing levels, increased use of agency staff and high turnover of management are taking a toll on the mental health and wellbeing of staff.
- Staffing challenges are not just affecting frontline workers. Uncertainty regarding long-term funding for the second opinion appointed doctor (SOAD) service is creating problems with resourcing the service and impeding its ability to provide vital safeguards for people in more vulnerable circumstances.

Workforce retention and staffing shortages continue to be one of the greatest challenges facing the mental health sector.

Figures from the British Medical Association show that, as at March 2023, around 1 in 7 full-time equivalent doctor roles in NHS mental health services in England were vacant. Figures for mental health nurses are worse, with data from NHS England showing that 1 in 5 mental health nursing posts were vacant in the first 3 months of 2022/23. NHS Confederation has described how this has left mental health services in "persistent crisis mode".

In its February 2023 report, the National Audit Office published the results of its survey of NHS mental health trusts, which highlighted trusts' concerns about shortages of medical and nursing staff, and psychologists. Reasons for these shortages included problems recruiting and retaining staff, a high turnover of staff between service areas, and competition from health and non-health sectors. As highlighted in our guidance 'How CQC identifies and responds to closed cultures' these types of issues with staffing are inherent risk factors that could indicate a service might develop a 'closed culture'. See also the section on closed cultures.

Not having the right levels of suitably qualified staff can have a huge impact on the safety of people who are detained under the MHA and the quality of care they receive. Through our monitoring activity, we've seen how staffing shortages have affected patients' access to therapeutic activities, stopped them from taking planned leave, or even prevented them from accessing fresh air.

As we discuss in this section, our monitoring visits have enabled us to see the effects of low staffing on services' ability to maintain safe observation levels and care for patients in a person-centred way. We've also seen the effect of poor staffing levels on the workforce, with patients again reporting feeling concerned about the wellbeing and morale of staff members.

As part of our new powers, we will be assessing how well integrated care systems are resourcing planned activity, which will include workforce.

Staff skills and levels of staff

The MHA Code of Practice states, "patients should be offered treatment and care in environments that are safe for them, staff and any visitors, and are supportive and therapeutic." To do this, services need to have an adequate number of suitably skilled staff.

Through our monitoring activity, we have seen the impact of the recruitment and retention challenges on providers, with a lack of suitably qualified staff and permanent staff leading to some services operating with lower than recommended staffing levels. Despite these challenges, we have seen examples of staff providing support effectively and in a respectful and friendly way.

> *"Senior staff were very open about the difficulties the unit was facing. We found staff nevertheless to be very committed, dedicated to caring for their patients, and optimistic about being able to pull through this period."*
>
> **Mixed gender eating disorder unit, July 2022**

> *"The patients we spoke with told us the substantive staff team… were lovely. We were told they were friendly, approachable and kind. Both patients told us that staff were nicer on [this ward] than staff anywhere else. However, one patient told us they found the turnover of staff and large numbers of agency staff 'difficult'. We were told there had been 3 different consultants over the last 6 months…"*
>
> **Mixed gender acute adult ward, September 2022**

Patients have told us about their concerns around staffing levels and we have found services struggling to recruit suitably qualified staff.

"All patients said there were not enough staff on the ward to provide patient care… On the day of the visit there were 3 qualified nurses and 5 healthcare assistants. Staff said registered nurses were moved to work on other wards to address staff shortages."

Acute admissions medium secure ward for men, October 2022

"There were 7 Band 5 nursing vacancies with newly qualified staff expected to fill 5 of the vacancies in September. This reflected the situation reported by all London mental health hospital providers, that there are problems recruiting Band 5 nurses and with them all competing for the same pool of available candidates."

Medium secure ward for men, July 2022

Mental health nurses are essential in providing high-quality care to people detained under the MHA. Nurses are with the patients every day forming therapeutic relationships and they play a key role in enabling and empowering patients.

We are concerned that not having enough nursing staff is affecting the ability of services to provide safe care. This is a particular concern when patients need one-to-one observation, as a lack of qualified staff can leave the remainder of the ward being cared for by a small number of nurses:

"On the day of our visit the ward did not meet the planned staffing levels of 6 staff. The actual staffing comprised 2 qualified staff and 3 healthcare assistants. One patient was on one-to-one observations and one member of staff was escorting a patient to the general hospital. This left 3 staff to care for 13 patients. The activity co-ordinator was also on the ward."

Assessment ward for men and women aged 65 and over, September 2022

In other services, we've seen how workforce challenges are affecting the quality of care people receive. Access to open spaces and fresh air, and a leave of absence, are vital in creating therapeutic environments and supporting people's recovery.

However, in multiple services, patients told us about times when they were not able to get any fresh air because there were not enough staff available to escort them, or that planned leave was cancelled.

> *"…patients said reduced staffing levels affected their access to fresh air and escorted section 17 leave because staff must escort them off the ward. Patients raised further concerns regarding their access to the gym based within the hospital grounds. They said there was only 1 gym instructor who was not available when patients wanted to access the gym because he did not work full time. Patients' access to the gym was dependent on the availability of staff."*
>
> **Medium secure rehabilitation ward for men, March 2023**

We held a series of interviews with people with lived experience of being detained under the MHA. In one interview, we spoke with Alice who had previously been detained in an eating disorder clinic due to having anorexia. She was also later detained in a psychiatric ward for a mental health disorder. Alice told us about what impact the staffing issues had on her:

> *"I love being outside but I couldn't go to the garden unless there was a member of staff available… Family and visitors weren't allowed on the ward and there wasn't a family visiting room."*
>
> **Interview with person with lived experience**

Article 8 of the Human Rights Act protects people's right to respect for their private and family life. We are concerned that cancelling patients' leave due to staffing issues could lead to a potential breach of their human rights.

Patients also continue to raise concerns about how staffing issues are leading to a lack of therapeutic activities and lack of one-to-one sessions with staff. Activities such as music, art or physical activity that are tailored to people's individual needs are important as they give people a sense of purpose, structure to the day and aid their recovery. Without these, patients tell us how this leads to boredom and could, in turn, lead to patient-on-staff violence, patient-on-patient aggression or self-harm.

> *"Half of the patients told us how [the way] some patients treated staff was unacceptable. In some cases, patients told us they had felt they had to intervene, and one patient said this led to them hitting another patient. Patients told us they were bored. Except for occasional table tennis, jigsaws, and the gym they said nothing else was offered."*
>
> **Acute admission for men, January 2023**

> *"One member of staff told us they rarely had time to complete one-to-one sessions with patients. They told us they would generally speak to patients when escorting them to the dining room as this was the only time they had. They attributed [this] to low staffing levels."*
>
> **Assessment ward for men and women aged 65 and over, September 2022**

Through our Give feedback on care service, one person told us how the lack of therapeutic activities available affected her son:

> *"Section 17 leave was agreed at ward round… but [the] consultant was unable to sign [the] form for another 32 hours. Having been confined to the ward 24 hours a day for several days, without therapeutic benefit or anything to relieve boredom, my son was anxious."*

Through our reviewer visits we have also heard that staffing problems can sometimes lead to concerns around the balance of gender between staff and patients on wards. For example, at one trust we were concerned that high levels of male staff were having a negative effect on some of the female patients who had experienced past trauma. At another trust, patients told us that this could lead to them feeling unsafe:

> *"Some patients told us they felt unsafe on the ward due to the high turnover of staff and male staff observing them, especially at night. One patient told us they had not had a shower for a week as the appropriate staff had not been on duty."*
>
> **10-bed medium-secure ward for women, December 2022**

Issues around staffing levels, particularly the shortfall in mental health nurses and the impact on patient care and safety, have been acknowledged in the NHS Long Term Workforce plan. The plan sets out commitments to grow the number and proportion of NHS staff working in mental health, primary care and community care by 73% by 2036/37. It also aims to increase training places for mental health nursing by 93% to more than 11,000 places by 2031/32. To support this ambition, by 2028/29 the plan states it will increase training places by 38% for mental health nursing.

We are encouraged to see attempts to improve staffing at a trust level through our monitoring visits. This includes recruitment drives through event days, as well as an increased focus on international recruitment.

While it is encouraging to see steps to tackle the systemic issues around the mental health nursing workforce, we are concerned that this is not enough to address the current shortfall and the problems this creates both for patients and staff.

The workforce plan focuses on recruitment and training of new staff. Although it mentions the importance of staff retention, we are concerned that it doesn't acknowledge the issues around staff wellbeing and burn out following the pandemic.

Impact of the lack of permanent staff

As highlighted in our 2022/23 State of Care report, consistent staffing is fundamental to building therapeutic relationships with patients. Therapeutic relationships are "a partnership that promotes safe engagement and constructive, respectful, and non-judgmental intervention." Based on acceptance and trust, therapeutic relationships have the capacity to transform and enrich a patient's experiences. Without this kind of relationship, patients are less likely to engage with treatments and interventions, which can affect their recovery time.

Therapeutic relationships play an important role in helping to create a culture where people feel psychologically safe. Broadly, psychological safety can be defined as "a climate in which people are comfortable expressing themselves". It plays an important role in mental health in empowering staff, patients and families to voice their suggestions, concerns and anxieties.

We remain concerned that staffing pressures, and a lack of permanent staff, is preventing people from developing these therapeutic relationships and means that people do not feel psychologically safe. For example, people told us how a lack of staff left them feeling anxious and unsafe.

> *"Patients told us the ward was often understaffed. This impacted on getting off the ward and feeling safe. Some patients had some anxiety that staff were only just in control of the ward, with comments such as 'not lost control but very busy'."*
>
> **Acute admission ward for male patients, January 2023**

In some services, it was concerning to see staffing issues contributing to patients not being offered person-centred care. For example, this is an issue at the 3 high secure hospitals where significant shortages of staff, in particular, registered nurses, continue to restrict patients' access to therapies and activities.

Staffing difficulties at these hospitals are longstanding. In our letter to the Secretary of State as long ago as June 2017, we asked what more NHS England and others could do to encourage and create incentives for staff to work in these very demanding settings. Despite some efforts from the system and each of the hospitals working individually and together, we are concerned that there has not been more progress made.

Through our interviews with people with lived experience, we spoke to Andrew, who was detained after trying to take his own life. He explained that more staff could have helped his recovery:

> *"If there had been more staff on the ward, I think I would have had more freedom and I think it would have helped my recovery. I wasn't allowed to be around other people without at least 2 people there who could restrain me."*
>
> **Interview with person with lived experience**

As staffing shortages persist, it's not surprising that many services are turning to agency and bank staff to fill vacancies. In mental health services, the use of agency staff, who can earn substantially more than permanent NHS staff, is higher than ever.

As we reported in our last MHA report, the use of agency staff can affect the morale of permanent staff. On our monitoring visits, permanent staff have continued to tell us how working alongside agency staff is putting them under increased pressure as they are required to carry out duties that agency staff were not trained to complete.

> *"We were told that there were currently several bank and agency workers which staff described as having 'a knock-on effect on the substantive staff' as they felt they had to work twice as hard as they knew the ward and the patients."*
>
> **Acute admission ward for men and women, September 2022**

It can also be difficult for agency staff to provide personalised care to patients they are not familiar with. This impacts on recovery for these patients, as it creates barriers to building meaningful therapeutic relationships.

In our interview with Andrew, who has experience of being detained, he went on to describe noticing the difference between permanent and agency staff:

> *"It wasn't necessarily an issue but I noticed a difference between permanent and agency staff. Some agency workers didn't have great English skills and it could be hard to communicate with them and they weren't very talkative. The permanent staff were better at holding conversations and building rapport with people, but they didn't have much time to spend with each patient."*
>
> **Interview with person with lived experience**

On one ward with a high number of agency staff, both patients and carers raised concerns about the lack of consistency and the knock-on effect on communication and the day-to-day running of the ward. At another service, patients told us they were concerned that agency staff did not always understand their needs and sometimes lacked the specialist training required to care for the people on the ward.

We have seen how a lack of training and support can prevent agency staff from providing the high-quality care they set out to deliver. Examples include a lack of basic support such as training on computer systems and access to all areas of the hospital. We raised issues around training for agency staff on some of our monitoring visits. As a consequence, a number of providers agreed to ward inductions for agency staff, including training on mutual expectations. This training enables staff and patients to understand what to expect from one another. This can clarify the relationship, reduce anxiety and uncertainty and improve communication between patients, staff and carers.

In our interviews with people with lived experience, we spoke with Julie who cares for her friend who has been detained several times. She told us about the impact of a lack of consistent staffing:

"When he was on the ward he only had a couple of visits from the mental health team. There was always a change of staff and there were periods where he didn't have anyone allocated to him. My friend's symptoms already mean that he finds it hard to trust people and the constant staff turnover didn't help."

Interview with person with lived experience

Daniel, who cares for his father who has been detained multiple times, noted similar issues:

"I felt there was a lot of churn of staff on the ward. They had day staff and night staff and there was inconsistency so I imagine they were agency staff. They didn't know the patients very well and didn't want to know the patients. They were there for numbers – not to forge any connection or relationship with patients on the ward. They were stand-offish and didn't engage with the patients at all, which is diabolical given it's the job they're paid to do. Small things like a cup of tea, my dad would have liked that, it would be an opening move for him to talk. He would use it well as a starting point and would ask or offer to make a cup of tea for something to do, but it wasn't received well 'you've already had lots of tea'. They didn't realise it was his way to engage. It's very basic what you can do and talk about in there with a bunch of strangers all unwell, trying to find something to talk about. A really difficult situation for everyone."

Interview with person with lived experience

Our monitoring activity has also alerted us to several concerns about the attitude of staff. This is supported by data from our complaints service, which shows that a large number of complaints (38%) received had an element that related to the attitude of staff (both agency and permanent).

This can be a particular concern in relation to agency staff. On one visit, some patients told us that agency staff could be "disrespectful" and "cold". On another visit, 2 patients described agency staff treating them in a way they perceived to be patronising.

