**Written submission from the Parliamentary and Health Service Ombudsman for pre-legislative scrutiny of draft Mental Health Bill**

**15 September 2022**

**About the Parliamentary and Health Service Ombudsman**

The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by UK Government departments, the NHS in England, and some other UK public organisations. We do this impartially and independently of Government, holding public bodies to account. PHSO is not part of Government or the NHS in England, nor is it a regulator. We are neither a consumer champion nor an advocacy service.

**How PHSO deals with complaints**

* PHSO considers complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly or where it has provided a poor service and not put things right. We expect people to complain to the NHS organisation or Government agency first, so it has a chance to put things right. If an individual still believes there is a dispute about the complaint after an organisation has responded, PHSO can then be asked to consider it. We also share the learning from complaints so that public services can improve.
* We look at complaints independently and impartially, carefully weighing up evidence from both parties and drawing on expert advice, such as input from independent clinicians, where relevant. Where we find unresolved failings, we made recommendations so the organisation can put things right.

**How PHSO deals with mental health complaints**

* The jurisdictional responsibilities around Mental Health Act (MHA) complaints are complex and risk overlapping. This can be confusing for people using mental health care, as well as for their families and for their carers. The Care Quality Commission (CQC), the Local Government and Social Care Ombudsman (LGSCO), PHSO and the Mental Health Tribunal can all look at different aspects of MHA complaints around detention decisions, treatment and aftercare.
* For example, in relation to detaining individuals under the MHA:
* the Mental Health Tribunal can look at applications to remove someone from detention under the Mental Health Act.
* the CQC can look at complaints around decisions to detain and how MHA powers are applied, such as placing a patient in seclusion or not allowing them to be involved in decisions about their care (powers it derives from the Mental Health Act 1983).
* PHSO can look at the process surrounding detention and general complaints about someone’s care.
* When an application to detain is made by an approved mental health professional, then the complaint would be considered by LGSCO.
* This makes it extremely difficult for complainants, whose detention make them among the most vulnerable in society, to navigate the system and seek resolution. MHA complaints are currently not being resolved in a simple, streamlined or consistent way.

**We welcome the proposals to improve the safety and quality of patient’s care, and increase the power of patients, families and carers**

* We welcome the proposals in the Bill to give more power, choice and autonomy to people detained under the MHA, as well as their families, carers and others interested in their care. This will improve the safety and quality of patients’ care and allow their care and treatment to be more personalised.
* These improvements are essential because poor care can have extremely serious consequences. In 2019 we published and laid in Parliament a report, [Missed Opportunities](https://www.ombudsman.org.uk/missed-opportunities), which included two very similar cases we had investigated involving failings in mental health care and treatment on the same ward of the same Trust. Two young men died, and we found a number of significant failings in their care and treatment.
* Key issues we have found in MHA complaints include:
* not involving families and carers in decision-making around care and treatment, or failures to communicate changes in care and treatment to families and carers,
* failure to update a care and treatment plan or risk assessment, and
* administering medication that caused a patient’s mental health to deteriorate.

*Care and treatment plans*

* We welcome the proposal that there should be a statutory duty to create a care and treatment plan for every person detained under the MHA. It is right that the Bill proposes to include all relevant parties (nominated person, independent mental health advocate, carer and anyone interested in the welfare of the patient) in decisions about care and treatment plans, as this will ensure the strengths, needs, expectations and wider social context relating to that person’s care are understood and reflected in their plan.
* We also welcome the inclusion of an obligation to establish milestones to review and revise the care and treatment plan, to review on request, as well as to have a ‘responsible person’ to monitor and follow up on the care and treatment plans. This will account for changing care needs and ensure the patient always receives the most appropriate care. The Bill also proposes that care plans should consider both current and future needs, which is essential.
* In both cases in our [Missed Opportunities](https://www.ombudsman.org.uk/missed-opportunities) report we found there were inadequate care and treatment plans. Failings included:
* Care and treatment plans were not updated to reflect all the patients’ needs or address all the risks present such as risk of suicide, reports of rape, substance abuse, aggression and non-compliance with the prescribed medication. There were no mitigation plans for present risks.
* A care and treatment plan was filled in further after a patient's death.
* The Trust’s initial review of failings contained inaccurate information about how the person’s care was reviewed.

*Treatment decisions*

* We welcome the proposal to increase the inclusion of patients, families and carers in decisions about treatment, and to include a nominated person in decisions if the patient does not have capacity. We also welcome the proposal to include more safeguards around changes to treatment. This is essential to keeping patients safe and allowing them and their loved ones to have choice and autonomy in their care.
* As we have seen in complaints we have received, these changes are essential. We have seen failings such as staff not taking specialist advice or carrying out a full risk assessment before prescribing atomoxetine to a patient, failure to properly monitor patients for side effects and staff not recording the rationale for prescribing lorazepam and its effects on the patient. We have also seen examples of de-escalation techniques not being used before administering rapid tranquilizers. The number of instances where these things happen could be greatly reduced as a consequence of the proposed changes in the Bill.

**There are further opportunities to improve access to justice for people who use mental health services**

*People using mental health services face barriers to justice*

* People detained under the MHA are often living in relatively closed inpatient settings. This can limit their ability to exercise their rights, for a number of reasons. These circumstances can make it much harder for a person or their family or carers to raise a concern about their care. Symptoms such as delusions can also mean that a person’s concerns may not always be taken seriously or believed.
* Overall, these conditions mean that people using mental health services, particularly people detained under the MHA, face additional barriers to justice when they have been let down by the services intended to support them. This is problematic because complaints provide a unique evidence base that helps services to improve. If people find it hard to complain, it is harder for services to understand what improvements they need to make.
* The draft Bill could be significantly improved by including measures that would make it easier for people to complain.

*Written complaints*

* The legislation that underpins our service requires that a complaint be made in writing. This can function as an additional hurdle to accessing justice and disadvantages for those whose first language is not English or those who do not have good literacy skills, such as people with communication difficulties, learning disabilities, or those who communicate using Braille or British Sign Language due to a sensory impairment. It can also disadvantage people experiencing symptoms of mental illness, who may find it harder to communicate difficult experiences clearly in writing. The law currently makes it harder for people living in these circumstances to access justice via the Ombudsman.
* The Bill should consider proposing that a complaint does not have to be made in writing and instead can be made through other means, such as over the phone or via a video call, to give complainants options in the way they communicate their complaint and experience. This might be particularly important for people who need to access mental health care, who may find it easier to communicate their experiences in other formats. LGSCO and the CQC are already able to receive complaints in a variety of formats.

*Helping people to complain*

* Section 35 of the Mental Health Bill proposes that patients should, as soon as possible, be told about their right to complain (including about their detention or treatment) and they should be told how to complain. Patients should also be given the outcome of a complaint as soon as is reasonably possible. We welcome this proposal.
* There is an opportunity in this section of this Bill to clearly define the roles of the PHSO, LGSCO, CQC and the Mental Health Tribunal. The Bill should be updated to state clearly what exactly each organisation can and cannot look at in relation to MHA complaints. This would make it easier and clearer for NHS organisations to signpost to the correct organisation and for people using services, their families and carers, to find the right place to raise a concern.
* We think it will be beneficial to introduce mandatory signposting. This would require providers of care under the MHA to provide information about the four routes of redress (tribunal, CQC, LGSCO and PHSO) and what each organisation can specifically look at. This information should be given to people who wish to complain about any aspect of their care or detention. This will help patients access justice more easily and quickly.

***Contact****: PublicAffairs@ombudsman.org.uk*