BOARD OF DIRECTORS MEETING (Open)

Date: **11th April 2018** **Item Ref:** 14 iv

TITLE OF PAPER	Mental Health Act (MHA) Committee, Q3 Performance Report, October to December 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	April 2018 Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	Relevant CQC MHA Monitoring Visit (Inspection) Reports and Provider Action Statements.
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality and Safety Strategic Objective: A101: Effective quality assurance and improvement will underpin all we do. BAF Risk Number: A101i BAF Risk Description: Inability to provide high quality care due to failure to meet regulatory standards (registration and compliance).
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Mental Health Act
IMPLICATIONS FOR SERVICE DELIVERY AND 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 (HoMHL)
Date of Report	21st February 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Date: **11th April 2018**

Subject: **Mental Health Act Committee, Quarter 3 Performance Report October – December 2017**

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

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

1. Purpose

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

2. Summary

This report was received and approved at the Executive Directors' Group (EDG) on 22nd February for information on performance of the MHA in practice. It was received for information and assurance at QAC on 26th February 2018.

It is presented to the QAC to provide assurance that the use of the Mental Health Act (MHA) by the trust is in accordance with both the Statute and its Code of Practice (MHA Code of Practice 2015).

The report is provided under the following headings:

1. Introduction
2. Internal Audit
3. Case law developments
4. The Committee's work in Q3
5. The Trust's monitoring of the MHA
6. The use of the MHA in the Trust
7. Glossary of Sections

Appendix 1 – Joint Improvement Plan following the CQC's Appreciative Inquiry into the practice of Approved Mental Health Professionals (AMHPs) and the use of the MHA in SHSC.

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.

There have been no CQC MHA Monitoring Visits in Q3, however those that did occur in 2016/17 raised issues that were in respect of adherence to the MHA Code of Practice, rather than failure to follow the law itself. A summary of the progress in Q3 against the Provider Action Statements that are generated by these visits is provided separately.

Last quarter, this report raised concerns that the utility of the weekly MHA audit had reached a plateau and was no longer driving improvement. On-going monitoring has shown improved results over the last quarter, and the weekly audit is to be reviewed as part of Part 2of the Internal Audit of the MHA and the MCA.

It was also noted in the last report that there had been no reports of any MHA-related incidents in 2 out of the 3 months in Q2; the HoMHL ascertained that this was the result of a technical problem, and all such incidents (and those that had been overlooked in Q1 and Q2) have now been captured and reported into the MHAC.

3. Next Steps

The MHAC will continue to meet on a monthly basis and to submit a quarterly report to the EDG, QAC and Board.

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 monthly Mental Health Act Committee.

6. Contact Details

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Mental Health Act Committee (MHAC)
Quarter 3 Performance Report, October to December 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).

The MHAC and its equivalent for the Mental Capacity Act - the MCA/Deprivation of Liberty Steering Group, Chaired by Anita Winter, now Associate Director for Patient Safety - will need to review their respective membership and their respective Terms of Reference in light of the reconfiguration of services. However parallel reporting and governance structures are now in place for both meetings.

The MHAC and the MCA/Deprivation of Liberty Steering Group are linked by the HoMHL role and by shared core membership. New core agendas and Terms of Reference will be finalised when the impact of the current reconfiguration is known.

In the meantime, practical steps continue to be 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 has been 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. Over 20 teams are due to go live with these Insight forms in January 2018.
- The current MCA/DoLS Practice Development workshops are being adapted to incorporate a MHA aspect.

2. Internal Audit

15 days are allocated in this cycle 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.

The HoMHL and Cath Dixon (Mental health Act Manager) met with auditor during Quarter 3 and a draft report is expected early in Quarter 4.

3. Case Law Developments

The impact of the decision by the Court of Appeal in *SSJ v MM; Welsh Ministers v PJ* [2017] EWCA Civ 194 in respect of deprivation of liberty resulting from conditions applied to Community Treatment Orders was included in bespoke training delivered to the Community Enhanced Rehabilitation Team (CERT) during Quarter 3.

The ruling decided – in contradiction of the MHA Code of Practice - that, in addition to recall, risk mitigation measures necessary safely to maintain the patient in the community on CTO, are permitted to amount to a deprivation of liberty, which will be lawful '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 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 MHA Committee's Work in Q3

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.

There were no new visits to the wards in Q3, and at the end of Q3, there were 10 open actions across the wards.

