Our regulatory activity in 2023/24

MHA monitoring visits

We carried out 823 MHA monitoring visits and spoke with 4,634 patients (3,343 in private interviews and 1,291 in more informal situations) and 1,435 carers.

Second opinion appointed doctor service

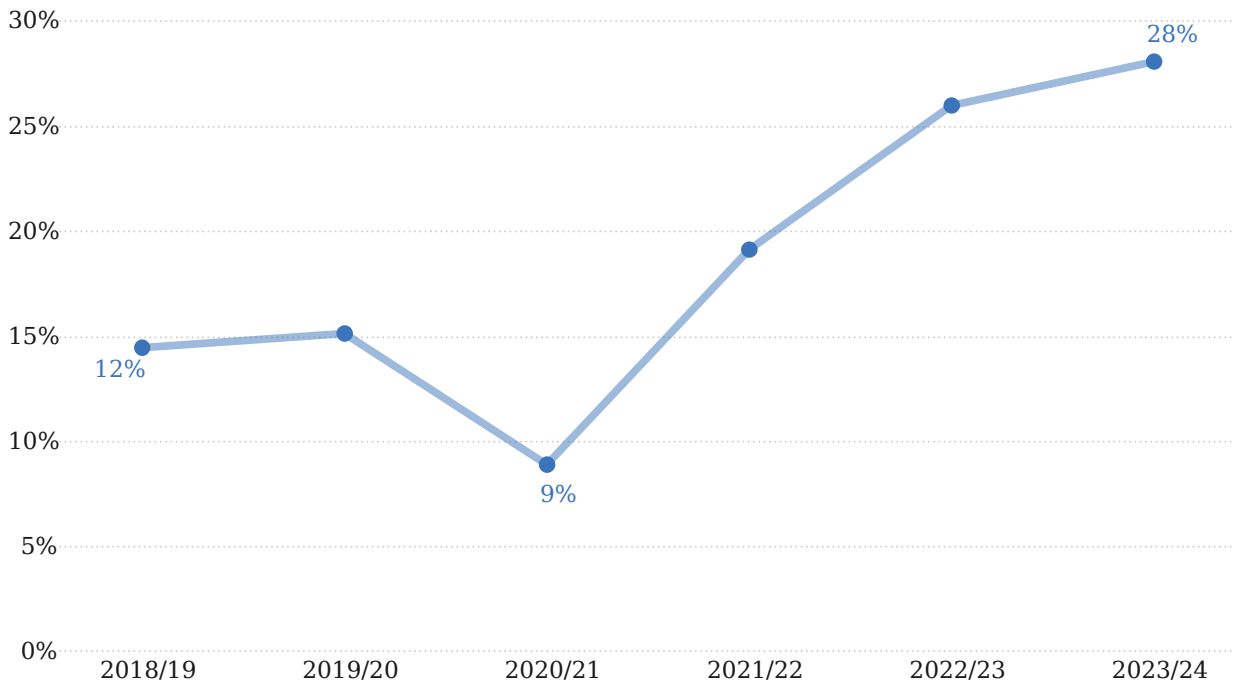
We received 15,698 requests for a second opinion appointed doctor (SOAD), which is similar to volumes received each year since 2020/21. Of the requests, 90% were for patients detained under the MHA.

Just over a quarter of all requests received were subsequently cancelled (28%; 4,402).

The number and proportion of total requests cancelled has generally increased year on year since 2017/18 (except for the dip in 2020/21), although the increase from 2022/23 to 2023/24 was much smaller than previous years (figure 3).

The most common reason for cancellation was due to the patient being discharged, which accounted for over a third of all cancellations (36%).