We've also heard concerns about staff attitudes from advocacy professionals. For example, at one service an Independent Mental Health Advocate (IMHA) told us they were concerned about the way staff were addressing patients. In response, staff were given a significant amount of training in compassionate focused care. This training was also undertaken by agency staff, who make up a large percentage of staff at the service. In addition, the provider took a new approach to recruiting agency staff:

> *"We have made the decision to utilise a different agency with more experience in working with complex individuals and high risk behaviours."*
>
> **Rehabilitation unit for people with a personality disorder, May 2022**

Staff wellbeing

As highlighted in our 2022/23 State of Care report, increasing demand and pressures on staff are taking a toll on their mental health and wellbeing.

We heard from our MHA reviewers that low staffing levels, work volumes, burnout, turnover of management and the use of agency staff was affecting patient care and the wellbeing of staff. One MHA reviewer said this is recognised by patients.

> *"I think it's really quite sad when you hear patients talk about real, genuine concern for staff wellbeing. They're more concerned about the staff than they are about themselves and that's really quite sad, because it should be the other way around, really."*

This is supported by a July 2023 report from the Public Accounts Committee (PAC), which warned that increased workload is leading to burnout for staff. This in turn contributes to a higher rate of staff turnover and is leading to a vicious cycle of more staff shortages. The report highlighted that 17,000 staff (12%) left the NHS mental health workforce in 2021/22, up from pre-pandemic levels of around 14,000 a year. Of those 17,000, 14% left due to work-life balance reasons in 2021/22, an increase from 4% in 2012/13. In addition, in its evidence submission, NHS England told the PAC that, in

common with all NHS staff, mental health problems are one of the biggest drivers of sickness among staff.

In our State of Care report, we noted that without the appropriate support in place, stress and burnout can affect the care being delivered. This is supported by evidence provided at the PAC meeting in July, where witnesses described how it is much more challenging for staff to deliver compassionate care to patients when staff feel burned out. While we heard about initiatives to support the mental health and wellbeing of staff during the pandemic, we have since heard that support for staff has been decreasing.

Second opinion appointed doctors

The staffing issues raised in this section are not just affecting frontline workers, we are also concerned about the resourcing of the second opinion appointed doctor (SOAD) service. While we welcome the recent additional funding of £200k from the Department of Health and Social Care (DHSC), this only for 2 years. We are concerned that uncertainty regarding long-term funding for the SOAD service is threatening its sustainability.

SOADs are consulted when people do not agree, or are too unwell to agree, to their treatment under the MHA. We are responsible for administering the SOAD service, and SOADs make independent decisions, reaching their own conclusions by using their clinical judgement.

We are experiencing challenges in retaining experienced SOADs. SOADs told us that despite a recent pay increase, other work is better rewarded, proportionately to the effort required, and this is a disincentive to choose SOAD work above it. This shortfall is creating a safeguarding issue for people whose rights are restricted under the MHA because there are not enough SOADs to meet the demand in a timely way.

In 2022/23, there were 15,370 requests for a SOAD. This is consistent with the previous year, when we received 15,832 requests for second opinions (see also section on Our activity). However, resourcing issues created by the funding shortfall mean that the SOAD service is not keeping pace with demand and the length of time is increasing between receiving a request and the SOAD certification of the care and treatment. In 2022/23, waiting times increased by 22% from 2021/22 (28 days in 2022/23, compared with 23 days in 2021/22). This was higher for patients on a community treatment order (CTO), which saw a 49% increase in waiting times (58 days in 2022/23 compared with 39 days in 2021/22).

The higher waiting times for CTOs reflect the additional challenges that SOADs face in completing these requests. It can be difficult for the SOAD to speak with the right people concerned with the patient's care in the community, and there is a general lack of understanding of the SOAD role within community settings.

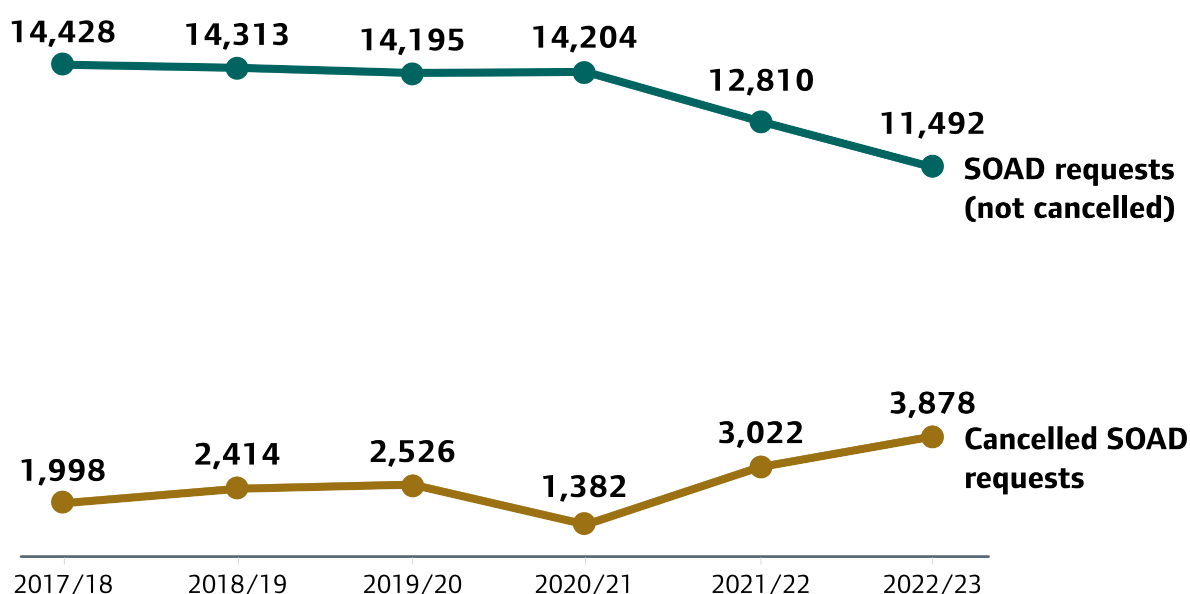
Increasing waiting times are especially concerning given the vital safeguards the service should deliver for people who are (or might be) made vulnerable. The SOAD service provides a safeguard for people who do not have capacity to consent to their treatment (last year this was 92% of SOAD requests).

The service is also vital for people who disagree with their treatment (last year this was 8% of SOAD requests).

Of the SOAD visits made, 3 in 4 second opinions (76%) resulted in no change to treatment plans, 18% were slightly changed and 4% of plans changed significantly as a result of a SOAD visit. In the remaining 2% of cases, no certificate was issued. If a SOAD is not notified that a patient's situation has changed, for example the patient might now agree to their treatment, the SOAD would not need to produce an additional certificate following their assessment.

SOADs have suggested that the length of time it is taking to respond to requests could also be a factor in the proportion of cancelled requests, which has been increasing year-on-year. Of the 15,370 requests received in 2022/23, 1 in 4 (3,878) were cancelled (figure 1).

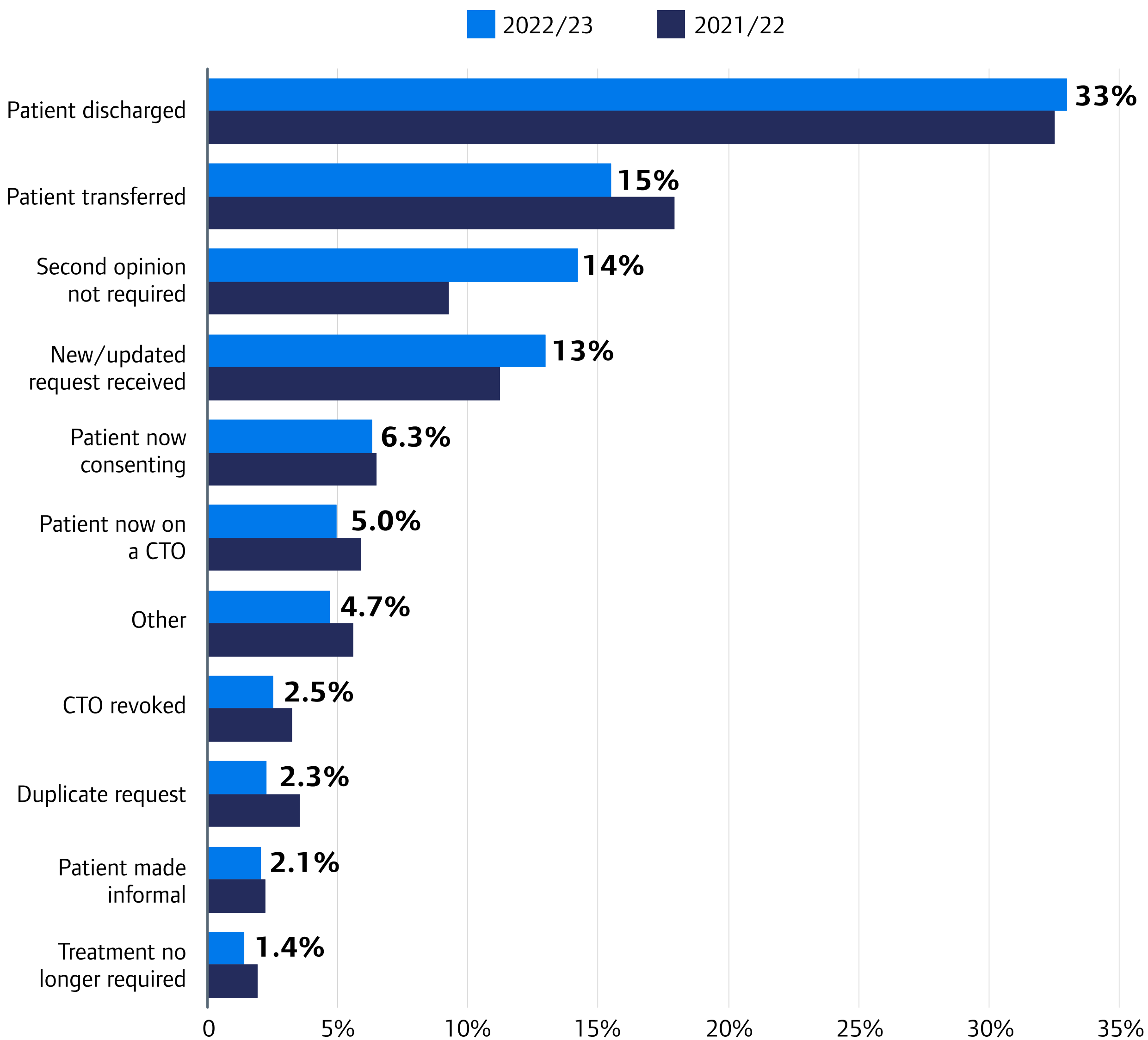
Figure 1: **SOAD requests over time**



Source: CQC

SOADs told us that cancelled requests may be because patients have been transferred or discharged. This is supported by our data, which shows that 48% of cancellations for 2022/23 are due to the patient being discharged (33%) or transferred (15%) (figure 2). When patients are transferred before a SOAD has responded to the request, this may lead to another request from a new service, in turn adding to the backlog. Not being able to respond to SOAD requests before people are discharged or transferred is a safeguarding issue and is putting people at risk.

Figure 2: **Reason for cancellation of SOAD visit**



Source: CQC

This year, we have seen that pressures on mental health services are adding to the SOAD workload when chasing requests. One SOAD told us that a shortage of beds means patients move between services and the increase in bank and agency staff can make it difficult to identify consultees.

We welcome the recent agreement with DHSC on funding for the SOAD service over the next 2 years to support with the challenges in delivering the SOAD service. To date, this funding has allowed us to increase the number of SOADs by 30%, with ongoing recruitment activity planned. Early data is also showing a decrease in wait times for second opinion appointments. However, we remain concerned that the one-off nature of this funding limits our ability to deliver the sustained improvements beyond 2024/25 that the service needs and address the significant risks to patient safety outlined in this section.

Inequalities

Inequalities

Key points

- We continue to have concerns around long-standing inequalities in mental health care. While we have seen examples of trusts making progress in tackling inequality over the last year, more is needed to address the over-representation of Black people who are detained under the MHA and placed on community treatment orders.
- We are concerned that local care pathways are not meeting the needs of people who need specialist support. In many cases, this is leading to prolonged detention in hospital, which has a detrimental impact on people's health and wellbeing. We are clear that there is still an urgent need to improve the provision of community care.
- We welcome the NHS national roll-out of the Patient and Carer Race Equality Framework (PCREF), which sets out to improve access, experience and outcomes, and meet the needs of people from ethnic minority groups. In line with our commitment to tackling inequality, we will be assessing the PCREF through our new assessment framework.
- We have seen positive examples of staff celebrating and understanding diverse cultural perspectives. However, we are concerned that people may be at risk of direct or indirect discrimination in services where staff do not recognise and respect people's protected characteristics as defined by the Equality Act 2010.

In our last report, we highlighted that inequalities in mental health care are systemic issues needing a system-wide response, but that change also needs to be driven at a local level by integrated care systems and providers.

Since our report, the architecture for the way our health and care services are delivered in England has changed, with integrated care systems and their respective boards gaining legal status in July 2022. In line with these changes, we are changing the way we do things at CQC, including our new responsibility to assess whether different parts of a system are working together and meeting the needs of their local populations. This includes assessing whether integrated care systems are developing and implementing an effective strategy that addresses health inequalities within the population.

Over the last year, we have seen examples of NHS trusts making progress in tackling inequality and improving the experiences of people with protected characteristics who are detained under the MHA. But we remain concerned that more needs to be done across the mental health sector to reduce inequalities and prevent discrimination. As reported in our State of Care report, while we have found a strong intention and commitment to address inequalities and act on issues, few integrated care systems have demonstrated an urgency to act on this area.

Racial inequality

Our last report highlighted long-standing concerns that not everyone detained under the MHA is treated equally. We particularly called for urgent action to tackle the over-representation of Black people detained under the MHA and those on community treatment orders (CTOs).