A separate report of the progress against each PAS is provided.

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, usually the result of human error. Such instances have been remedied immediately, or had been addressed prior to their being noted by the CQC.

4.2 CQC MHA Focused Visit (Appreciative Inquiry) – AMHPs and the use of the MHA

The report from the CQC announced focused MHA visit to the Trust in April 2017 was received in July 2017. A development plan, produced jointly with the Local Authority, has been finalised and is appended to this report. It was updated as a work in progress by the MHAC in July 2017 and finalised in December 2017.

The Committee will continue to 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 NHS Digital MHA Statistics – Annual Figures 2016/17

The Committee noted the publication of the annual data. The figures are no longer compiled from the KP90 returns, and the 2016/17 figures are incomplete; some providers did not return any data and some made only partial returns.

Based on the good data returned, the statistics report indicated a 2% increase in the use of the MHA for the period.

The Committee agreed that the current National figures are not helpful to the Trust in monitoring its use of the MHA, and that further calculations made in the new way are necessary.

4.4 Weekly MHA Compliance Audit

The Committee continues to review performance against the requirements of the audit. There has been some overall improvement overall in Q3, but the current system of reporting and transcribing of the results is a labour-intensive process for both ward staff and the MHA office.

Work has progressed with simplifying the submission process and removing the need to transcribe the individual return from each ward. A 'dashboard' summary can be produced from these data which can then be used by the governance meetings for each ward to monitor compliance with legal requirements. As noted above, the utility of the weekly audit is to be examined

4.5 MHA Breach Incidents

A drop-down menu of the different types of MHA-related incidents is now in use as part of the electronic incident reporting form is now in use, and the Committee receives a monthly summary. Delays in the MHA process for recall or detention dominated the figures in the first 2 months, with a marked reduction in December.

There were 10 reported incidents in October. Of these, 5 were in relation to delays in the detention or recall process.

There were 13 reported incidents in November. Of these, 8 were in relation to delays in the detention or recall process.

There were 10 reported incidents in December. Of these, 2 were in relation to delays in the detention or recall process.

Giz Sangha (Deputy Chief Nurse and Clinical Director) advised the Committee that any delay attributed to the lack of a bed might not be strictly accurate. A bed may have been available, but because the process of locating the patient or transporting them to hospital was delayed, the bed could not be held indefinitely and could have been allocated to another patient.

The remaining reports were in respect of documentation or process issues to do with detention, medication or leave of absence.

All MHA Breach reports are reported back to relevant managers for investigation and action.

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

There were 9 reported incidents* in Q3, compared to 12 incidents in Q2.

There were 3 reported incidents in October*; 2 reported in November; 4 reported in December.

The majority were incidents involving failure to return on time from authorised leave. All patients returned to the ward.

* 10 reports were submitted overall, 4 in October, but one incident was reported twice.

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 changes to sections 135 and 136 of the MHA came into effect on 11.12.17. The Committee had been involved throughout, monitoring the development of the policy and issuing briefing papers. Richard Bulmer (Service Director) led on the work, which was managed jointly with South Yorkshire Police through the Section 136/Joint Services group, chaired by Mr Bulmer. The committee received a Q2 report from the group

4.8 MHA Training

Compliance with MHA training for in-patient staff reached 84% at the end of Q3 (target is 80%).

The HoMHL delivered training on a newly developed MHA Competency Framework to 37 senior nursing staff in Q3.

Unfortunately the plans to amalgamate update training for MCA, MHA and Clinical Risk Management have encountered some difficulties, including a lack of confidence in the trainers nominated by directorates to deliver the legal aspects of the training and the time commitment involved in delivering this training over a whole day.

The Mandatory Training Steering Group is reviewing the approach to delivering these updates.

4.9 Changes to arrangements for Second Opinion Appointed Doctors (SOAD)

The CQC changes the procedure for booking a SOAD at the beginning of Q4. In preparation, all Consultants have been given access to the CQC portal to enable them to use the new system. Access will be arranged for any other doctor on request to the MHA office.

4.10 Changes to community RC in light of service reconfiguration.

The Committee contacted all RCs based in the Community to advise of the need to ensure that an appropriate treatment certificate is in place within 3 months of any change of RC that ensues from the changes to services.

