Sheffield City Council

NHS
Sheffield Health and Social Care
NHS Foundation Trust

Open BoD: 14.06.17
Item: 13i

OPEN BOARD OF DIRECTORS
14 June 2017

TITLE OF PAPER	Mental Health Act Committee Q4 Report, January to March 2017
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	Members to receive for information and assurance.

OUTCOME	Members are assured that: the Mental Health Act (MHA) is being implemented in the Trust in line with the Mental Health Act 1983 and its Code of Practice (2015); that CQC requirements are being met; and patients' rights are being protected through correct recording, monitoring and careful scrutiny of practice data by the members of the MHA Committee.
TIMETABLE FOR DECISION	June 2017 Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	Relevant CQC MHA Monitoring Visit (Inspection) Reports and Provider Action Statements.
BAF OBJECTIVE No and TITLE	Strategic Objective No 1. – Improving the Quality & Efficiency of Services BAF Risk 1.4
LINKS TO THE NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES ETC	HSE ❑ MH Act ■ Equality ❑ NHS Constitution: Patients ❑ Public ❑ Staff ❑
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	To maintain improvement in the implementation of the MHA and to preserve the rights of those subject to compulsion under the MHA will require on-going monitoring of procedures and practice and recommendations for changes where necessary. If financial implications come to light, individual business cases will be submitted for consideration.
CONSIDERATION OF LEGAL ISSUES	It is a legal requirement that the Trust complies with the MHA.

Author of Report	Anne Cook
Designation	Head of Mental Health Legislation
Date of Report	April 2017

SUMMARY REPORT

Report to: **Open Board of Directors**

Date: **14 June 2017**

Subject: **Mental Health Act Committee Q4 Report. January to March 2017**

From: **Liz Lightbown, Executive Director of Nursing, Professions and Care Standards**

Author: **Anne Cook, Head of Mental Health Legislation**

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1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
		✓		✓	

2. Summary

The Quarter 4 report is submitted by the Mental Health Act Committee (MHAC) to provide assurance that the use of the Mental Health Act (MHA) by the trust is in accordance with both the Statute and it Code of Practice (MHA Code of Practice 2015). Where necessary changes are recommended or made by the MHAC to assure compliance.

The report is provided under the following headings:

a) The Committee's work in Q4
b) Themes from CQC Q4 MHA monitoring visits
c) The Trust's monitoring of the MHA
d) Results of the weekly MHA compliance audit
e) Results of the monthly Community Treatment Orders compliance audit
f) The use of the MHA in the Trust for the year April 2016 to March 2017
g) Glossary

3. Next Steps

The MHAC will continue to meet on a monthly basis and to submit a quarterly report to EDG, until it is superseded by the overarching Mental Health Legislation Committee, previously approved by EDG. Plans are in place for transition to the new arrangements between October 2017 and April 2018.

4. Required Actions

Members to receive the report for information, assurance and approval.

5. Monitoring Arrangements

Monitoring of the Mental Health Act is the remit of the Mental Health Act Committee,

6. Contact Details

For further information, please contact:

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Mental Health Act Committee - Quarter 4 Report

1. Introduction – The Mental Health Act Committee

The Mental Health Act Committee (MHAC) continues to meet on a monthly basis. The Terms of Reference and membership have been reviewed following the appointment of the Head of Mental Health Legislation, Anne Cook, who came into post in Q4 and who now chairs the committee.

The current Terms of Reference have been adopted as interim measures. They will be superseded eventually by new Terms of Reference for a Mental Health Legislation Committee, which will unify the quality assurance and governance functions currently undertaken separately by the MHAC and the Mental Capacity Act/Deprivation of Liberty Steering Group. The rationale for unification is to improve the quality of patient experience by reinforcing knowledge of the Mental Capacity Act with a staff group that functions mainly under the remit of the Mental Health Act

The Executive Directors' Group and Quality Assurance Committee have approved the revised governance structure and the Head of Mental Health Legislation will work with the Executive Director and Interim Director of Care Standards to achieve the unified structure, which will require appropriate representation from the different care areas. An interim structure will be implemented by October 2017 in order to allow for transition to occur with minimal disruption to planned meetings and work plans, and the final unified structure will be in place by April 2018.

