

**TRUST BOARD
MENTAL HEALTH LEGISLATION REPORT**

19 April 2018

Paper Title:	Mental Health Legislation Committee Annual Report to Trust Board 2017/18
Lead Director:	Andy McElligott, Medical Director
Paper Author:	Teresa O'Keefe, MHA Advisor
Agenda Item:	24
Presented For:	Information
Paper Category:	Governance & Compliance

Executive Summary:

The purpose of this paper is to provide summary information on activity for the frequently used Sections of the Mental Health Act 1983. It draws upon local data covering Bradford and Airedale and makes some comparisons with national data released by the Care Quality Commission.

The use of Section 2 has, over the last five years remained at more than twice the pre 2014/15 level.

The use of Section 3 rose in 2014/15 by approximately 50% following the Cheshire West judgement, and has remained at the higher level over the following four years.

Comparisons with national data have proved difficult in this report, as the accuracy of the national data is questionable. NHS Digital highlighted that there had been a shortfall in the number of providers that had completed the MHA returns this year following a new system being introduced and the figures published show a dramatic decrease in the use of detentions, which it is believed, is not correct.

There has been a drop in both hospital manager and tribunal activity for the last two years. The drop in tribunal activity is only relative, in that there had been quite an increase prior to that. The drop in manager activity, we believe could be due in part to the priority that has had to be given to the appeals received for mental health tribunal hearings. The difficulty in setting hospital manager appeals prior to a tribunal has proved difficult as the Tribunal Judiciary are requiring speedier hearings to comply with the patients' Article 6 rights.

The hospital manager activity relating to Community Treatment Orders (CTOs) remains high representing 49% of all cases heard by them.

The report also provides a summary of the Committee's activity for 2017/18 and details of Executive and Non-Executive attendance at Committee meetings.

Recommendations:

That the Committee:

- Approves this report subject to any minor amendments

Governance/Audit Trail:

Meetings where this item has previously been discussed (please mark with an X):					
Audit Committee		Quality & Safety Committee		Remuneration Committee	Finance, Business & Investment Committee
Executive Management Team		Directors		Chair of Committee Meetings	Mental Health Legislation Committee
Council of Governors					

This report supports the achievement of the following strategic aims of the Trust: (please mark those that apply with an X):	
Quality and Workforce: to provide high quality, evidence-based services delivered by a diverse, motivated and engaged workforce	
Integration and Partnerships: to be influential in the development and delivery of new models of care locally and more widely across West Yorkshire and Harrogate STP	
Sustainability and Growth: to maintain our financial viability whilst actively seeking appropriate new business opportunities	

This report supports the achievement of the following Regulatory Requirements: (please mark those that apply with an X):	
Safe: People who use our services are protected from abuse and avoidable harm	X
Caring: Staff involve people who use our services and treat them with compassion, kindness, dignity and respect	
Responsive: Services are organised to meet the needs of people who use our services	X
Effective: Care, treatment and support achieves good outcomes, helps to maintain quality of life people who use our services and is based on the best available evidence.	X
Well Led: The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.	
NHSI Single Oversight Framework	

Mental Health Legislation Annual Report 2017/18

1. Introduction

- 1.1 This summary report provides the Committee with an overview of Mental Health Act activity for the period 1st April 17 to 31st March 2018.
- 1.2 It also provides a summary of the items discussed at Committee over the past 12 months, as well as confirming Executive and Non-Executive attendance for meetings held in April, July and October 2017 and January 2018.

2. Executive and Non-executive attendance in 2017/18

- 2.1 Table 1 covers attendance over that period. Nadira Mirza left the role of Committee Chair after the July 2017 meeting. Zulfi Hussain took over as Chair from October 2017. The meeting in April 2017 was chaired by Rob Vincent.

Table 1

Member	April 2017	July 2017	October 2017	January 2018	Attendance count
Nadira Mirza, NED (Chair until July 17)	X	✓			1/2
Zulfi Hussain, NED (Chair from Oct 17)	✓		✓	✓	3/3
Mike Smith Trust, Chair			✓	✓	2/2
Rob Vincent, NED	✓	✓	X	X	2/4
Gerry Armitage, NED			✓	X	1/2
Andy McElligott, Medical Director	✓	✓	✓	✓	4/4
Debra Gilderdale, Director of Ops and Nursing	X	✓	✓	✓	3/4
Paul Hogg, Director of Corporate Affairs	✓	X			1/2

3. Summary of items discussed at each quarterly meeting

3.1 At the April 2017 meeting the Committee Discussed:

3.1.1 UPDATE AND SUMMARY OF ACTIONS FROM ALL SUBSEQUENT CQC MENTAL HEALTH ACT VISITS

Since the last report to MHLC, one unannounced Mental Health Act compliance inspection had taken place to Heather Ward at Lynfield Mount Hospital and actions had been put in place to address the issues.

Allison Bingham / Simon Long agreed to arrange for CQC reports and action plans to be discussed regularly at local Governance meetings.

3.1.2 MENTAL HEALTH LEGISLATION ANNUAL REPORT

The report had provided summary information on activity of the frequently used Sections of the Mental Health Act 1983. The following key points had been noted:

- There had been a continued and significant increase in the numbers of Section 2 and Section 3 applications following the release of the Supreme court ruling (Cheshire West) in March 2014.
- Community Treatment Orders (CTOs), including the use of recalls totalled 54, which generated a lot of work for the MHA Team.
- There had been an increase in the use of nearest relatives exercising their right to order discharge and 34 cases had been received this year.

