Pressures on services and patient pathways

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

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Key points:

- A lack of community service alternatives is putting pressure on mental health services, with demand for inpatient services continuing to increase during 2021/22. Bed availability in many services is running close to or above capacity, leading to delays in admission, transfer and discharge.
- While some services are managing to accommodate patients without extended delays, many others are struggling to provide a bed. This can lead to people being cared for in unsuitable environments, such as health-based places of safety or psychiatric intensive care units for prolonged periods.

- Lack of beds and gaps in community and social care services are creating delays in discharging people from hospital. In some services this has led to the development of 'sub-acute' wards whose core purpose is to accommodate patients whose discharge from inpatient care is delayed.
- The impact of the COVID-19 pandemic on children and young people's mental health (CYPMH) services continues to be felt, with services struggling to meet rising demand. This is increasing the risk of children and young people ending up in inappropriate environments, such as general children's wards. To manage delays to beds on CYPMH wards, some services have been taking steps, including investing in new health-based places of safety, to care for people while they are waiting for a bed.

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

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

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

As part of NHS England's plans to improve mental health outcomes, the 2016 Five Year Forward View for mental health and subsequent action plan set out an ambition for Crisis Resolution and Home Treatment Teams (CRHTTs) to offer intensive home treatment as an alternative to acute inpatient admission in each part of England by 2020/21. NHS England reinforced their commitment to this aim in the NHS Long Term Plan. However, the impact of the pandemic will have stalled a full implementation of this aim, while increasing demand. Staffing shortages will continue to frustrate the aim for some time to come.

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

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

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

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

Pressure on inpatient services

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

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

> The ward had experienced an unprecedented demand and you had observed that admitted patients had been more acutely disturbed than usual. You considered this to be due to the limitations placed on community services by the lockdown restrictions, meaning that relapsing and distressed patients were not being seen sufficiently to spot and address early signs of relapse. Furthermore, the strain of the last year has been felt by the whole community, thus likely negatively impacting on the general mental health of those vulnerable to mental illness.
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> Psychiatric Intensive Care Unit, May 2021

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

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

> The [rehabilitation] ward had patients on the ward on what was described as a "sleep-over." These patients remained on the acute wards patient numbers rather than this wards patient numbers. While bed management tried to ensure the patients transferred to this ward fitted with the patient group this was not always possible. We were concerned that staffing on the ward may not reflect the increase in patients, as the acute ward patients were not within this ward's patient numbers. We were also concerned that these patients may not receive the care they needed or that their risk might not be fully understood or managed on the ward. There was a risk these patients fell between 2 different teams as the ward multidisciplinary team was different to the acute ward's team.
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> **Rehabilitation ward for men,** July 2021

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

> You told me that the ward had 6 beds and that all were single occupancy rooms with toilet and shower. You told me that the ward had, on the day of the remote visit, 7 patients. You explained that the additional patient was located in the low stimulus/seclusion room. When I asked how often this happened you confirmed that use of the seclusion room as an ordinary bedroom was routine. Following a comment in the previous report you acknowledged that the routine use of the low stimulus/seclusion room as a bedroom remained in place with consequences in terms of the use of the room as a bedroom and the need to re-allocate bedrooms when a seclusion room was required.
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> **Psychiatric Intensive Care Unit**, May 2021

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

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

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

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

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

Discharge delays

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

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

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

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

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

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

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

Admission ward for older adults, February 2022

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

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

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

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

Acute ward for women, August 2021

Children and young people's mental health services

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

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

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

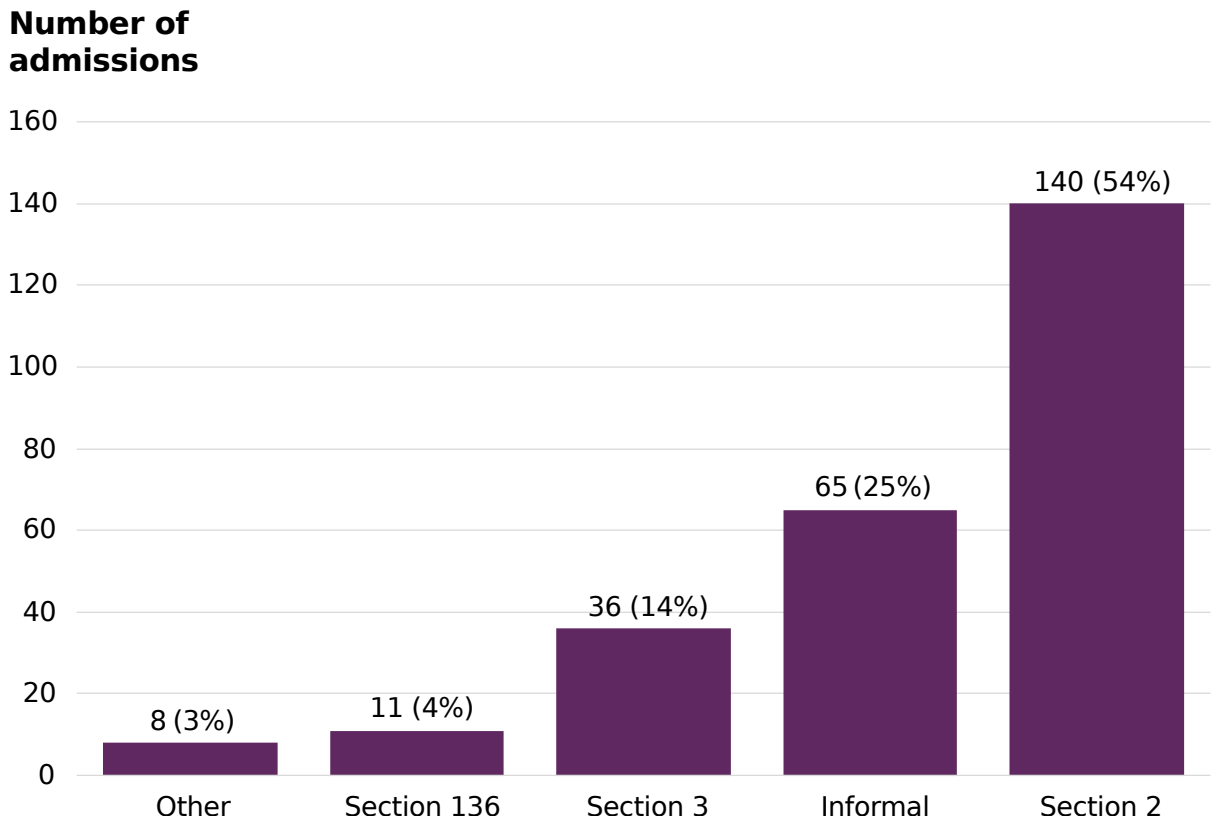
Children and young people's mental health ward, July 2021

