BOARD OF DIRECTORS MEETING (Open)

Date: 13 December 2017 **Item Ref:** 13ii

TITLE OF PAPER	Mental Health Act Committee Q2 Report 2017/18 July to September 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	December 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 Aim: Quality & Safety, Strategic Objective: A1 01
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 Mental Health Act.

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

SUMMARY REPORT

Report to: **OPEN BOARD OF DIRECTORS MEETING**

Date: **13 December 2017**

Subject: **Mental Health Act Committee, Quarter 2 Report, July to September 2017**

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

Author: **Anne Cook, Head of Mental Health Legislation (HoMHL)**

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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 2 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 was received at the Executive Directors Group and Quality Assurance Committee in November.

The report is provided under the following headings:

1. Introduction
2. Internal Audit
3. Case law developments
4. The Committee's work in Q2
5. The Trust's monitoring of the MHA
6. The use of the MHA in the Trust
7. Glossary of Sections

Assurance can be given that practice in the Trust is lawful, respects patients' rights and is the least restrictive possible, given the purpose of the MHA and its permitting of non-consensual detention and treatment.

The vast majority of matters raised in recent CQC MHA monitoring visits have been in respect of adherence to the MHA Code of Practice, rather than failure to follow the law itself. The Code of Practice is statutory guidance, and some aspects of it must be followed, however none of the instances of the Trust not adhering to the Code were 'musts'.

However, the MHAC has some concerns that the utility of the weekly MHA audit has reached a plateau and is no longer driving improvement. This will be monitored closely, but it should be noted that despite this, standards have improved greatly as a result of introducing the audit.

It is of note that for two of the three months covered by this report, no MHA-related incidents were reported; the HoMHL will attempt to ascertain whether this is accurate.

3. Next Steps

The MHAC will continue to meet on a monthly basis and to submit a quarterly report to the Executive Directors Group, Quality Assurance Committee and Board of Directors.

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:

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 2 Report – July to September 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 (HoMHL).

It had been intended that an overarching Mental Health Legislation Committee would be developed to unify the quality assurance and governance functions currently undertaken separately by the MHAC and the Mental Capacity Act and Deprivation of Liberty (MCA/DoLS) Steering Group. However, it has not proven viable to achieve a unified Committee; the options resulted in either an increased burden of meetings for core attendees or in an unacceptable reduction in the frequency of the scrutiny provided.

The main objective for unification was 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, especially as developing case law leads to ever closer links between the two statutes.

Despite the difficulties with unifying the Committees, its main objective remains viable. The MCA/DoLS Steering Group will become a Committee, and Terms of Reference for the MHA Committee and the MCA/DoLS Committee will be developed to facilitate parallel reporting and governance structures: the two Committees will be linked by the HoMHL role and by shared core membership. The new arrangements and Terms of Reference will be finalised when the impact of the current reconfiguration is known.

In the meantime, some practical steps are being taken to ensure that Trust staff who work predominantly with the MHA are aware of the increasing impact of the MCA, both Statute and case law, on practice:

- MHA training sessions now include specific reference to the fact that any practice or intervention concerning the care and treatment of patients that is not governed by the MHA will, by definition, fall under the MCA.
- Training is being delivered to all teams on new Insight forms for recording capacity and consent to treatment. These forms require consideration of which legal framework is appropriate and guide staff to the correct set of documents .
- Preparation is underway for the proposed amalgamation (under a human rights umbrella) of the update training for MHA, MCA and Clinical Risk Management.
- The current MCA/DoLS Practice Development workshops are being adapted to incorporate a MHA aspect. The first planned session (delivered on 9.10.17) was entitled 'Mental Health Tribunals and Mental Capacity'.

2. Internal Audit

15 days have been allocated to audit compliance with mental health legislation (MHA and MCA).

The Terms of Reference have been agreed, and the work will take place in 3 parts:

- Part 1 – 5 days for non-opinion supportive work to help the Trust establish robust governance and reporting arrangements at board sub-committee and feeding group level.
- Part 2 – 5 days for an assurance opinion piece on the robustness of the current MHA audit undertaken by the Trust.
- Part 3 – 5 days for an assurance opinion piece on the quality of MCA assessments and Best Interests documentation, plus the 2nd follow-up audit of the MCA.

The scope of the audit is limited to offering assurance opinions on these specific aspects of MHA and MCA systems. There will be no opinion offered on overall governance, although it is recommended by the auditors that this is subject to further internal audit on 2018/19.

