BOARD OF DIRECTORS MEETING (Open)

Date: 11 October 2017 **Item Ref:** **12iv**

TITLE OF PAPER	Mental Health Act Committee, Quarter 1 Report, April to June 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	October 2017 Meeting
LINKS TO OTHER KEY REPORTS/ DECISIONS	Relevant CQC MHA Monitoring Visit (Inspection) Reports and Provider Action Statements.
LINKS TO OTHER RELEVANT FRAMEWORKS BAF, RISK, OUTCOMES	Strategic Objectives: A1 Quality and Safety, A2 02 People
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	4 August 2017

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **11 October 2017**

Subject: **Mental Health Act Committee, Quarter 1 Report, April to June 2017**

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

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

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 1 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. This was received at the Executive Directors Group (EDG) on 17 August and the September Quality Assurance Committee.

The report is provided under the following headings:

- Introduction
- The Committee's work in Q1
- CQC MHA monitoring visits and focused visits
- The Trust's monitoring of the MHA
- Results of the weekly MHA compliance audit
- Results of the monthly Community Treatment Orders compliance audit
- The use of the MHA in the Trust for the year April 2016 to March 2017
- Glossary of Sections

3. Next Steps

The MHAC will continue to meet on a monthly basis and to submit a quarterly report to EDG, QAC and Board, until it is superseded by the overarching Mental Health Legislation Committee, previously approved by EDG. Work continues to refine the new structure. 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 and assurance.

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:

Liz Lightbown, Executive Director of Nursing, Professions & Care Standards
liz.lightbown@shsc.nhs.uk
271 6713

Anne Cook, Head of Mental Health Legislation
anne.cook@shsc.nhs.uk

Mental Health Act Committee - Quarter 1 Report – April to June 2017

1. Introduction – The Mental Health Act Committee

The Mental Health Act Committee (MHAC) continues to meet on a monthly basis, chaired by, Anne Cook, Head of Mental Health Legislation.

The Committee's current Terms of Reference have been adopted as an interim measure, and 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 a 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. Further work is being done to refine the new structure and its allied reporting mechanisms. 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 Q1

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. The audit for the final week of Q1 showed that 100% of leave forms had a review date. This gives assurance that practice in respect of s17 leave involves a regular review of the arrangements, as required by the MHA Code of Practice.

Maxine Statham (Assistant Clinical Director, LD Services) is in discussion with IT to explore the possibility of building a pro-forma for pre-leave risk assessment and post-leave review to be built into Insight .

2.2 Approved Mental Health Professional (AMHP) feedback forms

A form was developed in response to a complaint about the practice of a MHA section 12 approved doctor (approved by the Secretary of State as having 'special experience in the diagnosis or treatment of mental disorder).

AMHPs are able to approach any section 12 doctor on a list of those available to attend MHA assessments. The doctor involved was not employed by the Trust, and therefore there was no mechanism to address the complaint, other than AMHPs not using the doctor in future. The MHA Committee agreed that it would provide an equitable solution if a brief form were to be completed by the AMHP following every MHA assessment, whether or not the section 12 doctor was an employee of the Trust; Trust doctors expressed some misgivings, but a pilot of this form was run Q1. Only 1 feedback form was received, which was very positive about the Trust doctor concerned. The Committee will review the need for a feedback form

2.3 Clarification of the schedule for reviews of seclusion

Further to the amendment to the seclusion policy reported last quarter (clarifying that higher medical trainees were able to undertake certain functions), the schedule for reviews of seclusion has been reviewed further, including a survey of other Trust's polices by Dr Girgis and input from the higher trainee doctors via Dr Nick Long.

A new schedule was disseminated on 6.7.17 in response to this work. This clarifies which doctors (by grade) are able to undertake medical and MDT reviews, what to do when seclusion persists after the first independent MDT review, which reviews can substitute for others and what the review should address. The seclusion policy will be amended as soon as possible to take account of this clarification, but the Executive Director of Nursing, Professions and Care Standards authorised the release of the guidance in the meantime in order that seclusion reviews are timely, consistent and serve the appropriate purpose.

