Title: Mental Health Act 1983: Code of Practice 2015 **IA No:** 7086 **Lead department or agency:** Department of Health **Other departments or agencies:** Ministry of Justice Home Office	**Impact Assessment (IA)** **Date:** 16/03/2015 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Other **Contact for enquiries:** Dr Nicola Guy & Dr Alexandra Lazaro; mentalhealthcode@dh.gsi.gov.uk

Summary: Intervention and Options

RPC Opinion: Not Applicable

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year** (EANCB on 2009 prices)	**In scope of One-In, Two-Out?**	**Measure qualifies as**
£82.0m	0	0	No	In/Out/zero net cost

What is the problem under consideration? Why is government intervention necessary?

A number of reports highlighted significant concerns with the quality of care under the Mental Health Act (MHA) and lower health outcomes for these patients. CQC's annual report consistently highlighted that safeguards were not being properly applied. Evidence from Winterbourne View Hosptial most clearly illustrated the potential consequences where this was the case. Since 2008, when the previous Code was published, there have been changes to primary legislation, case law, professional practice and policy which need to be reflected. Stakeholders advised that in some areas the 2008 Code was confusing, contradictory or did not give useful guidance to support professional practice and delivery of consistently high quality care.

What are the policy objectives and the intended effects?

The primary and overarching policy objectives are to ensure consistenlty high quality care for patients subject to the Act, enhance equality, promote recovery and positive health outcomes. Patients, their families and carers, and professionals will have greater awareness and understanding of the Act, its safeguards, their rights and responsibilities and are better able to be involved in decisions about care and treatment and raise concerns if they think the Code is not being properly applied. In particular, the Code supports delivery of a number of key commitments in 'Closing the Gap' including to promote recovery, reduce the use of restrictive interventions and eliminate discrimination.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Two main options were considered:

- Option One: Do nothing. This would mean retaining a Code, that is out of date, not reflective of current best practice and ignores concerns raised in CQC's annual MHA report and at Winterbourne View or support delivery of 'Closing the Gap'.

- Option Two (option undertaken): Revise the Code. Since 2008 (when the Code was previosuly published) there were changes and updates in legislation, policy, case law, and professional practice. Updating the Code to reflect these changes ensured that our guidance is consistent with best practice and up to date, whilst addressing specific concerns raised in CQC's annual MHA reports and other places, especially about application of the Act and the quality of care at Winterbourne View Hospital.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 04/2018

Does implementation go beyond minimum EU requirements?			Yes / No / N/A		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** Yes/No	**< 20** Yes/No	**Small** Yes/No	**Medium** Yes/No	**Large** Yes/No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs.

Signed by the responsible SELECT SIGNATORY: Date: 16/3/15

Summary: Analysis & Evidence

Policy Option 2

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2014	PV Base Year 2014	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:** £82.0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional	1	Optional	**Optional**
Best Estimate	£3.7m		£16.3m	**£85.4m**

Description and scale of key monetised costs by 'main affected groups'

Costs with opportunity costs 4 times higher (e.g. costs of £21m with an opportunity costs of £85.4m) covering: Increasing transparency, accountability and greater involvement of patients and carers; Reviewing existing policies on seclusion, segregation; holding more people in health-based place of safety when detained under section 136 of the Mental Health Act, providing more Independent Mental Health Advocates; updating chapter numbers in policices; extra staff to lift blanket restrictions.

Other key non-monetised costs by 'main affected groups'

Potential cost redistribution between NHS providers, commissioners and local authorities; Costs of providing separate and appropriate sleeping and washing facilities due to family history, religious, cultural, and other reasons

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate			£33.5	**£167.4**

Description and scale of key monetised benefits by 'main affected groups'

Reduced anxiety due to increased transparenct & accountability of decisions on detentions & discharge; greater involvement of the patient in care planning; increased use of health-based places of safety; increased availability of independent mental health advocates; improved ways of communication, reduction in blanket restriction, reduction in the use of seclusion and segregation. Cost savings to Police due to fewer patients under section 136 are being detained in police stations.

Other key non-monetised benefits by 'main affected groups'

Quicker recovery of patients. Increased psychological well-being of carers, family members and care staff.

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5%

(1.5% discount rate for health benefits).

Key cost assumptions include the assumption that providers can deliver training on the changes in the Code as part of their recurrent training at no extra cost. The key benefit assumptions include the assumption that all patients who are detained under the Mental Health Act will experience a 0.04 QALY gain due to the reduced anxiety (which is assumed to be the outcome of the revised Code).

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	Yes/No	IN/OUT/Zero net cost

Mental Health Act 1983: Code of Practice
Impact Assessment number: 7087

Evidence Base

1.0 Background, context and rationale

1.1 This impact assessment provides analysis of the costs and benefits of the Government's new *Mental Health Act 1983: Code of Practice* 2015,[1] including a considering impacts of the wider programme including the revised Reference Guide,[2] web portal and accessible materials. It relates to the costs and benefits identified in relation to the specific revisions and enhancements in the 2015 Code. The changes to the Code are made subject to the parliamentary procedure set out in section 118 of the Act and will come into force on 1 April 2015.

1.2 The Code is statutory guidance, made under section 118 of the Act, which is addressed to registered medical practitioners, approved clinicians, managers and staff of hospitals and care homes, AMHPs, and other professions in relation to the medical treatment of patients suffering from mental disorder). As a matter of law, the Code must be followed by those to whom it is addressed unless there are cogent reasons for not doing so (R (Munjaz) v Mersey Care National Health Service Trust [2005] UKHL 58[3]). If such professionals' use of the Act is legally challenged, the guidance given in the Code will be relevant in determining the challenge. The Code is not statutory guidance for others, including commissioners of health services, the police and ambulance services, and others in health and social services (including the independent and voluntary sectors), but offers helpful guidance. The Introduction to the Code clarifies the use of terminology such as must, should, and could/may/can.

1.3 We are not revising the primary or secondary legislation.[4] The revisions to the Code provide guidance on legislation already in place and case law. In cases where an existing regulation is being updated or replaced and where compliance with the existing regulation is not 100%, cross-government guidelines require the impact assessment to take the actual compliance as the baseline, but assume 100% compliance with the updated regulation. This is the approach taken within this Code as the Care Quality Commission's (CQC) annual reports consistently show that some of the current guidance in the existing Code is not adhered to.[5] Since 2008 there have been changes and updates in legislation, policy, case law, and professional practice that also need to be reflected in the Code. These changes, plus the comments received during our public consultation July-September 2014, form the basis of the changes in the new Code.

1.4 In *Transforming Care: a national response to Winterbourne View Hospital,*[6] the Department of Health committed to reviewing and consulting on a revised Mental Health Act 1983: Code of Practice (the Code) and publishing a new version by the end of 2014, which would take account of the findings of the investigations into Winterbourne View. In

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf

[2] Department of Health. *Reference Guide to the Mental Health Act 1983.* 2015. www.gov.uk/government/publications/reference-guide-to-the-mental-health-act-1983.

[3] Regina v Ashworth Hospital Authority (now Mersey Care NHS Trust) (Appellants) *ex parte* Munjaz (FC) (Respondent). 2005. UKHL 58. www.bailii.org/uk/cases/UKHL/2005/58.html.

[4] The Government's Consultation Response did indicate two areas where we sought to consider further change legislation and the recent consultation paper, *No Voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf , also set out potential changes to primary legislation. The impact of any changes to primary or secondary legislation will be set out when any changes are proposed, and covered by an associated impact assessment.

[5] Care Quality Commission. Annual reports. www.cqc.org.uk/taxonomy/term/49.

[6] Transforming Care reference. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

January 2014 the Government published *Closing the Gap: priorities for essential change in mental health*[7] outlining its 25 priority areas for action. The new Code is a key lever for facilitating these changes, for patients subject to the Act, their families and carers.

1.5 The Department actively engaged with patients, former patients, carers, professionals and other stakeholders to identify issues they would like clarified. The major issues identified that can be addressed by the Code, are included in the new Code.

1.6 During our public consultation (July-September 2014) we asked two questions (Q35 and Q36) on the consultation stage impact assessment.[8] These responses were independently analysed to assist the Department of Health in preparing this final impact assessment. A small number of responses commented on the consultation-stage impact assessment (14 or 5% of total received commented on Q35 and seven or 2% of total received commented on Q36). Of those that responded 10 (71%) of those commenting thought the impact assessment was sufficient, and only one response (7%) did not think this was the case.[9] Comments about specific changes or things that needed to be included have been incorporated in this impact assessment. Our consultation response[10] provides more information on the specific comments received.

1.7 For this final impact assessment, it was decided to separate the financial impact assessment from the analysis of equality considerations. We have separately published an Equality Analysis, including consideration of Q6 in the consultation.[11] These two documents should be read together.

2 What policy options have been considered?

2.1 Option 1: Do nothing

- This option would mean retaining the 2008 Code for the Act. This would enable continuity for professionals in a Code that they are familiar with, is well used and generally provides good guidance on key areas of the Act.
- Pursuing this option would result in having a Code that was out of date and not reflective of changes since 2008 in legislation, policy, case law, technological developments and professional practice.
- The Care Quality Commission's (CQC) annual reports on the Act have identified areas where the safeguards of the Act were either not applied or where there were concerns with the quality and safety of care being delivered. CQC raised concerns about the Code not being applied or not being applied appropriately.[12]
- Stakeholders highlighted a number of areas where the existing Code is confusing or could be improved to support improved compliance.
- Evidence from CQC and others strongly indicated that patients and carers had little awareness of the Code, or understanding of their rights under the Act. This option would ensure that this continued.

[7] Closing the Gap: essential: priorities for change in mental health. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf
[8] Department of Health. *Consultation Stage Impact Assessment,* 2014. www.gov.uk/government/uploads/system/uploads/attachment_data/file/330710/MHA_CoP_Impact__Equality_Assessment.pdf
[9] Independent analysis of responses provided by The Evidence Centre: *Stronger Code: Better Care: Feedback from the consultation about revising the Mental Health Act (1983) Code of Practice*. 2014. Unpublished.
[10] Government Response to the Code of Practice Consultation 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396126/mha-con-res.pdf
[11] Department of Health. *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice
[12] Care Quality Commission. Annual reports. www.cqc.org.uk/taxonomy/term/49.