Data from NHS England continues to show that:

- detention rates for Black or Black British people are over 3 and a half times higher than for people in White ethnic groups (227.9 detentions per 100,000 population compared with 64.1 detentions per 100,000 population).
- the use of CTOs is over 8 times higher for Black or Black British people than for people in White ethnic groups (48.8 uses per 100,000 population compared with 6.0 uses per 100,000 population).

Through our engagement and monitoring activities, people from ethnic minority groups have told us about their negative experiences of detention and the impact this has had on them. For example, in one of our interviews with people with lived experience, Jennifer, who has bipolar disorder, described feeling like she was treated differently because of her ethnicity:

> *"I think being a Black woman on the wards, you are seen as more of a threat as someone with a mental health condition. You need to be expressive but if you are you are seen as a 'nutter'."*
>
> **Interview with person with lived experience**

At another service we visited, we heard about several incidents of patients making racially abusive comments to other patients. In this case, staff were robust in dealing with these incidents of racial abuse and escalated them to the police:

> *"Recently there were several incidents of patients making racially abusive comments. Staff got the trust's security lead and the police involved. A police officer came onto the ward and spoke to the specific patients about their behaviour and potential consequences. This was done sensitively given the patients' mental state, but it was successful in addressing these patients' behaviour."*
>
> **Psychiatric intensive care unit (PICU) for men and women, September 2022**

These examples highlight the need for change. The racial inequalities faced by people from ethnic minority groups when detained under the MHA are ongoing and need addressing. People from ethnic minority communities in the UK are more likely to experience mental illness, but are less likely to receive the mental health care support they need.

One of our key strategic priorities is to consider what more we can do through our statutory regulatory and monitoring roles under both the Health and Social Care Act and the MHA to improve the experiences of Black men when using mental health services. We want to raise public awareness and encourage local integrated care systems, local authorities and services to work together to take responsibility for identifying and addressing the long-standing inequalities in mental health care.

Tackling inequality is also a key feature of the NHS Long Term Plan. However, we know that poor-quality recording of ethnicity data is making it more difficult for organisations to effectively monitor and detect inequalities in access to services, and ensure they are meeting the needs of individual people.

In 2022, our focused review of ethnicity data recording in mental health services found that recording of ethnicity varied between systems, and that the ethnicity of nearly 1 in 6 patients was recorded as 'not known' and 'not stated'. In this report, we highlighted that systems with higher rates of not known and not stated ethnicity will not be able to effectively understand and, in turn, address inequalities in the care being provided.

Improving the quality of recording is essential to enable services to understand variation in referrals, treatments and deaths by ethnicity. The importance of good data remains a key area of focus and was recognised in a recent Lords debate on discussions around the reform of the MHA.

We welcomed the principles of the draft Mental Health Bill, which proposed to amend the MHA to increase the safeguards for people who are detained and reduce the over-representation of people from Black and ethnic minority groups. The bill also set out ambitions to decrease the overall use of CTOs and the racial disparity in their application. However, we are concerned that it is not clear how changes to the criteria for the application of CTO would achieve this aim.

Justification for using CTOs is still a matter of debate across professionals and groups of people who use services. However, we accept that a CTO may provide a less restrictive alternative way of managing a perceived risk. The draft bill proposed to tighten the criteria for CTOs and we supported the intention to make sure that CTOs are used 'only where there is a strong justification'. We also welcomed plans for a future review of CTOs following the proposed changes in the bill.

While we welcomed the ambition of the new bill, changes to legislation alone are not enough. The causes of racial inequality are multifactorial and need additional community resources, including outreach to minority groups.

We were disappointed that the bill was not included in His Majesty's speech in November 2023. However, we are pleased that non-legislative action continues, such as the Patient and Carer Race Equalities Framework (PCREF), and that the government remains committed to reform.

Improving patient experience

After a series of pilots, NHS England formally rolled out the PCREF in November 2023 – the first ever anti-racism framework for mental health trusts and mental health service providers. The PCREF is a mandatory requirement that sets out to improve access, experience and outcomes for people from ethnic minority groups.

There is expected to be an embedding and maturing period while the PCREF is adopted nationally. NHS mental health trusts and mental health care providers will be required to have a PCREF in place by the 31 March 2025.

Reflecting on the findings of its pilot and early adopter sites, in its publication of the PCREF, NHS England highlighted evidence of the positive impact of the new framework:

> *"… these pilot trusts have shown us what is possible when we listen to local communities and work with them to deliver care that is culturally appropriate, trustworthy and meets their needs. Inaction in the face of need is a clear indicator of systemic racism in operation and our pilot trusts and early adopter sites have been proactive in naming racism, identifying how it is operating across their services and the anti-racism framework (PCREF) has served to focus attention on strategies and actionable insights to counter."*

We welcome the national roll out of PCREF and will continue to work with NHS England as trusts embed the framework. We are also supportive of the recent Royal College of Psychiatrists 'Act Against Racism' campaign, which aims to help mental health employers tackle racism in the workplace. The guidance contains 15 actions to help organisations in the UK to tackle racism at a strategic and systemic level, and employers in the sector can sign up to a network committed to this objective.

As an organisation, we're committed to tackling inequality, with one of our core ambitions focused on regulating to advance equality and protect people's human rights. In December 2023, we published our updated human rights approach. This is integral to our new assessment framework and regulatory approach. It means we have a stronger focus on protecting and promoting people's rights when they use services, and we can act more quickly to protect people when their rights are at risk. This revised approach describes how we will influence change. It includes commitments for CQC to support this shift and the opportunities available to realise them.

Our role is to make sure people have safe, high-quality care. Care that doesn't protect and promote human rights is neither safe nor good quality. But a focus on human rights helps ensure people receive good care.

As part of our new assessment framework, we will be assessing the PCREF under the quality statement 'Equity in experiences and outcomes'. We will look at this area in all planned regulatory assessments in NHS-funded mental health services. We expect providers to actively seek out and listen

to information about people who are most likely to experience inequality in experience or outcomes. Care, support and treatment should be tailored in response to this.

Mental health trusts are required to implement the PCREF, and we will assess this using the well-led framework under the quality statement 'Shared direction and culture'. We expect providers to have a shared vision, strategy and culture. This should be based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

We plan to incorporate assessment of the PCREF into our MHA monitoring activity as we develop our approach.

In our last Monitoring the Mental Health Act report, we also highlighted how a lack of cultural understanding can negatively affect the outcomes of people from ethnic minority groups. Advocacy can help patients to be involved in their care, but it needs to be adaptable and responsive to an individual person's culture. We reported on a government-funded programme of pilots to test different models of culturally appropriate advocacy in both inpatient and community mental health settings.

The first phase has been successfully completed and the Department of Health and Social Care has reported a better understanding of barriers and enablers to implementing culturally appropriate advocacy models. It is hoped that culturally appropriate advocacy initiatives can potentially increase the uptake of advocacy and help to ensure people from ethnic minority backgrounds who use mental health services have better access to justice.

Preventing discrimination

The MHA Code of Practice guiding principle on respect and dignity states that 'there must be no unlawful discrimination' and that providers must be inclusive and respectful of people's individual needs, values and circumstances. This includes:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race, religion or belief
- sex and sexual orientation
- culture.

Through our monitoring activity this year, we have seen positive examples of staff celebrating diversity and understanding different cultural perspectives.

> *"Staff told us they celebrated different cultures on the ward and had recently promoted Black history awareness. They told us they would provide different types of food such as Jamaican dishes to embrace diverse cultures. "*
>
> **Dalston Ward (low secure ward for adult male patients who have an acquired brain injury), St Mary's Hospital, Elysium Healthcare, November 2022**

We also found positive examples, including at St Mary's Hospital, where staff had supported people to ensure they could practise their faith:

> *"There was a multi-faith room in the hospital. Staff told us they were able to support patients to visit different religious facilities in the community. They told us they were also able to arrange different religious representatives to visit the ward at a patient's request. "*
>
> **Dalston Ward (low secure ward for adult male patients who have an acquired brain injury), St Mary's Hospital, Elysium Healthcare, November 2022**

> *"We were told that on Fridays the staff team arranged for a member of staff who shared their faith to work on shift with them; this meant they could be supported to attend the local mosque for Friday prayers."*
>
> **Hopton Ward (rehabilitation service for male patients), Wickham Unit Avon and Wiltshire Mental Health Partnership NHS Trust, November 2022**

However, we also saw evidence of providers not enabling a culture where staff recognised and respected people's protected characteristics as defined by the Equality Act 2010. We are concerned that this may increase the risk of direct or indirect discrimination against people. For example, at one service we found that staff were unaware of how to provide patients with access to religious support:

> *"The hospital had no access to spiritual care or access to religious support. Staff were not aware as to how to access this, if required. "*
>
> **Mixed-gender child and adolescent (CAMHS) psychiatric intensive care unit (PICU), December 2022**

Last year we reported that there was greater visibility and focus on care for lesbian, gay, bisexual and transgender (LGBT+) people as an equality issue.

This is important as LGBT+ people have a higher risk of having mental health issues, with research from Stonewall showing that half of LGBT+ people had experienced depression, and 3 in 5 had experienced anxiety.

We expect all providers to respect the rights and needs of patients to avoid unlawful discrimination. At one trust we observed this in action where people were being well supported by the gender identity team:

> *"Staff were sensitively [supporting] one patient who wanted to be referred to as female. They were being supported by a peer support worker from the gender identity team within the trust."*
>
> **Additional support unit (ASU) Whipton Hospital, Exeter, Devon Partnership NHS Trust, August 2022**

At another trust, we were encouraged to see that a patient's correct pronouns were used in all records at one service:

> *"The patient's correct pronoun was used within all records we read... He said at present, staff treated him with respect and understanding. He had not experienced discrimination related to his gender from other patients and felt safe."*
>
> **Silverstone Ward (specialist dialectic behavioural therapy rehabilitation ward), St Andrew's Hospital, January 2023**

However, as highlighted in our previous report, further work is needed to ensure people feel respected and safe. This is supported by data from the Mental Health Foundation, which shows that around 1 in 8 LGBT+ people have experienced unequal treatment from healthcare staff because they are LGBT+. One in 7 people have avoided treatment for fear of discrimination.

During our visits, we have seen examples of a lack of respect for LGBT+ patients, for example services not respecting patients' choice of pronoun. At one service, we were particularly concerned that a patient was not taken seriously when correcting staff on their chosen pronouns:

> *"Patient C informed us that some staff had not respected their chosen pronouns when they were in a crisis. When they informed staff of this, they told them; to 'get over it' and 'deal with it' and that they were 'overreacting'."*
>
> **Psychiatric intensive care unit for men and women, June 2022**

Using wrong pronouns and names (or making assumptions) can make people feel unsafe or untrusting of staff, and have a detrimental effect on their care. Guidance for the Health and Social Care Act is clear that people using services should be addressed in the way they prefer, and all communication must be respectful. Providers must have due regard to the protected characteristics and provide care in a way that ensures people's dignity at all times.

Inclusive communication

Effective communication is essential to ensure that patients are respected and cared for in a way that meets their individual needs. The MHA Code of Practice is clear that it's the provider's responsibility to make sure patients are given information about how the Act applies to them, and to identify and address the individual communication needs of each person.

Since August 2016, all providers have had a duty to meet the Accessible Information Standard. This sets out requirements for all providers of NHS care and/or publicly-funded adult social care to identify, record, flag, share and meet the information and communication needs of people with a disability, impairment or sensory loss. As part of our monitoring activity, we look to ensure providers are communicating with patients and carers in ways that suit their needs.

During 2022/23, we saw positive examples of patients being given information in an accessible way, and providers using appropriate language about people's protected characteristics. This helped promote an inclusive and respectful culture where people could engage with staff.

However, we also found examples where providers did not consider inclusive ways of communicating with people with protected characteristics as defined by the Equality Act 2010, which negatively affected their health and wellbeing, as the following example shows:

> *"A patient's carer told us that their relative had a hearing impairment and needed to be able to lip read to fully understand what was being said. We were told that the responsible clinician refused to move their face mask when speaking with the patient, leaving the patient distressed and uncertain about what had been said."*
>
> **Ward for older people with functional mental health problems, September 2022**

Following our visit, we instructed the provider to address the issue and they agreed to make clear face masks available to staff to use as appropriate.

At another ward, we saw a cleaner being asked to interpret for a patient, which meant that they could not engage with staff when the cleaner was not there. Not being able to engage with people on the ward creates barriers and we were concerned that staff did not recognise the impact of this.

The MHA Code of Practice is clear that this is not good practice and that interpreters need to be skilled and experienced in medical or health-related interpreting. It also states that interpreters (both professional and non-professional) must respect the confidentiality of any personal information they learn about the patient through their involvement. Asking people who do not have this training to fulfil this role can be a risk to patient confidentiality and care, with the potential for misinterpretation.

We've seen some examples of good practice in this area, with interpreters available for all meetings and to translate documents, and staff using immediate voice translator technology. However, we are concerned that this is not always the case and sometimes people are left with no meaningful way to communicate with staff.

Supporting people's physical needs

Services must make sure they are meeting people's individual needs and that care is person-centred. Our reviewers found several examples where providers had not done this, which risked putting people with a physical disability at a disadvantage. For example, at one service the reviewer noted:

> *"One patient informed us that equipment provided was unsuitable for her and the bed was extremely uncomfortable and unsafe. We discussed this with the ward manager who told us that all patients with disabilities on the ward were given pressure mattresses despite this being unsuitable for the patient we spoke with."*
>
> **Acute admission ward for female patients, January 2023**

At another service, a bathroom had not been adapted for a patient who used a wheelchair, which led to their dignity being compromised:

> *"Staff supported a patient to use the toilet and undertake personal care. The patient was a wheelchair user and the toilet used was not large enough for the patient, equipment, and staff. The toilet was near the main entrance of the hospital. Staff used a temporary screen to try to maintain the patient's dignity."*
>
> **Rehabilitation hospital for men, March 2023**

Our updated human rights approach is based on the FREDA principles (fairness, respect, equality, dignity and autonomy). It clearly states that there can be no good care without this rights-respecting care.