4.11 Section 12 Doctors and AMHPs – Availability for MHA Assessments

Following an options appraisal in Q2, Dr Bowie (Clinical Director) has worked on developing a rota that will involve there being a doctor on s12 duty in office hours. Their diary will be cleared for the day, thereby maximising the opportunity for prompt s12 assessment, rather than pushing the assessment outside office hours. These arrangements will complement the rota of the dedicated AMHP team.

The Committee continues to work with Mel Hall, Strategic Commissioning Manager for Mental Health on behalf of Sheffield City Council and NHS Sheffield Clinical Commissioning Group, to improve and expedite access to section 12 doctors and AMHPs. Ms Hall presented a draft Project Initiation Document to the Committee, which aims to eliminate unnecessary spending on s12 assessments, and to simplify the payment of claims. The Committee agreed the paper.

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 (see glossary) 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. The tables below show the monitoring of section 5 for Q4 2016/17 to Q3 2017/18

Table 1: Use of s5(4)

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

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

Table 2: Outcome of s5(4)

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

With the exception of Q1, the overall use of section 5(4) for each quarter of the year has not varied greatly.

S5(4) was necessary for one patient during Q3 owing to the detention papers being invalid. In this case a fresh application was completed before the medic arrived on the ward. In all other 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)

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

Although the previous three quarters show a decreasing trend in the use of s5(2) during 2017/18, Q3 shows the numbers rising again. However despite the 60% increase on Q2 the use on Q3 remains on par with Q4 16/17 and Q117/18

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

Length of time subject to holding power	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Up to 24hrs	9	7	7	7
24-48hours	7	6	3	5
48-72hours	2	3	0	4

43.75% of MHA assessments took place within 24 hours, 31.25% within 24-48hrs and 25% within 48-72hours of the s5(2) being implemented.

Of the 4 that were subject to s5(2) for longer than 48 hours, 3 were in December. The explanation for these longer periods is unclear but may be due to the transition period of the reconfiguration of the AMHP service.

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

Outcome	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Section 3	13	9	7	5
Section 2	3	4	2	6
Informal	2	3	1	4
Transferred	0	0	0	1

In Q1 81% went on to be detained under sections 2 or 3. In Q2 this rose to 90% but dropped in Q3 to 68% when 9 of the 16 uses (56.25%) of s5(2) lasted 24hrs or more. This may suggest that detention under longer-term sections is less likely if the MHA assessment takes place later in the 72-hour period.

Paradoxically, if this is the case and longer-term detention is avoided in 25% of cases as a result, prolonged time on s5(2) would appear to result in a less restrictive intervention than if the MHA assessment takes place promptly.

5.2 Results of the Weekly Mental Health Act Compliance Audit

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 2017 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.

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 6: CTO Practice Q4 2016/17 to Q3 2017/18 by month

2017	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total subject to CTO as at the end of the month	63	63	62	59	63	59	58	57	57	59	57	61
No. of Outstanding Consent to Treatment forms	1	1	0	5	1	2	2	3	1	1	2	12
No. of Outstanding Capacity to Consent to Treatment Forms	4	2	3	7	3	4	3	4	4	3	4	13
No. of Outstanding Rights Given Forms	9	8	5	8	7	12	10	13	12	17	16	23

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 increase in overdue certificates for treatment, capacity to consent to treatment and explanations of s132A rights is largely due to the reconfiguration of the community services and services users being allocated different RC and Care Co-ordinators.

The MHAC agreed that the expectation for RC to have completed the relevant capacity form and certificate for treatment would be three months, and notification was sent as detailed above at 4.10.

6 Use of the Mental Health Act by the Trust: Q4 2016/17 to Q3 2017/18

6.1 Detention, emergency re-admission and changes of MHA status

Table 7: Table of Admissions by MHA section

Admissions	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Section				
2	58	87	73	74
3	24	35	43	30
4	4	2	2	1
35	0	0	0	0
36	0	0	0	0
37	0	1	0	0
37/41	1	1	0	0
47	0	0	0	0
47/49	0	0	0	0
48/49	0	1	0	0
38	0	0	1	0
Total	87	127	119	105

This table refers to those admitted from the community under detention. In Q1 there was a high admission rate with an increase of 46% in overall admissions under detention compared to the low of Q4 16/17. However, Q2 and Q3 show a continued decline in admission under detention.

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. Jason Rowlands (Director of Strategy and Planning) collates and interprets the National data and reports separately on this.

Emergency re-admissions.

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.

There were 20 re-admissions in Q3: 4.10%
Readmission ranged from 2 days to 24 days. The total number of admissions was 488.
11 of the 20 occurred within 7 days of discharge.