2.4 Weekly MHA Compliance Audit

The Committee continues to review performance against the requirements of the audit. Results fluctuate from week to week. 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, but this has not proved possible to date. The MHA manager will collate some comparative data to show the change in performance since the inception of the audit.

This audit is a labour-intensive process for both ward staff and the MHA office. Work is in progress to simplify the submission process by pulling some data through from Insight, and removing the need to transcribe the individual return from each ward. A 'dashboard' summary can be produced from these data in order to show trends over time; the preferred headings for the first iteration of this new tool have been provided to the developer. A summary of the audit is given below.

2.5 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 has developed definitions of what constitutes an incident and its severity, taking into account the definition of a 'serious;' incident found in the MHA Code of Practice. The Committee is working with the risk management team to include the identified incident in a drop-down menu on the electronic incident reporting form.

The MHA breach incidents in Q1 involved, in the main, the misplacing of detention papers on Maple Ward. This occurred on 3 occasions: 2 sets of papers were subsequently located. In the remaining case it was necessary to invoke the doctor's holding power and for there to be a further MHA assessment to detain the person involved. Staff who signed to say that they had seen the missing papers have been counselled about the need to ensure that they actually see and check the papers they sign for.

2.6 Incidents involving Missing Patients/Patients Absent Without Leave (AWOL)

The Committee has started to monitor incidents of missing/AWOL patients. The Committee noted that the terms 'AWOL' and 'missing' are not defined for the Trust's purposes in the Trust Policy, this should be addressed in the next version of the policy. The quality of the data for AWOL/missing patients is being improved. Since May 2017 it has been possible to identify the length of time a person is absent from the ward, and the Insight number is to be included in future in order to identify any patterns.

Of note is that the same patient (detained under MHA section 3) has been involved in all 8 AWOL incidents reported by Forest Close for May and June. Insight notes show that SY Police have raised safeguarding alerts owing to number of missing person reports being submitted to them for this individual.

The Clinical Director has reported that it is likely that this person will continue to fail to return from periods of authorised leave and/or to leave the premises unauthorised. A leave management plan is in place, and a professionals meeting is booked to discuss this issue further.

2.7 Section 135 Warrants

Allied to AWOL incidents, work has been done to clarify the process of obtaining a warrant from the Magistrates' Court pursuant to section 135(2). This warrant is required to provide lawful authority for the police are to enter private premises to return a detained patient to hospital.

The procedure has been clarified and distributed, but the Committee notes that the arrangements with the Court are unsatisfactory: only the legal adviser can contact the Magistrate, and the list of legal advisers is given only to the police. The Trust is not permitted access to this list. The problem is compounded by the legal advisers working on an entirely voluntary basis, therefore there is no guarantee that an advisor will answer when contacted by the Police. However, if life or limb is at risk, or there is a risk of serious damage to property, the police have powers of entry under the Police and Criminal Evidence Act.

2.8 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 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 and the Trust policy (including triggers for escalation if the MHA assessment is not done promptly) and preparation of updated patient information leaflets are in the final stages. The s136 policy includes reference to the Trust policy for searching, which has been uploaded onto the Intranet after a significant delay.

The commencement of the s136 element of PaCA is yet to be confirmed, delayed by the General Election. A system is already in place whereby the police are able to consult with a mental health professional prior to using their powers under s136. This will be a requirement when PaCA takes effect

The Committee reviews the use of s136 and has noted that the frequency of its use has been increasing. Richard (Sid) Fletcher is to be invited to talk to the Committee about the impact of Street Triage.

2.9 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 clarified. Linda Wilkinson (Clinical Director) has linked this to the 'Green Light' meeting, which addresses areas of cross-over between Mental Health and Learning Disability services.

A meeting took place on 6.6.17 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 discuss the interface between these meetings and to identify the correct reporting structure. The notes of the meeting have been distributed to the attendees for checking and clarification; they include a suggested reporting/governance structure linking each of the meetings to the others.