2.2 Option 2: Revise the Code

- Revising the Code does not affect the existing legislation, but aims to address some of the issues raised by CQC, in the response to Winterbourne View, and in the Health Select Committee review of the Mental Health Act 2007.[13]
- Updating the Code enables the changes and updates in legislation, policy, case law, and professional practice to be reflected in the Code. The accumulation of these changes indicate that now is a suitable time to update the Code in order to ensure that it is up to date and fit for purpose. This would increase clarity, remove confusion and assist professionals at key points.
- Stakeholders have strongly supported the need to update the Code in a number of key areas, whilst acknowledging that in many others it provides high quality, useful and timely guidance.
- Stakeholders, especially patients, former patients and their families and carers have reported little knowledge and understanding of the Code and the protections it provides. Making the Code more accessible and increasing awareness could fundamentally improve and increase the voice of these stakeholders in decisions about their care and treatment. This includes further actions to promote awareness and accessibility. For more information see the accompanying Equality Analysis.[14]

2.3 Option 3: Update the legislation *and* revise the Code (not considered further)

- This option was briefly considered but was not considered a viable option.
- Stakeholders did not generally favour a comprehensive reconsideration of the primary legislation in the shorter term and preferred an update to the Code as it could be implemented much more quickly.
- The consultation document *Stronger Code: Better Care*[15] included a small number of suggestions about possible changes to the secondary legislation which we sought views on. The Consultation Response set out that these would be taken forward.
- The consultation document *No voice unheard, no right ignored – a consultation for people with learning disabilities, autism and mental health conditions*[16] included potential changes to primary legislation. This consultation document took account of feedback received on the consultation on the Code of Practice in summer 2014 in developing its proposals.

2.4 Overall costs and benefits of Option 1 - Do nothing

- The costs of doing nothing would be to perpetuate and exacerbate the issues identified in the Serious Case Review into Winterbourne View, the CQC's Annual Act Reports and those identified through our engagement with patients, carers and service providers. Unless changes were made and the Code was made clearer and stronger in certain areas, we expect that problems will persist around the roles and responsibilities of commissioners, service providers and the rights of service users, their families and carers. These costs cannot easily be estimated or monetised, though the anecdotal evidence that has emerged from cases like Winterbourne View, indicates that human costs are very high.

[13] WV Serious Case Reform and Transforming Care reports, HSC report, CQC reports – see Equality Analysis on these : *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[14] Ibid *Equality Analysis*.

[15] https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[16] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf

- Option 1 would avoid any transitional costs to services associated with revising and implementing a new Code.

3 Overall costs and benefits of Option 2 – Option taken forward

- Option 2 allows the Code to reflect developments in legislation, policy, case law and current good professional practice and to provide improved guidance to those exercising powers under the Act. And address concerns raised about current practice and clarify ambiguities and uncertainties.
- In terms of costs, the Code itself clarifies existing legislation, but does not introduce new burdens.
- The Code Introduction sets out the use of the terms “must”, “should”, and “could/may/can” used in the document. “Must” is only used in relation to things currently in statute including other pieces of legislation such as the Mental Capacity Act 2005.
- The Munjaz case set out that people should have “due regard” to the Code but that departure was permissible. Further information is provided in the Code Introduction paragraphs ii-ix and figure iii.
- Benefits are included under the specific impacts considered in this impact assessment. Further benefits are set out in the Equality Analysis and Consultation Response.
- Examples of benefits include:
  - Enhancing awareness and understanding of the Code by patients, carers and professionals;
  - Greater recovery through least restrictive options, shorter periods in hospital and being located closer to home;
  - Provides greater safeguards for patients and reduces the likelihood of poor quality care;
  - Promotes the involvement of patients, and as appropriate, nearest relatives and carers, in discussions about care and treatment;
  - Reduces the likelihood of police cells being used as places of safety and for reduced lengths of time;
  - Reduces the likelihood of restrictive practices and associated issues to do with psychological harm and delayed recovery for patients and injuries to staff;
  - Promotes equality and reduces any discrimination;
  - Makes it clearer when the Mental Health Act should be used and when the Mental Capacity Act;
  - Enhances transparency, accountability and scrutiny of discharge decisions;
  - Some new inclusions reflect policy development and best practice to improve quality of care;
  - Enabling people to complain more easily if they identify concerns with care and treatment; and
  - Ensures that people who lack capacity, do not speak English, have sensory impairments or other needs for reasonable adjustments have these taken into account and everything possible is done to overcome the barriers.

3.1 Preferred option: Option 2 was strongly preferred and was taken forward because:

- Updating the Code of Practice enabled the Department to relatively quickly provide greater clarity around certain areas of the use of the Act to reflect developments in legislation, policy, case law and current good professional practice.

- Stakeholders were strongly supportive of this approach, especially the need to address major issues raised by CQC and the need to ensure policy improvements set out in *Closing the Gap* apply equally to patients detained under the Act.
- Option 1 would have meant that confusion in a number of key areas would remain and that the existing guidance was not reflective of the legislation, policy or practice in key areas. In particular, it would not enable the benefits of greater awareness and understanding on the part of patients, their families, carers and professionals to be fully realised.

3.2 Specific impacts

- In cases where an existing regulation is being updated or replaced, and where compliance with the existing regulation is not 100% cross-Government guidelines[17] require the impact assessment to take the actual compliance as the baseline, but assume 100% compliance with the updated statutory guidance. Analysis of impact has therefore been taken to be the difference between compliance levels and 100% compliance with the new Code.

4 Individual changes of significant impact

Change A: Better joint working between professionals, NHS-funded providers, commissioners and local authorities.

The new guiding principle 'Efficiency and equity' requires commissioners, providers and other relevant organisations to establish effective relationships to ensure efficient working and accountability defined through joint governance arrangements. This will enable them to provide more holistic and joined up packages of care, that considers the whole patient, and both their mental and physical health needs.

Benefits

This should enable better care and treatment, less delay in care planning and therefore discharge, and a more joined up approach. Good joint planning, which takes account of the patients history and circumstances, should reduce the "revolving door" of individuals being repeatedly detained in hospital. This should promote recovery and reduce costs especially in the longer term. It promotes Governmental policies on personalisation and integration.

Risks

This requires all 'partners' in the system to cooperate and work closely together in the interests of the patient. With tight budgets organisations can sometimes look inwards rather than looking at overall benefits to the patient and the public purse. Currently, the number of detentions is continuing to increase,[18] which illustrates that the benefits of cooperation are not yet bearing down on the use of detention. The emphasis in the Code on the overarching principles, joint working and the duty of integration in the Care Act 2014 mitigate against this.

[17] See paragraphs 103-106 of the guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/31608/11-1112-impact-assessment-toolkit.pdf

[18] Health and Social Care Information Centre (HSCIC). *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual report, England 2013/14*. 2014.www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-rep.pdfhttp://www.hscic.gov.uk/catalogue/PUB15812/inp-det-m-h-a-1983-sup-com-eng-13-14-exp-tab-v2.xls

Costs

The revised Code aims to facilitate better joint working between the NHS, local authorities and providers with more holistic, integrated packages of care, considering how best to provide the right care at the right time. This can lead to cost savings in the long run, but may lead to changes in the distribution of costs between the NHS and local authorities in the shorter run, for example more timely movement between NHS funded hospital care and jointly funded NHS and local authority aftercare in the community, In addition the greater transparency around decisions on detentions and discharge may mean that some people, who are currently held in a more restrictive setting than would be clinically appropriate, may be discharged to the community. This would similarly drive a cost re-distribution from NHS hospital services (including secure services) to CCGs and local authorities. These are decisions for local decision-makers rather than a requirement of the Code.

Change B: Increasing transparency, accountability and greater involvement of patients and carers

This range of changes (more transparency and accountability in decisions including discharge or renewal of detention, and greater awareness about one's rights when under the Act) are designed to ensure that patients, their families and carers are more informed and involved in the decisions that affect them.

Benefits

These policies should have a number of direct benefits. They should increase the dialogue and trust between professionals and their patients, potential future patients and family members. It will also mean that individuals are more likely to be able to seek recourse about things they disagree with or where the Code or provisions in the Act have not been properly applied. But it also means that issues should be resolved more rapidly. This is likely to lead to a reduction in anxiety for both patients and their families, which may be monetised in terms of quality adjusted life year (QALY) gains, quicker recovery and a reduction in complaints. Benefits to the individuals from compliance with Code, i.e. encompassing the overall effect of the changes can be found in section 5 of this document.

Risks

There is a possibility that the additional costs and requirements to ensure transparency outweigh the benefits of doing this, including putting additional pressures on staff. Regular initial and refresher training for both section 12 doctors and AMHPs will automatically be refreshed

Costs

The revised Code expects providers to make their policies and individual decisions more transparent, involve the patient and their nearest relative, and if different, carer, conduct more frequent reviews, and to increase accountability and scrutiny in decision making, not least by hospital managers. Data collection and analysis would be essential to achieve this.

To estimate associated costs we assume that achieving this would require ten days additional work by NHS mental health trust managers, and five days additional work by independent sector mental health hospital managers. We do not assume direct costs, only the opportunity cost of managers' time and employer's costs. We assume a five-year, linear transition for the system to reach its new steady state (reaching full compliance), giving a total cost of £1.3 million over this timeframe (see Appendix 1).

Change C: Training of staff who use the Code in undertaking duties under the Act

A range of professionals are likely to require a half-day refresher training setting out the changes in the Code. Examples include mental health nurses, psychiatric doctors, section 12 doctors, Approved Mental Health Professionals (AMHPs), Independent Mental Health Advocates (IMHAs), police officers, clinical commissioning groups (CCGs), CQC inspectors, Mental Health Act reviewers (part of CQC), and hospital managers.

Benefits

Professionals will be up to date with the changes and able to adapt their practice to reflect this. This should increase clarity and reduce poor practice such that compliance with the Code increases and risk of legal challenge reduces.

Risks

Training may be inconsistent or insufficient to instil knowledge or may incorrectly interpret guidance leading to perpetuation of poor practice. Most providers will probably provide half a day's training, but this may be insufficient. This could be supplemented through cascade training, on the job training and self-learning of the new Code. Regular initial and refresher training for both section 12 doctors and AMHPs will automatically be refreshed.