In light of the valuable, multi-faceted information provided by senior operational leads to the CQC's 'Appreciative Enquiry' into the role of Approved Mental Health Professionals (AMHPs) and the use of the MHA in Sheffield, which took place on 5.4.17, it is envisaged that membership of both the current MHAC and the future unified Committee will include staff with operational knowledge and experience, which can be utilised to inform and strengthen decision-making and quality assurance practices.

2. The Committee's Work in Q4

2.1 Section 17 form. Section 17 leave, granted by the patient's Responsible Clinician affords the only lawful authority for a patient to be absent from the hospital where s/he is detained. In response to the CQC MHA monitoring visits where it was identified that the Trust's documentation (the form is non-statutory) did not include a review date, the Committee amended the form and it became live electronically on Insight on Monday 16th January. S17 in Word document format has been removed from Insight. IT has been asked to change "end date" to "review date" in order to reduce confusion, and to make this as mandatory field.

2.2 Accepting Detention Papers. An improved checklist has been provided to staff in order to ensure the prompt identification and rectification of errors on detention papers, thereby minimising the risk of unlawful detention. A checklist for accuracy of MHA papers has been issued to AMHPs.

2.3 CQC MHA Monitoring Visits. The Committee has begun to monitor the progress of wards against their action plans; the Mental Health Act Office has resumed responsibility for the receipt and submission of information to the CQC, with the Care Standards team retaining a quality assurance role. Each Directorate is to maintain its own tracker of actions outstanding, and each will receive a copy of the monthly update collated for the MHA Committee.

2.4 Clarification of the Seclusion Policy. The policy has been amended slightly to make it clear that a Higher Level Trainee doctor has authority to contribute to Independent MDT reviews of seclusion. The MHA Code of Practice specifies that an approved clinician 'should' be involved (Chapter 26.142), however this is not practicable out of hours. (A 'should' in the Code of Practice' permits exceptions; 'must' does not). It is of note that this minor amendment was delayed by several weeks owing to the current procedures for ratification of policies. The update was published outside the normal arrangements at the direction of the Executive Director of Nursing in order to ensure that staff had access to accurate information in a timely manner.

2.5 Weekly MHA Compliance Audit. Over time it became apparent that staff completing the weekly form misunderstood some of the requirements. The Committee agreed to an updated version being produced, which contains permanent, detailed guidance. There are on-going plans to develop a dashboard to represent the outcome of the audits – some information can be pulled directly from Insight, reducing the time spent on completion of the form, but some aspects need to capture the quality of information, rather than simply its presence, and so individual checks of documents are necessary. Practice has improved with regard to adherence to the law and the Code of Practice, but some areas of concern persist. Any discrepancies or other problems shown up each week are addressed immediately by Committee members. It is intended that spot-checks of the accuracy of returns by the Head of MH Legislation and the MHA Manager will begin in the near future.

2.6 MHA Breach Incidents. It has become apparent that not all incidents involving potential breach of the MHA or Code of Practice are reported, and that those that are difficult to rate in terms of severity. The Committee is developing definitions of what constitutes an incident and its severity, and is working with the risk management team to ensure that staff members are able to identify what to report. Arrangements are in place to ensure that the Head of MH Legislation is copied into relevant incidents. The Committee agree to add all AWOL incidents to its scrutiny. There was one incident that required urgent detention of a patient whose original medical recommendation was sent back for amendment but not returned in time for the rectification to be made – Julia Walsh (Lead Social Worker) has sent an updated checklist to all Approved Mental Health Professionals to enable them to address problems with medical recommendations immediately with the doctor.