3. Case law developments

The Court of Appeal has delivered a judgment (*SSJ v MM; Welsh Ministers v PJ* [2017] EWCA Civ 194) in respect of conditional discharge from a restricted hospital order (MM) and the effect of Community Treatment Orders (PJ) with regard to potential deprivation of liberty. The case was heard before 3 very senior judges: Sir James Munby, President of the Family Division; Lady Justice Gloster, Vice-President of the Court of Appeal; and Sir Ernest Ryder, Senior President of Tribunals. Their ruling is how the law is now to be interpreted.

The ruling for MM determines that those patients who are subject to conditional discharge cannot be discharged to conditions which amount to a deprivation of liberty (as defined by the *Cheshire West* case) on the basis of their own consent to the deprivation. This is because the person would not be free to withdraw consent: withdrawal would result in either unlawful continuation of the imposition of the conditions, or risk to the public, as a result of ceasing to impose the necessary conditions.

Deprivation of Liberty authorised by the MCA would not be possible in these circumstances as it would be contingent on the person lacking capacity to consent to their treatment arrangements. The effect of this ruling is that capacitous patients who would require risk mitigation measures in the community that amount to deprivation of liberty ought not to be discharged from hospital by the Tribunal.

Perhaps more surprisingly, the Court of Appeal came to a contrary conclusion for PJ in respect of Community Treatment Orders (CTO).

CTO allows for a detained patient to be discharged from detention in hospital, subject to the Responsible Clinician (RC) retaining the power to recall them to hospital if necessary. The court ruling for PJ reiterated that consent is irrelevant. However, it determined that the purpose of CTO is to achieve the 'gradual integration of the patient into the community', and that this purpose would be frustrated by restricting the RC only to recalling the patient in order to protect and treat the patient and to protect the public.

The ruling decided that, in addition to recall, risk mitigation measures necessary safely to maintain the patient in the community on CTO, can amount to a lawful deprivation of liberty, 'as long as the patient is not exposed to a greater restriction than would be the case if s/he were to be compulsorily detained in hospital' (paragraph 64).

This outcome contradicts the MHA Code of Practice (CoP), itself statutory guidance, which states at paragraph 29.31 that conditions on CTO must not deprive a patient of their liberty. Although this is a 'must' in the CoP (permitting no exceptions) the CoP is now necessarily overruled by the court.

This judgment, which would allow a CTO patient to be detained in the community placement and forcibly returned there if absent without authorisation, may have implications for the management of CTO patients in staffed community settings, but its impact on those in non-staffed settings appears limited, given the absence of anyone present to monitor and supervise adherence to the liberty-depriving conditions.

4. The Committee's Work in Q2

4.1 CQC MHA Monitoring 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. EDG and QAC receive a Quarterly summary report.

A Standard Operating Procedure (SOP) has being adopted to support wards in reporting CQC visits, and a further SOP for producing and updating the PAS following a CQC MHA review visit is awaiting approval.

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.

There were 3 new visits to the wards in Q2. EDG has received the reports and PAS for each.

At the end of Q2, there were 17 open actions across the wards. Of these, 12 are matters that have the potential to affect all wards, not only those visited in a MHA review visit. These require a Directorate/Trust response.

Such a response is in place with regard to involvement in care planning, blanket restrictions and the recording of seclusion reviews.

Assurance
Assurance can be offered that the overwhelming majority of findings in the Monitoring Visits concern issues related to the MHA Code of Practice. Ward practice is therefore lawful except in isolated instances. Such instances have been remedied immediately, or had been addressed prior to their being noted by the CQC.

4.2 CQC MHA Focused Visit – AMHPs and the use of the MHA

The report from the CQC announced focused MHA visit to the Trust in April 2017 has been received, and a draft development plan has been produced jointly with the Local Authority, addressing the following themes:

- More support/investment in the community
- Review of the step down from hospital provision
- Escalation of none availability of Approved Mental Health Professionals for MHA assessments

- Improving feedback obtained from patients subject to MHA and the process of being detained under the MHA, including s 136
- Re-admission rates and the impact of Street Triage on s136 – please see para 4.7
- Availability of section 12 doctor or GP for MHA assessments – please see para 4.13
- Understanding the increase in admission of under 18s

The Committee will review the plan at future meetings. The current use of the MHA in the Trust is given in detail below at heading 6.

4.3 Clarification of the schedule for reviews of seclusion

A new schedule was disseminated on 6.7.17 in response to this work. This clarified 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.

Assurance
No new problems have emerged from the new schedule, and the seclusion policy as a whole will be amended as soon as possible to take account of this clarification.

4.4 Weekly MHA Compliance Audit

The Committee continues to review performance against the requirements of the audit. 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.