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

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

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

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



Source: CQC, notifications data, 2021/22

An MHA visit to a general children's ward

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

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

Staff in the children's emergency department told us that in order to keep patients who needed a CYPMH inpatient bed safe, they felt they had little choice but to admit them to a general children's ward. As a result, we were concerned these patients were not getting access to the full range of mental health care and treatment they needed.

It was clear that staff on the frontline were under a level of pressure they had not experienced before. We were concerned about the personal impact on individuals, as well as morale overall, as they had to deal with ever increasing numbers and levels of acuity, which required a complex skill mix to be developed on the job.

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

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

> We have concerns about safety in the event of an incident at the emergency department. For example:
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> - people waiting for a mental health bed when the department closes at 10pm remain under the care of a lone staff member until transferred to a mental health ward. Staff told us they contacted porters or, in one case, the car park attendant, to provide support. Staff can activate a personal alarm in the event of an incident, but there may be little or no response in an area that has closed for the night.
> - none of the hospital's staff have been trained in restraint; there are no security personnel based on site.
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> **Review of MHA admission pathways, West Midlands**, November 2021

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

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

As highlighted in the section on staffing and impact on patient care, staffing shortages can also lead to delays in children and young people accessing mental health inpatient care. This includes shortages in specialists to carry out assessments, as well as issues with staffing levels on inpatient wards. In some cases, this has led to services reducing bed numbers. For example, on our visit to one CYPMH hospital in March 2021, we heard how issues with staffing levels and problems with recruitment had led to the hospital reducing its capacity by half, leaving 11 beds to serve the whole county in which the hospital was located. At the time of our visit there were 26 children and young people from the county being accommodated in out of area mental health beds.

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

> The hospital had closed admissions to the ward due to the acuity of the current patient group. Staff told us the ward was seeing an increase in patients with a diagnosis of either an eating disorder or disordered eating requiring admission to a psychiatric intensive care unit. Staff explained they were not appropriately trained in caring for patients with these diagnoses. They had received support from the dietician and the eating disorder ward on site. All the qualified nursing staff were qualified in nasogastric tube feeding. At the time of our visit most patients on the ward had either an eating disorder or disordered eating. Staff had told us concerns had been escalated to NHS England.
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> **Psychiatric Intensive Care Unit for children and adolescents**, September 2021

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

The consultant psychiatrists told us that:

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

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

Pathways for people with a learning disability and autistic people

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

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

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

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

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

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

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

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

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

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

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

> One patient said that staff did not have the right training and skills to work with his autism, leading to frustrated behaviour that is not de-escalated but rather resulting in unnecessary seclusion. In addition, one member of staff independently raised that staff on the ward had concerns about not having specialist training in autism. The training had been requested by staff on multiple occasions.
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> **Low secure learning disability unit**, February 2022

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

> One patient had a diagnosis of autism and had spent a significant amount of time in seclusion. However, there did not appear to be anything in her care plans regarding the specific support she needed in respect of her autism. There was no sensory needs assessment or care plan, no positive behaviour support plan or any plan regarding the use of restrictive interventions. We could not see any psychological assessment or formulation. We noted that this patient had been referred to forensic services and we were concerned that this had been done when it appeared that not all options to provide treatment to this patient in a less restrictive setting had been explored.
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> **Acute ward for women**, February 2022

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

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

Deprivation of Liberty Safeguards

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

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

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

> Staff informed us that the DoLS authorisations across both wards had expired. We saw evidence of incident forms being completed. However, we are concerned that these patients remain de facto deprived of liberty, with no legal framework authorising this. This means they have no safeguards available to them. The trust should seek advice from the local authority over the likely timescales for DoLS procedures to be completed and what priority is being given to its patients. It should also review the decisions as to which legal framework to use in each patient's case so that, where the MHA might be applicable, this is considered as a potential means to enable the patients to exercise their rights and have appropriate safeguards in place.
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> **Wards for older men and women**, March 2022

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

> A patient was awaiting a standard authorisation therefore was currently not under any legal framework. I saw staff had documented confusing entries in the records. For example, referring to the patient as being informal and at times on DoLS. I also saw two mental capacity assessments completed for this patient where the latter dated assessment stated the patient had capacity and was informal. It was unclear to me what the legal status of the patient was. I raised this issue with the ward manager during the visit and requested this patient is reviewed urgently.
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> **Older person's ward for men and women**, September 2021

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

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