3.1.3 MENTAL CAPACITY ACT AND DOLS REPORT – UPDATE

- Training uptake had been positive, well attended and received and training slots until mid-2017 now filled.
- The Mental Capacity Specialist Pilot had progressed well and work had now commenced with the Mental Health Services to develop specialists in the area.
- Training had been planned for Inpatient Services, A&E Liaison, Crisis Team and First Response which should then ensure a specialist was accessible across sites.
- BDCFT had been recognised in the National Mental Capacity Action Group good practice round up and more detailed information would be added to the MCA Annual Report.

3.1.4 NEW SECTION 135 AND SECTION 136 ARRANGEMENTS

Teresa O'Keefe presented a report to the MHLC which had outlined changes in legislation and in particular in relation to Section 135 – A warrant to search for and remove individuals and Section 136 – Police powers to arrest a person believed to be suffering from a mental disorder and take them to a place of safety. A summary of the Trust's preparedness for the new legislation had been included in the report and Bradford and Airedale Mental Health Services Crisis Care Concordat Partnership had met to discuss the new legislation. Teresa O'Keefe confirmed that training and information would be provided for mental health professionals and Police colleagues.

3.1.5 FEEDBACK FROM SUB GROUPS

Mental Health Legislation Forum (MHLF)

The minutes from two previous MHLF meetings (February and March 2017) had been circulated to the MHLC for information and Teresa O'Keefe had summarised the key points.

The Chair made reference to the request for a MHA assessment on an unconscious patient. Teresa O'Keefe advised that the patient had actually been asleep, an

investigation had taken place and deemed him to be capacitous and was consequently admitted to Fern Ward.

Associate Hospital Managers Group (AHMG)

At the meeting Information Governance training had been provided and a discussion regarding barring orders had taken place. Teresa O'Keefe confirmed that all but one Hospital Manager appraisals had taken place.

MCA DoLS Meeting

Teresa O'Keefe summarised the key points and raised in particular the lack of Police representation at the meeting, although not recorded within the minutes she had felt it an important issue to raise. It was noted that the meeting was a Local Authority led meeting and Ruby Bhatti suggested raising Police attendance at the next meeting which could then be recorded in the minutes.

3.2 At the July 2017 meeting the Committee Discussed:

3.2.1 UPDATE AND SUMMARY OF ACTIONS FROM ALL SUBSEQUENT CQC MENTAL HEALTH ACT VISITS

Since the last report, three unannounced inspections had taken place, two on Low Secure wards (Baildon and Ilkley) and one on an adult acute ward (Fern). Provider Action Statements would be monitored via each ward's Quality and Safety forum and within each business unit's collective Quality and Safety forums. Additionally, CQC Reports and Provider Action Statements are now shared across business units to promote cross learning and joint improvement.

3.2.2 COMMITTEE DASHBOARD

The Dashboards assists the MHLC in assessing the Trust's compliance with performance and progress in delivery of key Mental Health Legislation targets and indicators. The Quarter 4 2016/17 Dashboard had been circulated for information and completeness.

Section 2 use continued to increase with 71 in a month. It was noted there had been a steady increase in Sections following the Cheshire West report in 2014.

3.2.3 MENTAL CAPACITY ACT AND DOLS ANNUAL REPORT

Mental Capacity Act Clinical Lead highlighted the following key points

- Since July 2016, 371 staff had been trained with an average of 15 staff per session. It was noted that there had been a good mixture of staff at each session which had worked well.
- The Mental Capacity Specialist Pilot had progressed well and work had now commenced within mental health services to develop specialists in the area.
- Following training there had been a notable increase in knowledge which had enabled specialists to support other staff.

3.2.4 CARE PROGRAMME APPROACH AUDIT UPDATE

A summary of the results of the CPA Peer Review audit carried out in March 2017 highlighted:

- Overall compliance had improved with an increase from 69.45% in September 2016 to 73.17% in March 2017.
- None of the criteria generated 100% compliance.
- The findings had shown an overall improvement and there had been a decrease in the number of areas with no assurance.
- The audit continued to identify similar trends in the areas that were below standard practices.

3.2.5 FEEDBACK FROM SUB GROUPS

The Chair had visited two of the three sub-groups and stated that the level of discussion, subjects and topics raised had been critical to the work of the Trust in terms of mental health and considered it incredibly important for MHLC to receive information regarding the Trust's practice. The Chair encouraged MHLC members to attend the forums.

Mental Health Legislation Forum (MHLF)

The minutes from MHLF meeting held on 24 May 2017 had been circulated to the MHLC for information and Teresa O'Keefe summarised the key points.

Associate Hospital Managers Group (AHMG)

One Associate Hospital Manager, reiterated that the quality of training received was very good and believed it had been responsive to the needs and requirements of the Hospital Managers.

3.2.6 TERMS OF REFERENCE FOR APPROVAL (MHLC AND MHLF)

Mental Health Legislation Committee

The MHLC Terms of Reference had been circulated electronically to members for approval and the following amendments were noted:

- Deputy Director of Mental Health Acute and Community Services (including CAMHS) to become a member of the MHLC (currently, Simon Long is interim Deputy Director for this service); Deputy Director of Quality, Governance and Informatics removed from the membership; Trust Secretary removed from membership and replaced with the Deputy Trust Secretary, MHL and CPA Lead would meet with FFT Patient Experience Lead, to identify a service user and/or carer representative to join the MHLC.