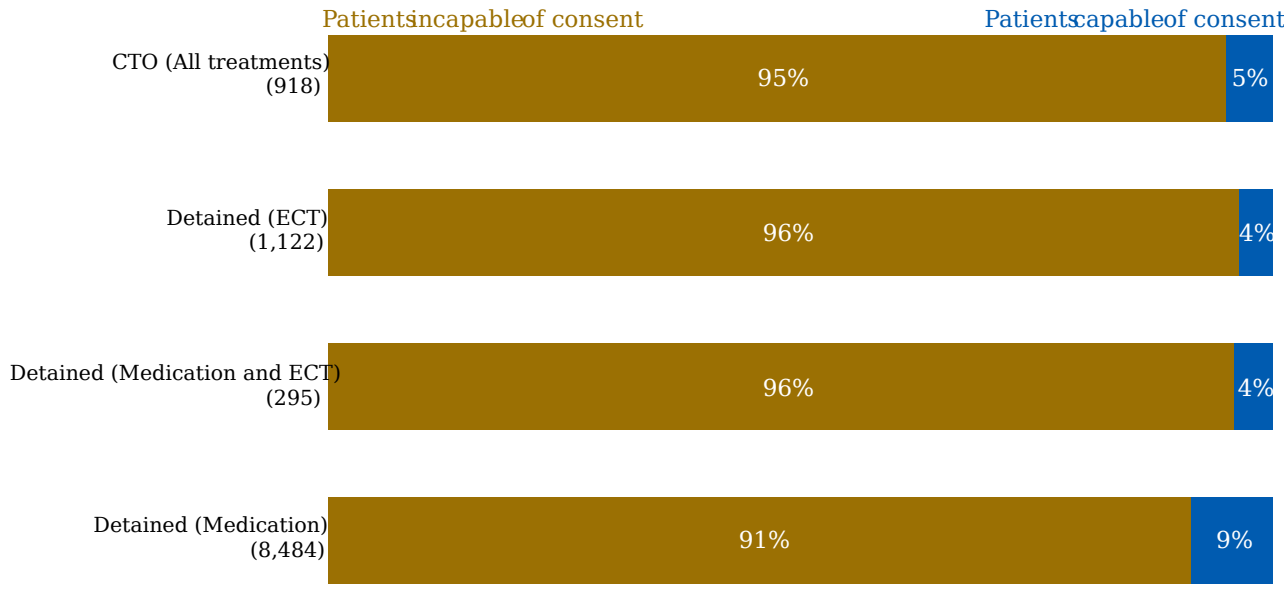
Figure 3: Percentage of total requests cancelled, 2018/19 to 2023/24



Source: CQC

Most requests were made for patients recorded as having no capacity to consent (92%, 9,986). For detained patients on medication, 9% of requests were for patients recorded as being capable of consent and refusing treatment (figure 4).

Figure 4: Patient capacity by treatment type, 2023/24



Source: CQC

Treatment plans are subject to change following review by a SOAD. They 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.

A SOAD can decide not to certify the proposed treatment if, in their view, this is not appropriate. The patient's circumstances may also change before the SOAD has completed their second opinion, meaning their certificate is no longer required, for example if the doctor in charge decides the treatment requiring certification is no longer necessary or the patient is discharged.

In 2023/24, following review of treatment plans by a SOAD:

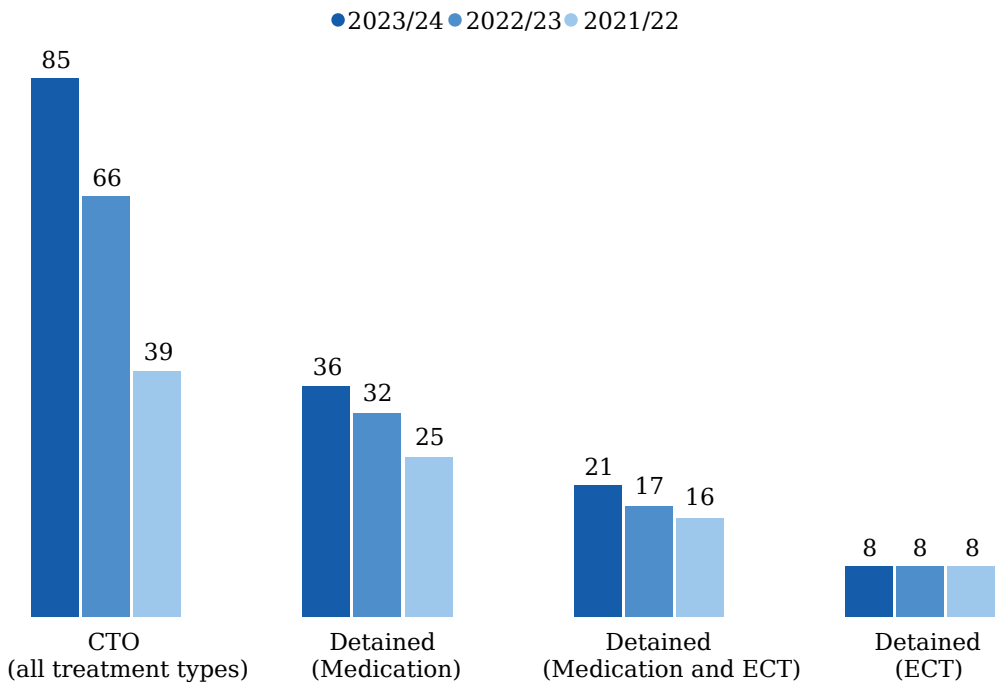
- 77% were not changed
- 18% were slightly changed
- 3% were significantly changed.