2.7 Policing and Crime Act 2017(PaCA) – changes to MHA sections 135 &136. These sections are police powers of arrest, to be employed if an officer believes that a person is in need of intervention because s/he appears to be suffering from a mental disorder. The person must then be accommodated in a 'place of safety'; Maple Ward has 2 'place of safety' beds. A briefing paper summarising the changes has been circulated to all staff, and guidance papers will be added to the on-call manager's file when the changes to the law commence. The Committee has asked for preparatory work to be done in respect of the section 136 policy in order that staff members are prepared for the reduced time-scale involved: reduced from 72 hours to 24 hours or 36 hours in exceptional circumstances. An action plan is in place. The Committee will monitor the use of the place of safety beds. The Committee accepted the proposal for a South Yorkshire-wide section 136 policy, but noted that the draft policy produced by the South Yorkshire Mental Health Strategic Partnership Board in March did not take account of PaCA. The Trust policy will therefore be necessary.

2.8 Memorandum of Understanding – Police use of Restraint in Mental Health and Learning Disability Settings: NHS Protect. The Committee noted that this supersedes the current Inter-Agency agreement with respect to MH crises in the community; the latter will also become out of date as a result of PaCA. The Committee noted that this Memorandum and its interface with the Crisis Care Concordat and the work of the South Yorks MH Strategic Partnership Board and the Trust's meetings with the Police and other partner agencies and the reporting structure from each needs to be understood properly and the reporting. A meeting is to be arranged between Jason Rowlands (Chair of the Crisis Care Concordat, Richard Bulmer (attendee at SY MH Strategic Partnership Board and Chair of Trust Police Liaison meeting), Giz Sangha (Clinical Director) and Anne Cook (Head of MH Legislation) to establish the interface between these meetings and to identify the correct reporting structure. Linda Wilkinson (Clinical Director) will link to the 'Green Light' meeting, which addresses areas of cross-over between Mental Health and Learning Disability services.

2.9 Memorandum of Understanding with Sheffield Teaching Hospitals. The Committee has amended this Memorandum to ensure its lawfulness. A Final version has been accepted for sign-off.

2.10 Community Treatment Orders (CTO). CTO (MHA section 17 A-G) allows for a patient to be discharged from detention in hospital under specified conditions, and allows for the patient to be recalled to hospital for treatment, or for the CTO to be revoked, returning the patient to detention without the need for a fresh MHA assessment and re-detention procedure. The number of patients on CTO appeared to be disproportionately high for the SW sector community team. Linda Wilkinson looked in detail at the data, and concluded that this did not represent inappropriate use of CTO; the reasons for CTO included poor medication adherence, multiple admissions, and the presence of co-morbid conditions such as substance misuse. CTO use will continue to be monitored, in particular time spent subject to CTO.

2.11 Locating the Report from the Approved Mental Health Professional (AMHP). CQC visits have revealed problems locating the AMHP form, completed at the time of detention, on Insight. This appears to be because it is entitled 'Mental Health Act Assessment'. The form will be re-named 'AHMP Report' to facilitate its location in the system. The IT department is working on this currently.

2.12 Feedback Form from AMHPs. The committee has instigated a pilot of feedback forms for AMHPs to provide feedback on the MHA section 12 doctor's role in the detention process. This is intended to allow some governance over the process if problems occur with doctors not employed by the Trust. The pilot will run for Q1 2017/2018.

2.13 MHA Training. Despite the extra training sessions provided in Q3 and Q4 2016/17, which had the potential to bring compliance to 90%, at the end of February compliance was 72% (130 out of 181). There were 46 staff in In-Patients and 11 in Specialist who still needed MHA training. Attendance has been affected by problems with staff release, staff sickness etc. Anne Cook will provide two additional extra sessions in May. With regard to training provided via the City Council Training hub, such as training in writing Tribunal reports, only staff employed in the Adult MH Directorate are able to access it. For contractual reasons Older Adults and Learning Disability Directorates are excluded). Anne Cook will discuss this with Bob Levesley (Learning and Development Consultant) in order to explore how that all staff who need MHA training might access it.