3.3 At the October 2017 meeting the Committee Discussed:

3.3.1 MENTAL HEALTH SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

The Programme Director for the West Yorkshire and Harrogate STP presented an update on the priorities and outlined the Mental Health Programme Overview:

- An ambitious target of 75% for suicide reduction in the face of national and regional increases
- The Medical Director noted the MHLC specific target in relation to a 50% reduction in Section 136 (S136) and work that had been done locally with the Police to reduce S136s. There had been variations in approaches across the patch and the ambition was to level it all up.

3.3.2 UPDATE AND SUMMARY OF ACTIONS ARISING FROM ALL SUBSEQUENT CQC MENTAL HEALTH ACT VISITS

Since the last report, 2 unannounced inspections had taken place, 1 on Clover Ward (Adult Psychiatric Intensive Care Unit) and 1 on the Dementia Assessment Unit. Provider Action Statements are monitored via each ward's Quality and Safety forum and within each business unit's collective Quality and Safety forums. Additionally, CQC Reports and Provider Action Statements are shared across business units to promote cross learning and joint improvement

3.3.3 COMMITTEE DASHBOARD

The Dashboard assists the MHLC in assessing the Trust's compliance with performance and progress in delivery of key Mental Health Legislation targets and indicators. The integrated performance report showed a good performance with achievement of the majority of indicators:

- No breaches below 95% in quarter 2 of 2017-18 for sections being reviewed on time. Members agreed to stretch the target to 98% and exception reports would be presented for scrutinising if the target had not been achieved.
- Hospital Managers Hearings had remained at around 12 per month for the last 6 years. Tribunal activity per month had increased to 20 per month, though stable for the last 4 years.
- Restraint Data: Heather ward 4 patients had accounted for 49 out of the 79 incidents (62%). There had been a small spike on the Assessment and Treatment Unit in August with 1 patient accounting for 15 out of 17 incidents (88%). On the Dementia Assessment Unit 5 patients had accounted for 75 out of 91 incidents in quarter 2 (82%)
- Ethnicity Data (slides 9-13) – provided details of Ethnicity, divided by adults up to the age of 64 and older adults aged 65 and over. Under 18's had been shown for quarter 2. The dashboard included some baseline data drawn from the 2011 National Census and in most areas there was a close alignment between population breakdown and numbers

detained. There had been a small spike in the over 65s in quarter 2 for people from a Caribbean background.

- Quarter 2 had seen a slight increase in Section 2s and 3s compared to quarter 1. The service was still averaging over 100 new sections per month and use of S136 had been on average 15 per month.

3.3.4 MENTAL HEALTH ACT ACTIVITY HALF YEAR UPDATE TO 30/09/2017

The paper provided summary information on activity for the frequently used Sections of the Mental Health Act 1983. There had been a levelling off in the numbers of Section 2 and Section 3 detentions, which had risen sharply following the release of the Supreme court ruling (Cheshire West) in March 2014.

- There had been a drop in both hospital manager and tribunal activity for the first time since 2014/15. The drop in manager activity could in part be due to the priority that had been given to appeals received for mental health tribunal hearings. The difficulty in setting hospital manager appeals prior to a tribunal had proved challenging as the Tribunal Judiciary had required speedier hearings to comply with the patients' Article 6 rights.
- The hospital manager activity relating to Community Treatment Orders (CTOs) continued to rise and represented 60% of all cases heard by them.

3.3.5 MENTAL CAPACITY ACT AND DOLS UPDATE

The Mental Capacity Act Clinical Lead, presented the Annual Report to the MHLC:

- Training uptake had been good and positive feedback had been received. Regular meetings had been arranged with HR to determine areas to target. Training had also taken place on wards to enable staff to access the training more easily.
- The Mental Capacity Specialist Pilot was on track and there were specialists now working in each mental health area.
- The Law Commissioners had reviewed the Deprivation of Liberty Safeguards and the Mental Capacity Act and the final report and draft Bill had been published. The proposed new scheme, if accepted, would be called Liberty Protection Safeguards however it would be 18 months to two years before introduction.
- A new MCA and DoLS team had been established at the Local Authority and had been working hard to reduce the waiting time for DoLS; currently there were 1267 DoLS assessments.

3.3.6 CARE PROGRAMME APPROACH AUDIT UPDATE

The CPA Peer Review audit carried out in September 2017 showed an overall decrease in compliance compared to the March 2017 audit.

- Decreased from 73.17% in March to 71.63% in September.
- None of the criteria generated 100% compliance.

- There were less areas with Significant Assurance; down from 16 in March to 11 in September.
- There were more areas with Limited Assurance, up from 11 in March to 13 in September.
- An increase since March in the number of areas with no assurance (i.e. compliance was less than 40%); this had risen from 5 in March to 10 in September.
- A Task and Finish project would be established (for 3 to 4 months) with the aim of improving compliance in advance of the next CPA audit and identifying any safeguarding concerns.