Not making reasonable adjustments to meet people's individual needs suggests a lack of person-centred care planning and can put disabled people at a substantial disadvantage. We continue to raise actions with providers when we see that reasonable adjustments have not been made.

Lack of specialist support

We are concerned that local care pathways are not meeting the needs of people who require specialist support. In many cases, this is leading to prolonged detention in hospital, which has a detrimental impact on people's health and wellbeing. For example, at one ward for Deaf/deaf men we reported that:

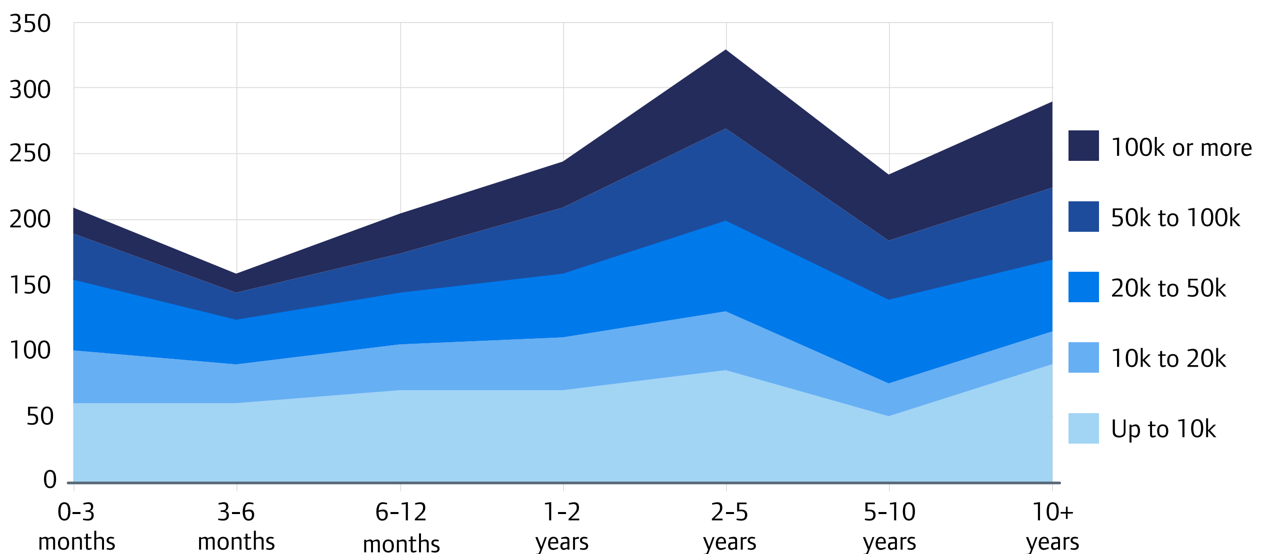
> *"Many of the patients had been detained under the MHA either on the ward, or at other facilities, for many years. Staff told us that a number of patients no longer required detention on a secure ward and could have been discharged if suitable aftercare provision was available in the community."*
>
> **Low secure mental health service for Deaf/deaf men, January 2023**

In particular, we remain concerned about ongoing problems with care pathways and a lack of community provision for autistic people and people with a learning disability. At the end of October 2023, 2,035 inpatients were autistic people or people with a learning disability. Of these, 92% (1,880) were subject to the MHA.

Information about how far away patients were placed from their home was known for 1,675 of the 2,035 patients. Of these, around half (855) had been in hospital for over 2 years (total length of stay is the time since the date of first admission to any hospital as part of this continuous period of inpatient care).

Figure 3 shows how far away from home autistic people or people with a learning disability were placed in hospital, and how long they spent in hospital.

Figure 3: **Distance away from home that autistic people or people with a learning disability were placed, over time (as of end of October 2023)**



Source: NHS England, Learning disability services monthly statistics
Note: Approximate figures based on sums of rounded published figures

Too often, this lack of community-based options of care means people find themselves in the wrong setting for their needs and/or with inappropriately trained staff or staff shortages.

We have been reporting on these concerns for many years. In 2020, our thematic review on restraint, seclusion and segregation highlighted the devastating impact of inappropriately detaining autistic people and people with a learning disability in hospital. In our final report, Out of sight – who cares?, we reported how a lack of care planning was leading to too many people ending up in seclusion and segregation in hospital for prolonged periods.

Our interim report, published in 2019, recommended that there should be an independent in-depth review of the care provided to each person who is in segregation on a ward for children and young people or on a ward for people with a learning disability, including their discharge plan.

Following our recommendation, in November 2019, the government committed to an urgent programme of Independent Care (Education) and Treatment Reviews (IC(E)TRs) for all people with a learning disability and autistic people who were in long-term segregation in specialist mental health inpatient settings. Led by Baroness Hollins, the aim was to review each person's care and treatment to make recommendations for improvement and identify any barriers to discharge.

As reported in our 2020/21 annual report, phase one of the review found that little had changed since the publication of our Out of sight report to improve the situation of autistic people and people with a learning disability.

In November 2023, Baroness Hollins published her final report. Figures show that as at May 2023, of the 114 people who received an IC(E)TR in the second phase, which ran between November 2021 and March 2023, 48 had been moved out of long-term segregation and only 7 people had been discharged from hospital. In her letter to the Secretary of State for Health and Social Care, Baroness Hollins described how autistic people and people with a learning disability have been "failed because of inappropriate care and treatment earlier in their pathway of care".

We hope that Baroness Hollins's report will act as a driver to help eliminate long-term segregation for autistic people and people with a learning disability. We expect care to be person-centred and providers to promote a culture that supports recovery, builds trust, and protects the safety and wellbeing of all people using services.

Following the publication of Baroness Hollins's report, the Department of Health and Social Care asked CQC to take the lead on IC(E)TRs for the next 2 years. In the first year, we will be working alongside NHS England. We are pleased to begin this work and will report further when we are able to.

For autistic people and people with a learning disability, long-term detention under the MHA does not often meet their needs. We supported the ambition of the draft Mental Health Bill to prevent inappropriate detention for autistic people and people with a learning disability. However, we have raised our concerns about some potential unintended consequences in the wording of

the current draft bill. This includes concerns that autistic people and people with a learning disability could be:

- subject to the criminal justice powers of the MHA because the bill was only changing the civil detention criteria and not the criminal detention criteria
- admitted under Deprivation of Liberty Safeguards (DoLS) instead of the MHA
- re-diagnosed with a concurrent psychiatric disorder so they meet the new criteria (for example, depression resulting from a placement that doesn't meet their individualised needs).

We are also clear that changes to legislation are not enough, and there remains an urgent need to improve community care. Having access to high-quality community-based services and support enables people to get the care they need in their local area. This is vital in providing early interventions before people reach crisis point, as well as avoiding unnecessary hospital admissions or delayed discharges. However, although the draft bill provided a welcome spotlight and sense of urgency to this issue, we are disappointed the bill isn't being progressed in this parliamentary session.

Children and young people

Children and young people

Key points

- Despite additional investment, rising demand and a lack of community support means that children and young people continue to face long waits for mental health support, care and treatment with NHS data reaching a new record with 496,897 open referrals to children and young people's mental health services in November 2023.
- This high demand and a lack of specialist beds means that children and young people with mental health needs continue to be cared for in inappropriate environments, such as acute or adult wards, which do not fully meet the requirements of the MHA Code of Practice.
- We are concerned that the care children and young people receive on adult wards and children's general wards is compromised by the fact that these wards are not designed for children and young people who have mental health needs.
- A lack of designated inpatient beds for children and young people has also led to problems with inappropriate ward layouts. We are concerned that this, combined with issues highlighted in the workforce section of this report, are leading to the use of blanket restrictions.

In our 2022/23 State of Care report, we reported that over the last year we have continued to see the impact of the pandemic on the mental health of children, with demand for services still increasing.

NHS monthly data shows that the number of children and young people undergoing treatment or waiting to start care has reached new records, with 496,897 open referrals to children and young people's mental health services in November 2023.

During 2022/23, the ongoing effects of the pandemic are being compounded by the cost of living crisis. In November 2022, NHS England's report, Mental Health of Children and Young People in England 2022, found that among 17 to 22 year olds with a probable mental disorder, 14.8% reported living in a household that had experienced not being able to buy enough food or using a food bank in the past year, compared with 2.1% of young people unlikely to have a mental disorder.

It is likely that the rising cost of living will have a further impact on children and young people's mental health, especially those who live in communities with the highest levels of deprivation.

Children and young people continue to experience delays in accessing care. Data published in the report from the Children's Commissioner on Children's Mental Health Services 2021-22 showed that in 2021-22, the average waiting

time in England between referral and the start of treatment increased to 40 days, up from 32 days in the previous year.

This delay increases the risk of their symptoms worsening and/or them being cared for in inappropriate environments. Analysis of NHS England data by the charity YoungMinds shows that in the year to March 2023, there were 21,555 urgent referrals to mental health crisis teams, up 46% on 2022 .

In this section, we explore the importance of early intervention and the impact of being treated in environments that are unsuitable for their needs, where discharge may be delayed due to poor provision of care in their community.

The importance of early intervention

In 2019, the NHS Long Term Plan set out NHS England's plans for improving access to children and young people's mental health services over 10 years. Following the pandemic, and the negative impact this had on children and young people's mental health, the government announced it was investing £79 million to boost mental health support for children and young people.

Despite this focus and additional investment, in December 2022 the mental health charity SANE reported that the expansion of mental health services was not fast enough to meet rising needs, leaving many children and young people with limited or no support.

In the March 2023 report, Children's Mental Health Services 2021-22, the Children's Commissioner described hearing from children in inpatient mental health settings that they wanted more earlier intervention to prevent crisis admissions. The report found that when children go to A&E, they sometimes present multiple times before an inpatient admission is considered.

Early intervention including, for example, home visiting programmes, school-based learning and mentoring schemes can reduce risk factors for young people and increase the chance of lifelong recovery from mental illness. As a result, ensuring that children and young people have easy access to early intervention support is crucial.

However, in October 2023, the Royal College of Occupational Therapists reported that almost two-thirds (65%) of paediatric occupational therapists say the cost of living crisis is making it more difficult for children and young people to access the therapies and interventions they need. The report, which details the findings of their 2023 children and young people's survey, highlighted that:

- 56% of families are having to reduce activities that would support their child's wellbeing, such as swimming lessons
- almost half (49%) are unable to take time off work to attend occupational therapy appointments
- 47% are so worried about money that they cannot prioritise occupational therapy.

In October 2023, to support children and young people and ensure that fewer reach crisis point, the government announced almost £5 million funding for early support hubs, set up to deliver mental health support for children and young people.

Separate to our monitoring work, our inspection of Somerset Foundation NHS Trust highlighted how investment in early intervention can significantly improve outcomes for children and young people. We found outstanding practice relating to the trust's specialist community teams, which had implemented a number of strategies to decrease their wait times. This included, for example, working in partnership with voluntary sector organisations, investing in early intervention such as the mental health in schools team, and upskilling staff so more could deliver therapy.

We found that their efforts over the past 4 years have resulted in achieving a no wait list for children and young people to access the service, and a decrease in referrals. As a result, caseloads for staff were lower and there were also better outcomes for those who did not meet the criteria to access the service.

Impact of delays in care

Increasing demand and issues with accessing help early on means that too many children are facing long waits for mental health support. These delays are having a huge impact on children, young people and their families. Through our inspections and monitoring visits, providers have told us that children are typically presenting with worse mental health issues than before the pandemic.

This is supported by a survey from YoungMinds, which highlighted that more than half of young people reported that their mental health got worse while they were waiting for support. Over a quarter (26%) said they had tried to take their own life as a result of having to wait for mental health support.

Analysis of NHS data by YoungMinds shows that the number of children in mental health crisis has reached record levels in England. These are children with the most acute mental health symptoms, who might need to go to hospital as a result of psychosis, severe self-harm or suicide attempts. The charity found that, for the first time, urgent referrals of under-18s to mental health crisis teams reached 3,732 in May 2023, 3 times higher than in May 2019.

Children and young people in inappropriate settings

The MHA Code of Practice is clear that children and young people should have:

- appropriate physical facilities
- suitably trained staff
- a hospital routine that will allow their personal, social and educational development to continue as normally as possible
- equal access to educational opportunities as their peers.

However, high demand and a lack of specialist beds in services for children and young people mean that those with mental health needs continue to be cared for in inappropriate environments that do not meet these requirements. We continue to see children and young people with mental health needs being admitted to adult wards or general children's wards, often for extended periods and in locations far away from home. This can present serious risks for them.

As we highlighted in our last MHA annual report, we continue to see examples of children and young people being admitted temporarily to section 136 suites because of a lack of alternative beds. These suites are designed as a place of safety for the admission of a person from a public place where there is an urgent need to keep them safe, under section 136 of the Mental Health Act. As self-contained units, these can provide relatively suitable accommodation for children and young people, provided that appropriately trained staff are available, but it removes such suites from their intended use. We have seen examples where suites are occupied for several days in these circumstances.

We are carrying out work as a priority to identify why children and young people continue to be admitted to unsuitable settings. This involves working with internal and external stakeholders to design and implement solutions so that all children:

- will not be asked to move to a placement that isn't safe
- will not be asked to live with other patients who are adults
- will be given the opportunity to express their wishes about where they are placed
- will only have people caring for them who understand their needs and can meet them.

We will consider the issues that affect the quality of care for children, and what actions we can take as the regulator to prevent children being cared for by providers who cannot meet their needs.

When we find that a child is being treated in an unsuitable setting, we hold a review meeting to look at the provider's actions. If the child is in an acute hospital, we ask the provider to respond and give updates and assurances on finding a suitable bed. We also check whether they have held a risk summit with the commissioners about the individual child. In cases involving autistic people and people with a learning disability, we check whether patients have been placed on the dynamic support risk register. Where possible, we also raise these cases with integrated care boards (ICBs).

We are now assessing the performance of local authorities and integrated care systems in how they provide care in the local population. One of the priorities set by the Secretary of State is around assessing leadership, which includes checking if the integrated care system:

- adequately involves people with appropriate experience and expertise in its activity, such as directors of children's services
- ensures its plans, strategies and commissioning decisions adequately consider the health and wellbeing outcomes for babies, children and young people, and the voices of children, young people and families.