3 Care Quality Commission (CQC)

CQC MHA monitoring visits are unannounced. Their scrutiny extends beyond compliance with the Mental Health Act alone and visits are focused on compliance with the Code of Practice 2015, which has the status of statutory guidance. Therefore any departure from the Code must be able to withstand judicial scrutiny.

During Quarter 4 there were two MHA monitoring visits; Burbage Ward on 4th January and Forest Close on 10th January. In common with the visits in Q3, the focus was on protecting patients' rights and autonomy, their care and treatment and the capacity to consent to it, Section 17 leave, and the impact of restrictive practices and blanket restrictions. The Provider Action Statements were submitted to the CQC on 9th February and 17th February respectively.

The Provider Action Statement (PAS) forms the basis of each ward's action plan for addressing any concerns identified by the CQC. To date, monitoring progress against these plans has been undertaken by the Care Standards Manager (GH), but from late April this responsibility will transfer to the Head of MH Legislation (AC) and the MHA Office. There is a tracking system in place, and the in-patient Senior Management Team has been asked to monitor and track progress against these plans for itself. When the transfer of responsibility from GH to AC is complete, AC and the MHA Manager will undertake visits to the wards to ensure that the necessary actions are underway or completed if reported as such.

Themes from Q4 CQC MHA Monitoring Visits

3.1 'Blanket Restrictions'

'Blanket restrictions' are rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application. Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each patient should be considered and documented in the patient's records.
MHA Code of Practice 2015, Paragraph 8.5

Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to money or the ability to make personal purchases, or taking part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights.
MHA Code of Practice 2015, Paragraph 8.7

Both MHA monitoring visits in Q4 identified the locking of the door to the wards' 'green rooms' as a blanket restriction on patients' ability to access these relaxing areas of the ward; however this is to be challenged in the PAS. The purpose of the green rooms is to provide a therapeutic and relaxing space in order to provide de-escalation of situations which might otherwise lead to seclusion. As the green rooms offer the least restrictive option for the management of potentially violent behaviour, it is necessary for them to be immediately available in the same way that the seclusion facility would be. This would not be possible if the rooms were not designated for de-escalation purposes, and such designation precludes their routine use as relaxation areas.

The Trust does not accept that limiting the use of green rooms to this specific purpose amounts to a blanket restriction as defined by the Code of Practice, a stance supported by the clinical workshop provided by Dr Paul Gilluley, National Professional Adviser in Forensic Mental Health at his clinical workshop for the Trust on 24.3.17. However, some of Dr Gilluley's advice contradicted the MHA Code of Practice – the matter of blanket rules and restrictions will be taken forward by Restrictive Interventions Project Group, with the In-patient Directorate taking a lead.

3.2 Other issues

The MHA monitoring visit to Burbage Ward in Q4 identified the need to update some of the information available on the ward, such as contacting the CQC and the 'you said, we did' board. These were easily remedied. However, there were also concerns about the ward's ability to adhere to the sleeping and bathroom arrangements for male and female patients, and about the seclusion facilities. Both will require refurbishment work in order to comply with the 2015 Code of Practice, but every effort is being made to meet the standards in the meantime.

The visit to Forest Close identified a lack of patient involvement in care planning – this has been addressed and all patients now have a collaborative care plan.

The MHA committee has reviewed the CQC MHA reports and the action plans that resulted from the Q4 MHA review visits and agreed with the actions. There are actions remaining open from previous visits; each has a plan and a timescale for completion. Compliance with the plans will be monitored for timely and informative response, as described above.

4 Monitoring of the Mental Health Act

The Code of Practice states at 18.39:

"Hospital Managers should monitor the use of Section 5 including:

i. how quickly patients are assessed for detention and discharged from the holding power,
ii. the attendance times of the doctor or Approved Clinician, following the use of Section5(4),
iii. the proportion of cases in which application for detention are in fact made following the use of section 5."

This is in order to ensure that these powers, which deprive the patient of his or her liberty with fewer safeguards than would otherwise exist, are used appropriately.