3.3.7 COMMITTEE BUSINESS CYCLE

Following a recommendation from Trust Board, a Business Cycle had been developed to identify the work flow of the MHLC. The spreadsheet outlined all areas where the MHLC could expect routine reports and proposed the following deep dives for 2018:

- A review of Blanket Restrictions and their application/management
- Community Treatment orders and the evidence to continue use
- Section 17 Leave
- Consent to Admission and Treatment

3.3.8 MENTAL HEALTH LEGISLATION FORUM (MHLF) UPDATE

The minutes from the MHLC meetings held in August and September had been circulated for information and Teresa O'Keefe summarised the key points.

The Committee considered the contents of the minutes of the MHLF meetings and agreed to receive further updates at the next MHLC meeting.

3.3.9 ASSOCIATE HOSPITAL MANAGERS GROUP (AHMG) UPDATE

The minutes from the AHMG meeting held in September had been circulated with particular reference to a Learning and Sharing event taking place in December for mental health professionals with a view to improving standards of report writing and presentation skills at tribunals and hospital manager hearings.

3.3.10 MCA DOLS LIN MEETING UPDATE

The last meeting had not taken place due to staff changes, an update would be provided at the next MHLC meeting.

3.4 At the January 2018 meeting the Committee Discussed:

3.4.1 UPDATE AND SUMMARY OF ACTIONS ARISING FROM ALL SUBSEQUENT CQC MENTAL HEALTH ACT VISITS

Since the last report, four unannounced inspections had taken place at the following; Maplebeck (male), Ashbrook (female), Step Forward Centre (mixed) and Bracken Ward (mixed). At the time of writing, only one of the four CQC reports had been received for Step Forward Centre. The following was noted:

- Clinical Learning and Safety Forum event – 8 December 2017: Due to severe bad weather attendance was lower than anticipated with 13 staff from a range of disciplines and it was agreed that the event would likely be repeated. In addition no medics were able to attend
- Although the CQC inspection report of Bracken Ward was awaited the Mental Health Act reviewer commented that he was unable to find a single concern relating to the ward. The Leadership team had since then been thanked.
- The Committee asked to see the revised CPA template It was agreed the template would be sent to the Chair, Medical Director and Director of Operations and Nursing for review and comment..

3.4.2 COMMITTEE DASHBOARD

The Dashboard assists the MHLC in assessing the Trust's compliance with performance and progress in delivery of key Mental Health Legislation targets and indicators. The integrated performance report showed a good performance with achievement of the majority of indicators:

- Incorrect Restraint data January to July 2017 had presented to Committee, however, the data was now correct for all quarters.
- MH Compliance no breaches below 98% in Q3 of 2017/18.
- Manager and Tribunal Data (slide 4) –tribunals and hearings for hospital managers were slightly up for Q3
- Section Data – average of 103 new sections each month across the whole of 17/18 to date.

3.4.3 SECTION 117 AFTERCARE RE-AUDIT

The report provided the MHLC with a summary of the results from the Section 117 aftercare audit completed in September 2017. The following key points were highlighted:

- Since the previous audit, compliance against comparable criteria had increased in two areas, remained the same in one area, and decreased slightly in one area.

3.4.4 MENTAL CAPACITY ACT AND DOLS UPDATE

The Mental Capacity Act Clinical Lead, presented the quarterly update of the Mental Capacity Act training and other updates. The following key points were highlighted:

- Mental Capacity training was currently around 80%
- The review of the Deprivation of Liberty Safeguards – feedback on final responses would be given at MHLC in April 2018.
- Draft guidelines from NICE reviewing Consent & Capacity circulated prior to MHLC meeting with a request for any feedback to Joanne Tiler by the end of January.

3.4.5 COMMITTEE BUSINESS CYCLE

Simon Binns reported that the following deep dives would be presented at the next meeting on 19 April:

- Blanket Restrictions Review
- Section 17 Leave

3.4.6 MENTAL HEALTH LEGISLATION FORUM

The minutes from the Mental Health Legislation Forum held in November and December 2017 had been circulated for information and Teresa O'Keefe summarised the key points.

3.4.7 ASSOCIATE HOSPITAL MANAGERS GROUP (AHMG) UPDATE

The minutes from the AHMG meeting held on 11 December 2017 made particular reference to the outcome to a patient discharged from Section 3 of the MHA who was doing well in the community and the change in police powers under Sections 135 and 136 which came into effect on 11 December 2017

3.4.8 SECTION 135 AND 136 MHA PLACE OF SAFETY CHANGES IMPLEMENTATION

The paper detailed changes to the MHA 1983 brought about by the Policing & Crime Act 2017 and outlined the main changes:

- Reduction in time a person can be detained under S136 from 72 hours to 24 hours.
- Training was carried out in house by the police but information was collated together with the Trust.
- To ensure compliance training communication has been sent to all wards, all community teams and all doctors. Face to face training has been provided to all senior nursing staff at ward level. Change in legislation is incorporated into MHA training.

3.4.9 SIR SIMON WESSLEY REVIEW OF THE MENTAL HEALTH ACTION SUMMARY AND TIMESCALE

The review of the Mental Health Act led by Sir Simon Wessley was due in the Autumn of 2018. This had been widely communicated through e-comms.

3.4.10 CHANGES TO ADVOCACY SERVICES IN THE DISTRICT

A letter from Bradford and Airedale Mental Health Advocacy (BAMHAG) previously circulated gave details of the changes to provide Independent Advocacy Support on behalf of Bradford Council's Department of Health and Wellbeing. The contract had now been awarded to Voiceability who would commence in April 2018. BAMHAG would continue to support the forensic unit.