2.10 The use of short-term sections of the Mental Health Act

Of note for Q1 is the relatively high use of nurses' and doctors' (or Approved Clinician in charge of the patient's care) holding powers under sections 5(4) and 5(2) MHA respectively. Section 5(4) was used on 7 occasions, and 5(2) on 16 occasions.

These are short-term powers (6 hours and 72 hours respectively) invoked to hold patients who have already been admitted informally to hospital, in order to assess them for detention.

Nurses' holding power may only be used to 'immediately restrain' a patient from leaving hospital because there are concerns for his own health or safety, or for the protection of others (section 5(4)). Doctors'/AC's holding power does not require this degree of urgency; the power can be invoked if it 'appears' to the relevant professional 'that an application ought to be made' to detain the patient under the MHA.

The use of these powers appears to be appropriate, with the majority of patients going on to be detained under longer-term sections. Questions may be raised legitimately about whether a patient had capacity to consent to informal admission in instances where the holding power has proved necessary within 24 hours of admission. However, the CQC's appreciative enquiry into the use of the MHA (see below) suggests that understanding of the assessment of capacity is good, and it therefore more likely that patients change their mind about remaining in hospital on an informal basis.

The use of short-term sections is monitored by the Committee at each meeting.

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, but the title remains unchanged at the end of Q1. A meeting is to be arranged with the new Head of Informatics and Information Systems to explore the possibility of expediting changes to Insight when there is a risk that failing to do so might impact on the legality of practice or a ward's ability to respond to a CQC visit/inspection.

2.12 MHA Training

Extra sessions were provided in May for in-patients staff and 24 staff are booked on the session due in July. This should enable the Trust to meet the 80% compliance target agreed with the CCG. As noted in the report for the last quarter, for contractual reasons, only staff members employed in Adult Mental Health Services are eligible to register for training delivered via the Local Authority training hub. This excludes some staff from the training for writing reports for MH Tribunals. However, it has been possible to arrange for 2 extra report-writing sessions to be delivered to staff who cannot register. The first of these is planned for July.

Progress is being made towards the amalgamation of the 3-yearly updates for Mental Capacity Act, Mental Health Act and Clinical Risk Assessment/Management. This combined training is due to start at the end of the year, and the core training materials are being developed. The three topics are being brought together under the umbrella of Human Rights legislation.

Anne Cook has developed a competency framework for practice in respect of mental health legislation for registered inpatient nursing staff. The framework was accepted by the ward managers meeting, and a version with 'answers' has been circulated. Anne will deliver training to senior nursing staff against this framework, which it is envisaged will then be used as part of the preceptorship of newly qualified nurses, and in support of clinical supervision for other registered staff.

2.13 Advocacy

Peter Brown (CAB) attended the June meeting of the Committee.

Mr Brown informed the meeting that since 1.4.17, the Sheffield Mental Health Advocacy Service was delivering the Sheffield Advocacy Hub. This included the delivery of the IMHA, IMCA, Care Act Advocacy, LDS Advocacy, NHS Complaints and Deprivation of Liberty Safeguards Relevant Person's Representatives, and 'generic' advocacy.

The aim is for all advocates to be skilled in all areas so one person will have one advocate to cover all needs. It will take a 3yr training programme for this to be achieved.

Mr Brown reported that there had been significant improvement in the waiting list for an IMCA and that there had been a huge increase in the number of referrals for the IMHA service – not only the referrals required for those lacking capacity to decide about IMHA input, which are now made automatically as a result of the weekly MHA audit.

In future the intention is to have an online referral system which would make the process more efficient and offer online guidance, however this has been estimated to cost four times more than anticipated, so the service needs to re-evaluate. The old forms are currently still in use and referrals are made the same way as always made.

Maxine Statham will meet with Mr Brown to discuss the provision of advocacy for LD patient accommodated in Sheffield away from their home services; the arrangements for payment differ by the type of advocacy provided.

The Committee noted that the CQC asks for information about who is supported by an advocate and whether they are invited routinely to meetings. However, the CAB rules about confidentiality preclude the advocate informing the service that they are acting for the patient, thereby impeding any invitations. Peter agreed to consider whether advocates could ask for permission to disclose their involvement as a standard part of their work with patients.

