Parliamentary and Health Service Ombudsman

Local Government OMBUDSMAN

CareQuality Commission

DEALING WITH COMPLAINTS FROM PATIENTS SUBJECT TO THE APPLICATION OF THE MENTAL HEALTH ACT (MHA): A MEMORANDUM OF UNDERSTANDING BETWEEN THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN (PHSO), THE LOCAL GOVERNMENT OMBUDSMEN (LGO) AND THE CARE QUALITY COMMISSION (CQC)

CONTENTS

1. Purpose and scope

2. Legislative Framework

2.1	Role of PHSO in complaints from detained patients
2.2-2.3	Role of LGO in complaints from detained patients
2.4	Role of CQC in complaints from detained patients
2.5	Role of CQC in managing the SOAD service
2.6-2.7	Role of PHSO in relation to complaints about the CQC
2.8	LASS & NHS Complaints Regulations 2009

3. How PHSO, LGO and CQC handle complaints

3.1-3.4	PHSO
3.5	LGO
3.6-3.8	CQC

4. General principles underpinning our collaborative working

5. Information sharing and liaison arrangements

6. Relationship with other bodies

6.1	First-tier Tribunal (Mental Health)
6.2	Role of the Approved Mental Health Professional

7. Relationship with other legislation

7.1	Mental Capacity Act 2005

8. Relationship with other Codes of Practice

8.1 Code of Practice: Mental Health Act 1983

ANNEX 1

A. Operational arrangements for complaints handling

1. Matters within the scope of the CQC
2. Matters within the scope of PHSO
3. Matters within the scope of LGO
4. How we will deal with specific cases
5. The process of assessment for compulsory detention

B. List of operational contacts in PHSO, CQC and LGO

Purpose and Scope

1.1 This Memorandum outlines the distinct roles of PHSO, LGO and the CQC regarding complaints in respect of patients who are, or who have been, detained under the MHA (or otherwise made subject to relevant MHA powers) and identifies areas where cooperation and collaboration between the three bodies is relevant and appropriate in delivering our core functions. This Memorandum does not aim to anticipate all possible scenarios requiring interaction between PHSO, LGO and CQC on complaints from this group but it does describe the general principles underpinning the relationship between us.

1.2 This Memorandum comes into effect on 1 July 2010 and will be reviewed after an initial 12 month period, or whenever any necessary revision comes into force whichever is the sooner. Thereafter it will be subject to periodic reviews every two years.

Legislative framework

Role of PHSO in complaints from or on behalf of detained (or otherwise relevant) patients

2.1 PHSO has a statutory responsibility[1] to consider a complaint (including those from detained patients) that someone has sustained injustice or hardship as a consequence of: failure in services provided by a health service body; failure to provide a service which it was a function of the body to provide; and/or maladministration connected with any other action (other than the provision of, or a failure to provide, a service) taken by or on behalf of such a body. The service failure or maladministration can result from the activities of employees of the body, persons delegated to act for the body, or persons acting on behalf of the body.

Role of LGO in complaints from detained (or otherwise relevant) patients

2.2 The Commission for Local Administration in England consists of the three Local Government Ombudsmen and the Parliamentary and Health Service Ombudsman [ex officio]. The three Local Government Ombudsmen have a statutory role[2] in considering complaints from detained patients, or someone acting on their behalf, who claim to have sustained injustice as a direct consequence of maladministration or service failure by a council. The Ombudsmen may investigate the actions of employees and members of a council and they may also consider the actions of any other person who performs on its behalf any statutory function of a council.

2.3 The LGO may consider any matter coming to his or her attention if this occurred during the course of an investigation and the

[1] The Health Service Commissioners Act 1993 (HSC Act 1993).
[2] The Local Government Act 1974

Ombudsman considers that someone [including a detained patient] may have suffered an injustice as a result of that matter.