The Committee requested further information about the impact on service users during the transition period.

3.4.11 FEEDBACK FROM SUB-GROUPS

The MCA Clinical Lead had attended the MCA DoLs meeting at Airedale and would share a quality report at the next MHLC meeting.

Mental Health Act Activity Report

4. The Work of Associate Hospital Managers

- 4.1 All Non-Executive Directors of the Trust Board, are in fact "hospital managers" within the meaning of the MHA. Some have trained to sit as panel members at patient hearings, however due to other commitments, this is no longer expected. However, a number of NEDs have agreed to observe 2 hearings every year to give assurance to the Board. Patient hearings, therefore, are heard by Associate Hospital Managers, usually simply referred to as "hospital managers".
- 4.2 The Mental Health Act Department currently have only 16 hospital managers that they can call upon to sit as panel members on a regular basis. This number has reduced over the last two years following a number of resignations due to other personal commitments. For this reason a recruitment drive is planned for May 3rd when an open evening will be held at New Mill. The plan is to bring the numbers back up to approximately 22.

5 Outcome of Managers Hearings

- 5.1 Hospital Managers have a duty to discharge a patient if the requirements of the Act are not being met. There are three ways in which a service user may have their case heard by a hospital managers' hearing: The first occasion may arise if they decide to appeal against their detention in hospital. The second will arise if a nearest relative orders the discharge of their relative and this is barred by the consultant. The third circumstance will arise if the consultant wishes to continue the detention, or continue a Community Treatment Order, beyond the original period, initially after 6 months and then annually.

In order to renew a detention the consultant must provide a statutory report, having first consulted with at least one other professional, and in the case of a CTO, this professional must be an approved mental health professional (AMHP), and the consultant must have seen the client within 2 months of expiry; this can occasionally prove difficult if the client does not turn up for appointments. Following

receipt of the statutory report to order renewal a hospital managers meeting is convened.

- 5.2 It is important that in all cases, the Board, through the Mental Health Legislation Committee has assurance that hospital managers are appropriately fulfilling their responsibilities – both discharging people from detention under the Act where this is legally appropriate and ensuring that users continue to receive treatment and care under the Act if that is necessary. There is a system in place to monitor those cases where hospital managers have authorised an individual's discharge under the Mental Health Act. In each case the hospital managers who heard the appeal or renewal, receive a report from the Responsible Clinician two months after the discharge giving details of progress since the decision was made. In addition, each case is considered by the Hospital Manager Group at their regular training meetings, with one of the panel giving feedback to the group.
- 5.3 There is a time lapse between an appeal being lodged and a case being heard. The standard for the setting of appeals to the managers is within 7-10 days for section 2 appeals and 3 weeks for sections 3 and 37. It is therefore to be expected that a number of people would make sufficient progress with treatment that detention would no longer be necessary by the time of the scheduled hearing.

In addition to this, a large proportion of clients appeal to both the hospital managers and the mental health tribunal at the same time. Strict timescales must be observed with regard to hearing dates for tribunals, and if an early date is offered by the tribunal, the hearing before the hospital managers is delayed for 28 days after the tribunal has been heard, as recommended in the Code of Practice to the MHA. For this reason there will be a significant number of requests which do not materialise as actual hearings.

6 Hospital Manager Hearings and Renewals Activity

- 6.1 There were a total of **63 Appeals** and **138 Renewals** being lodged with hospital managers a total of 201 cases.

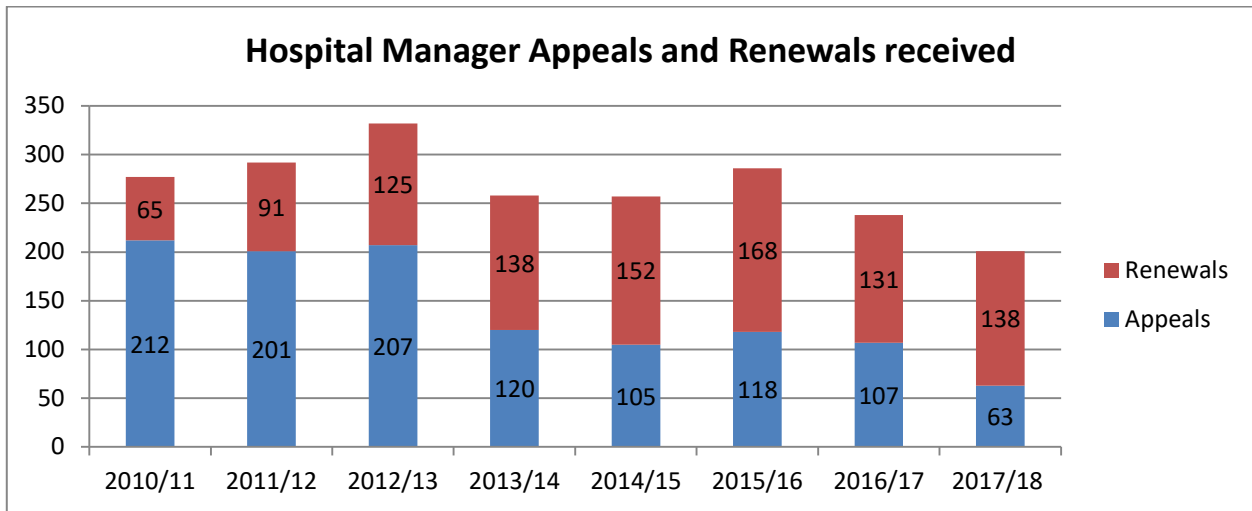
Nearest relatives exercising their right to order the discharge of their relative has remained relatively high at 28, however, 13 of these were regraded to informal status by the RC, 5 were subsequently withdrawn by the relative prior to the RC making a decision and 3 proved not to be valid requests; for these and other reasons, only 5 cases had hospital manager hearings planned, and of these, only 3 cases were heard, as one client was AWOL, and one client was made informal by the RC before the hearing could take place. All 3 cases heard resulted in no discharge.