Costs

This should not constitute a considerable additional burden on providers, as staff, who are expected to deal with patients who are subject of the Mental Health Act, already receive training on the Mental Health Act and the Code of Practice with annual refreshers.[19]

As service providers and professional bodies will anticipate the publication of the revised Code (and, from the consultation documents, they will also have a good understanding of the likely changes it will include), it will be possible to schedule annual refresher training courses to include the revised Code. In these cases, there will not be any additional training-requirement (apart from replacing its content – which is not assumed to be considerable), and therefore the training will impose *no extra* opportunity cost (in terms of the value of the best alternative use of staff members' time while attending the training) or direct costs on providers. The Department has developed a generic slide pack summarising key changes to assist this.

Change D: Reviewing and revising existing policies on restraint, seclusion, segregation, enhanced observation, rapid tranquilisation, mechanical restraint

The new Code provides enhanced guidance in relation to measures to avoid the use of restrictive interventions, as well as establishing a range of procedural safeguards where, as a last resort, they have to be used. These changes serve the purpose of bringing the Code into alignment with 2014 guidance *Positive and Proactive Care: reducing the need for restrictive interventions* (PAPC).[20] Whereas PAPC applied only to adult patients, the Code renders many of its measures also applicable to children and young people who are in receipt of mental health

[19] For example, people who are expected to regularly deal with people under the Mental Health Act receive some 50 hours of training as part of their Continuing Professional Development – part of which is about the Mental Health Act and the Code of Practice.

[20] Positive and Proactive Care: reducing the need for restrictive interventions. Department of Health. 2014. https://www.gov.uk/government/publications/positiveand-proactive-care-reducing-restrictive-interventions

services; it also has the effect of escalating the recommendations in PAPC to the status of statutory guidance to certain people (see figure i in the Introduction to the Code).

Key Changes:

The Code requires that unless there is a cogent reason to do so, prone (face down) restraint must not be used. Restrictive interventions should not be used to humiliate or punish. These changes require provider organisations to review their existing policies for the use of physical interventions and in some instances to make changes to the associated training requirements.

The Code introduces changes to seclusion procedures and practice. Under the 2008 Code a multidisciplinary team (MDT) review was held as soon as practicable after seclusion commenced with subsequent nursing reviews every 2 hours and medical reviews every 4 hours. The MDT had the power to significantly change (and extend) review intervals. Under the new Code: nursing reviews should be completed a minimum of 2 hourly for the entire duration of seclusion; medical reviews should be four hourly until the MDT review whereupon they should, under no circumstances, be reduced to less than two medical reviews per day. The new Code also introduces a standardised content for medical reviews of patients in seclusion and, where these are undertaken by junior doctors, specifies the need for access to, and support from, an approved clinician.

The new Code introduces the use of security needs assessments. In the case of secure services, providers should ensure the balanced use of physical, relational and procedural security measures to reduce risks with an expectation that no single approach overshadows the others and that only people who need all three types of measures should be placed in secure settings.

Benefits

The revisions to the Code, together with PAPC, are designed to deliver on the Coalition Government's commitment to reduce the use of restrictive interventions in health and social care, and in particular in inpatient mental health care. The Serious Case Review into Winterbourne View[21] and other reports have shown the considerable costs to both patient and staff health and wellbeing of using restrictive interventions and that recovery can be delayed. These changes are designed to address these, whilst also keeping the patient, staff and others safe.

The reduced use of restrictive interventions, as well as an emphasis on de-escalation and alternative techniques, should lead to reduced confrontation, anxiety, stress, and trauma for patients, their families and staff. A more positive experience of health and care services will promote recovery and reduce the amount of time patients spend in hospital as well as supporting integration into society through improved participation in employment and community life, contributing to savings on the economic/social costs of mental health problems in England. Changes to the use of restraint and seclusion, as well as the balanced of use of security needs assessments will ensure that patients are better safeguarded and that their human rights respected in practice.

Changes to restraint practice will be associated with reduced restraint related injuries (and deaths), improved patient satisfaction, a reduction in complaints, reduced litigation, reduced damage to therapeutic relationships and reduced emotional trauma.

[21] South Gloucestershire Safeguarding Adults Board. *Winterbourne View Hospital: A Serious Case Review*. 2012. http://hosted.southglos.gov.uk/wv/report.pdf. Department of Health. *Transforming Care: a national response to Winterbourne View Hospital Review*. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf

Risks

Changes in seclusion practice will have greatest impact on doctors, as in some services medical reviews will need to occur with increased frequency. In particular this will impact on hospitals seeking to establish adequate arrangements for 'out of hours' cover. This is likely to prove more challenging for small providers in geographically remote settings and could potentially mitigate against the provision of services to patients who are likely to require periods of seclusion, in such localities.

Risks associated with the introduction of changes to seclusion practice and also the requirements for security needs assessments should relatively easily be overcome by providers. There are significant market forces in the provision of mental health services which are likely to incentivise providers to make the necessary changes.

In order to reduce the use of physical restraint and in particular to end the use of prone restraint and pain based techniques, all staff working with patients who are subject to detention under the Act will need to be appropriately trained in the use of relevant alternative techniques and supported, using a phased approach, to use alternatives to all forms of restrictive interventions. Given the size of the workforce that will be required to adopt alternative ways of working, the multitude of hospital service providers and the absence of a regulatory framework for providers of training in physical restraint techniques, some services may come up with 'divergence' or 'alternative' strategies to try and circumvent the new guidelines. A rigorous approach to regulation on the part of the Care Quality Commission (CQC) will be key to mitigating such risks.

For some staff and organisations, delivering against both PAPC and the new provisions within the Code will require a sustained and substantial change in culture and leadership. For some this may prove challenging however the risk of service providers struggling to deliver the necessary changes is already mitigated by the Department of Health's ongoing funded two year programme 'Positive and Safe' which was introduced to support organisations to deliver against the aims and objectives of PAPC; this includes work-streams relating to workforce issues, culture and leadership, commissioning, maintaining compliance and transparent reporting. Escalation of the PAPC requirements to the status of statutory guidance will ensure that delivery against this important agenda remains an important organisational priority for providers.

Costs

Mental health hospitals will be required to implement a number of changes to reflect the requirements of the revised Code in relation to the use of restrictive interventions including seclusion, segregation, rapid tranquilisation, mechanical restraint, as well as on enhanced observation. Many of these requirements were previously included in PAPC, therefore services are already working towards implementation by April 2015;[22] for this reason, they already form part of the baseline position.

In particular, the Code reaffirms the requirement that hospitals providing mental health treatment, should set up and regularly review a restrictive interventions reduction programme.[23] These should include improvement targets and clearly identify who is responsible for progressing the different parts of the plan.

[22] Positive and Proactive Care Briefing. NHS Confederation and Care Quality Commission. 2014. http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Positive-and-proactive-care.pdf

[23] Restrictive intervention reduction programmes are overarching, multicomponent action plans which aim to reduce the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of PAPC.

The Code restates the PAPC requirement for providers to assess patients on admission for potential risks of behavioural disturbance.[24] The results of the assessment should be used to inform the development and implementation of effective, personalised and enduring systems of support that meet patient's needs, promote recovery and enhance quality of life outcomes for the patient and others who provide care and support to them. Assessments should also be used to inform the development of individual behaviour support plans, which, based on an understanding of a patient's needs include circumstances that are likely to predict behavioural disturbance and consequent individualised preventative strategies.

The Code includes guidance on 'enhanced observation', on rapid tranquilisation, and additional guidance on mechanical restraint.

These all represent new guidance compared to the previous Code. The majority of requirements were previously included in PAPC. As these requirements were costed as part of the impact assessment of the costs and benefits of the Positive and Safe programme these will be uncosted within the current impact assessment. In other words, they form part of the baseline ('Do Nothing') scenario.

In 2013/14 93[25] children and young people were detained under the Act with a smaller proportion being subjected to restrictive interventions. As a component part of 'Positive and Safe', a second volume of PAPC with specific regard to children and young peoples' issues, as well as the needs of those in transition to adult services is currently being prepared. This will share the principles and, where appropriate, key actions contained in PAPC; publication is expected within the first quarter of 2015/16. The costs and benefits of children and young peoples' PAPC guidance will be fully costed as part of the impact assessment to support the ongoing implementation of *Positive and Safe*.

In a range of areas, the Code provides more detailed guidance on the nature of actions required by providers than PAPC. For instance, the Code requires providers to set up 'provider policies' to ensure and demonstrate adherence with PAPC, as well as to guide the day-to-day operation of services with specific regard to:

a) individualised assessments of risks and need for support;
b) the use of behaviour support plans;
c) how restrictive interventions should be implemented;[26]
d) how restrictive interventions which are used by the provider should be authorised, initiated, applied, reviewed and discontinued, as well as how the patient should be supported throughout the duration of the application of the restrictive intervention;
e) local recording and reporting mechanisms around the use of restrictive interventions;
f) post-incident analyses; and
g) workforce development, including training requirements relating to the application of restrictive interventions.

Such requirements are essentially practical guidance (or additional clarification) on how to implement the requirements of PAPC. For this reason, these are unlikely to impose a significant ongoing additional burden on providers compared to the baseline.

[24] Assessments should take account of the patient's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances. Assessments of behavioural presentation are important in developing an understanding of a patient's needs.

[25] Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014, Annual figures, p.22.
http://www.hscic.gov.uk/searchcatalogue?productid=16329&q=title%3a%22Inpatients+formally+detained+in+hospitals+under+the+Mental+Health+Act%22+&sort=Most+recent&size=10&page=1#top

[26] Including an assessment of the potential of restrictive interventions to cause harm to the physical, emotional and psychological wellbeing of patients and policy on how providers will take account of a patient's individual vulnerabilities to harm such as unique needs associated with physical/ emotional immaturity, older age, disability, poor physical health, past history of traumatic abuse etc.

Whilst at all time remaining in line with the aims of PAPC, there are a few areas where (because the code solely applies to patients subject to the provisions of the Act) the revised Code goes beyond PAPC in setting out specific requirements. This includes increased guidance on 'enhanced observation', mechanical restraint, rapid tranquilisation, as well as review procedures around seclusion and long term segregation. Given these additional requirements, providers will again need to review and possibly revise some of their existing policies.