Section 5(4) is the Nurses holding power in respect of an informal patient who is indicating that he wishes to leave hospital. If it appears to the nurse that it is necessary for the patient's health or safety, or for the protection of others, the patient may be immediately restrained from leaving hospital. The power can last up to six hours and during that time the patient should be examined by a doctor who has authority to furnish a report under s5(2) as a matter of priority.

Section 5(2) provides for the doctor (or approved clinician) to detain a patient for up to 72 hours if it appears to them that an application for the patient's admission under s2 or s3 ought to made

The tables below show the monitoring of section 5 for Q1-Q4 2016/17.

Table 1 Use of S 5(4)

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Number of section 5(4)	2	3	8	5
Dr arrived within:				
Up to 1hr	1	2	3	1
1-3 hrs		1	3	2
3-6 hrs			1	2

Table 2 Outcome of S 5(4)

Outcome	Q1	Q2	Q3	Q4
Section 5(2)	1	2	5	2
Section 2				
Section 3			1	
Informal	1	1	2	3

The use of section 5(4) appears to have increased markedly in the last 2 quarters of the year, up 160% on the first two quarters, albeit with the peak use in Q3. The reason for this is unclear, but may reflect the impact of the Smoke-Free policy coming into effect on 31.5.16. The MHA Committee will continue to monitor the use of section 5(4) and will explore the data underlying the figures, such as the length of time between informal admission and the invoking of the holding power, and the outcome

Table 3 – Use of S 5(2)

	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Number of times used	14	11	13	18

Table 4 - Length of time subject to Section 5(2)

Length of time subject to holding power	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Up to 24hrs	3	7	6	9
24-48hours	7	2	6	7
48-72hours	4	2	1	2

Table 5 - Outcome following the use of the Section 5(2)

Outcome	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Section 3	9	7	5	13
Section 2	4	3	6	3
Informal	1	1	2	2

The use of section 5(2) has also increased in the last 2 quarters of the year, but less markedly that the use of s5(4)

Quarter 4 shows that 50% of those subject to s5(2) were assessed for detention within 24 hours, and a further 38% within the following 24 hours. Only 2 patients were held into the third 24-hour period.

In Q4 83% went on to be detained under sections 2 or 3. These figures offer strong assurance that holding powers are being used appropriately and that deprivation of liberty as a result of these urgent powers has been minimal. Assessment for s5(2) is occurring within the six hours' duration of s5(4), and detention pursuant to section 2 or 3 has been completed, where necessary, very promptly.

5 Mental Health Act Compliance Audit

The Mental Health Act compliance audit is completed each week by the Ward or Deputy Ward Managers for all the wards. The audit was developed from feedback reports from the CQC MHA visits where the Trust was reported to lack compliance with the MHA and the code of practice. The audit has developed over time and is focused on ensuring patients' rights are not violated,

This assurance is achieved by ensuring that:

i. they are given an explanation of their rights,
ii. capacity to consent has been assessed,
iii. patients are medically treated under the appropriate lawful authority.

The Audit forms are checked for correctness on receipt, any anomalies are questioned at this time, and any necessary urgent action requested.

A further level of assurance has been in place since January 2017. In order to ensure that patients lacking capacity to instruct an Independent Mental Health Advocate (IMHA) are not denied the opportunity to appeal against their detention (*MH v THE UNITED KINGDOM - 11577/06 - [2013] ECHR 1008 (22 October 2013*), referral to an IMHA is now explicitly required by the patients' rights forms, and audited. The audit includes how many detained patients who lack capacity have been referred to the IMHA service,

Members were asked to note in the previous report that the UK Upper Tribunal had reached a conclusion that appeared to contradict MH v UK. The UT ruled that if a patient lacks capacity to apply to the First Tier Tribunal 'the inevitable result' is that the Tribunal lacks jurisdiction (R(OK) v First Tier Tribunal and Cambian Fairview [2017] UKUT 22 (AAC)).