- 6.2 In total 121 appeals and renewals were heard (12 appeals and 109 renewals).
- 6.3 Of the 12 appeals heard, 11 (91%) were not upheld and 1 (9%) was discharged.
- 6.4 Of the 109 renewals heard, 108 (99%) were renewed and 1 (1%) was discharged.
- 6.5 Combining the outcome rate of all manager hearings, i.e. 121 heard, with 2 clients discharged, the discharge rate is less than 2%, which appears particularly low compared to an average discharge rate by the tribunal of 7% in relation to comparable sections (i.e. Section 2 and Section 3). However, it is still difficult to

make comparisons as the managers consider renewals which the tribunal don't and the tribunal consider referrals, which the hospital managers don't.

6.6 Hospital Managers Appeals and Renewals Activity Summary Table for past 8 years

Requests rec'd	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Appeals	212	201	207	120	105	118	107	63
Renewals	65	91	125	138	152	168	131	138
Total rec'd	277	292	332	258	257	286	238	201
Not Heard	134	147	165	114	99	75	107	86
Re-grade Prior by RC	55	66	66	43	50	37	49	37
Withdrawn	27	32	34	13	11	9	17	6
Other Reasons*	52	49	60	58	38	29	41	43
<p>*Other reasons manager hearing not heard include: Regraded informal by Tribunal prior (1) CTO terminated (12) Discharged onto CTO (6) CTO revoked (5) Unable to set in timeframe (15) No RC available (2) Client AWOL (1) Transferred out (1)</p>								
Outcome of cases heard								
Appeals								
Heard	102	104	65	39	40	40	36	12
Denied	84	86	50	32	31	34	28	11
Adjourned	10	7	2	1	1	0	0	0
Discharged	8	11	13	6	8	6	8	1
Renewals								
Heard	32	41	102	105	118	126	95	109
Renewed	19	37	98	101	110	118	95	108
Adjourned	7	1	2	0	2	1	0	0
Discharged	6	3	2	4	6	7	0	1



7 Mental Health Tribunals

- 7.1 There is a time lapse between an appeal being lodged to the Tribunal and a case being heard. The standard for the setting of appeals to the Tribunal is within 7 days for section 2 appeals and between 5 to 8 weeks for all other sections. It is therefore to be expected that a number of people would make sufficient progress with treatment that detention would no longer be necessary by the time of the scheduled hearing. Hence there will be a significant number of requests which do and not materialise as actual Tribunal hearings.
- 7.2 Tribunal activity has stopped rising for the first time since 2011/12, and is now back to the level seen in 2015/16. In the current period there were 401 requests processed.
- 7.3 Of the 401 requests processed, 232 were heard and 169 were not heard. The large number of cases not heard could indicate a thorough MHA assessment by the professionals having taken place prior to the hearing, which resulted in 107 (63%) of the cases not heard being discharged from Section or from CTO prior to the hearing. The other significant factor relating to cases not being heard was the 48 (28%) cases of those not heard, related to clients withdrawing their requests. The most common reason for clients withdrawing is because they are satisfied with their progress and are willing for the discharge decision to be made by their own RC.

Of the 232 heard, there was 205 (89%) not discharged, 24 (10%) discharged, 2 (1%) adjourned. Of the 24 discharged 8 of these were restricted cases; in other words, the RC has no power to discharge as this has to be approved by the Home Office through the tribunal process. If we discount the restricted sections, this takes the tribunal discharge rate down to 7%.