Adult wards

The MHA states that children and young people admitted to hospital for mental health treatment should be accommodated in an environment that is suitable for their age. The Code of Practice highlights the "clear difference between what is a suitable environment for a child or young person in an

emergency situation and what is a suitable environment for a child or young person on a longer-term basis."

We are concerned about the suitability of adult wards for children who require mental health treatment. By their nature, children on adult wards are often not able to socialise with others their own age, miss out on peer support and have limited access to educational opportunities. In addition, staff who are often used to treating adults may not tailor the care they provide to meet the needs of younger patients.

Beyond the initial crisis, hospital managers need to consider the appropriateness of mental health care that can be provided on the adult ward, as well as whether the patient can mix with people of their own age, receive visitors of all ages, and access education. Under the MHA, admission to an adult ward must only happen in exceptional circumstances, where this is considered suitable for the person. If a patient under 18 years of age is admitted to an adult ward for longer than 48 hours, the hospital managers must tell CQC.

Last year, we reported a 32% rise in the number of people under 18 being admitted to adult wards (260 admissions in 2021/22 compared with 197 in 2020/21). Figures this year show that the number of notifications has dropped by 25% and are now similar to 2020/21 figures at 196 notifications.

Of the 196 notifications received in 2022/23, the vast majority (85%) of admissions were classed as emergency, with the remainder planned admissions (14%). The main reason provided for admitting the child to an adult ward was because there was "no alternative mental health inpatient or outreach service available for young people". Where specified, most patients were given a single room (76% of admissions).

The length of time children and young people spend on adult wards has fluctuated in recent years. Figures from the Mental Health Services Data Set (MHSDS) show the number of adult bed days within a reporting period that are used by children, but they do not show the number of children. For example, 10 bed days could mean that 1 child may have been on an adult ward for 10 days in a month, or 10 children may have been on an adult ward for 1 day each. In 2022/23, across England children and young people spent on average 313 bed days per month on adult wards, reflecting the high demand for specialist mental health beds for under 18s.

We have also seen young people who needed a psychiatric intensive care environment waiting on an acute mental health ward, which can pose serious risks to their safety.

People have also told us about their concerns around the way in which children and young people are transitioned from children's services into adult services. Guidance from the National Institute for Health and Care Excellence (NICE) is clear that practitioners should start planning for adulthood from year 9 (age 13 or 14) at the latest. However, we have heard examples of young people being moved onto adult wards as soon as they turn 18, and feeling like they are suddenly being expected to act as an adult.

Young people have reported how this can make their anxiety worse and their families have described the differences in responsibility of care and the daily structure and activities within the environments. Providers need to make sure that transition planning is in place and individual needs are considered when children and young people are going to be moved into the care of adult services.

General children's wards

The MHA Code of Practice is clear that children and young people should be treated by staff who have the right training, skills and knowledge to understand and address their specific needs. But we remain concerned that children and young people with mental health needs are being treated on paediatric wards intended to treat children with physical health needs.

A recent report by the Healthcare Services Safety Investigations Body (HSSIB), found NHS paediatric wards may not be a safe environment to care for children and young people exhibiting high-risk behaviours. The report highlights the potential negative impact on the wellbeing of patients and their families, as well as a risk to other patients and staff. Primarily designed to care for patients who only have physical health needs, there are many self-harm and ligature risks present on paediatric wards. In addition, the crowded and noisy nature of paediatric wards make them unsuitable for children and young people experiencing a mental health crisis.

We are particularly concerned that if children and young people with an eating disorder are admitted onto a general children's ward first, they may not have the safeguards of the MHA or access to advocacy support.

Out of area placements

When a young person under 18 goes to hospital, they should be placed as close to home as possible. In 2016, the Five Year Forward View for Mental Health set a target of ending out of area placements for adults and children by 2020/21. However, between April 2022 and March 2023 on average there were still 388 out of area placements started each month. A member of our service user reference panel (a group of carers and people who are, or have been, detained under the Mental Health Act) told us about carers with family members who are under 18 and detained far from home. They explained how this makes it difficult to have regular contact with families and can make the experience of being detained feel more isolating.

As we highlighted in our last MHA report, out of area placements can also present challenges when patients are ready to be discharged, such as securing appropriate community support back in the person's local area.

Issues with unsuitable environments

Whether on a general children's ward, adult ward or in acute admissions, the care given to children and young people is compromised by the fact that these wards are not designed for children and young people who have mental health needs.

As reported in our last MHA report, we remain concerned that many of the settings do not meet people's sensory needs. For example, often noisy and

bright wards can create a particularly difficult sensory environment for autistic people and people with a learning disability. Services must determine each patient's unique sensory profile and preferences to ensure they receive care that meets their needs.

But we did not find this had happened in all services:

> *"For an autistic patient we were unable to locate a sensory assessment. In the absence of such an assessment it was difficult to ascertain what reasonable adjustments needed to be made."*
>
> **Ward for female children and young adults aged 8 to 18 years of age, March 2023**

At another service, staff raised concerns that the ward dynamics and acuity of other patients were challenging and often detrimental to autistic patients who were regularly admitted there.

We also continue to see wards in need of repair. For example, we have heard how a lack of a family visiting room, broken equipment and loud environments can negatively affect the experiences of children and young people:

> *"The ward had been without communal televisions for several months after they were broken… There had been no water machine on the ward for several months after it was broken. Patients had to ask staff for drinks."*
>
> **Children and young people's mental health inpatient service, August 2022**

> *"Besides the education room, there was no evidence of any other therapeutic activities on the ward. The patient activities cupboard was locked. The sensory room was unlocked and could be freely accessed by patients, however it was noticeably minimalist with limited sensorial decoration."*
>
> **Low secure mental health ward for female patients up to the age of 18, January 2023**

Detention under the Mental Health Act 1983 provides children and young people with a number of important safeguards, such as the right to appeal against detention. The 2007 amendments to the Act resulted in greater protections for the rights of children and young people. These include the duty to ensure an age-appropriate environment. However, staff on non-specialist wards may not be familiar with these safeguards.

Increased risk of restrictive practice

A lack of designated inpatient beds for children and young people has also led to inappropriate ward layouts, as services attempt to accommodate people with differing mental health needs.

From our monitoring activity, we are concerned that this, combined with issues highlighted in the workforce section of this report, are leading to the use of blanket restrictions. We encourage providers to challenge the use of blanket restrictions to ensure that they are not unintentionally restricting people's liberty and therefore at risk of infringing people's human rights. Providers must make sure that any blanket restrictions in place do not conflict with an individual's tailored care plan. We have heard from young people that bathrooms and bedrooms were locked despite being ligature-free:

"The bathrooms within bedrooms were locked even though they were ligature free. Young people were unaware why this was.

Mixed-gender child and adolescent (CAMHS) psychiatric intensive care unit (PICU), December 2022

At another service, we were concerned about a blanket restriction meaning that lights were left on at night for all patients:

"All the children and young people we spoke with told us they had to sleep with the lights on at night. The children stated they were unable to sleep at night and have raised the issue with the staff on several occasions."

Psychiatric intensive care unit (PICU) for children and young people of all genders between the ages of 8 and 18, January 2023

At an eating disorder service, patients told us that staff were 'too rough' when administering the nasogastric feeding tube, which caused them distress:

"Some staff, especially agency staff, were considered by patients as rough when restraining patients for nasogastric (NG) feeding. Patients found the experience of waiting to be NG feed distressing as they knew what was about to happen especially when they were waiting in a group in the lounge and seeing peers being called out to have a feed. They told us that this was made worse by staff wearing gloves as they came into the lounge and staff not waiting to close the lounge door before starting to restrain them to take to the room where the feed was to be administered."

Eating disorder ward for children and young people, July 2022

Our concerns were echoed in a recent report by HSSIB, which found that therapeutic elements on paediatric wards can end up being reduced or removed and restrictive practices having to be implemented to manage situations. This can include secure areas with restricted access and exit, police or security presence and use of restraint and sedations.

Restrictive practices

Restrictive practices

Key points

- In all services, we expect care to be person-centred where staff listen to and try to understand people, including how they communicate their needs, emotions or distress.
- Over the last year, we have seen positive examples of people being involved in their care and supported as individuals. This has helped to keep them safe and reduce unnecessary restraint.
- While we recognise that the use of restraint may be appropriate in limited, legally justified, and ethically sound circumstances, it must be remembered that it can have a significant impact on a person's mental health, physical health, and their emotional wellbeing, and could even amount to a breach of their human rights.
- Services must work to understand the events that led up to any incidents where restrictive practice was used, report on them, learn from them, and actively work to reduce them in future.
- In August 2023, we published our cross-sector policy position on reducing restrictive practice, which clarifies our expectation of providers. We are committed to helping services promote positive cultures that support recovery, engender trust between patients and staff, and protect the rights, safety and wellbeing of all patients and people using services.

Most people know that restraint, seclusion, and segregation are the more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice that easily become day-to-day normal responses to perceived risk or lack of time. This includes, for example, not being able to make hot drinks after a specified time, or denying people access to visitors, friends, or food due to a lack of staff or time.

In all services, we expect care to be person-centred where staff listen to and try to understand people, including how people communicate their needs, emotions or distress. Providers must use this understanding to support adjustments that remove the need to consider the use of any restrictive practice.

We recognise that the use of restrictive practices may be appropriate in limited, legally justified and ethically sound circumstances in line with people's human rights. This means that any restriction must be:

- lawful
- for a legitimate aim
- the least restrictive way of meeting that aim.

However, our expectations are clear: everyone in health and care has a role to play in reducing the use of restrictive practices. In its place, we expect to see regularly reviewed, trauma informed care plans that are tailored to people's specific needs.

In our last report, we highlighted the progress made by some services in reducing the use of restrictive practices and creating therapeutic environments for patients. While we have seen improvements in some areas, overall there is significant work still to be done. For example, we remain concerned about the disproportionate use of force against some groups of people, including:

- people from Black and minority ethnic groups
- autistic people and people with a learning disability.

Our cross-sector policy position on reducing restrictive practice, published in August 2023, clarifies our expectation of providers. Building on our work to encourage providers to reduce their use of restrictive practices and considering best practice in person-centred care, the policy is clear that we expect providers of all registered services, including mental health services to:

- promote positive cultures that support recovery
- engender trust between patients and staff
- protect the rights, safety and wellbeing of all patients and people using services.

We also ask providers in all sectors to record and analyse incidents at board level or equivalent and work to reduce them.

We are embedding our policy position on restrictive practice in our assessment framework for inspecting services. Working with British Institute of Learning Disabilities (BILD) and the Restraint Reduction Network, we have also developed training for CQC staff to improve our reporting where we identify restrictive practices during inspections.

Person-centred care

Over the last year, we have seen examples of services struggling to provide personalised care.

In one example, the family of a patient told us through our complaints service that their relative was restricted from seeing their emotional assistance dog, which was causing them unnecessary distress. We found that staff had not recorded in the patient's treatment plan the therapeutic rationale for withholding visits from the emotional assistance dog. In addition, we found no reference to nationally recognised guidance or best practice to support the decision.

At another service, we saw how the lack of care planning could lead to patients being kept in seclusion for longer than needed:

> *"There was no seclusion care plan for the patient and no clear steps recorded in order to bring seclusion to an end. The record of seclusion did not include the information required as set out in the Code of Practice. This included information about the person responsible for authorising the seclusion, who undertook 2-hourly nursing reviews and details of the patient's presentation at the time, the date and time seclusion ended nor the details of the person who determined this. In the records we reviewed, the recording of seclusion reviews was inconsistent."*
>
> **Psychiatric intensive care unit for men, September 2022**

However, we are pleased to have also seen positive examples of people being supported as individuals, which has helped to keep them safe and reduce unnecessary restraint. For example, at one service, we observed how staff providing person-centred care to patients in long-term segregation helped them to progress:

> *"The patients in long-term segregation had complex needs and the staff showed commitment to individualised person-centred care. While patients remained restricted, most had progressed on this ward compared to their previous places of detention. Progress for long-term segregation patients could take time and we heard about a positive example of one patient who we observed in the quiet area listening to music. He had previously been in holds throughout his time out of long-term segregation and then in a zoned area of one room. He was making progress that appeared to be small steps but, for him, were huge achievements aided by staff."*
>
> **Increased support and treatment ward for men, January 2023**

At another service, the care plans we read showed evidence of patients' involvement and that people were aware of their rights under the MHA. The hospital's booklet explained environmental blanket restrictions, contraband items, and the ward's locked door. Staff told us that restrictions were discussed regularly. All patients could use their mobile phones on the ward. Patients who did not have a mobile phone could use the ward's tablet to speak with their families.

"Individualised restrictions were discussed with the patients during ward rounds. Blanket restrictions were reviewed by both patients and staff during weekly patients' forum meetings."

Acute admission ward for women, November 2022

We expect services to have strong safety and learning cultures, focusing on improving expertise, listening and acting on people's experiences to deliver person-centred care, and taking clear and proactive action when safety doesn't improve.

Use of restrictive practices

As noted at the start of this chapter, in limited, legally justified, and ethically sound circumstances, for example where there is no other option but to restrain a person to avoid harm to themselves or others, the use of restraint may be appropriate.

But restraint must:

- never be used to cause pain, suffering, humiliation or as a punishment
- only be used to prevent serious harm
- be the least restrictive option, applied for the shortest possible time
- only be carried out with the correct authorisations beforehand.

We have heard of examples of restraint being used appropriately in this way. For example, during our interviews with people with lived experience, Kevin told us about seeing his daughter restrained:

"Before they restrained her, they told me that it may be distressing to watch, and they offered for me to move away but I decided to stay nearby and watch it. I wanted to witness it so I could see for myself what happened. It was distressing to see it, especially as my daughter is only small and (the staff) were big. But I was really impressed with how they did it. The staff were extremely professional during the restraint. I couldn't have asked for them to handle it any better than they did..."