In relation to the combined requirement for provider policy changes, it is assumed that NHS mental health trust managers will need to spend around five days reviewing and updating their existing policies, while for independent sector mental health hospital providers, around three days will be required. The rationale in assuming that it would take longer for NHS mental health trust managers is that these typically have a more varied patient mix and physical environment. We do not assume direct costs, only the opportunity cost of managers' time. We assume that this will be a one-off cost. There are 57[27] mental health trusts and 190[28] independent sector mental health hospitals in England. We assume that the average earnings of these managers are £79,000 and £60,000 respectively. Including employer costs, this gives a total opportunity cost of £0.3 million (see Appendix 1).

Monetised costs of non-use of prone restraint techniques (including training changes) were approximately quantified in the impact assessment for positive and proactive care and should be replicated. They largely centre on the training requirements of the workforce.

There should be no significant cost associated with requirements for security assessments as this is part of deciding on the most appropriate placement and care plan for an individual. Costs of changes to seclusion practice (and long term segregation) cannot readily be quantified. For large providers (especially in urban settings) there are likely to be none. However, for smaller providers and those in rural settings, there is typically less capacity for prompt attendance at hospitals by doctors. Providers will need to examine on-call arrangements and may need to develop additional capacity which may incur a recurring cost.

Change E: Fewer people who are detained under section 136 will be held in police cells and those that are will be held for less time

A revised chapter drafted with the Home Office and building on the Crisis Care Concordat,[29] focuses on reducing the use of police stations as places of safety in favour of health based places of safety.

Benefits

People should be assessed more quickly and in a setting that is able to care for them appropriately and where appropriate discharge them to community services more quickly. Police officers should be freed up to deal with other emergencies for which they are uniquely trained and equipped.

It is assumed that the current number of detentions (6,028 in 2013/14) in police cells will decrease to fewer than 17% of all section 136 detentions (or approximately 4,000) over five years. The average stay in custody is estimated at around 10 hours and the average cost for

[27] NHS Benchmarking, 2014/15

[28] List of independent sector mental health hospitals: http://www.carehome.co.uk/mental-health-hospitals/index.cfm/searchcountry/England/

[29] Crisis Care Concordat: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

each police detention is estimated at around £2,000.[30] This means approximately 2,000 extra people will be taken to hospital. It cannot be assumed that mental health hospitals, with their current occupancy rates[31] could necessarily accommodate this extra number without some extra investment in creating additional capacity. Due to the unpredictable frequency of these admissions, is assumed that each mental health trusts would have to invest in one more bed to deal with this caseload. The average cost of an inpatient bed day in mental health wards is approximately £325.[32]

In areas where "street triage" schemes are diverting people to mental health services before use of section 136 we are seeing a reduction in the overall number of people who are detained under section 136, but we do not have national figures to estimate the impact this may have over the next five years. This means the figures above should also be an overestimate of the costs of additional use of health-based places of safety.

It is not assumed that Police forces would be able to make direct savings by closing custody suites if fewer people were held in custody under section 136. But it can be reasonably assumed that these custody places could be used to accommodate prisoners when the number of cells in prisons becomes critically low (as part of the 'Operation Safeguard' contingency plan). The average cost of holding someone in a police custody is approximately £2000 per person per night, therefore using the same assumption as for the costs of additional health-based places of safety (five year transition during which compliance will linearly increase reaching 100% in the final year, affecting around 3,000 patients five years after the publication of the revised Code), this amounts to £15 million cost savings (see Section 5).

Risks

There may be insufficient capacity in health based settings especially at crucial times or in certain locations to meet demand. Patients may be taken to other unsuitable places of safety or held for longer to avoid use of police stations.

Costs

It is assumed that the current number of detentions (6,028 in 2013/14) in police cells will decrease to fewer than 17% of all section 136 detentions (or approximately 4,000) over five years. The costs are assumed to be the hospitalisation costs of the 2,000 people for an average of one day each (This is likely to be an over-estimate since section136 detentions typically last just over 10 hours, however, we need to allow for extra capacity to allow the system to deal with fluctuations in section 136 detentions. We are also examining whether the improvement of the system's overall response to mental health crisis is leading to a reduction in the overall number of people who are detained under section 136).

The revised Code strengthens the requirement that 'a police station should not be used as a place of safety except in exceptional circumstances'. Unlike the 2008 Code, which suggested that it was 'preferable for a person thought to be suffering from a mental disorder to be detained in a hospital or other healthcare setting where mental health services are provided', the revised Code sets out that 'in most cases, a person thought to be suffering from a mental disorder and taken to a place of safety under section 136 should be detained in a hospital or other health-

[30] This estimate is an aggregate based on figures provided by individual police services.

[31] Crisis Care Concordat:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

[32] Estimated approximated cost. See, for example, PSSRU Unit Costs of Health & Social Care 2014, available at:
http://www.pssru.ac.uk/project-pages/unit-costs/2014/

based place of safety'. It is expected that the strengthening of this requirement will lead to a considerable reduction in the number of cases where people are held in police custody rather than in a hospital. During 2013/14, an estimated 6,000[33] orders were made where the place of safety was a police custody suite, these account for 26% per cent of the total orders made under Section 136 during 2013/14. It is difficult to judge what proportion of these people were appropriately held in a police cell, and estimates from one area put this percentage at around 17%.

Based on this, it is assumed that as the outcome of the revised Code, 17% of those, who are held under Section 136, will be taken to police cells, suggesting that approximately 2,000 more people will be taken to hospital (2013/14 figures). The average length of stay of these people is 10 hours and 32 minutes[34] and the average cost to health services of each detention is assumed to be £2,000.[35]

It is assumed that the transition to the new steady state (in the reduction in the number of patients detained under section 136 who are taken to police custody) would take 5 years and that the rate of transition will be linear (20% in year 1, 40% in year 2 and so on). For the five-year transition period, these assumptions give a total discounted present value of £10.9 million (see Appendix 1).

Change F: More IMHAs will be provided

A new change has been proposed, to provide that if a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer.

Benefits

A Right to be Heard[36] sets out a long list of benefits of IMHA provision and recommended that provision be promoted for individuals whom lack capacity. This is likely to increase understanding and involvement of patients in discussions about care and treatment, and reduce patient anxiety and confusion. Given their specialist knowledge of the Act, IMHA are likely to provide an effective safeguard and champion of a patient's rights.

Risks

There may be insufficient capacity to provide the IMHA support required, in particular where this needs to be a specialist e.g. with knowledge of learning disability or autism, or to accommodate cultural or religious preferences. There is also a need to adequately support individuals who are deaf, for whom English is not a first language or who have difficulty communicating for other reasons.

Costs

The revised Code requires that if a patient lacks capacity to decide whether to seek help from an IMHA, an IMHA should be introduced to the patient so that the IMHA can explain what help they can offer.

[33] Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment Annual report, England, 2013 http://www.hscic.gov.uk/catalogue/PUB12503/inp-det-m-h-a-1983-sup-com-eng-12-13-rep.pdf

[34] http://www.publications.parliament.uk/pa/cm201314/cmpublic/care/140204/am/140204s01.htm#Column597

[35] E.g. http://www.cheshire-pcc.gov.uk/Document-Library/Policies/Mental-Health-Strategy-2013-15.pdf

[36] The Right to be Heard: Review of Independent Mental Health Advocate (IMHA) Services in England. University of Central Lancashire. 2012.

The CQC has found that in 2012/13, patients in 92%[37] of wards had access to IMHA services. In 2012 Newbigging et al[38] found that providers spend £162 (£165 when updated with today's prices) on IMHA services per qualifying patients (including training costs and overheads). The cost of ensuring that, following the publication of the revised Code, all qualifying patients estimated not to be in receipt of the services will have access to IMHA services, is estimated to be up to £0.7million each year. For a five-year period following the publication of the revised code (so that the cost-calculation remains consistent with the calculation of other recurrent cost items in the impact assessment) the present discounted value of costs will total £3.2 million (see Appendix 1).

We acknowledge that take-up rates of IMHA services (in terms of the proportion of eligible patients who request IMHA services) could increase as the outcome of the revised Code. Feedback, including during the consultation, from stakeholders did not provide robust evidence which would allow us to estimate this, nor whether it would increase the costs of a service.

We acknowledge that training IMHA who can provide services in different languages, and who can help people who have learning disabilities or other types of communication problems may cost more, for which reason the estimates presented above might be underestimating the costs.

Change G: Provision of separate and appropriate sleeping and washing facilities due to family history, religious, cultural, and other reasons

The Code already required that separate sleeping and washing facilities are provided for men and women. Compliance with the guidance on sleeping accommodation (as measured by monthly breach reporting) is extremely high, but CQC reports some non-compliance relation to toilet and bathroom accommodation (see Equality Analysis for more information). The changes introduced ensure that the revised Code conforms with guidance introduced in 2009 and 2010 in relation to single sex accommodation.[39] These changes also highlight other reasons why separate facilitates may be required.

The impact assessment that accompanied the introduction of policies on single sex accommodation previously quantified the costs to the NHS of introducing these, and £100m was provided via strategic health authority (SHA) finance teams to support implementation.[40] Given this the failure to comply by some organisations is particularly disappointing and we will be expecting to see swift compliance in this area with the requirements set out in the 2015 Code.

Benefits

Ensuring separate sleeping and washing facilities is a key means of advancing equality and reducing discrimination (see Equality Analysis) and promoting recovery for these individuals. Evidence indicates that where these are not available there are greater numbers of complaints, self-harm and that lack of these can be a trigger for confrontations and use of restraint.

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[37] Monitoring the Mental Health Act in 2012/13. Care Quality Commission. 2014. p. 26. http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

[38] Newbigging, K. *et al* (2012) 'The Right to Be Heard; Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England', University of Central Lancashire, http://www.uclan.ac.uk/research/environment/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf

[39] 2009 DH Guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200215/CNO_note_dh_098893.pdf . 2010 DH Guidance: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf

[40] https://www.gov.uk/government/publications/impact-assessment-of-delivering-same-sex-accomodation; http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098893.pdf

Risks

Providers have already had 5 years and funding to enable compliance. It is therefore considered a small risk that it may not be possible for all providers to provide these reasonable adjustments.

Costs

Some patients may request separate living accommodation e.g. due to transgender or separate washing facilities e.g. for religious, cultural or other reasons. These costs are not quantified due to the very variable circumstances that may be require these and which it is not possible to model and because these requests are covered by the Equality Act 2010.

Change H: Some people will be discharged, either completely, or to community treatment order (CTO) or guardianship

The Code includes the guiding principle 'Least restrictive option and maximising independence'. This will encourage, where appropriate, discharging an individual or placing them in the community under a CTO or guardianship.