7.4 Tribunal Activity for the past 8 years is shown below:

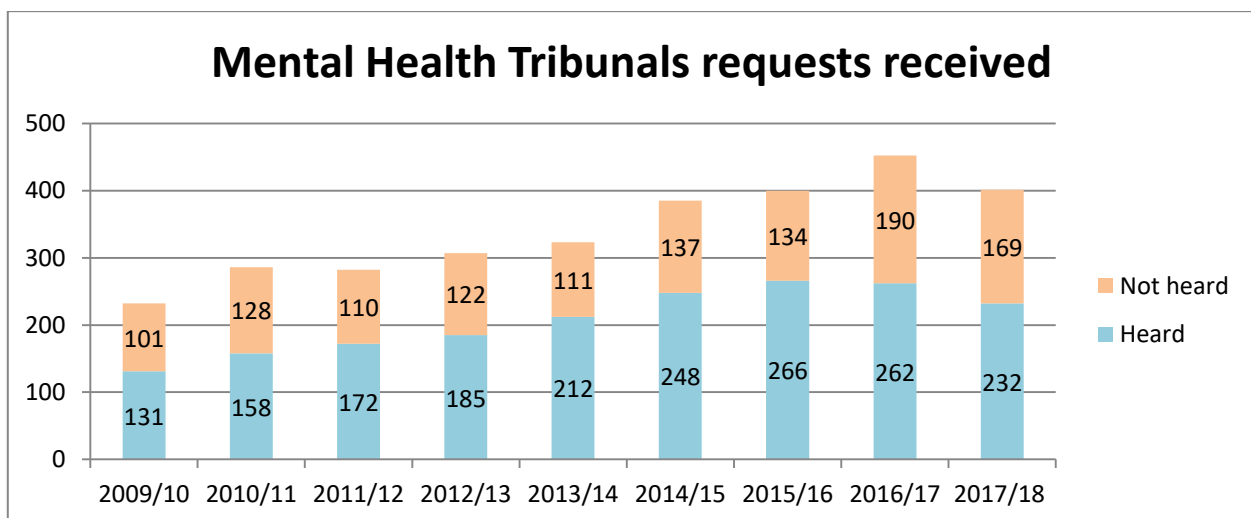
	Year:							
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Requests rec'd	286	282	307	323	385	400	452	401
Not Heard	128	110	122	111	137	134	190	169
Re-grade by RC	64	53	74	54	84	89	123	107
Re-grade by AHM	0	6	11	6	2	4	3	0
Withdrew	40	41	29	32	30	26	43	48
Transferred	11	4	7	10	8	3	3	0
Adjourn/Re-listed	6	4	1	9	8	6	10	1
Placed on CTO	5	0	0	0	0	1	0	0
*Other reasons	2	2	0	0	5	5	*8	*13

***Other reasons tribunal not heard:**

No profession or judge (3)	Patient sent to prison (1)
CTO lapsed or terminated (3)	Patient no eligible (2)
New RC not seen CTO client (1)	No MOJ statement (1)
Discharged by nearest relative (1)	Patient died (1)

Outcome of case heard

Heard	158	172	185	212	248	266	262	232
Not Discharged	137	160	163	196	212	237	237	205
Discharged	16	9	12	9	23	20	19	24
Adjourned	5	3	10	7	9	5	6	2
Other	0	0	0	0	4	4	0	0



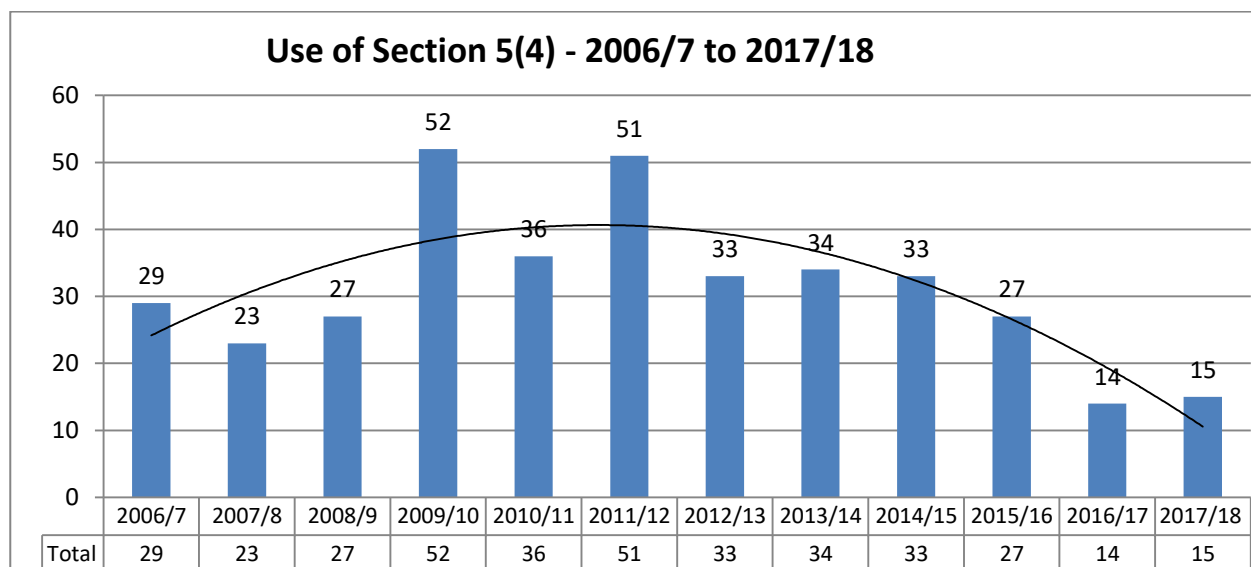
8 Activity data for key sections

Detailed below is the MHA activity, both within BDCFT and nationally. The national data has been taken from NHS Digital, however, this year the accuracy of the national data is questionable. In the CQC report “Monitoring the MHA 2016/17” it is reported as follows: *“This is the first report using new data. NHS Digital highlighted that there had been a shortfall in the number of providers that had completed the MHA returns through NHSDS including no returns at all, partial returns, or poor quality returns.”* The CQC advise in their report that they will continue to work with services, NHS Digital and NHS England to improve this.

For this reason, whilst this report indicates data as provided nationally, it does not make comparisons, as it has in previous years.