Although this reflects a significant increase, Sheffield's readmission rates appear to be below the national average see table 8 below:

Table 8 - Benchmarking Trends

	2014-15	2015-16	2016-17
Number of people re-admitted within 30 days of discharge	36	32	41
Sheffield readmission rate – adult acute wards	5%	5%	8%
National readmission rate – adult acute wards	9%	8%	9%

Table 9: Table of Status Changes (refers to patients already in hospital)

Changes	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
Informal to s5(4)	5	7	4	5
Informal to s5(2)	16	11	8	13
s5(4) to s5(2)	2	5	2	3
Informal to s2	2	2	4	1
S4 to S2	0	2	1	1
S5(4) to S2	0	1	1	1
S5(2) to S2	4	4	2	6
Informal to S3	6	0	3	5
S5(4) to S3	0	0	0	0
S5(2) to S3	12	9	7	5
S4 to S3	2	0	1	0
S2 to S3	38	33	37	49
5(2) to Informal	2	3	1	4
S5(4) to Informal	3	2	1	1
S4 to Informal	1	0	0	0
S2 to Informal	49	63	48	47
S3 to Informal	70	77	69	86
S37- to informal	1	0	0	0
Total Activity	205	218	198	227

During Q3 the number of patients detained under s2 and being further detained under s3 saw an increase of 32% from Q2. This indicates that more patients are remaining in hospital for a longer period.

Q3 shows an increase in the number of people coming in hospital informally but then going on to be detained under s5(2) (Doctors holding power for up to 72hrs). This may be as a result of fewer people being admitted directly under detention during this quarter and more beds therefore being available (also reflected in the reduction in reports of delays in the MHA process).

Of note from the Q1 report was the relatively high use of holding powers: 23 uses in total. 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 showed that the holding powers were applied 7 times during this period. Of these 7 patients, 3 were detained within 7 days of informal admission (42.85%).

The combined figures for these short-term powers in Q3 show a return to 23 uses. Of these, 17 patients were made subject to s5(4) or s5(2) within 7 days of informal admission (73.91%): 4 returned to informal status; 19 of the 23 were further detained (82.6%). This may give cause to question whether informal admission was appropriate.

6.2 Informal admission

Form CAT1 is currently in use to determine whether a person is giving informed consent to informal admission, and it will be rolled out as an Insight form early in the New Year. It should be completed prior to admission, as completion 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.

Although CAT1 is used for informal substance detoxification admissions, the statements on it are not entirely relevant to the 'contractual' nature of a detox admission. For example, the references to possible detention on CAT1 are unlikely to apply, given that detention is not lawful for substance misuse in the absence of further mental disorder. For this reason, the detox admissions are excluded from Table 10, however, despite its shortcomings, all detox patients had a CAT1 completed before or on the day of admission. Since November 2017, the MHA office has been monitoring the use of CAT1.

Table 10 – CAT1 (excluding detox admissions)

Month	No of informal admissions	CAT1 completed before admission	CAT1 completed after admission	Unable to determine
November	14	5	9	0
December	11*	3	7	1

* This excludes 1 patient who self-presented to a ward, and 1 patient transferred in from Rotherham, who had a clear statement of capacity to consent to admission.

It is evident that the use of CAT1 is not yet embedded in practice, and it can be assumed that staff managing access to beds are not ascertaining that CAT1 has been completed prior to admission. The MCA/DoLS Steering Group is monitoring the implementation of the CAT1 as one component of the suite of capacity and consent forms to be included on Insight.

6.3 Community Treatment Orders

Table 11: Table of Community Treatment Orders

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

*Revocation is when a person on CTO has been recalled to hospital and the CTO is then revoked placing the patient back under section 3/37. 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.

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	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.
5(4)	Nurses Holding Power	Nurse's holding power in respect of informal patients. 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 or Approved Clinician who has authority to furnish a report under s5(2).
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	24 hours with a possible extension to maximum 36.

Appendix 1

Joint Development / Improvement Plan

On the 5th April 2017 CQC held a planned focused visit hosted by SHSC. The purpose of the visit was to look at the current mental health act practice, look at any improvements which might be made using data and inform future policy positions. The CQC team, made up of Mental Health Act Reviewers, a CQC policy manager, a specialist advisor and an expert by experience, met with Sheffield citywide leaders, managers and frontline staff.