The Committee also enquires about the ability of an IMHA to attend at short notice (within an hour or two) to attend an Independent review of seclusion, in light of this being good practice as defined by the MHA Code of Practice. Unfortunately this is not likely, and several days' notice would be required. (This may be achievable within the time-scales set by the updated review schedule).

The Committee will continue to work with CAB to ensure that patients' rights are respected as far as these practical constraints will allow.

3. CQC MHA Monitoring Visits and Focused Visits

The Committee continues to monitor the progress of wards against their action plans. Each Directorate should maintain its own tracker of actions outstanding on the Provider Action Statement (PAS), and each receives a copy of the monthly update collated for the MHA Committee.

A Standard Operating Procedure is being developed to support wards in reporting the visit and producing their PAS. It is in its second draft at quarter end.

As is the case with CQC Comprehensive Inspections, the Monitoring Visits involve compliance with aspects of the MHA Code of Practice as well as with the MHA itself. For this reason, the PAS may include actions which also feature in the Action Plans produced by the Trust in response to the CQC's Comprehensive Inspection.

Efforts are being made to ensure that wards are not being asked for duplicate information in updating the PAS and the main CQC action plan.

At the end of Q1, there were 9 open actions across the wards. Of these, 5 are matters that affect all wards, not only those visited in a MHA review visit. These require a Directorate / Trust response and cannot be achieved solely by the individual ward actions. A full report of MHA monitoring visits is provided separately.

There were no new visits to the wards in Q1, however on 5.4.17. However, the CQC undertook an announced 'focused MHA visit' to the Trust as part of its exploration of national trends in MHA assessment, transport of patients and admission to hospital.

The purpose of this programme of visits was to:

'1. Collect information on the uses of compulsory powers, look at activity changes, explore reasons for increases or decreases of detentions, and consider any response taken by services, including local commissioning bodies to respond to changes.

2. Gather evidence on the management of local Approved Mental Health Professional (AMHP) services, what information is collected by AMHPs and understand any current issues impacting on AMHP provision including how AMHP services respond during out of hours.'

This announced visit to the Trust was one of 12 such appreciative enquiries into rising rates of detention under the MHA and into the configuration and management of Approved Mental

Health Professional (AMHP) services Nationally. Detention rose by 9% in 2015/16, following a 10% rise in 2014/15 (Source: NHS Digital). In Sheffield, detention under the MHA increased by approximately 14.5% in 2015/16.

The CQC's findings were released to the Trust on 8.6.17 but are not published more widely. The information gathered from the Trust will inform a national briefing report to support future planning.

During the visit, the CQC:

- Spoke with five patients.
- Spoke with four carers (one was contacted via the telephone following our visit).

- Carried out focus groups with the Clinical Commission Group (CCG), Head of Service for Mental Health and Learning Disability, Strategic Commissioner Mental Health, a Bed Manager, Trust Board, Governance and Operational leads, Clinical Directors, AMHP leads, Child and Adolescent Mental Health Services (CAMHS) workers, Responsible Clinicians for the wards and section 12 Doctors, local AMHPs, Service Directors and Ward Managers.
- Received a joint presentation by Sheffield Health and Social Care NHS Foundation Trust and Sheffield City Council.

The CQC team had read and analysed the information provided by the Trust in response to its request made in advance of the visit.

The main themes in the report's conclusion are:

- Service users and carers felt that more help in the community, prior to things coming to a crisis would reduce the need for admission
- The need to examine data on admission and re-admission as evidence given to the CQC was conflicting (perhaps owing to different definitions)
- The need to improve feedback from service users about their experience of detention(including their experience of s 136)
- Detention of under 18s

The key issues for staff (as reported to the CQC) are:

- Reduction in AMHP numbers
- Arrangements for s12 and GP attendance
- Possible impact of Sheffield's reduction in bed numbers (from 240 in 2014 to 153 this year) on AMHP practice with regard to delaying MHA

The Committee will examine the report and develop an action plan. The current use of the MHA in the Trust is given in detail below.