Role of CQC in complaints from detained or otherwise relevant patients

2.4 CQC has a statutory responsibility[3] to consider any complaint about the exercise of the powers or the discharge of the duties conferred or imposed by the MHA in respect of a patient who is or who has been detained under this Act, or who is or has otherwise been a relevant patient. Relevant patients are patients under supervised community treatment (SCT); patients subject to guardianship; and those who are 'liable to be detained' under the MHA. (The latter category includes detained patients on leave of absence from hospital; conditionally discharged patients who have not been recalled to hospital; patients detained under holding powers of s.4, 5, 135 or 136[4] and patients who were detained and are now receiving aftercare under Section 117).

2.5 The CQC is responsible for the appointment of Second Opinion Appointed Doctors (SOADs) and manages the SOAD service in accordance with the provisions of the Act. SOADs are independent consultant psychiatrists: the opinion given by the SOAD is the SOAD's personal responsibility and there is no appeal to the CQC against this opinion.

Role of PHSO in relation to complaints about the CQC

2.6 PHSO has a statutory responsibility[5] to consider complaints about maladministration on the part of government departments and non-governmental public bodies, including the CQC. PHSO can, therefore, consider complaints that injustice has been sustained in consequence of maladministration by the CQC.

2.7 PHSO promotes good administration by public bodies in line with six 'Principles of Good Administration'[6].

Local Authority & NHS Complaints Regulations 2009

2.8 All NHS bodies which provide services to detained or otherwise relevant patients must operate a complaints procedure in accordance with these Regulations. Councils which have responsibility for social services must also operate a complaints procedure in accordance with these Regulations. The CQC may deal with a complaint either prior to it being made to the NHS body or to the council or following the

---

[3] The Health & Social Care Act 2008 Schedule 3; this amends s. 120 (1) (b) of the Mental Health Act. **Note**: the CQC, as regulator, has a wider remit to keep under review the use and application of the powers of the Mental Health Act.

[4] Reference Guide to the Mental Health Act, para 1.36: Department of Health 2008.

[5] The Parliamentary Commissioner Act 1973

[6] Published by PHSO in March 2007. PHSO have also published 'Principles for Remedy' and 'Principles of Good Complaint Handling'.

response by that body. In all cases, the complainant has a right to put their complaint to the PHSO if dissatisfied with the NHS body's final response or to the LGO if dissatisfied with the response of the council. This Memorandum acknowledges the potential overlap in our respective jurisdictions and describes the circumstances in which we will decide the appropriate body to deal with the complaint.

Handling complaints from detained patients

The approach used by PHSO in handling complaints

3.1 PHSO has discretion as to whether or not to investigate complaints. PHSO assess all complaints (which are within remit[7] and are properly made) against the following criteria:

- Evidence of maladministration/service failure
- Evidence of unremedied injustice
- Possibility of worthwhile outcome

3.2 The HSC Act 1993 prevents PHSO from investigating matters where the aggrieved has or had a right of appeal to a tribunal or court of law, (except in circumstances where it was not reasonable for the person to have resorted to that remedy). Appeals against being compulsorily detained under the MHA are heard by the First Tier Tribunal (Mental Health). (See paragraph 6.1 of this Memorandum).

3.3 PHSO will consider whether there is another complaint handler with a similar remit to investigate (e.g. the CQC in the case of complaints from detained patients). In such cases, in accordance with the principles set out in this protocol, PHSO may agree that it is appropriate and in the patient's best interests for the other dispute resolution forum to deal with the complaint.

3.4 PHSO will also consider whether intervention short of an investigation would resolve matters for the complainant. In those cases where PHSO does carry out an investigation, the report will set out the findings: if PHSO finds that something has gone wrong, it can recommend action for the body to take to put things right; to provide an appropriate remedy (including financial redress); and to demonstrate that lessons have been learned. Recommendations for systemic remedy are shared with regulator (CQC or Monitor in the case of Foundation Trusts) and are followed up to ensure compliance. Investigation reports are shared with the commissioning body and, in the case of NHS Trusts, with the relevant Strategic Health Authority.