The application in this case had been made by the patient's solicitor, who had determined that the patient lacked capacity to appeal. However, the Tribunal rules state that in mental health cases, the application must be signed by 'the applicant or by any person authorised by the applicant to do so'. By definition, the patient was unable, through lack of capacity, to authorise the application. The UT judgment concluded that the patient's right to have a tribunal was protected by the existence of the Secretary of State's powers to refer a case to the Tribunal (MHA s67), and by the possibility of judicial review of the decision if the Secretary of State (SoS) refused to refer the case.

This decision has caused some concern, given that if the SoS does refuse, the patient would have to seek judicial review proceedings funded by means-tested legal aid - if the person is eligible) before it can be determined whether or not they may challenge their detention.

The results of the weekly audit are reported to the Clinical and Service Directors, Ward Managers, Deputy Ward Managers, Responsible Clinicians, the Head of Mental Health Legislation and the Interim Director of Care Standards, each week. The Mental Health Act Committee receives information at the monthly meetings.

Table 6 - In-patient MHA Practice Q1 to Q4 2016/17

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
% of detained patients given rights as required by MHA s132	94	96	95	95	91.5	98	98	99.8	99	98	99	98
% of detained patients with evidence of collaboration in their care plan	85	86	87	89	87	84	87	85	87	86	84	83
When leave has been granted under MHA s17, % of s17 authorisation forms offered/given to the patient	100	96	96	93	93	95	89	94	94	93	94	93

Since the audit began 15 months ago there has been a considerable increase shown in compliance. Initially just one or two wards would achieve 100% compliance with any of the standards. However now most wards report 100% compliance in most of the areas tested. The lower percentage of evidence of collaboration in care plans reflects that the majority of older patients admitted to ward G1 do not have capacity to collaborate in their plans of care.

6 Monthly Community Treatment Orders Compliance Audit

Patients placed on a CTO can be treated for one month without any consent to treatment certificate or Second Opinion Appointed Doctor's (SOAD) certificate. The MHA requires those detained in hospital or subject to a CTO be given information to help them understand how the Act applies to them and the rights afforded them, this includes the right to refuse treatment, the rights to apply to the Mental Health Tribunal, the rights to an Independent Mental Health Advocate (IMHA). Chapter 4 of the Code of Practice states this must be done as soon as practicable after the start of the detention or CTO.

The monthly audit completed in respect of Community Treatment Orders looks at compliance with the necessary forms, with regard to capacity and consent and with the requirement to explain patients' rights under section 132A Mental Health Act. The results of the audit are report to Community Team Managers, Community Responsible Clinicians, Clinical and Service Directors and Assistant Directors.

Table 7 - CTO Practice Q1 to Q4 2016/17

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total subject to CTO as at the end of the month	71	66	69	75	73	62	62	57	57	63	63	62
No. of Outstanding Consent to Treatment forms	9	8	7	7	7	9	8	4	1	1	1	0
No. of Outstanding Capacity to Consent to Treatment Forms	10	9	9	10	5	12	8	6	2	4	2	3
No of. Outstanding Rights Given Forms	16	16	21	12	17	14	11	3	2	9	8	5

The number of people subject to CTOs was at a high in July 2016, decreasing in Q3, but increasing slightly in Q4. As detailed above, the MHA Committee has audited the use of CTO in response to an apparent anomaly, and will continue to review its use and the time patients spend subject to compulsion in the community.

The outstanding consent to treatment forms and record of rights given are being actively monitored; teams are reminded on a weekly basis of whose rights have not been given and explained

7 Use of the Mental Health Act by the Trust during Q1-Q4 2016/2017

Tables 6 to 8 below show the number of detentions by section of the Mental Health Act 1983 that have been processed by the Trust for the year 2016/2017

Table 8 – Table of Admissions by MHA section

Admissions	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Section				
2	87	63	76	58
3	43	29	32	24
4	1	2	1	4
35	0	0	0	0
36	0	1	0	0
37	0	1	1	0
37/41	4	2	0	1
47	0	0	0	0
47/49	0	0	0	0
48/49	0	0	0	0
38	0	0	0	0
Total	135	108	110	87

This table refers to those admitted from the community under detention. It shows a 35% decrease in overall numbers in Q4 compared to the peak in Q1.