A report was completed by CQC on their findings on the 8th June 2017. This response has been produced by the Strategic Commissioning Manager for mental health on behalf of Sheffield City Council and Sheffield CCG joint commissioning team, and by the Mental Health Act Committee of Sheffield Health and Social Care NHS FT.

The CQC team interviewed a number of stakeholders through a series of focus groups over the day. The report highlights the findings from the day split across the groups; it shows that overall the use of the Mental Health Act in Sheffield is used with care, understanding and respect. There are clear areas of good practice such as the reduction in the number of people being sent out of area for acute care and the development of the Home Treatment teams. Another area which shows a positive approach is the availability, awareness and use of the Independent Mental Health Advocates to inform people of their rights and enable the person's voice to be heard and the positive comments from carers reporting feeling part of the mental health act assessment process.

The report also highlights areas which could indicate a need to change and improve. While the facts surrounding these areas may 'accurately reflect the views of the focus group, there is a need to ensure that any inaccuracies are widely promoted to ensure professional groups are fully aware of what is happening within the complexities of mental health provision. Some of these issues raised by this report are linked to practice the clinical leads will address these; however there are areas for commissioning to seek assurance and work with the mental health provider to address. These areas are broken in to 7 main themes listed below with comments and proposed actions.

Theme	Raised with the CQC by	Summary of Comments made to the CQC and source	Action Date to be completed	Action Owner
1 More support / investment in community mental health services	Patients and Ward Managers	Patients & Ward Managers expressed the need for more support and investment in community services. Each of the other focus groups spoke about the community investment of the home treatment teams and the shift in resources from inpatient to community services	To discuss at Mental Health Act Committee July 2017.	Melanie Hall (SCC) Anne Cook (SHSC) obo MHA Committee
Update July 2017	The July MHA Committee meeting attended by Ms Hall – it was agreed that Ms Hall's commissioning response to the CQC report would be expanded by Denise Woods, Graham Hinchcliffe and Anne Cook to include all the themes identified (resulting in this version of the development/improvement plan). Ms Hall reported that there is an on-going programme of commissioning of community services in Sheffield. It was noted that there had been a misunderstanding or miscommunication to the effect that the SORT team was no longer to exist. Any impact on the changes to the SORT team resulting from service reconfiguration are to be reviewed in March 2018			
Update September 2017	MHA Committee is aware of on-going Progress plans for reconfiguration of community services. Expanded action plan submitted to Ms Hall for discussion at October meeting			
Update Oct/Nov 2017	Ms Hall unable to attend MHA Committee in October or November – agreement of expanded plan deferred to December			
Update January 2018	Ms Hall attended December MHA Committee, and agreed expanded plan There has been significant progress with the reconfiguration of services: Single Point of Access (SPA) and a dedicated AMHP service now afford improved and quicker access to services			

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2 Review the step down from hospital provision – OP, LD, AMH, CAMHS	Ward Manager's focus group.	Ward Managers raised concerns that there is little provision for people who are *'better but not ready to go home'* this was within the context of a recent system change as 4 beds are reduced from a step down provision.	System wide review of step down from acute ward provision and alternatives to hospital. To be raised at Contract Management Group July 2017.	Melanie Hall (SCC)
Update January 2018	Ms Hall attended MHA Committee in December 2017. She reported that progress had been made via the Contract management Group, of which she is a member. The Contract Management Group have agreed that the services deemed as 'step down' and 'step up' will be the focus of a workshop in January 2018. The aim is to include these services in the on-going mental health transformation programme in the Accountable Care Partnership.			
3 Escalation of none availability of AMHPs – especially Dementia services	Ward Manager's focus group.	Ward Mangers reported that when AMHPs say they cannot do a MHA assessment in health based place of safety they have a process to escalate to a senior manager who find capacity from other localities. Dementia services shared they do not have anywhere to escalate issues when they are unable to get an AMHP	To discuss at Mental Health Act Committee. July 2017	Melanie Hall (SCC) Anne Cook (SHSC) obo MHA Committee
Update July 2017	Issues discussed at MHA Committee 19.7.17.			
Update August 2017	Any AMHP/section 12-related incidents leading to inability to undertake a MHA assessment are now included in the report of MHA breaches which is reviewed by the MHA Committee each month . Anne Cook checked the extent and impact of this on dementia services with Tony Bainbridge (Assistant Clinical Director, Dementia Services) on receipt of CQC report. Mr Bainbridge reported that this is not in fact a frequent issue, and an incident report is submitted if there are problems of this nature. It is possible that the focus group interpreted it as an inability to get and AMHP when in fact it is just that another call has taken priority over the one requested.			