However, it is of concern to the Committee that teams apparently see the audit only as a burdensome and bureaucratic exercise. Recent feedback from two Consultant Psychiatrists has indicated that the same omissions or errors are occurring repeatedly, suggesting that the audit is not driving any improvement in practice, and that the audit is prompting action to address shortcomings after the fact, rather than providing assurance that the actions have already occurred.

The feedback is explicit that ‘CQC required forms’ are not being prioritised on the grounds that Consultant time does not allow their timely completion. The forms in question include CAT1, which records informed consent to informal admission (and which should be completed before admission); CAT2 which records informed consent to medical treatment; and CAT3 which determines the source of authority for treatment persisting beyond 3 months.

It is these forms which provide assurance that both admission and treatment are lawful. They are not CQC requirements, except inasmuch as the CQC inspections seek evidence of the taking and recording of consent.

It is acknowledged that the 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.

Assurance
Assurance is limited at this time. The utility of the audit in its current form is to be addressed by the Internal Audit; auditors are aware of the current difficulties. The MHAC will continue to monitor compliance against the audit, and to seek means of highlighting its role in ensuring lawful detention, lawful treatment and the upholding of patient rights. The matter will be maintained under review.

4.5 MHA Breach Incidents

It has become apparent that some incidents involving potential breach of the MHA or Code of Practice might not be reported, and that those that are might be difficult to rate in terms of severity and likelihood of recurrence.

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, and the options for selection have been finalised.

There were 3 reported incidents in July:

- A period of 2 hours' detention without authority when a MHA s5(2) form was completed incorrectly – subsequently detained under s3
- A delay in requesting a Second Opinion Appointed Doctor for patient HS, leading to
- No authority being in place to treat HS – this was addressed and remedied urgently

There were no reported incidents in August or September.

Assurance
The HoMHL will seek to establish whether the nil reports are accurate.

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

There were 12 incidents in Q2: 5 incidents reported in July; 6 reported in August; 1 reported in September.

All patients returned safely.

Assurance
Work is being undertaken by the Inpatient Directorate to look into the frequency and reasons for patients going AWOL, including whether the same individuals are involved and the practice around the granting of leave under MHA s17.

4.7 Policing and Crime Act 2017(PaCA) – changes to MHA sections 135 &136

The commencement of the s136 element of PaCA is yet to be confirmed, delayed by the General Election. It is now thought likely that the changes will take effect in December. Section 136 leads are aware.

The Committee reviews the use of s136 and has noted that the frequency of its use has been increasing despite the advent of Street Triage.

Richard Fletcher (Senior Practitioner) gave a talk to the Committee in September about the impact of Street Triage.

Richard reported that despite its title, Street Triage is mainly used for patients within their home: s136 cannot be used in a patient's home, as its powers apply only in public places. 83% of Street Triage cases have had previous involvement with SHSC.

Richard reported that there is overwhelming clinical evidence that if Street Triage is utilised, or if there has been other formal communication between police and mental health professionals, then the likelihood of A+E attendance or s136 detention is minimal. The opportunity for discussion with a mental health professional is available to the police 24-hours per day, provided by the Liaison and Diversion Service and the Out of Hours Team. However**,** the avoidance of s136 is dependent upon the police contacting services before they make the decision to detain under s 136.

It appears, therefore, that in circumstances where the police consult with Street Triage, there is a high conversion rate from s136 to further detention, providing assurance that only those requiring further detention are brought to hospital.

Conversely, where the police act alone and use s136 without consultation with SHSC, there is a low conversion rate, with very few going on to be detained under further section. This equates to unnecessary use of the s136 beds, and consequently to their not being available for patients who may need further to be detained.

It is of note that the PaCA amendments will require the police to consult with a mental health professional prior to using their powers under s136; this has the potential significantly to reduce instances of officers acting alone.

The current increase in s136 may also be the result of the second bed coming into use on Maple Ward.

Richard Fletcher described a scheme he and Richard Bulmer (Service Director) visited in Newcastle; it may be possible to reduce the use of s136 by 50% by adopting some of the same successful strategies. Mr Bulmer is due to report to the MHA Committee in November, and will include information about the Newcastle approach.

4.8 Memorandum of Understanding – Police use of Restraint in Mental Health and Learning Disability Settings: NHS Protect

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.

Assurance
The suggested reporting/governance structure linking each of the meetings to the others has been adopted and Mr Bulmer's reports to MHA Committee will reflect these links.

4.9 The Use of Short-Term Sections of the Mental Health Act

These are short-term powers (up to 6 hours in the case of Nurses Holding Power, s5(4) and up to 72 hours for Doctors/Approved Clinicians, s5(2)) invoked to hold patients who have already been admitted informally to hospital, in order to assess them for detention.