4. <u>The Trust's Monitoring of the Mental Health Act</u>

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 under longer-term sections of the MHA, are used appropriately.

Section 5(4) is the Nurse's 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). Attendance within 6 hours is 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 be made. Section 5(2) does not refer to the health or safety of the patient or to the protection of others, and may be invoked whether or not the patient is indicating a wish to leave. Section 5(2) can therefore be utilised in circumstances which lack the urgency necessary for section 5(4).

The tables below show the monitoring of section 5 for Q2 2016/17 to Q1 2017/18

Table 1 Use of S 5(4)

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Number of section 5(4)	3	8	5	7
Dr arrived within:				
Up to 1hr	2	3	1	4
1-3 hrs	1	3	2	3
3-6 hrs		1	2	0

Table 2 Outcome of S 5(4) for Q2 2016/17 to Q1 2017/18

Outcome	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Section 5(2)	2	5	2	5
Section 2				1
Section 3		1		0
Informal	1	2	3	1

The use of section 5(4) has continued to increase albeit the peak use remains in Q3 16/17. However, the fact that the all but one patient went on to further detention would indicate an appropriate use of this holding power.

The reason for the marked increase since Q2 16/17 remains unclear, but may reflect the impact of the Smoke-Free policy coming into effect on 31.5.16, and being implemented more stringently over time. 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) Q2 2016/17 to Q1 2017/18

	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Number of times used	11	13	18	16

Table 4 - Length of time subject to Section 5(2) Q2 2016/17 to Q1 2017/18

Length of time subject to holding power	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Up to 24hrs	7	6	9	7
24-48hours	2	6	7	6
48-72hours	2	1	2	3

Table 5 - Outcome following the use of the Section 5(2) Q2 2016/17 to Q1 2017/18

Outcome	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Section 3	7	5	13	9
Section 2	3	6	3	4
Informal	1	2	2	3

There has been a slight decrease in the use of section 5(2) in Q1 17/18 compared to Q416/17. However there is still an increase compared with Q2 & Q3 of 16/17.

Q1 shows a decrease in the number of those subject to S5(2) where a MHA assessment took place within 24 hours – 43.7% compared to 50% in Q4 – and a smaller decrease in the number of assessments taking place in the next 24 hours – 38.8 in Q4 and 37.5 in Q1. The percentage of those assessed in the final 24hours increased from 11.1% in Q4 to 18.75% in Q1.

In Q4 89% went on to be detained under sections 2 or 3; 81% in Q1 went on to detained under sections 2 or 3. This may suggest that detention under longer-term sections is less likely if the MHA assessment takes place later in the 72-hour period.

Nonetheless, these figures offer strong assurance that holding powers are being used appropriately and that deprivation of liberty as a result of these short-term powers has been minimal. In Q1, assessment for s5(2) occurred within the six hours' duration of s5(4), and detention pursuant to section 2 or 3 or the ending of compulsory powers was completed within the 72-hour timescale set by law in 100% of cases, and within 48 hours in 81% of cases.

5. Results of the Weekly Mental Health Act Compliance Audit

The Mental Health Act compliance audit is completed each week, usually by the Ward Manager or Deputy Ward Manager 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 on receipt, any anomalies are questioned at this time, and any necessary urgent action requested. The MHA Committee agreed at the June meeting that any uncorrected figures will be shown as a nil return in future.

If the figures do not add up to 100% an explanation is requested. Where there is not a sufficient explanation, the ward manager is asked to take urgent action to address the matter.

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.

6. Results of the 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 reported to Community Team Managers, Community Responsible Clinicians, Clinical and Service Directors and Assistant Directors. A summary of the audit is presented to the Mental Health Act Committee on a monthly basis

Table 6 - CTO Practice Q2 2016/17 to Q1 2017/18

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Total subject to CTO as at the end of the month	75	73	62	62	57	57	63	63	62	59	63	59
No. of Outstanding Consent to Treatment forms	7	7	9	8	4	1	1	1	0	5	1	2
No. of Outstanding Capacity to Consent to Treatment Forms	10	5	12	8	6	2	4	2	3	7	3	4
No of. Outstanding Rights Given Forms	12	17	14	11	3	2	9	8	5	8	7	12

Discounting the high number of people subject to CTO in July and August 2016, the use of CTO remains fairly constant ranging from 57 to 63 people subject to CTO at the end of each month .