Benefits

People living in the community are more likely to maintain contact with family and friends, which has been proven to be a key driver in promoting recovery and reducing the amount of time spent in hospital, including over the longer term.

Risks

To be fully effective this requires a high degree of inter-agency joined up working. Evidence since CTOs were first introduced has indicated that the expected benefit of a corresponding reduction in detentions has not materialised. The full cost-benefit study of the use of CTOs has not yet been completed. The revised Code emphasises the need to make decisions on the use of CTOs only for patients who will benefit from them and ending their use as soon as they are no longer appropriate.

Costs

It is not possible to accurately judge whether the new Code will increase (through emphasis on least restrictive option) or decrease (through emphasis on more discriminating use of CTOs and clear discharge procedures) the use of CTOs. An increase in CTOs may lead to some costs shifting to local authorities paying for support for people whose hospital care costs are currently completely funded by the NHS. As the number of CTOs has been increasing in the previous years, we do not expect large changes above those already occurring. If CTOs did increase at least some of those would be people who would otherwise be receiving s117 aftercare, with the same cost to local authorities. The overall impact of a significant move to the least restrictive option is likely to be an overall reduction in care costs, given the high costs of inpatient care.

Change I: A large number of organisations such as local authorities, commissioners, and providers will have to update their policies, procedures and documentation

To implement the changes set out in the Code relevant organisations will need to update their documentations, forms and training/publicity material on the Code including any references to particular pages/paragraphs in the Code.

Commissioners, providers, local authorities and others may also decide to purchase hard copies of the Code to ensure that these are readily available, including particularly for patients.

Benefits

This will make it easier for staff and patients to understand the changes and ensure that the materials being used are up to date and accurate, hence promoting compliance. It will lessen the possibility of organisations not being compliant and continuing with poor practice in some areas. The publication of the Code in alternative formats (e.g. electronic) and the efforts to increase searchability should enable people to navigate more easily, find material more quickly and reduce the need for manual updating.

Risks

This will be an additional task which many organisations may not have factored in and which will take time to implement effectively. This may be a particular concern for smaller providers.

It is important that organisations have sufficient time to update policies, procedures and documentation and to train staff in the changes. To mitigate this we are consulting on the changes in advance and ensuring that there will be at least three months between when the Code is laid in Parliament and when the changes come into force. This will give organisations time to make the necessary changes.

Costs

Updating paragraph and chapter numbers in policy documents which refer to the Code:

The revised Code will have different paragraph and chapter numbers, which will have to be updated in the policies, guidance and documents of local authorities, commissioners, NHS foundation trusts, NHS trusts and independent sector mental health. We assume that senior managers from each of these bodies will spend three days to update their policies and guidance. We do not assume direct costs, only the opportunity cost of managers' time. We assume that this will be a one-off cost.

There are 57 mental health trusts, 211 CCGs, 152 local authorities and 190 independent sector mental health hospitals in England. We assume that the average earnings of these managers are £79,000 for mental health trust and CCG managers and £60,000 for local authorities and independent sector mental health hospital managers. Including employer costs, this gives a total opportunity cost of £0.6 million.

To do this commissioners, providers, local authorities and other organisations may purchase hard copies of the new Code. The Code is available free of charge electronically or to down load, including a shortened version in easy read. We estimate the cost of acquiring hard copies of the Code for 57 mental health trusts and 190 independent sector mental health hospitals at around £0.03m (see Appendix1).

Change J: Use of the Act may be affected by a recent Supreme Court judgment (P v Cheshire West)

The Supreme Court judgment P v Cheshire West[41] in 2014 revised the test for deprivation of liberty as being: when a person lacks the mental capacity to consent to the arrangements for their care and/ or treatment, and the person is under continuous supervision and control and not free to leave.

This clarified test applies across all care homes, hospitals and State-arranged placements in community settings (such as supported living). The scope of the judgment is far broader than the interface between Act and the Deprivation of Liberty Safeguards (DoLS) in the Mental Capacity Act 2005 (MCA). However, the judgment is relevant to considering the use of the Act or the MCA for patients lacking capacity.

P v Cheshire West will increase the cost of administering the DoLS (particularly for local authorities giving DoL authorisations) and the workload of the Court of Protection. The practical implications of the revised test remain to be fully explored through evolving case law. Local authorities are monitoring closely the impact of the judgment and will report the numbers of DoLS applications they receive and DoL authorisations they give. The Department will continue to monitor these numbers and keep the need for additional guidance under review – working closely with our system partners.

This impact assessment does not consider the implications of P v Cheshire West, although the new chapter 13 provides guidance to reflect the judgement Increased costs are a result of the judgment not the revised Code. For this reason, the expected increase is part of the baseline and should not be costed as part of this impact assessment.

Change K: Reduction in blanket restrictions and blanket locked door policies

Entire unit or ward populations should not arbitrarily be denied access to outside space or areas of the hospital e.g. the kitchen or fridge. This is particularly true for informal (voluntary) patients who are free to leave at any point. Restrictions and the use of blanket locked door policies that are not based on detailed assessments of risk and are a proportionate response to those risks, cannot be justified. CQC have raised concerns about the use of blanket restrictions across whole wards/units, and found that over 77% appeared to be without justification. Under no circumstances can a locked door be a substitute for low staffing levels.[42]

The new Code sets out that any restrictions should be 'avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals' and that in implementing them these need to be 'authorised by the hospital managers on the basis of the organisation's policy and subject to local accountability and governance arrangements'.

In the short term to enable compliance it will therefore be necessary for a review of existing blanket restrictions to determine whether they meet the new requirements and to implement alternative policies. In relation to locked doors and given the strong evidence from CQC it is expected that there should be considerable changes in practice. In many cases this will mean that a locked door is unlocked or alternatively if locked people will know the process e.g. to unlock it.

[41] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014. WLR 2 https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf.

[42] Monitoring the Mental Health Act, CQC report 2012/13 http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

Given the breadth of possibilities which may be covered by blanket restrictions and that these will be subject to local circumstances it is for providers to review their policies, consider alternative approaches and implement, or alternatively justify why a restriction is required. It is not possible within this IA to consider all the possibilities but we have costed this in relation to locked doors. Where it is decided that it is justifiable to remain with the current restrictions then (other than the review and documentation) there should be no further costs or benefits. However, given that this guidance relates to unjustified restrictions it is expected that most providers will need to implement changes.

Benefits

Chapter 8 aims to ensure that providers avoid the use of blanket restrictions which apply indiscriminately to all patients on a ward or in a hospital, e.g. restricting access to outside areas or the internet. This is designed to promote a risk based approach to decisions about blanket restrictions especially blanket locked door policies. This should reduce anxiety for patients and not delay recovery. It should also improve relationships between patients and staff, as we know that blanket policies can be a major source of confrontation and even aggression, as patients do not understand why they are not able to leave, or regard it as unfair that policies are not explained or justified. It can be a major trigger for incidents that involve restraint. In the case of informal (voluntary) patients removal of blanket restrictions removes the risk of them being unlawfully deprived of their liberty in this way with resultant attention from CQC. Removing this will ensure benefits in terms of a patient's wellbeing and recovery are promoted and reduce the risk of litigation for unlawful detention. Benefits to the individuals from compliance with Code, i.e., encompassing the overall effect of the changes can be found in section 5 of this document.

Risks

Given the current low levels of compliance with the guidance in the current Code, there is the potential for some providers to have difficulty in implementing this satisfactorily. Evidence from CQCs inspections should improve compliance and monitor the impact this has, including on the welfare and recovery of patients.

Costs

The requirement in the new Code is that blanket restrictions can only be used where justified and proportionate and blanket locked door policies can only be implemented where it does not constitute unlawful deprivation of liberty. Any blanket restrictions need to be risk based. The fact that the Care Quality Commission's (CQC) 2012/13 report 'Monitoring the Mental Health Act' finds that in many of these cases staff-shortages explain to the use of blanket policies, imply an increase in staffing costs for mental health hospitals. The CQC found that "in one in five"[43] wards patients who were not formally detained were prevented from leaving. The revised Code aims to ensure that no policy results in the unlawful deprivation of liberty (or 'de facto detention') of patients who are not subject to legal powers of detention.

On average from 2011/12 to 2013/14, the number of non-detained NHS inpatients in a year is 60,000[44]. The mean number of in-year bed days for these patients is 72 days[45] in 2013-14, and the recommended ward size 15 people[46]. Taking this into account, we can expect 156 wards that were previously locked to be opened. Assuming an opportunity cost (the implicit cost that

[43] Ibid: Monitoring the Mental Health Act, CQC report 2012/13,

[44] The Mental Health Bulletin England, HSIC report 2013/14 (See Table 2.1 from the supporting national reference data tables: http://www.hscic.gov.uk/searchcatalogue?productid=16329&topics=0%2fMental+health&sort=Relevance&size=10&page=2#top) http://www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf

[45] The Mental Health Bulletin England, HSIC report 2012/13 (page 29) http://www.hscic.gov.uk/catalogue/PUB12745/mhb-1213-ann-rep.pdf

[46] Ten standards for adult in-patient health care, Royal College of Psychiatrists report 2011 (page 4) http://www.rcpsych.ac.uk/pdf/OP79_forweb.pdf

the staff member cannot fulfil its main duty) of monitoring a now unlocked ward at 2 hours per ward per day, totalling 14 hours of the typical 37.5 hour week[47] worked by a mental health nurse with an assumed salary of £25,000, and including employer's costs, this implies costs across mental health institutions that incrementally increase to £1.6 million per annum over the course of 5 years. Assuming that it would take 5 years for the system to reach its new steady state and compliance with the Code to reach 100% (with a linear transition), we find a discounted present value cost of £5.0million. We think that this is a maximum cost and based on CQC figures that it could be considerably less (see Appendix 1).

Change L: Increase in take up of Victim Contact Scheme (VCS)

It is not clear if there will be an increase in the number of victims in the VCS as a result of the new Code.

The revised Code sets out more clearly what statutory obligations hospitals have in respect of victims, and contains clearer information on the rights of victims. Increased awareness of their statutory obligations by professionals, combined with a clearer understanding of their rights by victims, may result in an increase in the number of victims who are offered victim contact, and who elect to receive it.