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

Of note from the Q1 report was the relatively high use holding powers, s5(4) was used on 7 occasions, and s5(2) on 16 occasions. This prompted some concerns for EDG that the powers were being used in a way that reflected an increase in restrictive interventions.

The combined s5(4) and s5(2) figures for Q2 show that the holding powers were applied 7 times during this period. Of these 7 patients, 3 were detained within 7 days of informal admission. Two were further detained under section 3 and 1 person reverted back to informal status.

A patient's capacity to consent to informal admission is recorded on a CAT1 form. For the 3 patients detained within 7 days of admission, two CAT1 forms were completed in the community (as they ought to be) and 1 was completed on the ward.

Completion of the CAT1 form after the patient has arrived on the ward may lead to a period of unauthorised deprivation of liberty if it transpires that the patient either lacks capacity to consent, or has capacity and does not in fact consent to the restrictions on their liberty that informal admission entails.

Assurance
The MHA office will begin to monitor the completion of CAT1 forms from 1.11.17 to ensure that they are a) completed prior to admission; b) record that all the necessary information has been provided to the patient. This will ensure that, where there is doubt that the patient gave informed consent, action can be taken promptly to address the issue.

Further detail of the use of short term powers is provided under heading 5.1.

4.10 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 was entitled 'Mental Health Act Assessment'.

Assurance
The form has been re-named 'AHMP Report' to facilitate its location in the system.

4.11 MHA Training

Compliance with MHA training for in-patient staff reached 83% at the end of Q2 (target is 80%).

Three Bespoke sessions for the CERT Team have been provided as required by the CQC comprehensive inspection, reaching 77% of the team for basic MHA and Level 1 MCA. A final session is planned for early December.

Progress continues 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. However, there may be difficulties with identifying sufficient trainers to deliver this. A meeting on Friday 29th September was poorly attended, and staff who were present expressed concerns that they lacked the expertise (particularly of the MHA) to deliver the training competently.

These concerns have been fed back to the Mandatory Training Steering Group for further consideration.

The HoMHL has developed a competency framework for practice in respect of mental health legislation for registered inpatient nursing staff. Two sessions of training for 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, are booked for 6th and 17th November.

4.12 Advocacy

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

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 is awaiting confirmation about whether this can be achieved.

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

4.13 Section 12 Doctors and AMHPs – Availability for MHA Assessments

The Committee is working to understand and address delays in MHA assessments following this being highlighted in the CQC focused MHA/AMHP visit. Mel Hall, Strategic Commissioning Manager for Mental Health on behalf of Sheffield City Council and NHS Sheffield Clinical Commissioning Group has provided data and other input to this process. There are plans for a city-wide AMHP rota, and Dr Peter Bowie (Clinical Director, Specialist Services) has undertaken an options appraisal in order to maximise the availability of MHA s12 approved medical staff in office hours in order to reduce the incidence of requests for MHA assessment being pushed into out-of-hours' time. The result of the options appraisal will be reviewed by MHAC.

Dr Sobhi Girgis (Consultant Psychiatrist Forensic Service) has outlined a project to identify and ensure the timely response to requests for MHA assessments. The objective of the evaluation is to ascertain the pattern of requests for MHA assessments (in/out of hours), to establish the time from request to assessment, and to ascertain the reasons for delay. The intention is to develop a system for proper recording and monitoring of practice in respect of MHA assessments.

Assurance
Any delay in undertaking a MHA assessment, and the reasons for it appear to be being reported as incidents. This issue is addressed in the development plan resulting from the CQC focused visit.

5 The Trust's Monitoring of the Mental Health Act

5.1 Holding Powers
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 Section 5(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.

The tables below show the monitoring of section 5 for Q3 2016/17 to Q2 2017/18

Table 1: Use of s5(4)

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

* Discrepancy in numbers because in 1 case the AMHP arrived to complete S2 before doctor informed of s5(4)

Table 2: Outcome of s5(4)

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

Section 5(4) has been used less in Q2 than any time during the previous year. During one month of this quarter s5(4) was not used at all and in one case was only applied due to the admitting Section 2 paper work being invalid.

This is a 42% decrease in the use of s5(4) compared to Q1. In all cases the medic arrived within 3 hours of the s5(4) commencing. The fact that the all but one patient went on to further detention would indicate an appropriate use of this holding power.

Table 3: Use of S 5(2)

	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Number of times used	13	18	16	10

There has been a decreasing trend in the use of s5(2) during 2017/18. There is 38% decrease in Q2 compared to Q1.