	In future the Senior AMHP Manager will be the person to whom to escalate these issues; the duty to get an AMHP to attend is specified in the new job description. The JD is explicit under 'Specific Duties and Responsibilities' that the Manager has the responsibility to manage the service. This would include the 'first point of escalation' where there are any issues in regard to the AMHP service/function. All referrals for MHA Assessments will be received and managed by the proposed Daytime Team and allocated to an AMHP on receipt of the referral. There were no reports of delays to MHA assessments to MHA Committee in August.			
Update October 2017	No reports of delays to MHA assessments to MHA Committee in September or October. Concerns that not all incidents were included on the monthly summary – Anne Cook to investigate			
Update November 2017	Missing reports resolved. All incident reports (including backlog) now included in report to MHA Committee			
Update January 2018	Delays in MHA assessment appear to be reducing. Delays in MHA assessment or recall dominated in October and November, accounting for 50% of the 10 MHA incident s reported in October, and 61.5% of the 13 reported in November. This reduced to 2 of the 10 incidents in December (20%)			
Theme	**Raised with the CQC by**	**Summary of Comments made to the CQC and source**	**Action Date to be completed**	**Action Owner**
4 Availability of section 12 or GP	CCG, AMHP leads, local AMHP focus group and Doctors	All groups identified this theme. It appears that sourcing a section 12 doctor/GP on an evening is easier than in-hours	To discuss at Mental Health Act Committee. Look at current spend and how this is distributed. July 2017 Is there scope to commission something different to improve the availability of section 12/GP for MHA?	Craig Housley (CCG) Anne Cook (SHSC) obo MHA Committee
Update July 2017	Ms Hall attended the MHA Committee meeting in July. Options to maximise the availability of s12/GP discussed. SHSC to supply the s12 rota and MHA Assessment referral tracker to Ms Hall. Ms Hall to attend a separate meeting (outside MHAC) with the financial information in respect of payments for s12/GP attendance. Meeting planned between Julia Walsh (Lead SW); Peter Bowie (Clinical Director); Sobhi Girgis (Consultant); Mel Hall and Anne Cook 16.8.17			

Update September 2017	Documents supplied. Meeting took place – frequent payments for both medical assessments occurring – options to increase doctors' availability and thereby reduce delays in assessments and also reduce the second payment explored. Proposal for the rota s12 doctor to clear their diary received a mixed reception – this would still only provide 1 s12 doctor. Dr Bowie will write out to those involved to canvass opinion.
Update October 2017	Dr Bowie's canvassing of results was presented to MHA Committee by Dr Garneti. The result was for 'Option 1': the development of a rota of doctors (consultants, higher trainees and speciality doctors) assigned specifically to section 12 duties, with diaries cleared otherwise in order not to push assessments out of office hours. These doctors to be based at the crisis hub, Longley Centre, with the duty AMHP. Conflict of Interest Guidance clarified and published on the Intranet; this may reduce the possibility of delays resulting from the contradictory guidance contained in the MHA Code of Practice and the Reference Guide to the MHA Code of Practice, respectively Dr Girgis informed the MHA Committee of a project to ascertain the pattern of requests for MHA assessments in and out of office hours and to assess the time taken between request and assessment. Also to ascertain whether there are difficulties with first medical recommendations and/or second, and to assess the level of GP involvement
Update January 2018	The new s 12 rota became operational at the beginning of January, as described above The MHAC was informed in December 2017 that a project is to underway (CCG) which is intended to reduce spending on doctors' claims for Mental Health Act assessments and to increase the availability of doctors to undertake their role in respect of s12.