Treatment plans were most likely to change for detained patients receiving medication, either alongside ECT or receiving medication only (see the section on the Second Opinion Appointed Doctor service).

The length of time between receiving a request and the appointed SOAD starting their second opinion continued to increase. The average number of days for both patients subject to a community treatment order (CTO) and detained patients in 2023/24 was 37 days, compared with 33 days in 2022/23. The most notable increase was for patients subject to a CTO, which saw an increase of 19% compared with 2022/23 (85 days in 2023/24 compared with 66 in 2022/23) (figure 5).

SOADs continue to carry out second opinions both remotely and in person.

Figure 5: Average number of days to SOAD starting second opinion



Source: CQC
Note: Figures for 2022/23 in this chart are different to those included in the 2022/23 MHA report, as data has since been updated.

Absence without leave (AWOL) notifications

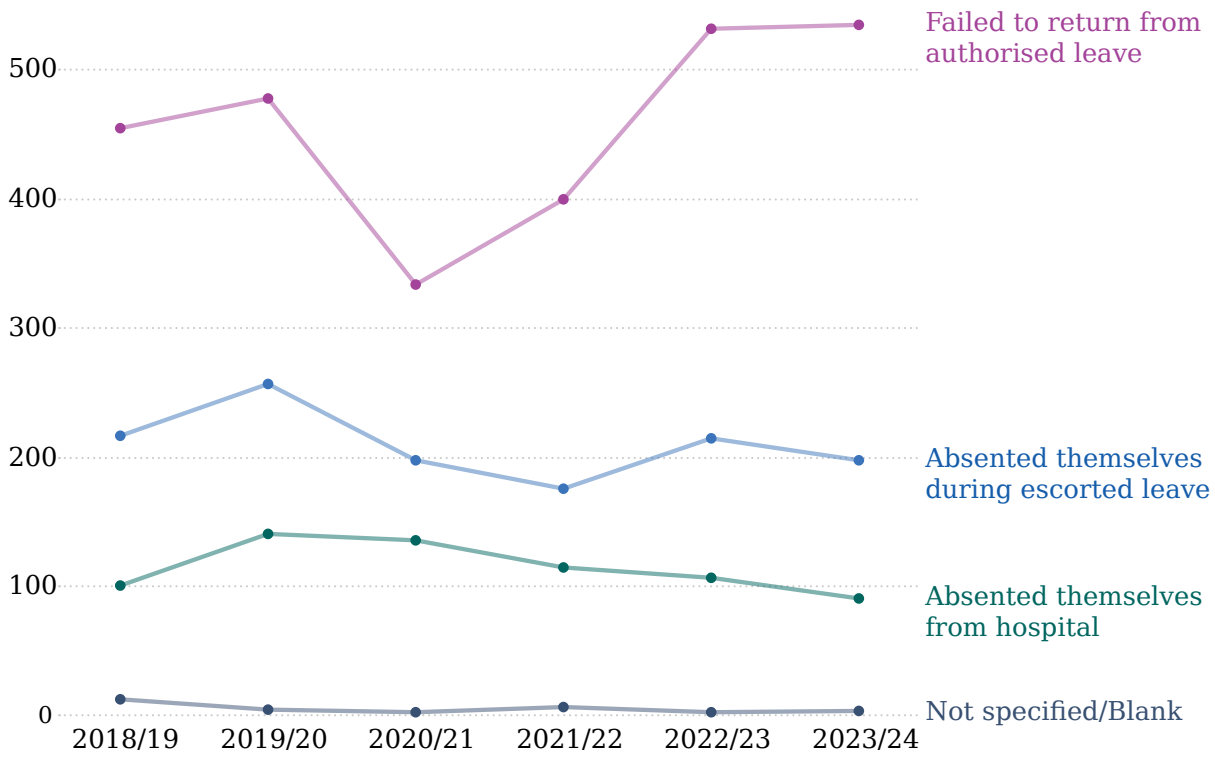
In 2023/24, we were notified of 824 incidents of a detained patient being absent without leave. This was similar to the number of notifications in 2022/23 (853) following a drop in numbers during the pandemic.