---

[7] The assessments of s.12 approved doctors do not constitute a NHS service and are, therefore, outside the remit of the PHSO in the following circumstances:
(i) if given by a doctor who is not on the staff of the Trust where the patient is examined; or (ii) if the recommendation is given as a result of a special examination carried out at the request of a local authority officer at a place other than a Trust or clinic administered by a Trust authority.

The approach used by LGO in handling complaints

3.5 The Local Government Ombudsmen have discretion over whether to investigate any complaint but will pursue matters within jurisdiction on comparable grounds to PHSO. The Ombudsmen may discontinue an investigation if:

(a) There is no evidence of material fault by the Council
(b) The injustice claimed is not significant
(c) The Council provides a suitable remedy for the complainant

In all other cases the investigation will be concluded by the issue of either a public report or a statement recommending any appropriate corrective action and / or a suitable remedy which may include financial compensation. Recommendations are followed up to ensure compliance. Published reports and statements may be shared with PHSO, CQC, the Council and members of the public. LGO reports and statements will not generally name or identify in anyway the complainant or any other individual. The Ombudsman may direct that an issued report remain confidential, and not be made public, after balancing the public interest in publishing the report against the interests of the complainant or other persons concerned.

The approach used by CQC in handling complaints

3.6 The CQC first decides

- Whether the complaint is in remit (essentially whether this issue engages powers and duties of the MHA in respect of a detained or otherwise relevant patient); and
- Whether CQC can achieve a satisfactory outcome

If so, it has a range of possible interventions, including:

- Supporting the complainant in pursuing the complaint themselves against the body concerned
- Requiring information from the hospital managers
- Requesting that the hospital managers undertake or revisit an investigation
- Contacting a Mental Health Commissioner and asking them to visit and follow up the issues raised
- Investigating the complaint.

3.7 In all cases, CQC will monitor the outcome and decide whether any further action is required and advise of PHSO's role in the complaints process.

3.8 Where CQC upholds a complaint in whole or in part it may:

- Make recommendations to the hospital managers on remedies for the service failing (including recommendations for financial compensation to complainants);

- Refer findings of general application to its visiting teams and lead assessors for continued monitoring and review, who may, in turn, require services to publish statements as to the action they propose to take as a result of such monitoring or review[8].

General principles underpinning our collaborative working

4.1 PHSO, LGO and CQC acknowledge each other's statutory responsibilities and will take account of these when working together.

4.2 PHSO, LGO and CQC recognise the need to collaborate and cooperate to enable a particularly vulnerable group of people to get their complaints addressed as seamlessly and as effectively as possible. This Memorandum aims to provide clarity as to which route will secure the most useful outcome both in terms of resolving the matter for the individual as well as the wider issue of patient care and service improvement for those detained under the MHA.

4.3 PHSO, LGO and CQC agree that the principles underpinning our approach are:

- Being customer-focused: we will be clear about which body is best placed to deal with the complaint, liaising with each other as necessary and providing one named contact for the complainant.
- Being 'joined-up': we will take into account the 'fit' with our respective remits; the immediacy of the issues raised; the need to secure a timely and effective response; and the wider 'public benefit' test.
- Being proportionate: we will avoid double handling or pursuing unnecessarily protracted processes
- Being open and transparent in our dealings with each other.

Information sharing and liaison arrangements

PHSO statutory requirements

5.1 The Health Service Commissioner Act 1973 (s.15) prevents the Health Service Ombudsman from disclosing any information obtained in the course of, or for the purposes of, an investigation, unless this is *i) 'for the purposes of the investigation and any report to be made in respect of it* or

[8] MHA s.120B Note: action statements can only be required as an outcome of an investigation carried out under the general remit at MHA s.120 (1).

ii) the information is to the effect that any person is likely to constitute a threat to the health or safety of patients'

5.2 In order to establish which body is best placed to consider a complaint, PHSO may, therefore, share such information as is necessary to make that decision (*'for the purposes of the investigation'*). (The practical arrangements are set out in Annex 1).