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5 Improvement could be made on feedback obtained from patients subject to MHA and the process of being detained under the MHA, Including s 136	Strategic Manager with responsibility for AMHP service and Senior Operational Managers	We were told by the Strategic Manager with responsibility for AMHP service and Senior Operational Managers that there was some collection of data through the quality and dignity survey (patient experience on the ward) and feedback with focus on people having been placed under s 136	To discuss with Patient Experience Team and agree an action plan SHSC Service User engagement team to be asked to contribute, consider if Laura Di Bona could lead – meeting booked for 9.8.17	Sarah Neil SCCG Mia Bajin Jo Evans

Update July 2017	Meeting with Laura Di Bona cancelled			
Update January 2018	The Policing and Crime Act 2017 amended MHA s136 with effect from 11.12.17, reducing the period of time a patient can be detained from 72 hours to 24 hours. Anne Cook has asked the s136 group to gather patient experience data in light of this significant change FFT and Care Opinion surveys continue			
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6 Different perspectives about admission rates and re-admission; lack of impact of street triage on s136.	Joint presentation/data analysis	Readmissions were defined as within 28 days of discharge [from in-patient services] Trust planned to look at data relating to readmissions to identify trends.	Admission/readmission data to be collated and included in MHAC Quarterly Reports Street Triage activity and outcomes to be analysed and presented by Richard (Sid) Fletcher (Senior Practitioner)	Cath Dixon John Wolstenholme Richard (Sid) Fletcher to attend MHA Committee 20.9.17
Update September 2017	Richard (Sid) Fletcher attended MHA Committee as planned and gave a presentation explaining that although the scheme is named ' Street Triage', most of its work occurs in patients' homes (s136 cannot be used in the home). It was reported that there is overwhelming clinical evidence that if there is communication between the police and MH services before the police use s136, the likelihood of A&E attendance or the use of s136 is minimal. Mr Fletcher attributed the lack of impact of Street Triage on s136 was the continuing tendency of the police to act without prior reference to the service, or to other available advice. The availability of the second s136 bed may also have contributed to the limited impact – the second bed being used simply because it I sknown to be there			
Update November 2017	Richard Bulmer (Service Director) submitted a report to the MHA Committee. Mr Bulmer and Mr Fletcher Bulmer had visited Northumberland to examine how they deal with their Section 136 as they have reported low numbers of people being detained under S136. The report stated the commitment to joint working to ensure that only those people who need to be taken into hospital for 136 mental health act assessment in Northumberland Tyne and Wear (NTW) is impressive – it is			

<table>
<tr><td></td><td>hoped that s136 use in Sheffield can be significantly reduced adopting this model. Mr Bulmer chairs a specific s136/police liaison group</td></tr>
<tr><td>Update January 2018</td><td>The Policing and Crime Act 2017 took effect on 11.12.17 in respect of s136. There is now a legal obligation for the police to consult with a MH professional whenever practicable prior to utilising s136. The MHA Committee monitors use of s136 monthly, and will continue to do so in light of these changes to the law</td></tr>
<tr><td>Update January 2018</td><td>Re-admission
Note - CQC feedback on the day referred to readmission following discharge from community provision subsequent to discharge from in-patient services – this is not how emergency re-admission is defined by the Trust.

The MHA Committee’s quarterly reports to EDG and QAC now include re-admission data, please see benchmarking trends below</td></tr>
<tr><td></td><td>Benchmarking Trends
<table>
<tr><th></th><th>2014-15</th><th>2015-16</th><th>2016-17</th></tr>
<tr><td>Number of people re-admitted within 30 days of discharge</td><td>36</td><td>32</td><td>41</td></tr>
<tr><td>Sheffield readmission rate – adult acute wards</td><td>5%</td><td>5%</td><td>8%</td></tr>
<tr><td>National readmission rate – adult acute wards</td><td>9%</td><td>8%</td><td>9%</td></tr>
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7 Under 18 admissions – significant increase, but CQC could not ascertain possible reasons (CAMHS invited to attend Committee)	Data analysis	Data analysis by the CQC showed a significant spike in the detention of under 18s in 2016/17 – admissions doubled	Data provided to Dr Vaidya (Consultant Psychiatrist CAMHS) Nick Harrison (CAMHS) to be invited to present findings to MHA Committee	Dr Girish Vaidya Nick Harrison
Update July 2017	Invitation sent to CAMHS suggesting an 'Under 18s' focus for the September meeting. No response received			
Update August 2017	Future dates for MHA Committee meetings sent to CAMHS team, with standing invitation to MHA Committee. It was agreed that the January 2018 would be held at the Becton Centre. Presentation arranged for the October meeting			
Update January 2018	The presentation planned for October 2017 did not take place owing to sickness. CAMHs staff attended the MHA Committee meeting in January 2018. The presentation was about the service in general – the specifics of the CQC AI were not addressed. It is not clear whether the rise in detention of under 18s continues, or what the reasons were/are for the increase noted by the CQC. CAMHS staff to be asked to review.			

Authors / update by:

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