Reason for AWOL notification

The most common reason for AWOL notifications was “Failed to return from authorised leave” (see Figure 6). There were fewer notifications with this reason during the pandemic, but numbers have since risen.

For the other reasons provided (“Absented themselves during escorted leave”, and “Absented themselves from hospital”), numbers of notifications have remained more stable.

Figure 6: Reason for AWOL notifications, 2018/19 to 2023/24



Source: CQC AWOL notifications data

Note: The total each year includes patients who were AWOL on more than one occasion.

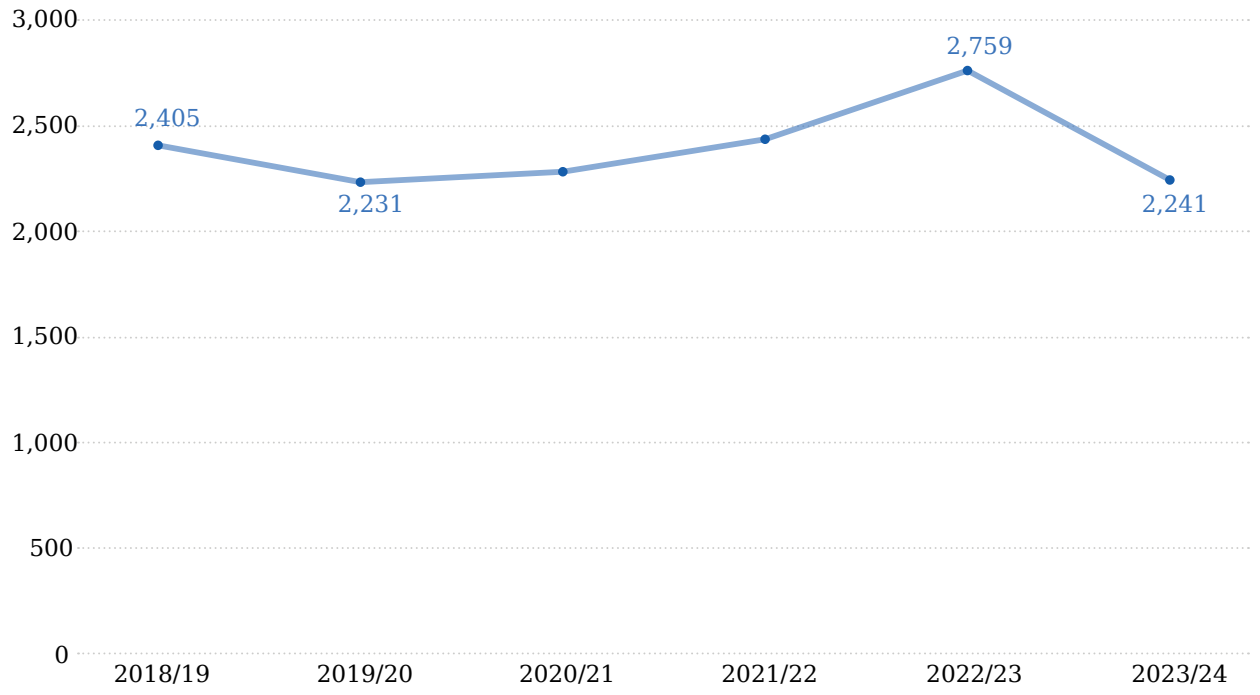
Male patients are more likely than female patients to have an incident of being absent without leave. Of the 824 incidents where a detained patient was absent without leave, 733 notifications recorded the patient's gender, of these, 79% were males.

Complaints data

CQC has a discretionary duty under section 120 of the MHA to investigate complaints relating to the care and treatment of people who are, or have been, subject to the formal powers of the Act.

In 2023/24, the number of complaints and contacts received through the MHA complaints system (2,241) reduced by 19% compared with 2022/23. However, this number was comparable with volumes received in previous years, before the increase in 2022/23 (figure 7).