5.3 PHSO may wish to share information arising from casework for the wider benefit of improving services for patients: this may include sharing potential concerns at an early stage; identifying more specific trends; and details of action plans, developed as a result of recommendations following the conclusion of an investigation. To this end, PHSO and CQC have developed a separate Memorandum of Understanding setting out the agreed protocols for doing so. *(Link).*

5.4 A list of named operational contacts is set out in Annex 1.

LGO statutory requirements

5.5 The Local Government Act 1974 [S32(2)] prevents the LGO from disclosing any information obtained in the course of, or for the purposes of, an investigation, except for the purposes of that investigation and any report or statement issued following completion of that investigation. A Council may serve a statutory notice on the LGO to the effect that disclosure of specified information would be contrary to the public interest. Such a notice would prevent the Ombudsmen communicating that information although the Secretary of State has the power to discharge the notice.

5.6 The Local Government Ombudsmen have statutory powers[9] to consult the Parliamentary and Health Service Ombudsman where they consider that a complaint relates partly to a matter within the remit of PHSO. The LGO and PHSO have the power to conduct joint investigations and to report jointly on complaints that cross the boundaries of their jurisdictions.

5.7 The LGO may, in the course of an investigation, share information with the CQC if it is necessary, and only if it is necessary, for the purpose of that investigation.

5.8 A list of operational contacts is set out in Annex 1.

[9] The Regulatory Reform (Collaboration between Ombudsmen)Order 2007

Relationship with other bodies

The First-tier Tribunal (Mental Health)[10]

6.1 The Tribunal is an independent judicial body. Its main purpose is to review the cases of detained, conditionally discharged, and SCT [Supervised Community Treatment] patients under the Act and to direct the discharge of any patient where it thinks it appropriate. Complaints which are, in effect, about being wrongly or unfairly detained will, therefore, be dealt with by the Tribunal.

The role of the Approved Mental Health Professional [AMHP]

6.2 Complaints from detained patients which are about (or include) the actions of an Approved Mental Health Professional (AMHP) in their exercise of a council function fall within the remit of the LGO. The type of complaint which could involve the AMHP are:

- The AMHP's role in making the application for compulsory detention under the MHA[11]
- The AMHP's role in approving the Responsible Clinician's decision to manage a patient by means of Supervised Community Treatment [SCT][12]
- The role of a council in acting as - or approving someone else to act as - the patient's Guardian
- S.117 Aftercare arrangements: any aftercare services required for a patient who is discharged from compulsory detention are provided free of charge under S.117 of the MHA. The Primary Care Trust and the Local Social Services Authority (LSSA) are jointly responsible for agreeing and providing the necessary aftercare services until such time as both are satisfied that they are no longer required. S.117 will automatically apply to any patient on SCT until such time as the patient is discharged as no longer requiring these services.

6.3 In the case of complaints to the CQC which also involve S.117 aftercare arrangements, the joint responsibility of the Primary Care Trust and the Local Social Services Authority will generally require liaison with PHSO and LGO to determine the most effective way of dealing with the complaint. All three bodies will identify a named contact for the purpose of ensuring effective coordination and supporting good customer service.

---

[10] The First-tier Tribunal has replaced the former Mental Health Review Tribunal (MHRT) in England. It was established under the Tribunals, Courts and Enforcement Act 2007. There will be a right of appeal, on a point of law, from this Tribunal to a new Upper Tribunal.

[11] The Local Government Act 1974 empowers the LGO to investigate complaints about the functions of a local authority. It will not generally consider the merits of the AMHP's decision-making, but will review the process and whether or not this was undertaken in accordance with the law and the Code of Practice.

[12] See page 12, footnote 21.

Relationship with other policies/legislation

Mental Capacity Act 2005 (MCA)

7.1 The MCA sets out a single clear test for assessing whether a person lacks capacity to make a particular decision at a particular time and describes a list of factors that decision-makers must take into account in deciding what is in a person's 'best interests'. Giving medical treatment to someone who lacks capacity to consent, can be done lawfully providing it is in his or her 'best interests' (although there are limitations, described in the Act).