Benefits

An increased number of victims may seek to use the VCS to address issues resulting from the crime they were subjected to. This ensures that they received the information they are entitled to under the Code of Practice for Victims of Crime[48] and allows them to make representations about future discharge conditions, which may help provide reassurance.

Risks

There is the possibility that expectations may be raised and not all victims may be able to access the VCS.

Costs

It is not clear if there will be an increase in the number of victims in the VCS as a result of the revised Code. The revised Code sets out more clearly what the statutory obligations hospitals have in respect of victims, and contains clearer information on the rights of victims. Increased awareness of their statutory obligations by professionals, combined with a clearer understanding of their rights by victims, may result in an increase in the number of victims who are offered victim contact, and who elect to receive it, but we are unsure of the likely effects.

Change M: Changes to CQCs inspection regime to monitor compliance with the Code more effectively

CQC already had statutory responsibility for monitoring the Act and used the Code to inform their methodology for discharging this duty. The new introduction makes it clear how CQC intends to do this generally for all providers it registers and in particular how they will use the Code to monitor the application and discharge of powers under the Act.

[47] Mental health nurse Job Information, National Careers Service
https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/mentalhealthnurse.aspx
[48] Victims Code: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254459/code-of-practice-victims-of-crime.pdf

Benefits

Providers, inspectors and Act Commissioners should be clearer what they are looking for and what a good service looks like. This should improve the quality of care and ensure that where care is not up to standard, that quicker and more appropriate action is taken. The Code will provide clear guidance to both the CQC and the providers it regulates on what CQC will expect to see in place for the Act when they are carrying out inspections and monitoring visits.

Risks

There may be different and conflicting information about what good looks like and inspectors may take different judgments about this. This should be mitigated by the training they will receive, wider changes to CQCs regulatory and inspection approach and by ensuring consistency of messaging. Further information is available in CQCs impact assessment to support the development of their new approach.[49]

Costs

CQC will have to adapt its inspection regime. Its inspections might take longer, and there may be additional litigation costs where a rating is challenged in the courts. These additional cost implications have been included in CQC's own impact assessment regarding changes in their inspection regimes to reflect new legislation, and for this reason these remain uncosted in this impact assessment.

Change N: Introduction of guidance on commissioning beds, including in an emergency and out of area

Paragraphs 14.77-14.86 in the revised Code set out the responsibilities of commissioners in ensuring that services are in place to meet the needs of local populations, and explain section 140 of the Act, which requires CCGs to notify local authorities in their areas of arrangements which are in place for the reception of patients in cases of special urgency or the provision of appropriate accommodation or facilities for under 18s.

It also requires local authorities, providers, NHS commissioners, police forces and ambulance services to ensure they have a joint policy for the safe and appropriate admission of patients. It also emphasises that it is good practice for these bodies, including NHS commissioners, to meet regularly to discuss local policies. While this may not already happen routinely across the country, local partnerships have now been established through the Mental Health Crisis Concordat.[50] The Code also provides that in order to promote a patient's recovery, NHS commissioners and providers should work together to take steps to place individuals as close as is reasonably possible to a location that the patient identifies they would like to be close to (e.g. their home or close to a family member or carer).

In making these decisions, the changes outline that carers should be involved in decisions as far as is possible commissioners should have a mechanism for challenging decisions about where to place a person. Where a patient informs a commissioner of difficulties in visiting the patient because of the distance they need to travel, the commissioners should consider, where necessary, what assistance to provide so they are able to visit patient.

[49] CQC IA – http://www.cqc.org.uk/content/provider-handbooks-hospitals

[50] Crisis Care Concordat: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf

Benefits

These changes should help ensure that rapid, safe and appropriate care is provided by the right service for people of all ages in an emergency Moreover, appropriate, timely care minimises the likelihood of an individual's mental state declining, which may reduce the length of stay. Having in place pre-agreed policies mean staff do not have to spend excessive time making ad-hoc arrangements.

Rapid, safe and appropriate care provided by the right service for people of all ages in an emergency. Appropriate, timely care minimises likelihood of individual's mental state declining which may lead to need for more acute care/detention under section 136, for example.

If an individual is placed close to where they want to be, this could increase their likelihood to co-operate (if they have capacity). In taking medication, and being placed where they want to be minimises likelihood of the individual's mental state declining avoidably. Recovery can be more easily promoted with regular presence of family/friends/carers, care is better co-ordinated, especially as carers or family members in many cases likely to understand an individual's preferences and needs, and discharge should be more smooth into the community where an individual is known, e.g. to the local authority's social services (for housing/social care needs), or to primary/community NHS support.

There will be fewer complications in co-ordinating funding and discharge if an individual wants to be located close to home (as most will) leading to shorter lengths of stay and possibly less costly placements.

Risks

There may be complex cases where an individual does not wish to be located close to home or has known family/carers, so it would be difficult to determine where they should be placed to receive the appropriate care. Where in some areas relationships between local partners are less developed and there may be disagreements around responsibilities, it is hoped that these policies to promote partnership working will mitigate this.

There may also be questions of capacity at times of peak demand for inpatient services, where a hospital cannot accept an individual who has expressed a wish to be placed there. These issues are taken into account in the guidance, which requires steps be taken to place individuals as close as is reasonably possible.

It is important to note that involving family/carers will not always be practicable or appropriate if, for example, they are known to be abusive or at risk of inflicting psychological harm on a patient – their involvement in decisions under these circumstances would not be in the best interest of the patient. If commissioners are asked to provide financial assistance to family/carers, if an individual is placed far away from them, decisions will need to be taken as to how regularly family/carers would be expected to visit within reason.

It remains to be determined whether commissioners would have to pay for every visit including travel, accommodation, subsistence, and if funding limits are locally determined, a mechanism would need to be designed to avoid the creation of an unreasonable postcode lottery. Overall, the current lack of guidance on these points, which the Department will consider developing with NHS England and other relevant stakeholders in due course, currently leaves this open to interpretation. It is envisaged that this guidance would set out what constitutes a reasonable challenge about a placement and who is responsible for taking the ultimate decision.[51]

[51] See Action 4 in Action Plan, Page 74 in Government Response to the Code of Practice Consultation 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396126/mha-con-res.pdf

Costs

These are complex factors to cost. However the drive to commission mental health services which meet local needs and therefore allow most patients to be placed close to home, (subject to their clinical needs, which may mean that they need a specialised service which may be further from home) is part of the overall direction of travel for mental health services and an additional £120m is being invested in this between 2014 and 2016.[52]

There may be potential litigation costs for commissioners if their decision about a patient's placement location is challenged and then escalated by a carer subsequently, for example. The most obvious cost will come in the form of payments to family/carers to facilitate their visiting an individual is placed 'out of area', if a commissioner deems it appropriate to provide that financial assistance.

Change O: Introduction of guidance in relation to potential conflicts of interest and admission decisions for staff in NHS trusts and NHS foundation trusts

Requirements in relation to conflicts of interest are set out in the Mental Health (Conflicts of Interest) (England) Regulations 2008.[53] The revised Code encourages NHS trusts and NHS foundation trusts (in addition to the requirements in regulations for independent sector hospitals) to ensure that the recommendations given by doctors about whether to admit someone are not based in the same hospital.

The Code specifically says this is good practice- a patient's welfare and the need for timely assessments and admission, particularly out of hours, should always be the priority. The Code also encourages different providers to collaborate and produce of joint list of doctors who are available to provide a second recommendation. Many trusts and foundation trusts already have in place policies and procedures to ensure that the second recommendation comes from a person working independently or in a different location, site or team so as to not risk any potential conflicts of interest.

Benefits

This is designed to reduce any conflicts or perceived conflicts of interest and to ensure that decisions are made solely on what is necessary on the interests of the individual. This should reduce concerns by some stakeholders about the appropriateness of admissions and reduce complaints or criticisms of clinical decisions as the second opinion is seen as more impartial.

Risks

There are risks that sufficient doctors are not available to make the second recommendations and that this could lead to delays in assessment, people being kept temporarily in unsafe or unsuitable locations, and potentially not receiving the care they need leading to harm to themselves or others.

[52] Achieving better access to Mental Health Services by 2020. Department of Health. 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361648/mental-health-access.pdf

[53] Conflict of interest regulations: http://www.legislation.gov.uk/uksi/2008/1205/contents/made

Costs

There is no change in relation to the costs of paying for the second recommendation and many trusts and foundation trusts already have in place policies that support this practice. There may be additional costs if unreasonable delays result from implementation

Change P: introduction of requirement for commissioners, providers and local authorities to have a human rights and equality policy

Chapter 3 includes a requirement for all commissioners, providers and local authorities to have in place a 'human rights and equality policy' to monitor compliance with existing human rights and equality legislation, train staff accordingly and identify actions to address any concerns with compliance.

Benefits

The policy is designed to ensure greater compliance with existing regulatory requirements and to promote more personalised care. It has the flexibility of enabling organisations to determine how best to do this to reflect the needs of their patients and their respective organisations. Further benefits are included in the Equality Analysis.[54]

Risks

It may take time for organisations to develop and agree policies and train staff accordingly. The Code however does not introduce new requirements – these are already set in the respective legislation. This is a means of monitoring and addressing those concerns that materialise.

Costs

Commissioners and providers will be required to review existing arrangements to assure themselves that care pathways include rigorous and timely physical health screening. For most it is anticipated that such arrangements will already be in place. Some providers will need to amend existing care pathways but will already have sufficient resource and capacity in terms of medical and nursing expertise, hence there will be no significant associated costs.

Change Q: New guidance on supporting physical healthcare

New guidance has been included in chapter 24 in relation to supporting the physical healthcare, including sensory impairments and co-morbidities, of patients whilst subject to treatment under the Act.

Benefits

As our Equality Analysis[55] set out these was designed to address concerns about poor health outcomes, enabling prevention, earlier intervention and better care, support and treatment whilst in hospital, including promoting better mental health and recovery and promote greater health equalities. This should have considerable benefits for the individual and reduced costs to the wider health system.

[54] *Equality for all: Mental Health Act 1983: Code of Practice: Equality Analysis*. 2015. https://www.gov.uk/government/consultations/changes-to-mental-health-act-1983-code-of-practice

[55] Ibid Equality Analysis

Risks

These requirements already exist but commissioners and providers have not ensured that they are followed through. There is a possibility that, even with the introduction of these requirements in the Code, that they will not result in an improvement in outcomes. Commissioners need to ensure that they use commissioning contracts to monitor compliance, and NHS England needs to ensure that this takes place.