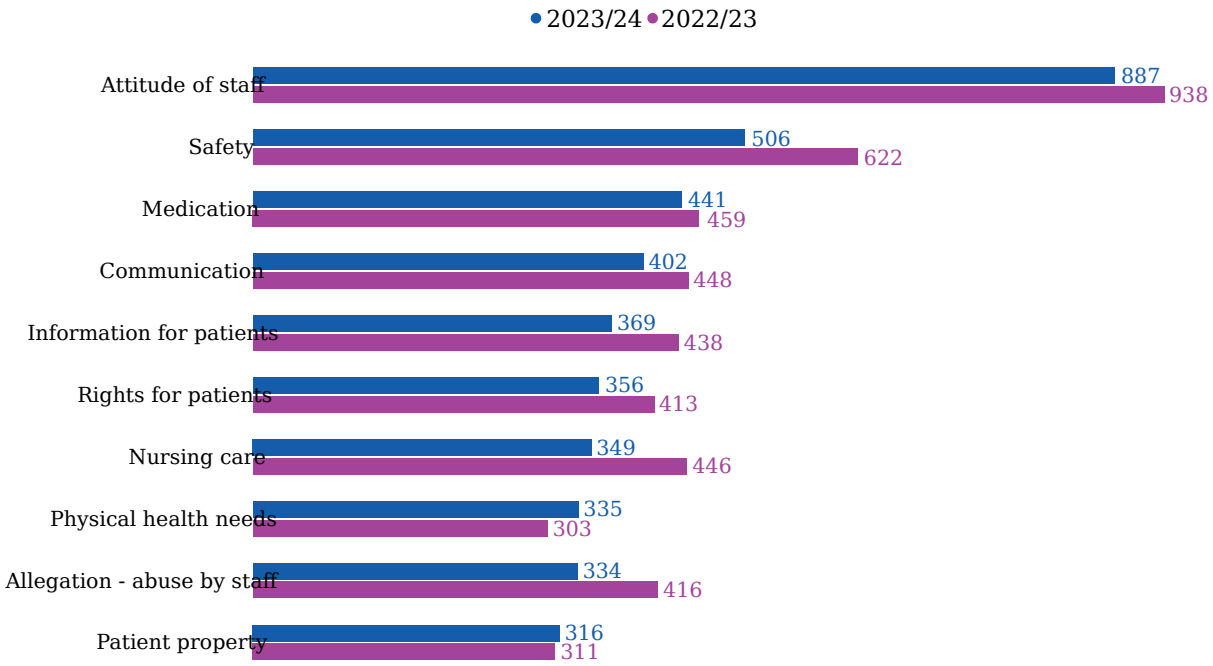
Figure 7: Total complaints received 2018/19 to 2023/24



Source: CQC

The largest proportion of complaints (43%, 887) were in relation to the attitude of staff, followed by safety (25%, 506) (figure 8).

Figure 8: Number of complaints by category



Source: CQC

Note: A single complaint can be assigned to more than one category, therefore the figures above total more than the overall number of individual complaints.

Most complaints and contacts were made by telephone (95%), which was similar to last year (94%).

Investigations of complaints

We investigated 10 complaints in 2023/24. These in-depth investigations were carried out by MHA reviewers when complainants contacted CQC after they were not satisfied with the responses received from initial complaints investigations by the mental health trust or independent hospital to which they had first complained.

Across the 10 investigations, we looked at 33 concerns raised by complainants. We upheld fully 15 of those concerns raised and partially upheld 10. The concerns we fully upheld included:

- the length of time a provider's complaints handling process took to complete
- inappropriate use of the urgent treatment provisions of the Act (section 62)
- detaining a young person on an adult medical ward for 11 months because a more suitable placement or hospital setting could not be found
- not conducting a MHA assessment appropriately, and not empowering and involving the person in their assessment in a suitable manner
- not providing information to a person detained under the Act and their nearest relative about their legal status and rights as required by section 132 of the Act.

When we uphold complaints, we make recommendations for action that providers should take to learn from the issue and to improve. Following our investigations of complaints during 2023/24, the following are some examples of action taken in response to the recommendations:

- A mental health trust apologised for delays in its complaints investigation process. The trust reviewed and updated its process to bring it in line with new national guidance and to speed up the process.
- A mental health trust reviewed its processes relating to urgent treatment and provided updated guidance to its medical staff.
- Another mental health trust apologised for failing to ensure a young person was cared for in the most suitable environment and subsequently carried out a serious case review following our investigation. In the same case, an acute hospital trust apologised for any distress caused to the young person while being cared for in its hospital. The acute trust took action to improve its care and treatment of young people who have an eating disorder to avoid other patients having a similar experience.

- A local authority, a mental health trust and an acute hospital trust gave an apology for any distress caused by the failure to meet the needs of a person during their MHA assessment. All 3 organisations took action to improve communication and joint working between the liaison psychiatry team, the approved mental health professional team and ward staff of the acute hospital trust.
- Similarly, a mental health trust, a local authority and an acute hospital trust all took action to review and update their policies and practice to ensure people are informed of their rights.

