Care Quality Commission

Patient-centred care

This is the 2021/22 edition of Monitoring the Mental Health Act

Go to the latest Monitoring the Mental Health Act.

Key points:

- We have found some good practice around advance planning for future care. However, we have ongoing concerns about how well people are involved in their care planning process and about the quality of care plans.
- In line with the cultural shift called for by the independent review of the MHA, we have seen some very good practice of services supporting patients to have a voice in the running of services.
- Some carers have continued to tell us about a lack of involvement in their relative's care, including difficulty in contacting wards or arranging visits. However, we have also heard of some good practice examples of services involving carers in their relative's care and treatment.

- While we welcome proposals in the draft Mental Health Bill to improve the availability and flexibility of Independent Mental Health Act Advocates (IMHAs), we are concerned patients are not being given enough advocacy support.
- Despite the pressures on many services, they have put a sustained focus on challenging blanket restrictions.
- Services that focus on maintaining therapeutic relationships have reported a reduction in the use of restraint. Services should continue to implement the Use of Force Act and review their policies and procedures in line with it.

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

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

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

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

> Staff encouraged patients to complete advanced statements about their preferences for care and treatment in the future. Most patients had chosen not to.
>
> **High dependency unit and complex care units for men and women**, June 2021

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

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

> Patients told us that staff involved them in decisions about their care. They said that their key nurses review their care plans with them every 4 weeks. There was evidence of patients' views and how they had been considered in care plans and the minutes of individual patient reviews. Patients told us that doctors explained their medication to them and why they needed to take it. One patient in particular felt that her consultant had given her choice and control over decisions regarding which medication to take, which had made a real difference to her recovery.
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> **Jordan and Kenly Wards (women's low secure), Chadwick Lodge, Elysium Healthcare No 2 Limited**, August 2021

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

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

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

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

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

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

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

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

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

Involving carers

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

Carers told us:

- They were very confident that their relatives were getting good care and treatment.

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

Arbour Lodge, a ward for older men, August 2021

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

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

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

Advocacy

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

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

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

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

The IMHA told me:

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

Acute admission ward for women, April 2021

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

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

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

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

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

The peer support worker told us:

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

- They took patient views to meetings.

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

People we spoke with on our visits were positive about the care and support peer support workers provided, and believed that it supported their recovery. In one service, peer support was offered to patients in long-term segregation across the 3 high security hospitals, and helped patients to engage. However, peer support workers should not, and in law cannot, be a replacement for independent mental health advocacy.

Least restrictive practice

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

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

Medium secure unit for men with personality disorder, May 2021

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

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

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

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

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

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

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

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

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

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