Interview with person with lived experience

In our interview with Andrew, he shared his experience of being restrained while detained:

> *"I was physically restrained a few times and held down until I calmed down, but they never hurt me. I've never really looked into what they are allowed to do, but it felt appropriate at the time and if I was in their shoes, it's exactly what I would do."*
>
> **Interview with person with lived experience**

While these are positive examples, it must be remembered that the use of restrictive practices can have a significant impact on a person's mental health, physical health, and their emotional wellbeing. Use of restrictive practices could even amount to a breach of their human rights. Services must work to understand the events that led up to any incidents where restrictive practice was used, report on them, learn from them, and actively work to reduce them in future.

We expect services to take a proactive and preventative approach to stop situations reaching crisis point. If aggression occurs despite this, de-escalation techniques can help staff to respond in line with the least restrictive principle. Every patient's situation is different, and the detail of the de-escalation will depend on their needs, the environment and what has to be done to keep everyone involved safe. Person-centred planning and support can promote quicker de-escalation and reduce unnecessary restraint. Providers must have effective processes to call on and use staff with specialist skills in a timely way if a person reaches crisis.

Research published by the National Institute for Health and Care Research highlights the importance of therapeutic relationships in successful de-escalation. It states, "the fears and anxieties of both patients and staff are a key barrier to successful use of de-escalation… stronger therapeutic relationships between patients and staff could make a difference."

The Mental Health Units Use of Force Act 2018 aims to reduce the use of force and ensure accountability and transparency about the use of force in mental health services. Services are required to have a policy, co-produced with patients, that commits to reducing the use of force. Guidance for the Act also includes requirements over training, recording and reporting the use of force, and requires services to identify a Responsible person, who is accountable for implementing the Act.

At one service, our reviewer raised concerns that some people hadn't received any information about the Act, but other wards in the same trust have readily available information. It is essential that information for patients about the use of force is available across all wards.

Policies and governance

It is vital that staff understand policies relating to restrictive practice. Through our monitoring visits we have seen variation in how well staff knew and understood policies around restrictive practice.

Approved leave and access to fresh air are important for people's recovery, and decisions around people's ability to take leave should be based on risk. However, at one service we saw evidence of leave being used as a reward or punishment which, the MHA Code of Practice states as being completely unacceptable:

"The way the care plan and contract were presented indicated that section 17 leave was being used as a reward or punishment."

Ward providing treatment and rehabilitation to male patients who have complex needs relating to mental illness, acquired brain injury or progressive neurological conditions, January 2023.

Another ward had applied strict blanket policies around patients' access to fresh air and we saw evidence of staff failing to be flexible in how they applied the policy. Blanket policies are applied to everyone regardless of their individual needs and are contrary to person-centred trauma informed care. The MHA Code of Practice is clear that blanket restrictions should be avoided and should never be for the convenience of the provider. Any blanket restrictions should be:

- agreed by hospital managers
- documented with the reasons for such restrictions clearly described
- subject to the organisation's governance procedures.

"Staff applied a blanket approach to all patients who wished to access fresh air …. There was a list of prescriptive times displayed in the office. We observed a patient requesting time off the ward for fresh air. Ward staff informed the patient they had missed the prescribed time for fresh air and would have to wait approximately 2 hours. The patient was becoming visibly agitated. The qualified nurse granted immediate time off the ward. We are concerned ward staff did not exercise flexibility without the nursing staff intervening."

Acute admissions ward for male patients, February 2023

Limiting fresh air time is unacceptable, and we instructed the service to ensure it was included as part of people's individual care plans.

Mental Capacity Act and Deprivation of Liberty Safeguards

We are concerned that poor understanding of the Mental Capacity Act (MCA) and issues with the management of Deprivation of Liberty Safeguards (DoLS) are contributing to the over-use of restrictive practices.

As highlighted in our 2022/23 State of Care report, we continue to see a variable understanding of the interface between the MCA, which DoLS are part of, and the Mental Health Act (MHA). Where both frameworks could be used, it is not always clear how staff decided that using the DoLS framework would be most appropriate for a particular patient.

We have observed some providers not delivering adequate training on DoLS, resulting in a lack of understanding among staff. This could lead to them applying restrictions without considering whether less restrictive options are available in line with the MCA. We have also seen that some people are being discharged from detention under the MHA because other options such as DoLS are considered to be more appropriate. However, this leads to some people being 'de facto detained', as delays in DoLS assessments mean they are deprived of their liberty for longer than they need to be or without the appropriate authorisation in place. We continue to encourage the government to bring forward the much anticipated Liberty Protection Safeguards reforms.

Social and physical environment

We have seen how unsuitable physical environments increase the risk of restrictive practice. For example, on one ward we visited, access to fresh air and other therapeutic facilities were all off-ward, meaning patients could not access them unless staff were available to supervise:

"Access to the 2 ward gardens was down several flights of stairs and patients could not access the gardens without staff supervision. There was no other access to fresh air on the ward. The arts and crafts room, education room in which the computers were located, occupational therapy kitchen and multi-faith room were all off-ward and patients could not access them unsupervised. These limitations amounted to blanket restrictions."

Low secure mental health service for Deaf/deaf men, January 2023

At another service, the seclusion room did not have en-suite bathroom facilities, which we were concerned could have a negative effect on people in seclusion:

> *"The seclusion room had the toilet, shower and sink within the seclusion room and not in en-suite arrangement. This meant that young people using these facilities would have to sleep, eat and be in the same room as a toilet, which may compromise their dignity and have a negative effect on their experience of seclusion."*
>
> **Acute ward for female patients of adult age, January 2023**

Bathroom facilities, including those for patients in seclusion, must protect people's human rights, especially by ensuring privacy and dignity. They must also be planned and designed with a person's individual needs in mind. It is not acceptable to have a toilet in the main area of a seclusion room. Any requirements around maintaining safety should be assessed to ensure that they have the least impact on privacy possible and should be regularly reviewed.

We require any service in a new building to have these facilities to be able to register with us and we also expect, where possible, any refurbishment of seclusion facilities to create en-suite facilities.

It is disappointing that we continue to see the use of dormitories in mental health settings. We know that patients and carers have an overwhelmingly negative opinion of shared sleeping arrangements. As we raised in our last MHA report, on wards where dormitories are still in use, some patients have raised specific concerns with us about safety and privacy. We are clear that dormitory accommodation is unacceptable, and we welcome the government's plans to invest over £400 million to eradicate dormitories. So far, over 600 beds have been replaced across 34 sites and we urge the government to continue to prioritise the eradication of all mental health dormitories.

We have seen how people's experience can improve when providers adapt service environments to meet their individual needs. For example, at one service, we found the new long-term seclusion suite had its own secure garden and bathroom arrangements that were both safe and dignified:

> *"The long-term seclusion suite…[which] had been purpose built since our last visit, was a much lighter and airier environment and was much more resilient to damage. The suite had appropriate observation arrangements for using the bathroom whilst respecting the patient's privacy and dignity as this was done by means of an infra-red camera. The suite had separate bedroom and lounge areas. Anti-rip bedding and clothing was available where needed. The suite had its own secure garden with a bench for the patient to sit on when they wanted. We observed warm, kind and respectful interactions between staff and the patient in the long-term segregation suite."*
>
> **Folkestone, Tonbridge, Poplar, Maidstone and Rochester wards (wards for autistic people and people with a learning disability), Cedar House, Coveberry Limited, December 2022**

At another service, we noted a number of quiet spaces for patients to use:

> *"Staff and patients had designed a quiet sensory space with self-soothing tools such as a blackboard wall. Patients had included inspirational recovery messages."*
>
> **Bridford ward for women (acute ward), Glenbourne Unit, Livewell Southwest, August 2022**

We found other positive examples, including an acute unit that had safely introduced an open-door policy. We support services in making policies as least restrictive as possible, assessing the level of risk on an individual basis, as the following shows:

"Both the ward entrance door and the door of the main hospital building were kept unlocked. We were told that the open-door policy did not increase the risk of detained patients going absent without leave. At least one staff member was always present in the communal lounge area which was situated near the door. Patients were encouraged to write on a whiteboard when they were leaving the ward, including a brief note on their destination and expected time of return. Patients were supported to maintain contact with friends and relatives, and several patients had regular visitors. Patients could access their own internet enabled mobile phones on the unit. The patients' kitchen was open 24 hours a day."

Abbey Ward (mixed gender acute admissions ward for adults of working age), Wotton Lawn Hospital, Gloucestershire Health and Care NHS Foundation Trust, December 2022

Closed cultures

Closed cultures

Key points

- Through our monitoring activity this year, we have seen that more people, including staff, are now aware of the factors that can lead to a closed culture developing.
- We have seen positive examples of good practice where patients have been involved in decisions around their care and treatment, highlighting the benefits of an open and inclusive culture.
- However, we are still concerned that too many abusive and closed cultures persist. Many of the concerns raised in this report, for example around consistent staff shortages and lack of training and supervision of staff, are inherent risk factors and potential warning signs of when closed cultures could be developing.
- While it is positive to see awareness of the risk factors of closed cultures we, along with providers and staff, need to continue to be vigilant to the inherent risks and warning signs to ensure people are not being put at risk of deliberate or unintentional harm.

We define a closed culture as "a poor culture that can lead to harm, including human rights breaches such as abuse". In services where there is a closed culture, people are more likely to be at risk of deliberate or unintentional harm. As a regulator and a member of the UK National Preventive Mechanism, we have a duty to act when we believe that people are at risk of ill treatment, so their human rights may not protected.

The likelihood that a service might develop a 'closed culture' is higher if an inherent risk factor is present. Certain features of services will increase the potential for inherent risks. For example:

- services where people are unable to leave of their own accord
- live-in services such as shared lives or supported living services
- any service where one-to-one care is provided
- where a provider changes the type of service it offers in response to market or other influences.

While closed cultures can develop in any type of health and care setting, we are particularly aware of the increased risk in services that care for people with a mental health condition, autistic people and people with a learning disability.

In 2021, we published guidance on how we identify and respond to closed cultures. This guidance highlights the impact of closed cultures on people's human rights and raises awareness of the signs we look for that may suggest

a service is at risk of developing, or has developed, a closed culture. The guidance recognises that where there is a risk of a closed culture, we may carry out an unannounced inspection or inspect out of hours. This is separate to our monitoring visits.

Through our monitoring activity this year, we have seen that people, including staff, are aware of the drivers that can lead to a closed culture developing. This wider awareness has led to concerns being raised with us directly through complaints and staff speaking up, allowing us to act quickly and ensure issues are appropriately escalated.

However, as we reported last year, we are still concerned that too many abusive and closed cultures persist. Many of the concerns raised in this report, for example, are inherent risk factors and potential warning signs of when closed cultures could be developing.

In this section, we look at some of the issues raised in this report in relation to the inherent risk factors and warning signs we identified in our guidance on closed cultures. We summarise our findings under the 4 indicators of closed cultures identified in our guidance:

- people may experience poor care, including unlawful restrictions
- poor skills, training and supervision of staff providing care
- weak leadership and management
- lack of external oversight.

We also highlight some of the good practice we have seen through our monitoring activity that help to prevent this from happening.

While it is positive to see awareness of the risk factors of closed cultures we, along with providers and staff, need to continue to be vigilant to the inherent risks and warning signs to ensure people are not being put at risk of deliberate or unintentional harm.

Patient experience

Empowerment and involvement is a guiding principle of the MHA Code of Practice, and states clearly that patients should be fully involved in decisions about care, support and treatment.

As outlined in our guidance on closed cultures, where this is not happening and care plans are not being individualised or do not reflect the person’s voice, this could be a warning sign that closed cultures may be developing.

Through our monitoring activity, we are pleased to see many positive examples of good practice where patients have been involved in decisions around their care and treatment, highlighting the benefits of an open and inclusive culture:

> *"The feedback we received from patients was overwhelmingly positive. All patients felt staff were incredibly kind, helpful and supportive. One patient told us that being on Ladden Brook and the 'incredible' support he had received from the staff team had 'saved his life'. All patients we spoke with told us that the responsible clinician was very nice and that they felt he listened to them and involved them in decisions about their medication and treatment. Patients told us they were involved in their care plans and that they had been offered copies."*
>
> **Fromeside Ladden Brook (medium secure rehabilitation ward for men), Avon and Wiltshire, April 2022**

> *"All care plans we read showed patients' involvement. Staff documented the level of engagement the patient had in writing their care plan, mental capacity concerns, whether the patient agreed or disagreed with the content of their care plan and if the patient signed their care plan. All care plans we read were frequently reviewed by staff and the patient. Staff documented whether the patient accepted or declined a copy of their care plan."*
>
> **Silverstone ward (specialist dialectic behavioural therapy rehabilitation ward), St Andrew's Hospital, January 2023**

Carers also play a key role in ensuring that the patient voice is listened to and in reducing the likelihood of closed cultures developing. At one service, a carer told us they were grateful that staff sought their views on communicating with their autistic relative:

> *"The carer said it was also the only ward to have taken notice of their experience as a carer, to have sought their insight and to have used that information to best communicate with the patient."*
>
> **Mixed-gender acute ward for adults of working age, February 2023**

However, we continue to see evidence of people not being involved in their care. As an example, we received a complaint that the specific needs of a deaf person with a learning disability were not adequately addressed. Neither the patient nor their family were given information about rights and the family members were excluded from care and treatment decisions.

This complaint is also a potential warning sign that the service is not safeguarding people against discrimination, harm or abuse. This is just one of multiple examples where providers have not enabled inclusive and respectful cultures. Other examples, as highlighted in our section on inequalities include:

- incidents of patients making racially abusive comments to other patients
- services not respecting patients' choice of pronoun
- providers not considering inclusive ways of communicating with people with protected characteristics as defined by the Equality Act 2010.