Notifications of deaths of detained patients and patients subject to a community treatment order

During 2023/24, we were notified of 288 deaths, of these:

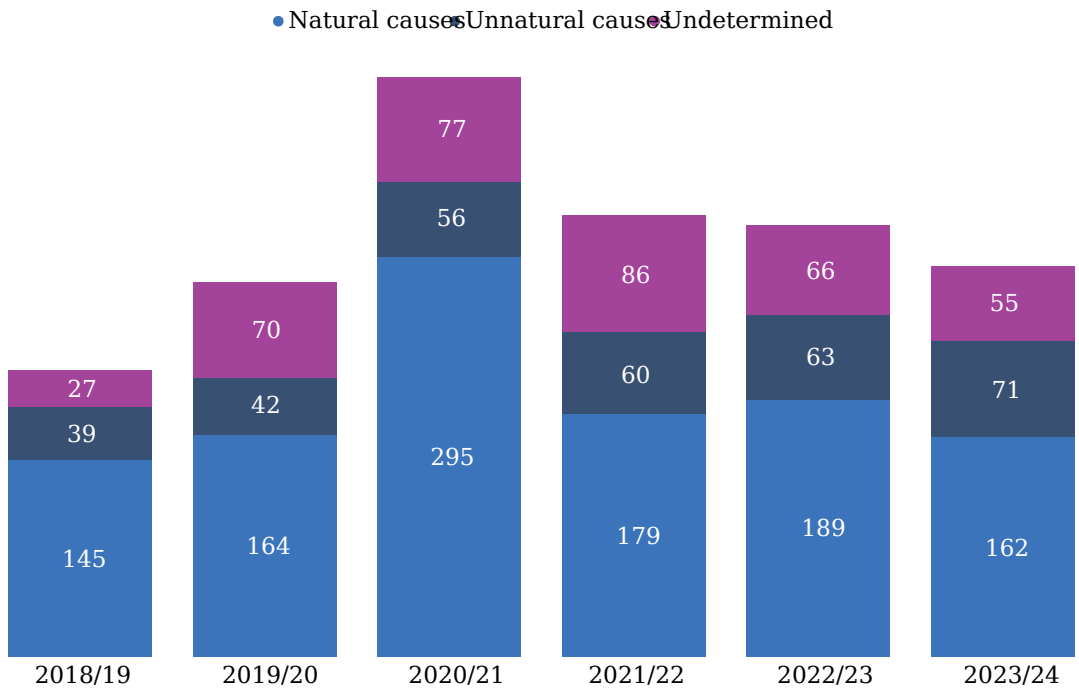
- 225 were detained patients
- 63 patients were subject to a CTO.

Reporting of CTO deaths is not compulsory, therefore figures may be underestimated.

Of the 288 deaths:

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

Figure 9: Deaths of detained patients and patients subject to a community treatment order, 2018/19 to 2023/24



Source: CQC

For patients in detention and those subject to a CTO in 2023/24:

- of the 162 deaths from natural causes, the most common cause was heart disease (31 deaths)
- of the 71 deaths from unnatural causes, the most common cause involved ligatures (18 deaths).

A higher proportion of patients who died in detention were male (61%), compared with 51% of all people who were detained. Rates of detention were slightly higher for males (91.4 per 100,000 population) than females (83 per 100,000 population).

During the year, 8 young people died while detained. All these deaths were reported to be of unnatural causes except for one person whose cause of death is currently undetermined. Six of these deaths involved ligatures.

Regarding absence without leave or while on leave:

- 11 deaths were reported of detained patients who were absent without leave (AWOL) (5%). Of these deaths, 8 were reported as unnatural causes, 2 of natural causes and one is currently undetermined. Seven people who were absent without leave when they died originally had authorised leave. All but one of these was of unnatural causes, with one currently undetermined.
- 52 deaths were of detained patients who were on leave (23% of deaths of detained patients). Of these deaths, 19 were of unnatural causes.
- 21 deaths were of detained patients who were on escorted leave (9%). Of these deaths, 14 were of natural causes. The purpose of leave for the majority of these 21 patients was being transferred to an acute hospital or emergency department. Only one patient was confirmed to have absconded from their escorted leave before their death.

1. There were 4 deaths of detained patients who had been secluded (2%). Of these deaths, 3 were of unnatural causes and one is currently undetermined.

There were 13 deaths of detained patients who had experienced control or restraint within 7 days of death (6%). One notification directly described the restraint of a patient prior to their death, which was from natural causes. Six deaths were from unnatural causes.