Safeguarding Vulnerable Adults in Mental Health Services

Dr Julie Hankin
National Professional Advisor for Mental Health
Overview

- CQC role and responsibilities
- CQC’s findings from monitoring activity 2011/12
- Implications for practice
About CQC

- Regulator for health and adult social care since 2009
- Look at **outcomes** and **regulate against regulations** with a focus on **how** care is delivered
- Protect and promote the rights of people subject to the MHA
- Monitor the operation of MCA/DoLS
- **Involve people** who use and provide services and listen to their voices
- Use a wide **range of sources** of evidence, this includes what local people tell us about their services
- Currently developing **strategy** for 2013-16
3(1) The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.

4(1) In performing its functions the Commission must have regard to-

…

(d) The need to protect and promote the rights of people who use health and social care services (including, in particular, the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005, and of other vulnerable adults)

Health and Social Care Act 2008
Safeguarding is a key priority that reflects both our focus on human rights and the requirement within the Health and Social Care Act 2008 to have regard to the need to protect and promote the rights of people who use health and social care services. Regulated providers of health and adult social care services have a key role in safeguarding. We will monitor how these roles are fulfilled through our regulatory processes by assessing their compliance with the national standards of quality and safety.
CQC’s Role

• Make sure that providers have appropriate systems in place to safeguard people who use the service, and that those systems are implemented and followed in practice to ensure good outcomes for people who use the service.

• Where regulatory information suggests a breach of regulations or the registered person not being fit for the role, we will consider what regulatory action is needed and undertake that work, where necessary, in partnership with other agencies.

• We will also ensure that when we receive safeguarding information we will pass it on in a timely manner to the local authority and/or the police.
Statutory framework

Mental Health Act 1983
And
Code of Practice

Mental Capacity Act 2005
specific standards that relate to safeguarding and safety, effective safeguarding also requires compliance with a range of other standards as well, for example:

• robust recruitment and vetting processes for staff

• having enough well-trained, competent and supported staff; providing effective and appropriate treatment

• having systems in place to enable people who use services and their representatives to feed back concerns

• ensuring that people using the service are respected and as fully involved as possible in their care and support.

• Compliance with the full range of standards should result in positive outcomes for people, where the risk of abuse, neglect or harm is far less likely to arise in the first place.
Safeguarding Adults: The role of healthcare managers and their boards

Safeguarding encompasses:

- Prevention of harm and abuse through provision of high quality care

- Effective responses to allegations of harm and abuse, responses that are in line with local multi agency procedures

- Using learning to improve service to patients.
Safeguarding Adults Principles

Principle 1 – Empowerment
Presumption of person led decisions and consent

Principle 2 – Protection
Support and representation for those in greatest need

Principle 3 – Prevention
Prevention of neglect harm and abuse is a primary objective.

Principle 4 – Proportionality
Proportionality and least intrusive response appropriate to the risk presented

Principle 5 – Partnership
Local solutions through services working with their communities

Principle 6 – Accountability
Accountability and transparency in delivering safeguarding
Safeguarding adults is integral to:

- **Patient Care.** Achieving high quality care for patients. Safeguarding is particularly relevant to domains 4 and 5 of the NHS Outcomes Framework - patient experience and protecting people from avoidable harm.

- **Regulations.** Safeguarding is a fundamental requirement for registration and complying with the Care Quality Commission, Essential Standards for Quality and Safety.

- **Legislation.** Duty to comply with other legislation including the Human Rights Act; Equality Act; Mental Capacity Act and Safeguarding Vulnerable Groups Act.

- **Cost Effectiveness.** Quality Innovation Productivity and Prevention – harm neglect and abuse cost the NHS millions each year in avoidable admissions and care.

  - **Example:** The total treatment cost for pressure ulcers in the UK is to be £1.4 - £2.1 billion annually, comprising 4% of NHS expenditure.
Findings from monitoring activity
Context

- The number of people subject to the Act is rising
- Services are under pressure (e.g., provision of AMHPs, transport to hospital, high bed occupancy, increased workloads, access to psychological therapies)

What we found:

- Some hospitals/wards are doing a very good job in treating patients with dignity and respect.
- CQC found some overall improvement but most of the concerns highlighted in previous reports remain,
- There is a significant gap between the realities CQC is observing in practice and the ambitions of the national mental health policy - *No Health without Mental Health.*
- CQC is concerned that cultures may persist where control and containment are prioritised over the treatment and support of individuals.
Top 5 issues of concern from MHA monitoring 2011/12

1. Patient participation and care planning
   e.g. patient involvement in care planning, access to their care plans, administration of the MHA, comprehensiveness of care plan

2. Ward environment and facilities
   e.g. ward in poor state of repair, furniture/facilities needed, areas of the ward are dirty, inadequate gender separation

3. Medication, capacity and consent
   e.g. incomplete/missing capacity assessments and records of discussions with patients, incorrect/expired/missing T2/T3 forms

4. Leave
   e.g. withdrawal of leave as ‘punishment’, expired s17 forms, patient access to their s17 forms, unclear s17 documentation,

5. Rights of detained patients
   e.g. patients uninformed about their rights, patients unaware of an IMHA service, records that patients have been reminded of their rights are incomplete
Context:

- The umbrella legislation of the Mental Capacity Act (2005) is still not well understood or implemented in practice
- Concept of deprivation of liberty not easy to understand in practice
- Clear evidence of regional variation has been a consistent finding for the last 3 years

Key findings:

- Use of restraint not always recognised or recorded as such – therefore not easy to monitor or challenge
- Wide variation in how supervisory bodies carry out their functions
- People’s voices – not clear whether they’re being heard in the DoLS system
Restrictions on liberties

- **Physical intervention / restraint**
  e.g. restraint as the standard first line response to disturbed behaviour, male staff restraining female patients, patient injuries reported, no routine medical reviews following restraint

- **Seclusion/segregation**
  e.g. delay in review by clinician, patients effectively in seclusion but without relevant safeguards, food/drink given in a way that compromises patient dignity

- **Rights of informal patients**
  e.g. informal patients prevented from leaving ward without a capacity/best interest assessment, staff automatic use of holding powers to prevent patients leaving, no door notice informing patients how to leave if ward door is locked

- **Access to food & drink**
  e.g. food/drinks only available at set times of the day, patients are not permitted to make their own, or take drinks to their bedrooms.

- **Access to fresh air**
  e.g. ward rules around when patients can use outdoor space, patients allowed very limited use of garden/courtyard
Dementia

• In more than half of all PCT areas, people with dementia living in a care home were more often admitted to hospital with avoidable conditions than those who did not have dementia.

• In almost a third of hospital admissions of people with dementia there was no record of the person’s dementia.

• People with dementia have longer stays in hospital, more readmissions and higher mortality rates than similar people without dementia.

• The impact on outcomes for patients with dementia was greater in relation to elective admissions.

• The impact on outcomes for patients with dementia was greater in younger age groups.
• Treating people with respect and involving them in discussions about their care: services met the standard in 92% of inspections carried out, a rise from 86% in 2011/12.

• Protect people from the risk of abuse and prevent it from happening: services met the standard in 96% of inspections, compared with 86% the previous year.

• Support for their staff through training, supervision and appraisal: services were meeting the standard in 95% of inspections, compared with 90% in 2011/12.

• CQC also saw some improvement in the way that NHS mental health and learning disability services planned and delivered care and treatment for patients. However, this was from a very low base and the providers still have a considerable way to go. Services met the standard in 85% of inspections, up from 76% in 2011/12.
Early warning signs


• In the first nine months of 2012/13, CQC found that mental health and learning disability services struggled to maintain adequate staffing levels: services met the standard in 80% of inspections. This compared with 91% of inspections in the whole of 2011/12.
Care Update: Independent Mental Health and Learning Disability

• Planned and delivered care and treatment for patients. They met this standard in 86% of inspections, a rise from 69% for the whole of 2011/12.

• Support for their staff through training, supervision and appraisal. Services met the standard in 89% of inspections carried out, compared with 81% the previous year.

• Treating people with respect and involving them in discussions about their care: services met the standard in 93% of inspections, compared with 85% in the whole of 2011/12.

• Protect people from the risk of abuse and prevent it from happening: services met the standard in 93% of inspections carried out, a rise from 73% in the previous year.

• Assure themselves of the quality of the care they provided and manage the risk to patients: services met the standard in 91% of inspections, compared with 82% in 2011/12.
Implications for Practice
Protecting people’s rights

MCA & Safeguards:

- Inclusive practice
- Assessments
- Advocacy
- Reviews

MHA adds:

- AMHP
- Hospital managers
  eg s132, scrutiny, hearings, governance
- CQC complaints investigation

Decisions
- Best interests
- CQC monitoring

SOAD
Tribunal
Protecting people’s rights

…and what about

• Visiting professionals/care coordinators
• Commissioners of services
• FT governors
• Provider service boards
• Community organisations
• anyone else…??
Practice implications

- Do we have a clear view of what we are seeking to encourage - what good looks like?
  - Care planning is thoughtful and person-centred
  - Restrictions are kept to a minimum
  - Easy access to good advocacy
  - Staff are appropriately trained and providers trust, value and invest in their staff
  - There is reasonable staff turnover
  - Good leadership - managers have proper oversight
  - Organisations are open and embrace challenges, ideas, changes, collaborations
Practice implications (cont)

• Are there signs to help recognise a culture that condones restrictive practices?
  • There are many rules and blanket policies in place
  • Lack of meaningful patient activities
  • Disturbed patient behaviour
  • Restricted access to external people
  • Overreliance of medication
  • Inadequate staffing and skill mix
  • Shift patterns are fixed
  • Providers don’t recognise what they’re doing as restrictive practice
  • There is a culture and language that isn’t challenged
  • Patients remain in services for a long time
  • Services are geographically isolated
  • Gut feeling
Resources to support quality and promotion of rights

- Codes of Practice – MHA, MCA, DoLS
- Care Programme Approach guidance
- DH, 2008 Human Rights in Healthcare: A framework for local action
- DH, 2012 Winterbourne View Review Concordat: Programme of Action
- Mind, 2011 Listening to experience: An independent inquiry into acute and crisis mental healthcare
- National mental health outcomes strategy - implementation framework (July 2012)
- NICE guideline – Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (Dec 2011)
- Wardipedia - http://www.wardipedia.org/