7.2 The MCA sets out the provisions whereby people can plan ahead for a time when they may lack capacity. **NOTE**: advance decisions to refuse treatment are rendered ineffective if the patient falls within the scope of Part IV (Consent to Treatment) of the MHA.

7.3 The MCA has established important '*Deprivation of Liberty Safeguards*' (DOLS) to protect people whose liberty needs to be restricted in order to receive care and/or treatment that is in their best interests. A DOLS authorisation must be in place (commissioned by the PCT or LA) and a representative appointed to look after the person's interests[13].

Code of Practice: Mental Health Act 1983

8.1 The Code provides guidance to registered medical practitioners, approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking duties under the Mental Health Act. Whilst the MHA does not impose a legal duty to comply with the Code, the people listed above to whom this Code is addressed must have regard to it. The reasons for any departure must be recorded, as departures from the Code could give rise to legal challenge.

Signed

Name: Ann Abraham (Parliamentary & Health Service Ombudsman)

Date: 24 June 2010

Signed

Name: Cynthia Bower (CQC)

Date: 02 June 2010

[13] In support of DOLS, the MCA creates the following important safeguards: i) Court of Protection ii) Office of the Public Guardian and iii) Independent Mental Capacity Advocate (IMCA).

Signed 

Name: Tony Redmond Local Government Ombudsman (London)

Date: 30.6.10

Signed 

Name: Jane Martin Local Government Ombudsman (Coventry)

Date: 30.6.10

Signed 

Name: Anne Seex Local Government Ombudsman (York)

Date: 30.6.10

ANNEX 1

A. Detailed arrangements for working together on handling complaints

Scope of matters within the remit of the CQC

1.1 Complaints from **detained or otherwise relevant patients** about the matters listed below will be dealt with by the CQC insofar as they a) arise as a result of being detained (or liable to be detained); b) relate to the application or discharge of one or more powers or duties under the MHA; and c) can best be dealt with by immediate intervention.

i) The provision of information relating to detention[14]
ii) Care and treatment under the powers of the MHA Part 4 and 4A[15]
iii) Locked wards
iv) Disclosure of confidential information[16]
v) S.17 leave and restricted visiting[17]
vi) Personal and other searches and removal of belongings[18]
vii) Restraint/seclusion[19]
viii) Complaints relating to the operation of the Second Opinion Approved Doctors (SOAD) scheme[20]
ix) Supervised Community Treatment (SCT)[21]
x) Guardianship[22]

---

[14] The MHA (s.132) requires hospital managers to ensure that detained patients (or those on SCT) are provided with information to understand how the Act applies to them.
[15] Medical treatment given under the terms of the MHA is defined broadly in s.145 (1) and (4) to include "nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care" "for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations". As such it will be open to CQC and PHSO to discuss and agree to prioritise one or other organisation when medical treatment is the root of the complaint.
[16] The MHA permits a number of situations where confidential information about detained patients will need to be disclosed, even if the patient does not consent.
[17] The Responsible Clinician (RC) can permit leave of absence under s.17 of the MHA. Hospital managers must have a policy on the restriction or exclusion of patient visits.
[18] Hospital managers must have written operational policies on searching patients, their belongings and their visitors. The CQC has specific powers to review a decision to withhold postal packets.
[19] Hospital managers must have written policies on the use of restraint and physical interventions.
[20] SOADs provide an additional safeguard to protect patients' rights, primarily by deciding whether certain treatments are appropriate and issuing certificates accordingly. SOADs are required to consult two people ('statutory consultees') before issuing a certificate approving treatment.
[21] SCT provides a framework for the management of patient care in the community rather than under detention and gives the RC the power to recall the patient to hospital for treatment if necessary. The decision whether SCT is the right option is taken by the RC **and requires the agreement of the AMHP;** as such, the CQC will liaise closely with the LGO where it is appropriate. [Note: Patients on SCT are entitled to after-care services under s. 117 of the Act, the planning of which are the responsibility of the PCT and the LSSA].
[22] The CQC is responsible for reviewing the exercise of powers in relation to Guardianship: the purpose of guardianship is to enable patients to receive care outside hospital when it cannot be provided without the use of compulsory powers. **A guardian may be the LSSA or someone else approved by the**

xi) Complaints relating to Section 117 aftercare for previously detained patients[23]

Scope of matters to be dealt with by PHSO

2.1 Complaints about NHS commissioned mental health services where the complainant is not detained under the MHA and who is not otherwise a 'relevant patient'. This will include complaints from those patients who have agreed to hospital admission on an informal basis following assessment for possible compulsory detention.