Hospital managers have a duty to ensure that patients who are detained under the MHA are aware of their rights, such as in relation to complaints, appeals, advocacy, legal advice, safeguarding and the role of CQC. Some patients find it difficult to understand their rights, especially when they are very unwell. We expect services to provide information to patients, and their families, in a format that is appropriate for the individual person to help them understand. This should happen as soon as possible after detention and then regularly throughout their period of detention. Our monitoring visits have enabled us to see evidence of patients being told about their rights, and in some cases, we have seen good examples of providers ensuring that patients are informed of more detailed information, such as policies on mobile phone use.

However, we have also seen examples of patients not being told their rights or not understanding them. We interviewed people with lived experience and asked them whether they knew about their right to a tribunal and whether they knew which section of the MHA they, or their loved one, were detained under. Some of the people we asked could not recall being told about tribunals or what section the detention was under. Where patients are given no or poor information about their rights, this could be a warning sign of closed cultures developing.

Staffing

Many of our concerns around closed cultures are linked to issues with staffing. High turnover of staff, consistent staff shortages and lack of training and supervision of staff are all inherent risk factors for services developing a closed culture. In our section on workforce, we highlight multiple examples of services operating with lower than recommended staff levels, and examples of staff, in many cases agency staff, not being given the training they need to be able to care for people in detention.

We have also seen examples where staffing shortages are leading to the inappropriate use of restrictive practices, including the use of blanket restrictions. For example, in our section on workforce we highlight that patients in multiple services told us about times when they were not able to access fresh air because there were not enough staff available to escort them or planned leave was cancelled. We have also seen evidence of strict blanket policies around access to fresh air.

The MHA Code of Practice is clear that access to fresh air and leave is important for people's recovery, and that decisions around people's ability to take leave should be based on risk. However, at one service we saw evidence

of leave being used as a reward or punishment. Not only is this completely unacceptable and dehumanising, it is also a potential warning sign that the service could be developing a closed culture.

Positively, we have seen examples of services taking steps to mitigate against these risks. This includes, for example, reducing the use of blanket restrictions and encouraging patients to move around service environments freely. In our section on restrictive practices, we highlight the example of an acute unit that had safely introduced an open-door policy.

Leadership and management

As highlighted in our 2020/21 State of Care report, problems with oversight of leadership and management are a common theme in services with a closed culture. As well as playing a key role in setting the culture of an organisation, managers are responsible for ensuring that services are fit for purpose.

As we highlight through this report, this year we have continued to raise our concerns about the condition and suitability of the physical environment that people are living in. This includes, for example, wards with broken equipment, lack of en-suite facilities in seclusion rooms, and the increased risk of restrictive practice due to unsuitable physical environments. Not adequately addressing concerns around the physical environment could be a warning sign that a closed culture could be developing.

We have seen some good examples where services have been alert to this risk and have taken steps to address it. For example, in our section on restrictive practice we highlight the example of a new long-term seclusion suite that had its own secure garden and bathroom arrangements that were both safe and dignified.

Where things aren't working well, we would expect that managers would engage and respond well to recommendations from external agencies. This may include, for example, making changes to the physical environment in response to a MHA monitoring visit.

External oversight

Warning signs that a closed culture could develop include where there is a lack of monitoring by, or limited interaction with, outside agencies. The outbreak of the COVID-19 pandemic, and the restrictions introduced in response to this, increased the risk of closed cultures developing as it prevented external bodies, such as reviewers, and friends and family from visiting.

While these restrictions have not been in place for a long time, we continue to see the legacy of COVID-19 in restrictions around cleanliness and reduced visiting. However, we have also seen examples of NHS mental health trusts demonstrating open and inclusive cultures. For example, at one trust we visited there was continual external oversight from the independent mental health advocates (IMHAs) who were based at the hospital:

> *"There were two IMHAs who shared the role, so there was always cover. They were based at the hospital, so could meet with patients very readily. The IMHA said they always attend the community meeting on a Monday. The IMHA said that they would welcome more engagement from the consultant psychiatrist."*
>
> **Acute ward for men, October 2022**

As well as formal regulation, such as our monitoring visits, visits from family, friends and independent mental health advocates (IMHAs) all play an important role in providing external scrutiny and preventing closed cultures from developing.

However, we remain concerned about patients, particularly autistic people, people with a learning disability and children and young people, being placed in hospitals far from family and carers for prolonged periods. Being placed far from home can make it more difficult for families and carers to be involved in their relatives' care and in turn increase the risk of closed cultures developing.

We know that more needs to be done to understand whether the culture in mental health services is safe and caring. We are committed to improving how we can be better at understanding the culture of a service, and how we identify potential risks or actual harm, neglect, discrimination, abuse, inequalities and human rights infringements in care provision.

We will spend more time on site so we can focus on behaviours, attitudes, working practices and environments during our assessments of inpatient mental health settings. This will enable us to observe activity and interactions over extended periods of time and it will provide us with the opportunity to talk for longer to more people, their friends and family and to members of staff. Our focused approach has been co-produced with people with lived experience, and covers themes such as:

- respectful and compassionate communication
- positive, supportive and kind ward cultures
- providing access to support
- safe, caring and therapeutic environments
- positive relationships with families and carers
- promoting the principle of least restrictive practice

If people are at risk of or experiencing unsafe care, inequitable or disrespectful treatment or if the standard of their care falls below that which we would

expect, we will take action to protect them. We want our strengthened approach to also positively influence providers to identify warning signals of unsafe and uncaring cultures on their own wards and to make the necessary improvements.

As part of our commitment to tackling closed cultures, we are looking at how we can incorporate this into our monitoring of the MHA and strengthen our assessments of a service's culture and understanding of the experiences of detained patients.

Our activity

Our activity

MHA reviewer visits

In 2022/23, we carried out 860 MHA monitoring visits. We spoke with 4,515 patients (3,410 in private interviews and 1,105 in more informal situations) and 1,200 carers. We also spoke with advocates and ward staff.

Second opinion appointed doctor service

In 2022/23, we received 15,370 requests for a second opinion appointed doctor (SOAD) – this is a fall of 6% since 2017/18.

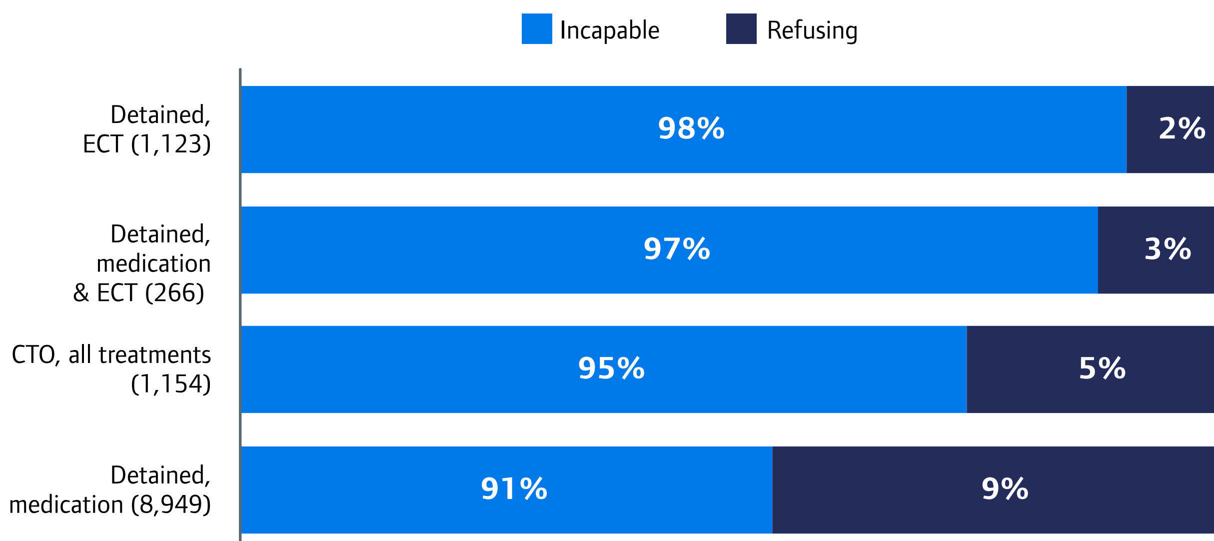
Of the 15,370 requests received:

- 1 in 4 were subsequently cancelled (25%; 3,878)
- 91% were for patients detained in hospital under the MHA.

The number of (uncancelled) requests has fallen by 19% since 2020/21. The proportion of cancelled requests has been increasing year-on-year (28% increase on 2021/22), with a dip in 2020/21. Requests are most frequently cancelled because the patient has been discharged or transferred.

Most requests were made for patients recorded as having no capacity to consent to treatment (92%; 10,575). Requests for electroconvulsive therapy (ECT) plans were almost all for patients deemed incapable of consenting (98%; 1,100).

Figure 4: **Reason for requesting a SOAD visit**

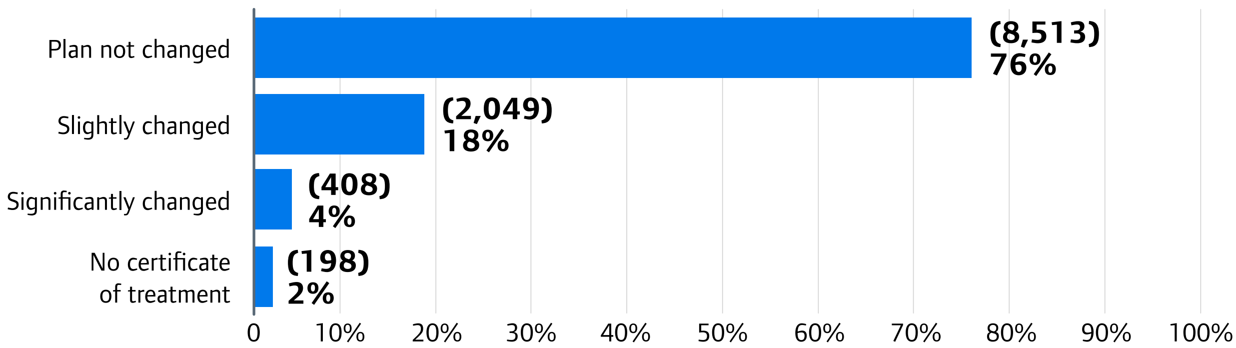


Source: CQC

Nearly 3 in 4 of the requests had a decision made (73%; 11,168), and 2% remained open without a decision (324).

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. In many cases (3 in 4), the second opinions resulted in no change to the treatment plan (76%; 8,513).

Figure 5: **Outcome of SOAD Visit**

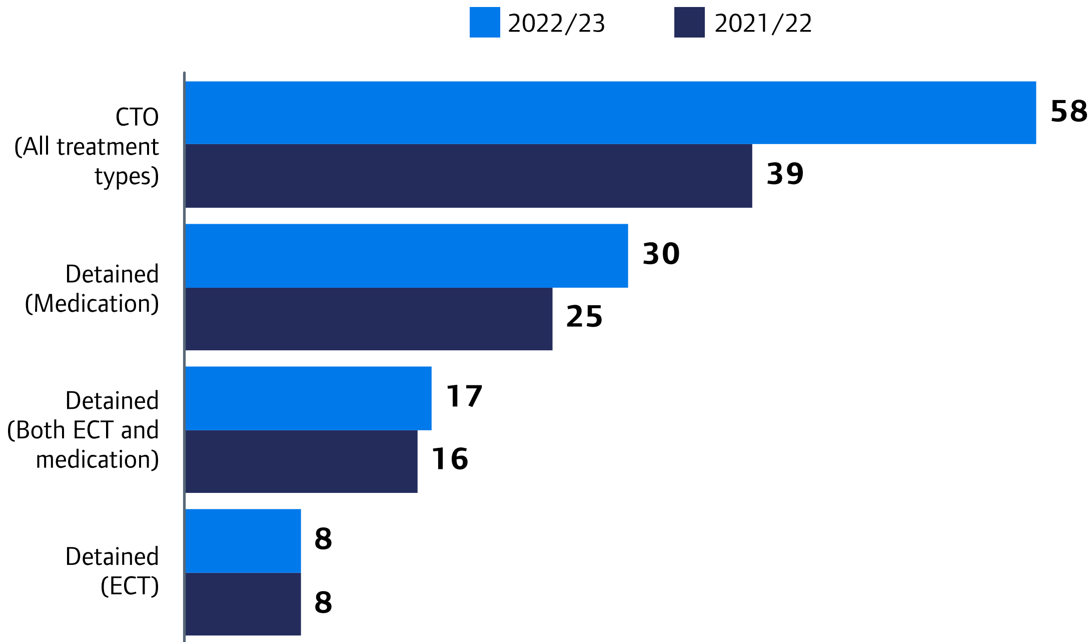


Source: CQC

The time between receiving a request and the appointed SOAD starting their second opinion took longer during 2022/23 compared with 2021/22, with a 22% increase in waiting times (28 days in 2022/23, compared with 23 in 2021/22). This was especially true for patients on a CTO, which saw a 49% increase (58 days in 2022/23 compared with 39 in 2021/22).

The term 'visit' includes those that have taken place online and in person, as the way in which visits are recorded doesn't allow us to differentiate between the two.