Table 9 – Table of Status Changes

Changes	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
Informal to s5(4)	2	3	9	5
Informal to s5(2)	13	9	12	16
s5(4) to s5(2)	1	2	5	2
Informal to s2	1	0	2	2
S4 to S2	0	0	1	0
S5(4) to S2	0	0	0	2
S5(2) to S2	6	3	9	4
Informal to S3	3	9	14	6
S5(4) to S3	0	0	1	0
S5(2) to S3	8	8	7	12
S4 to S3	1	0	0	2
S2 to S3	35	30	32	38
5(2) to Informal	1	2	2	2
S5(4) to Informal	1	1	3	3
S4 to Informal	0	2	0	1
S2 to Informal	50	56	51	49
S3 to Informal	69	80	71	70
S37- to informal	0	0	0	1
Total Activity	191	215	219	205

Table of Status Changes refers to patients already <u>in hospital</u>

Table 9 shows a decrease in the overall number of section changes from Q3 to Q4. There has been a marked decrease in patients being admitted informally and subsequently detained under section 3; a total of 126 patients were re-graded to informal and 49 of these were re-graded from section 2, therefore not being subject to detention for any longer than 28 days. This appears to offer assurance that patients are not being detained longer than is necessary. However, if those re-graded to informal are disregarded, there is an increase in the use of detention in the last two quarters (92 and 85 respectively), compared to the first two (70 and 64 respectively): an increase of 32%.

Following the CQC's 'Appreciative Enquiry' into the use of the MHA, it has become apparent that there is a need to formalise scrutiny and governance in order to understand Sheffield's position relative to other providers, their local populations and their bed-stock.

Table 10 – Table of Community Treatment Orders

CTO	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17
New CTO	18	6	10	12
Recalls	5	5	10	7
*Revocation	2	2	5	4
Discharge from CTO	5	5	8	4

*Revocation is when a person on CTO has been recalled to hospital and the CTO is then revoked placing the patient back under section 3. Not all recalls end with revocation; most are discharged back into the community within the 72hrs although occasionally the patient will consent to staying in hospital on an informal basis.

CTO use has been audited on behalf of the MHAC, and will continue to be monitored as described above

Glossary of Sections

Section	Reason	Maximum Length of time
Informal	Not detained under the Mental Health Act	
2	Admission for Assessment	28 days
3	Admission for Treatment	Initially up to 6months, can be renewed for a further 6 months then on a yearly basis
4	Emergency Admission for Assessment	72hours
5(2)	Doctors Holding Power	72hours
5(4)	Nurses Holding Power	6hours
35	Remand to Hospital for Report	28days at a time – maximum 12weeks
36	Remand of Accused Person to hospital for treatment	28days at a time – maximum 12weeks
37	Court Order for admission to Hospital for treatment	Initially up to 6months, can be renewed for a further 6 months then on a yearly basis
37/41	Court Order for admission to Hospital with restrictions	No time limit
47	Transfer to hospital of persons serving prison sentence	Initially up to 6months, can be renewed for a further 6 months then on a yearly basis
47/49	Transfer to hospital of persons serving prison sentence with restrictions	Restriction ends on the expiry of the sentence
48/49	Transfer to hospital of un-sentenced prisoners with restrictions	Until return to court
38	Interim Hospital Order	Initially up to 12 weeks can be renewed for 28days up to an overall total of 12months
CTO	Community Treatment Order (must have been detained in hospital under a treatment order immediately before CTO)	Initially up to 6months, can be renewed for a further 6 months then on a yearly basis
S17	Authorisation of Leave	
S17 (A)-(G)	Community Treatment Order	Initially up to 6months, can be renewed for a further 6 months then on a yearly basis
135/135	Police powers to take or keep a person in a Place of Safety	Currently 72 hours. On commencement of the Policing and Crime Act 2017 provisions, 24 hours with a possible extension to maximum 36.