2.3 Complaints about NHS services provided during a period of detention or to a relevant patient, unless these relate to the application of one or more powers under the MHA, in which case these may be more appropriately dealt with by the CQC.

2.4 Complaints from detained (or otherwise relevant) patients about the way in which the CQC has dealt with their complaint.

Scope of matters to be dealt with by LGO

2.5 Complaints about the actions of any council, including complaints about the actions of anyone acting on behalf of a council in the exercise of a statutory function, in so far as those actions impact upon a person subject to the application of the Mental Health Act.

Dealing with specific cases

3.1 Where PHSO, LGO or CQC receive a complaint from a detained (or otherwise relevant) patient or someone acting on their behalf which it considers should be dealt with by one or both of the other parties to this Memorandum, anonymised details of the complaint will be sent to the appropriate point of contact and agreement sought to the way forward. If agreement is reached in principle, the referring body will confirm this to the complainant, provide contact details and offer to forward papers on their behalf if they consent to this.

3.2 When CQC write to complainants, concluding their involvement in a complaint against an NHS body, it will include in that letter an agreed form of wording to refer to the Health Service Ombudsman, who will consider first, the handling of the complaint by the CQC and, additionally, if she so decides, the substance of the complaint itself.

LSSA (a 'private guardian') and is social-care led. Guardians have the right to decide where a patient should live; can require the patient to attend for treatment; and demand that a doctor and an AMPH has access to the patient where s/he lives.

[23] See paragraphs 6.2 - 6.3 page 9. The PCT and the LSSA are jointly responsible for agreeing and providing the necessary aftercare services until such time as both are satisfied that they are no longer required. The CQC will, therefore, liaise with PHSO/LGO as necessary and as set out in this Memorandum.

3.3 Paragraph 5.3 of this Memorandum above refers to the separate Memorandum of Understanding between PHSO and CQC, outlining the ways in which it is intended to share information about any particular issues or emerging themes from our casework for the benefit of patients and improved quality of service provision.

The process of assessment for compulsory detention

4.1 Complaints about the process of assessment for detention under the MHA do not fall within the remit of the CQC, unless:

- The person being assessed was liable to detention at that time (i.e. detained under holding powers of either s.5, s.135 or s.136); or
- The assessment led to detention under the Act.

4.2 Where a person assessed is neither liable to detention at the point of assessment, nor detained as a result of that assessment, complaints about that assessment cannot be considered by CQC. A complaint about the role of the AMHP in that process falls within the remit of the LGO because it is the Council as the LSSA which has the statutory duty to appoint sufficient AMHPs to carry out this function under the MHA (see paragraph 6.2 of this Memorandum). Complaints about the s.12 doctors' assessments may not be within the Health Service Ombudsman's remit but can be put to the professional regulatory body concerned (see page 5 footnote 7 of this Memorandum).

B. List of operational contacts

PHSO: Customer Services & Assessment
James Johnstone 0300-061-1533 Email: james.johnstone@ombudsman.org.uk

Chris McAlpine 0300-061-4401 Email: chris.mcalpine@ombudsman.org.uk

CQC: Information & Advice Operational Lead
Craig Jennings 0115 873 6276 Email: Craig.Jennings@cqc.org.uk

LGO: Assistant Ombudsmen (Social Care)
London
Janette Cuthbert 0207 217 4666 Email: J.Cuthbert@lgo.org.uk
Coventry
Donna Rutter 0247 682 0045 Email: D.Rutter@lgo.org.uk
York
Neil Hobbs 01904-380-229 Email: N.Hobbs@lgo.org.uk