Figure 6: **Average number of days to SOAD starting second opinion**



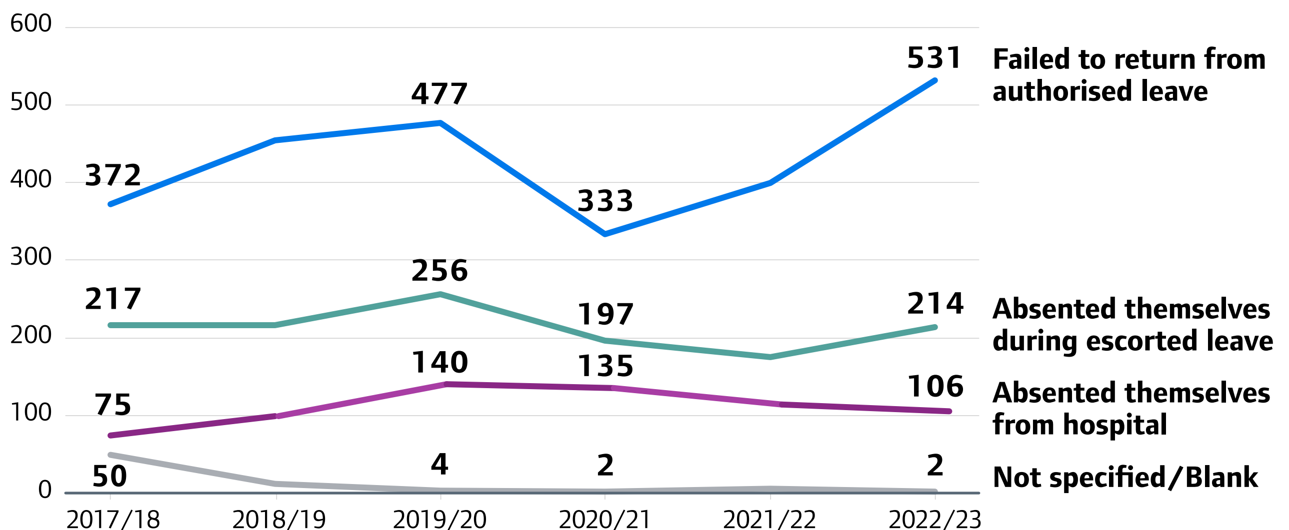
Source: CQC

Absence without leave (AWOL) data

In 2022/23, we were notified of 853 incidents of a detained patient being absent without leave. There were 694 notifications in 2021/22.

The number of AWOL notifications decreased during COVID but have now increased to pre-pandemic levels. The proportions for the reasons for absence have been fairly stable throughout the period, with 'failed to return from authorised leave' being the main reason.

Figure 7: **Reason for AWOL notifications, 2017/18 to 2022/23**



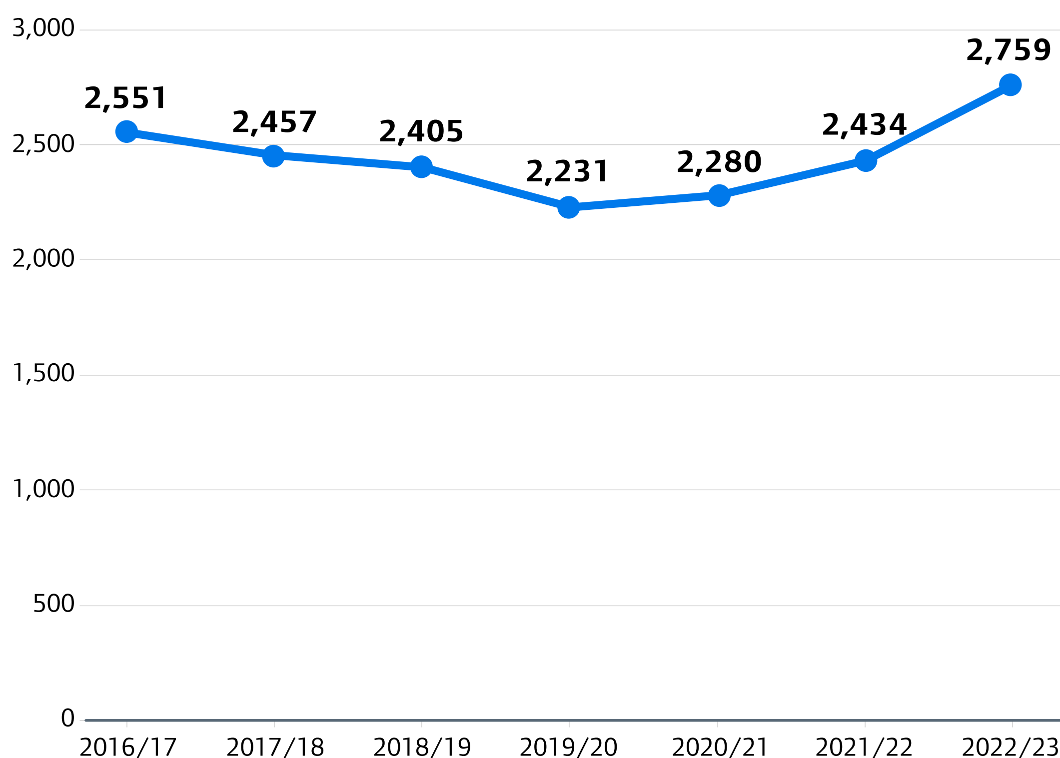
Source: CQC
Note: The total each year included patients who were AWOL on more than 1 occasion.

Of the of 853 incidents of a detained patient being absent without leave, 822 notifications recorded the patient's gender. Of these, 83% were for males. Detention rates during 2022/23 showed a slightly higher rate for males than females, (83.7 per 100,000 population compared to 82.9 per 100,000 population).

Complaints data

In 2022/23, we received 2,759 cases through our MHA complaints system. This was a 13% rise on 2021/22, and an 8% rise compared with 2016/17.

Figure 8: **Complaints cases received 2016/17 to 2022/23**



Source: CQC

The majority of complaints were made by telephone (94%).

By region, London had the highest number of cases per location, at 4.60. This was a 30% increase on 2021/22.

All regions have received a higher average number of complaints about the way the MHA was applied, per registered location.

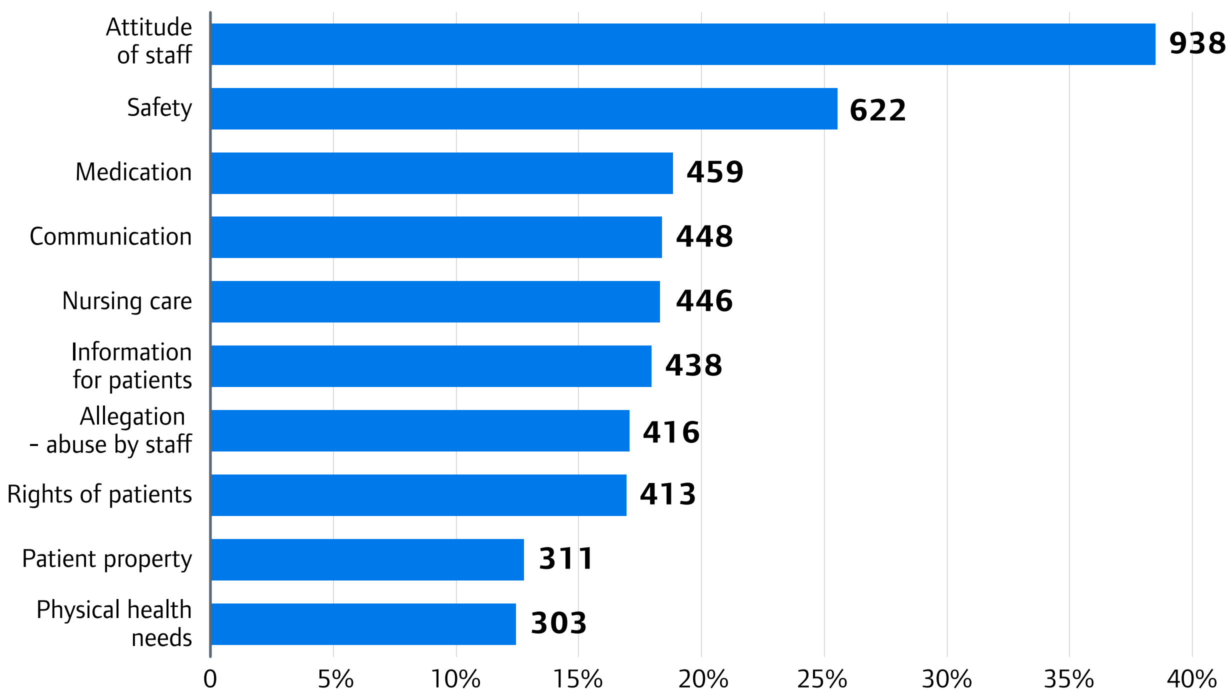
Figure 9: **Average number of complaints by region, 2021/22 to 2022/23**

Region	% change in average number of complaints per location	Average number of complaints per location
London	30%	4.60
South West	29%	2.21
North East	26%	3.38
North West	25%	2.90
East Midlands	16%	3.74
South East	15%	2.41
East of England	8%	2.28
West Midlands	5%	1.76
Yorkshire and The Humber	3%	2.39

Source: CQC

The largest proportion of complaints (38%) related to the attitude of staff. Safety was the second most common category, relating to 26% of complaints.

Figure 10: **Types of complaints received, 2021/22 to 2022/23**



Source: CQC

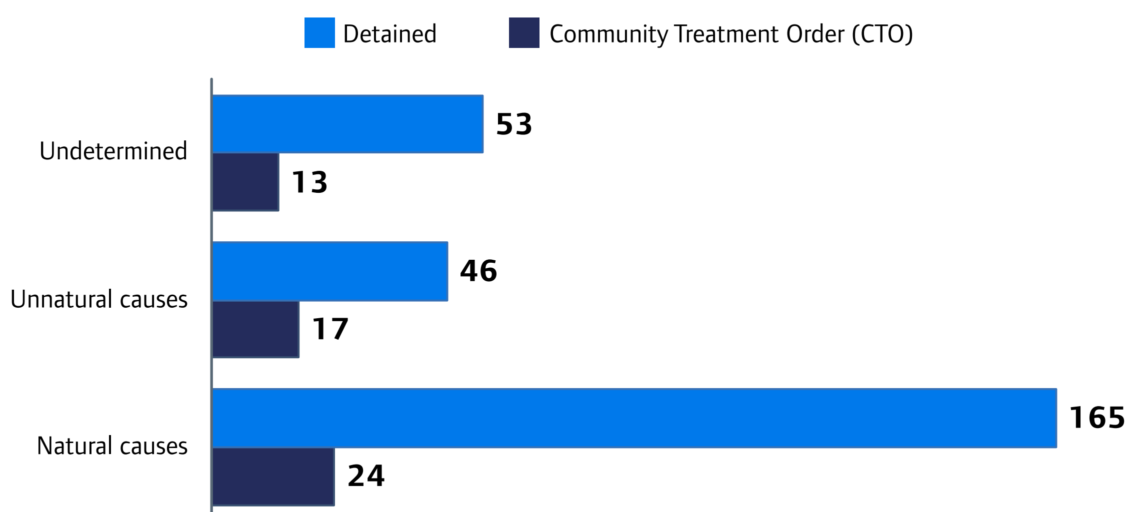
Notifications of deaths of detained patients and patients on a community treatment order

During 2022/23, we were notified of 318 deaths (264 detained patients and 54 patients on a CTO). It should be noted that the reporting of CTO deaths is not compulsory, and for this reason, figures may be underestimated.

Of the 318 deaths:

- 189 were from natural causes (that is, a result of old age or a disease, which can be expected or unexpected)
- 63 were due to unnatural causes (a death as a result of an intentional (that is, harm to self or by another individual) or unintentional (an accident) cause
- 66 deaths are currently still undetermined (the cause of death has not yet been determined by a coroner or CQC does not hold information on cause of death).

Figure 11: **Deaths of detained patients and patients on community treatment orders, 2022/23**



Source: CQC

Of the 189 deaths from natural causes notified to CQC, 129 (68%) were premature (people aged 74 years and under), with the remaining 60 (32%) in people aged 75 and older.

People who have a severe mental illness (defined as psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired) have a greater risk of poor physical health and have a greater risk of dying prematurely compared with the general population. Research shows that mental health services need to look beyond the severe mental health illness and consider the patient's physical health.

Looking at the data on deaths in detention and for patients on a CTO, we found the prominent cause of natural death was from pneumonia (37 deaths). Contextual data informs us that those with severe mental illness (SMI) are at higher risk of dying of respiratory disease.

It should be noted that the data refers to the underlying cause of death and therefore this does not account for co-morbidities or contributing illnesses. Most unnatural causes of deaths were due to hanging or self-strangulation/ suffocation (53%).

A higher proportion (64%) of people who died in detention were male. Detention rates during 2022/23 were slightly higher for males than females (83.7 per 100,000 population compared to 82.9 per 100,000 population).

In 2022/23, there were 6 young people (aged 18 to 20) who died while being detained under the MHA (2% of deaths). Four of the deaths were unnatural, one natural and one is currently still undetermined.

Appendix A: First Tier Tribunal data

The First-Tier Tribunal (Mental Health) has provided its activity and outcome statistics for the year 2022/23.

Comparing figures for 'total discharge by Tribunal' against 'no discharge', it shows that success rates for appeals remain similar to previous years' levels. The Tribunal discharges patients in about 10% of its decisions relating to detention overall. Around 25% of appeals by restricted patients 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 compared with unrestricted patients.

Figure 12: **Outcomes of applications against detention to the first-tier Tribunal (Mental Health) 2022/2023**

		Section 2	Other unrestricted	Restricted	All detained patients
Activity of Mental Health Tribunal	Applications	9,621	15,168	3,132	27,921
	Withdrawn applications	1,043	3,690	1,055	5,788
	Discharges by clinician prior to hearing	3,481	5,523	5	9,009
	Cleared at Hearing [a,b,]	7,009	11,443	2,408	20,860
	Heard [c]	6,466	8,317	2,412	17,195
Decision of Mental Health Tribunal	Absolute Discharge	379	317	77	773
	Delayed Discharge	182	135	0	317
	Conditional Discharge	0	0	350	350
	Deferred Conditional Discharge	0	0	71	71
	Total discharge by Tribunal	561	452	498	1,511
	No Discharge	4,716	8,484	1,398	14,598

a. The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial yea .
b. Mental Health Tribunal is 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

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 with the 'other unrestricted' detained group, which may be the most appropriate comparison.

Figure 13: **Applications against CTOs to the First-Tier Tribunal (Mental Health), 2022/23**

Applications	4,323
Withdrawn applications	866
Hearings	4,276
Oral Hearings[a]	3,687
Paper Reviews (considered on papers and therefore patient not present)	589
Discharges by Tribunal	135
No discharge by Tribunal	3,255

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

Source: HM Courts and Tribunal Service

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 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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The Care Quality Commission is a member of the UK's National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.

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