Costs

For a small number of providers it may well be that additional resources will be required, specifically to ensure timely access to medical expertise for the purposes of medical examination and screening. Numbers of services falling into this category are unclear and hence such costs cannot readily be monetised. It is likely that this will be more of an issue for smaller services and those in geographically remote locations, where new arrangements for access to medical practitioners 'out of hours' may be required. It is unclear whether associated costs will be absorbed by providers or passed to commissioners.

There are costs to the affected organisations in terms of developing, agreeing and monitoring the new policy, and any additional professional development or remedial actions to address concerns.

Change R: Updated guidance in relation to medicinal prescribing

In the case of medications that are used to treat mental disorder, particular care is required when prescribing medications that exceed the maximum dosage listed in the British National Formulary (BNF) or where multiple medications are used to treat a patient. This does not represent a change: just a reminder to prescribers of the need for caution in light of concerns raised by CQC (especially relating to polypharmacy and use of high dose antipsychotics).

Benefits

This reinforces requirements elsewhere in Code to prescribe in accordance with GMC guidance. It could reduce suffering and ongoing service use, associated incidence of long-term conditions linked with high dosage antipsychotic medication and polypharmacy. These include potentially disabling *tardive* conditions (dyskinesia, akathisia, parkinsonism etc), cardiac abnormalities, increased risk of type 2 diabetes, obesity, loss of seizure control in epilepsy etc. It could lead to enhanced quality of life outcomes for patients and should encourage greater adherence to NICE guidance.[56] It could also reduce ongoing costs associated with legal claims resulting from harm suffered by patients due to high dose antipsychotics and polypharmacy. Data is however not available to quantify these benefits.

Costs

No monetised or non-monetised costs have been identified.

Risks

No risks have been identified. All decisions should be clinically-based on those that are based on the requirements of the patient.

[56] See for example https://www.nice.org.uk/advice/ktt7 *Low-dose antipsychotics in people with dementia* (NICE January 2015). A summary of the evidence-base on low-dose antipsychotics in people with dementia. It is a key therapeutic topic which has been identified to support medicines optimisation but it is not formal NICE guidance.

Change S: Enabling patients to meet and communicate with family, friends and other visitors in private and/or electronically

Evidence from Winterbourne View Hospital and other places has highlighted that patients are not able to communicate privately with family and friends, including on the telephone, in person or due to lack of access to the internet. These changes are designed to ensure that this does not happen and that patients can communicate privately if and when they wish.

Benefits

This should promote greater contact with family, friends and community which can all be strong drivers in promoting recovery. Private communication should enable a patient to raise any concerns they have about their care and treatment without fear that they will be overheard by members of staff and hence have the possibility to be addressed more quickly. Use of the internet and mobile communications are considered essentials in maintaining a private and family life and employability skills.

Risks

For some patients and in some hospitals, safeguards may need to be put in place to ensure that a patient does not access inappropriate websites, make inappropriate phone calls or take inappropriate photographs on smart phones. The rights and privacy of other patients and staff need to be protected and any restrictions need to be proportionate and risk based.

Costs

Following the implementation of the 2015 Code, and in light of the research carried out by the CQC[57] in 2012/13, there may be costs associated with the requirement that patients cannot have restricted internet access unless clinically appropriate. The CQC report found that some 53.3% of wards have a 'blanket ban' on internet access – with 48.3% applying this blanket ban regardless of whether a patient is detained under the Act or an informal patient. Assuming that patients currently residing in a ward without any blanket ban already have the appropriate level of internet access, and assuming that following the revision 80% of wards that have a blanket ban now will no longer restrict internet access, we can expect patients to have access to internet when they need it.

During the consultation, few comments were received in relation to how these mobile devices will be supplied. However, feedback from patients, former patients, carers and advocates indicates that in most cases it is use of existing self-owned mobile devices that is being sought as it is having the right to use these taken away on entering hospital which causes upset, resentment and confusion. This should result in few additional costs for providers.

It may be necessary e.g. to enable training in computer skills for patients or desirable e.g. from a risk-based assessment a provider may determine that restricting access to communal computers or specific websites (so that these cannot be used inappropriately) or to enable section 17 leave via skype (which we understand is increasingly common but need to be governed by section 17 rules) is easier than to do so than with patients' private devices.

If providers would have to purchase computers, and assuming 3 computers will be needed per 15 people who should be given access to the internet (at a cost of £321.41[58] each), we estimate a one off cost of £0.5 million to purchase the required number of computers. We assume that

[57] http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

[58] NHS Supply Chain data, http://my.supplychain.nhs.uk/catalogue/search?LastCartId=&LastFavouriteId=&HideMaskedProducts=false&QueryType=All&Query=laptop

there is already internet-access in these wards, therefore it will not be an extra expenditure. These costs are considered to be maximum implementation costs, not least because in practice, many providers already have computer labs as part of preparing patients for discharge or to enable skype, so it would be updating existing facilities, and not due to new requirements in the Code. It would be expected that such periodic upgrades are already factored in to provider budgets.

5 Summary of costs taking into account the opportunity cost of using these monies:

The costs associated with updating the Code are outlined in the table below, over a five year period with a baseline at 2013/14. Some costs are on-going, and others are one-off costs; this is captured in the table for all changes that will lead to monetised costs. The total cost over this timeframe is expected to come to around £21.3 million.

It should be noted that NICE estimates that an increase of expenditure of around £15,000 will on average force the NHS to make economies (e.g. on staff or on drugs or on procedures) that will lead to a loss of a QALY. DH methodology for assessing policies is designed to ensure that we observe the same budget constraint as NICE does. Thus, we compare the benefits of a policy with the costs, in terms of the health benefit, that could have been generated through funding to the NHS (at a rate of £15,000 per QALY).

At the same time, DH assigns a value of £60,000 to a QALY, consistently with similar valuation of policies that mitigate mortality or morbidity risk by other government departments, based upon studies of what members of the public are on average willing to spend to reduce their own mortality risk, or to improve their own health outcomes. A policy proposal that costs £15,000 to the NHS is therefore presented with an opportunity cost of £60,000 on the assumption that it would force an economy that would displace a QALY, and therefore lead to a drop in overall health benefits that would be valued by the public at £60,000.

As a rule of thumb, the true opportunity cost of funding in the health and social care system is assumed to be £4 for every £1 lost (=£60,000/£15,000). The present value of the total of all costs, including opportunity costs, is about £85.4 million.

Present Discounted Value (£m)	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	
Change B - Increasing transparency, accountability, involvement	£0.1	£0.2	£0.3	£0.4	£0.4	£1.3
Change D - Revising policies on restraint and seclusion	£0.3	£0	£0	£0	£0	£0.3
Change E - Fewer people detained under section 136	£0.8	£1.5	£2.2	£2.9	£3.5	£10.9
Change F - Increased IMHA provision	£0.7	£0.7	£0.7	£0.6	£0.6	£3.2
Change I - Updating documentation	£0.6	£0	£0	£0	£0	£0.6
Change I - Buying copies of the Code	£0.03	£0	£0	£0	£0	£0.03
Change K: Reduction in blanket restrictions and blanket locked door policies	£0.4	£0.7	£1.0	£1.3	£1.6	£5.0
Total (£m)						**£21.3**

Total opportunity costs (£m; opportunity cost estimated at 4x costs)	**£85.4**

Note: The cost are discounted at 3.5%b per year to adjust future costs to today's equivalent costs (called the 'present value'), taking into account societal preference for deferred incursion of costs.

6 Summary of benefits:

It has proven particularly difficult to quantify or monetise some of the benefits associated with the new Code. We therefore think that these represent a very conservative estimate of potential benefits. There is a strong likelihood that benefits could be considerably higher than those set out in this document.

Increased trust in services, reduction in patient's anxiety and quicker recovery

The revised Code is likely to lead to more trust in services and as an outcome could improve the psychological well-being of patients who are detained under the Mental Health Act or can be expected to be detained under the Mental Health Act in the near future and can also lead to quicker recovery.

We believe that, following the publication of the revised Code, due to:

a) The increased transparency and accountability of decisions on detentions and discharge;

b) The greater involvement of the patient, as well as carers and family members as appropriate, in a patient's care planning;

c) The increased use of health-based places of safety (rather than police cells) in section 136 detentions;

d) The increased availability of independent mental health advocates

e) The improved ways of communication with friends and family and the greater privacy in doing so while being detained in hospitals;

f) The reduction in blanket restrictions;

g) The reduction in the use of seclusion and segregation; and

h) all other changes in the way patients are treated while under the Act.

Patients who are detained under the Act (as well as those who are likely to be detained in the future) will be less anxious while under the Act. To remain conservative in our assumptions, we assume that, as the outcome of the revised Code, only the number of patients who are detained under the Mental Health Act at one point in time will experience a slight reduction in the anxiety they experience – we use the average number for 2011/12 to 2013/14, that is, 22,668 patients[59].

We also assume that the reduction in patients' anxiety will be proportional to the extent of increased compliance with the revised Code in the five years following publication. We assume a linear transition in compliance rates (20% in the first year, 40% in the second year, and so on). We assume that the slight reduction in anxiety will correspond to a half-notch increase in the EQ-5D questionnaire's anxiety / depression dimension (one notch increase would correspond to going from 'extremely anxious' to 'severely anxious', from 'severely anxious' to

[59] HSCIC (October 2014). **Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014, Annual figures.** Please consult tables 4 and 5 of ten year time series, available at: http://www.hscic.gov.uk/searchcatalogue?productid=16329&topics=1%2fMental+health%2fHuman+rights&sort=Relevance&size=10&page=1#top

'moderately anxious', or from 'moderately anxious' to 'slightly anxious'). Such a move is associated with a 0.04 QALY gain on average. In the calculations, we monetise the QALY gains from the marginally reduced anxiety for 22,668 patients over five years (in proportion to the predicted increase in compliance with the revised Code), and also discounting future gains by 1.5% to take into account time preference rates. The assumptions used to monetise QALY gains follow standard cross-government guidelines. The net present value of benefits due to lower anxiety of patients, who might be detained under the Mental Health Act, accrued over the five years is estimated to be totalling £157 million.

There is also likely to be a beneficial effect of reduced anxiety on both care staff and family members of patients. Informal patient could also benefit from the increased transparency as the outcome of the revised Code. To remain conservative in our calculations, we chose not to monetise these effects.