The number of outstanding consent to treatment and capacity to consent forms and records of rights given are being actively monitored; teams are reminded on a weekly basis of whose rights have not been given and explained. The relatively high number of 'rights given forms' outstanding for June is largely due to the number of CTOs being renewed this month and the practicalities of explaining rights when patients are in the community, rather than detained on the ward.

7. Use of the Mental Health Act by the Trust: Q2 2016/17 to Q1 2017/18

Tables 7 to 9 below show the number of detentions by MHA section that have been processed by the Trust by quarter from Q2 2016/17 to Q1 2017/18.

Table 7 – Table of Admissions by MHA section

Admissions	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Section				
2	63	76	58	87
3	29	32	24	35
4	2	1	4	2
35	0	0	0	0
36	1	0	0	0
37	1	1	0	1
37/41	2	0	1	1
47	0	0	0	0
47/49	0	0	0	0
48/49	0	0	0	1
38	0	0	0	0
Total	108	110	87	127

This table refers to those admitted from the community under detention. It shows a 46% increase in overall detention uses in Q1 17/18 compared to the low of Q4 16/17. Q1 figures also show a 15.45% increase over Q3 16/17. This is largely due to the increase of people being admitted under section 2 and section 3. The reasons for the use of detention are not fully understood. There may be a link to the reduction in bed numbers and the increased availability of alternatives to (informal) admission, meaning that most admissions are now compulsory under the MHA.

Table 8 – Table of Status Changes (refers to patients already in hospital)

Changes	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
Informal to s5(4)	3	9	5	7
Informal to s5(2)	9	12	16	11
s5(4) to s5(2)	2	5	2	5
Informal to s2	0	2	2	2
S4 to S2	0	1	0	2
S5(4) to S2	0	0	2	1
S5(2) to S2	3	9	4	4
Informal to S3	9	14	6	0
S5(4) to S3	0	1	0	0
S5(2) to S3	8	7	12	9
S4 to S3	0	0	2	0
S2 to S3	30	32	38	33

Changes	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18
5(2) to Informal	2	2	2	3
S5(4) to Informal	1	3	3	2
S4 to Informal	2	0	1	0
S2 to Informal	56	51	49	63
S3 to Informal	80	71	70	77
S37- to informal	0	0	1	0
Total Activity	215	219	205	218

This table shows an increase in the overall number of section changes from Q416/17 to Q1 17/18. There has been a marked decrease in patients being admitted informally and subsequently detained under section 3; a total of 145 patients were re-graded to informal and 63 of these were re-graded from section 2, therefore not being subject to detention for any longer than 28 days. The number of patients subject to section 2 who were re-graded to informal is nearly double the number of those subject to section 2 who were re-graded to section 3; this appears to offer assurance that patients are not being detained longer than is necessary.

If those re-graded to informal are disregarded, there is a decrease in the use of detention in the first quarter 2017/18 (73) compared to the previous 3 Quarters 74,92 and 79) respectively

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 9 – Table of Community Treatment Orders

CTO	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
New CTO	6	10	12	15
Recalls	5	10	7	8
*Revocation	2	5	4	6
Discharge from CTO	5	8	4	7

*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 MHA Committee, and will continue to be monitored as described above.

8. 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	72 hours
5(2)	Doctors Holding Power	72 hours
5(4)	Nurses Holding Power	6 hours
35	Remand to Hospital for Report	28 days at a time – maximum 12weeks
36	Remand of Accused Person to hospital for treatment	28 days 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 28 days up to an overall total of 12 months
CTO	Community Treatment Order (must have been detained in hospital under a treatment order immediately before CTO)	Initially up to 6 months, 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 6 months, 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.