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

Length of time subject to holding power	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Up to 24hrs	6	9	7	7
24-48hours	6	7	6	3
48-72hours	1	2	3	0

The percentage of those being held under s5(2) where a MHA assessment took place within 24 hours has increased from 44% in Q1 to 70% in Q2 and no one was subject to s5(2) for longer than 48hrs (18.75% were held for longer than 48hrs in Q1)

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

Outcome	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Section 3	5	13	9	7
Section 2	6	3	4	2
Informal	2	2	3	1

In Q1 81% went on to be detained under sections 2 or 3. In Q2 this rose to 90%. This may suggest that detention under longer-term sections is less likely if the MHA assessment takes place later in the 72-hour period.

Assurance
These figures offer 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 Q2 all assessment for s5(2) occurred within the six hours' duration of s5(4), In respect to s5(2) detention pursuant to section 2 or 3 or the ending of the compulsory power was completed within the 72-hour timescale set by law. In fact completion within 48 hours occurred in 100% of cases.

5.2 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.

Assurance
Assurance is limited currently. Please see above, 4.4.

5.3 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 : CTO Practice Q3 2016/17 to Q2 2017/18 by month

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Total subject to CTO as at the end of the month	62	57	57	63	63	62	59	63	59	58	57	57
No. of Outstanding Consent to Treatment forms	8	4	1	1	1	0	5	1	2	2	3	1
No. of Outstanding Capacity to Consent to Treatment Forms	8	6	2	4	2	3	7	3	4	3	4	4
No. of Outstanding Rights Given Forms	11	3	2	9	8	5	8	7	12	10	13	12

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 is largely due to the number of CTOs that are renewed and the practicalities of explaining rights when patients are in the community, rather than detained on the ward.

However compliance in terms of completed treatment certificates has increased with only 1 outstanding at the end of the September 2017 compared to 8 at the end of October 2016.

6 Use of the Mental Health Act by the Trust: Q3 2016/17 to Q2 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	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Section				
2	76	58	87	73
3	32	24	35	43
4	1	4	2	2
35	0	0	0	0
36	0	0	0	0
37	1	0	1	0
37/41	0	1	1	0
47	0	0	0	0
47/49	0	0	0	0
48/49	0	0	1	0
38	0	0	0	1
Total	110	87	127	119

This table refers to those admitted from the community under detention. In Q1 there was an increase of 46% in overall admissions under detention compared to the low of Q4 16/17. However, Q2 reports fewer admissions than Q1 (6%) although still a 36% increase from Q4. Although most people's admissions to hospital under detention are under section 2, Q2 saw an increase in the use of Section 3 as a route to admission.

There were 7 emergency re-admissions (within 28 days of discharge) in Q1: 5.88%. Readmission ranged from 3 days to 21 days.

There were 3 emergency re-admissions in Q2: 2.29%
Readmission ranged from 3 days to 19 days.

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	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
Informal to s5(4)	9	5	7	4
Informal to s5(2)	12	16	11	8
s5(4) to s5(2)	5	2	5	2
Informal to s2	2	2	2	4
S4 to S2	1	0	2	1
S5(4) to S2	0	0	1	1
S5(2) to S2	9	4	4	2
Informal to S3	14	6	0	3
S5(4) to S3	1	0	0	0
S5(2) to S3	7	12	9	7
S4 to S3	0	2	0	1
S2 to S3	32	38	33	37
5(2) to Informal	2	2	3	1
S5(4) to Informal	3	3	2	1
S4 to Informal	0	1	0	0
S2 to Informal	51	49	63	48
S3 to Informal	71	70	77	69
S37- to informal	0	1	0	0
Total Activity	219	205	218	198

This table shows a decrease in the overall number of section changes from Q1 17/18 to Q2 17/18. This partly reflects the decrease in the overall number of admissions in Q2 17/18. The overall decrease in the number of section changes from Q1 to Q2 equates to 9%. The number of people being admitted informally and subsequently detained under s3 remains low at just 3 for the quarter, however of the 12 people that were subject to holding powers (s5) following informal admission 7 were further detained under section 3 (3 were further detained under S2).

Furthermore the number of patients subject to s2 and then re-graded to s3 during Q2 is at the 2nd highest level of the last 12months; conversely, the number of patients subject to s2 and s3 who were re-graded to informal during Q2 is lower than any of the previous 3 quarters. This could be indicative of patients remaining in hospital for a longer period.

Table 9: Table of Community Treatment Orders

CTO	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
New CTO	10	12	15	10
Recalls	10	7	8	11
*Revocation	5	4	6	7
Discharge from CTO	8	4	7	6

*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.

Assurance
The quarterly figures will be reviewed by the MHAC in order to identify and analyse any emerging trends.

7 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.