In addition, it is expected that, due to the revised Code, patients will be more involved in discussions regarding their care and could be discharged more quickly. These may promote recovery and wellbeing and lower length of stay. These effects could result in patients' quicker recovery. We are currently seeking stakeholders' views on the extent to which these effects might contribute to quicker recovery, and may choose to monetise the corresponding health benefits in the light of the information received.

Utilisation of police cells which are no longer used for section 136 detentions

It is not assumed that Police forces would be able to make direct savings by closing custody suites if fewer people were held in custody under section 136. But it can be reasonably assumed that these custody places could be used to accommodate prisoners when the number of cells in prisons becomes critically low (as part of the 'Operation Safeguard' contingency plan).

The average cost of holding someone in a police custody is approximately £2000 per person per night, therefore using the same assumption as for the costs of additional health-based places of safety (five year transition during which compliance will linearly increase reaching 100% in the final year, affecting around 3,000 patients five years after the publication of the revised Code), this amounts to £15 million cost savings.

Summary of monetised benefits (**£ millions**) over five years assuming linear transition in compliance rates

	Year 1	Year 2	Year 3	Year 4	Year 5	Present Discounted Value
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	
Value of Reduced Anxiety	£10.9	£21.4	£31.7	£41.6	£51.3	£156.9
Police cost savings	£0.8	£1.5	£2.2	£2.7	£3.3	£10.5
					Total:	£167.4

Note: Benefits are discounted at 1.5% per year to adjust future benefits to today's equivalent costs (called the 'present value'), taking into account societal preference for earlier realisation of consumption benefits.

7 Implementation and next steps

The Code was laid in Parliament on 16 January 2015 and will come into force from 1 April 2015. Organisations and professionals need to be compliant with the new Code from this date.

Organisations and professionals have had since July 2014, when a draft revised version of the Code was published for consultation, to review existing policies, procedures and training and to consider what action is needed.

CQC is currently preparing guidance for its inspection teams on how to monitor and assess against the new requirements in the Code from 1 April 2015. CQC will allow for a 'bedding in' period while providers adjust their systems, update policies and roll out training. This should be completed within 6 months of the new Code coming into force i.e. 1 October 2015.

The impact assessment will be reviewed three years after implementation of the new Code (1 April 2018).

8

Appendix 1: Further detail on the estimates on specific changes in this IA

Change B: Increasing transparency, accountability and greater involvement of patients and carers

	Number of trusts	Manager's annual earnings	Oncosts (assumed at 25% of salary)	Days' work required (out of 252 working days in a year) (2)	Opportunity cost
NHS Mental Health Trusts	57	£79,000	£19,750	10	£223,363
Independent mental health hospital	190	£60,000	£15,000	5	£282,738
Total					£506,101

Notes: Salaries for NHS managers: NHS Staff Earnings Estimates to November 2014 - Provisional statistics are available at: http://www.hscic.gov.uk/searchcatalogue?productid=17354&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top

Salaries for managers in independent sector providers are assumed at £60,000. Oncosts are assumed at around 25% of the salary. This assumption is based on the proportion of oncosts to salary for NHS Staff in the PSSRU Unit Costs of Health and Social Care 2014, available at: http://www.pssru.ac.uk/project-pages/unit-costs/2014/

Assumed transition:

Year	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	
Cost per year (£m; without NPV adjustment)	£0.1	£0.2	£0.3	£0.4	£0.5	£1.5
Cost per year (£m; with NPV adjustment)	£0.1	£0.2	£0.3	£0.4	£0.4	£1.3

Change D: Reviewing and revising existing policies on restraint, seclusion, segregation, enhanced observation, rapid tranquilisation, mechanical restraint

	Number of trusts	Manager's annual earnings	On costs per year	Days' work required (out of 252 working days in a year)	Opportunity cost (£m)
NHS Mental Health Trusts	57	£79,000	£19,750	5	£0.1
Independent mental health hospital	190	£60,000	£15,000	3	£0.2
Total					£0.3

Notes: Salaries for NHS managers: NHS Staff Earnings Estimates to November 2014 - Provisional statistics, available at: http://www.hscic.gov.uk/searchcatalogue?productid=17354&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top

Salaries for managers in independent sector providers are assumed at £60,000.
Oncosts are assumed at around 25% of the salary. This assumption is based on the proportion of oncosts to salary for NHS Staff in the PSSRU Unit Costs of Health and Social Care 2014, available at: http://www.pssru.ac.uk/project-pages/unit-costs/2014/

Change E: Fewer people who are detained under section 136 will be held in police cells and those that are will be held for less time

Assumptions	
Assumed proportion of section 136 detentions which are appropriately held in Police custody	17%
Average cost to health services of each detention	£2,000
Extra number of patients taken to hospitals	2,060

Note: The extra number of patients taken to hospitals was estimated by:
- subtracting the assumed 17% number of detentions appropriately held in police custody from the number of section 136 police detentions in 2012/13 and 2013/14 (Source 1 below);
- then calculating the average.

Sources:

Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983 and Patients Subject to Supervised Community Treatment, England - 2013-2014, Annual figures - Report, published by the Health and Social care Information Centre, 29 October 2014. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=16329&q=title%3a%22Inpatients+formally+detained+in+hospitals+under+the+Mental+Health+Act%22+&sort=Most+recent&size=10&page=1#top

Assumed transition:

Year	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	
Cost per year (£m; without NPV adjustment)	£0.8	£1.6	£2.5	£3.3	£4.1	£12.4
Cost per year (£m; with NPV adjustment)	£0.8	£1.5	£2.2	£2.9	£3.5	£10.9

Change F: More IMHAs have to be provided

Assumptions

CQC reports that the proportion of wards with access to IMHA services is (1):	92%
Then the assumed proportion of wards without IMHA services is:	8%
Increase in IMHA services is:	
Annual spend on IMHA services per qualifying patient (2)	£165
Number of qualifying patients	53,176
Additional spending:	£703,793

Sources:

1. Monitoring the Mental Health Act in 2012/13 (page 26), http://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

2. Providers spend £162 (£165 when updated with today's prices) on IMHA services per qualifying patients (including training costs and overheads) – sourced from: Newbigging, K. *et al* (2012) 'The Right to Be Heard; Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England', University of Central Lancashire, http://www.uclan.ac.uk/research/environment/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf

Assumed transition

Year	1	2	3	4	5	
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	Total
Cost per year (without NPV adjustment) - £m	£0.7	£0.7	£0.7	£0.7	£0.7	£3.2
Cost per year (with NPV adjustment) - £m	£0.7	£0.7	£0.6	£0.6	£0.6	£3.2

Change I: A large number of organisations such as local authorities, commissioners, and providers will have to update their policies, procedures and documentation

	Number of trusts	Manager's annual earnings	Days' work required (out of 252 working days in a year)	on-costs	Opportunity cost (£m)
NHS Mental Health Trusts	57	£79,000	3	£19,750	£0.1
Independent mental health hospital	190	£60,000	3	£15,000	£0.2
Local Authorities	152	£60,000	3	£15,000	£0.1
CCGs	211	£79,000	3	£19,750	£0.2
Total					£0.6

Notes: Salaries for NHS managers: NHS Staff Earnings Estimates to November 2014 - Provisional statistics, available at: http://www.hscic.gov.uk/searchcatalogue?productid=17354&topics=0%2fWorkforce&sort=Relevance&size=10&page=1#top

Salaries for managers in independent sector providers are assumed at £60,000. Oncosts are assumed at around 25% of the salary. This assumption is based on the proportion of oncosts to salary for NHS Staff in the PSSRU Unit Costs of Health and Social Care 2014, available at: http://www.pssru.ac.uk/project-pages/unit-costs/2014/

Purchasing hard copies of the new Code:

Assuming that each Code costs £20:

	Number of trusts	Assumed number of copies acquired	Cost
Mental Health Trusts	57	15	£17,100
Independent MH hospitals	190	3	£11,400
Total Cost (£)			£28,500
Total Cost (£m)			£0.03

Change K: Reduction in blanket restrictions and blanket locked door policies

Assumptions

A	Number of non-detained patients (NHS) (1)	59,331
B	Mean length of Stay (2)	72
C	Proportion of non-detained patients with restricted movement 9assumed)	0.2
D	Patients per ward (assumed)	15
E	Frequency of Patients per day (=B divided by 365)	0.2
F	Number of non-detained patients with restricted movement (=A*C)	11,866
G	Expected number of non-detained patients with restricted movement at any given point (=E*F)	2,341
H	Expected number of locked wards that must now be opened (=G/D))	156
I	Average Salary of a Mental Health Nurse (NHS) (3)	25000
J	Mental Health Nurse on-costs (NHS) (estimated at 25% of the salary)	6100
K	Average weekly hours worked of a Mental Health Nurse (NHS)	37.5
L	Assumed staffing requirement per week, per ward (NHS)	14
M	Opportunity cost of opening one ward (NHS) (=(I+J)/(L/K))	£11,611
N	Expected Opportunity cost of all wards that must be unlocked (NHS) (=M*H)	£1,811,839

Notes:

1. Average of the number of non-detained patients in the last – Source: Mental Health Bulletin, Annual Report From MHMDS Returns - 2013-14, published by the HSCIC - See Table 2.1 from the supporting national reference data tables, available at: http://www.hscic.gov.uk/searchcatalogue?productid=16495&topics=0%2fMental+health&sort=Relevance&size=10&page=2#top

2. Total number of bed days in year/total number of patients in hospital Source: Mental Health Bulletin, Annual Report From MHMDS Returns - 2013-14, published by the HSCIC

3. Average salary for a Mental Health Nurse sourced from PSSRU Unit Costs of Health and Social Care 2014, available at: http://www.pssru.ac.uk/project-pages/unit-costs/2014/

Oncosts are assumed at around 25% of the salary. This assumption is based on the proportion of oncosts to salary for NHS Staff in the PSSRU Unit Costs of Health and Social care 2014.

Assumed transition

Year	2015/16	2016/17	2017/18	2018/19	2019/20	Total
Assumed uptake towards steady state (%)	20%	40%	60%	80%	100%	
Cost per year (without NPV adjustment)	£0.39	£0.79	£1.18	£1.58	£1.97	£5.92
Cost per year (with NPV adjustment)	£0.38	£0.76	£1.14	£1.53	£1.91	£5.72