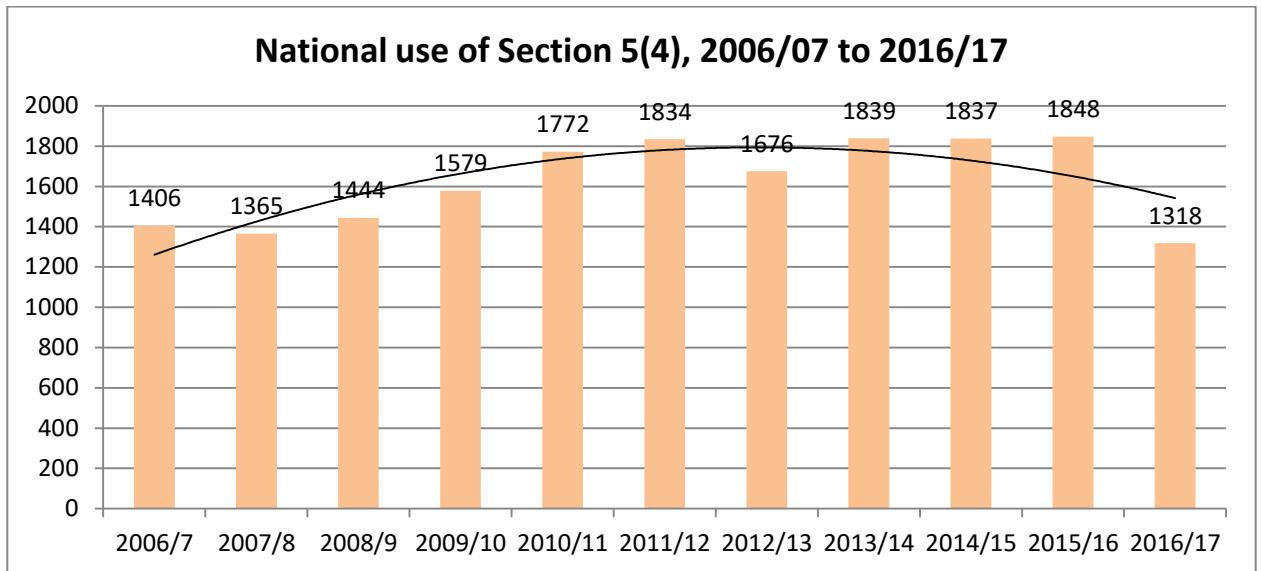
8.1 Section 5(4)

Section 5(4) is the power for a nurse to detain an informal in-patient for up to six hours. The patient has to indicate they wish to leave hospital and there has to be an immediate risk of harm to the patient or some other person if this were to be allowed. The nurse only has this power to prevent the patient from leaving if there is no doctor immediately available to complete a section 5(2) instead.



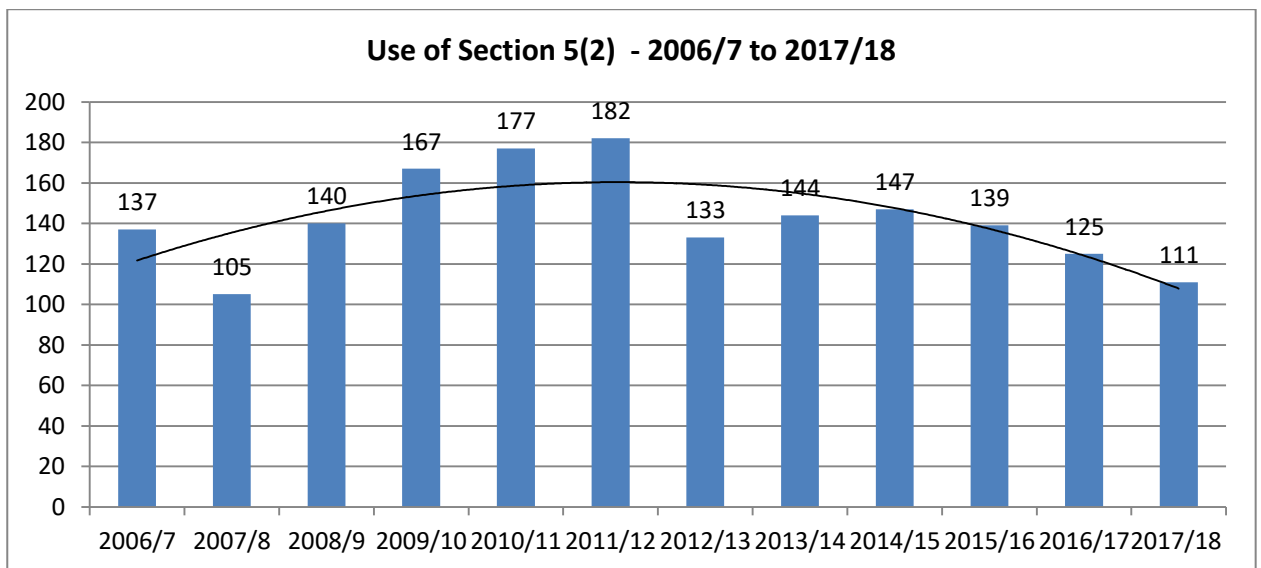
Comments

The use of Section 5(4) has again remained relatively low in comparison to years prior to 2015/16. This is likely to be due to the fact that most patients are now admitted under Section due to the Cheshire West ruling with less informal admissions and very thorough assessments of capacity prior to admission.



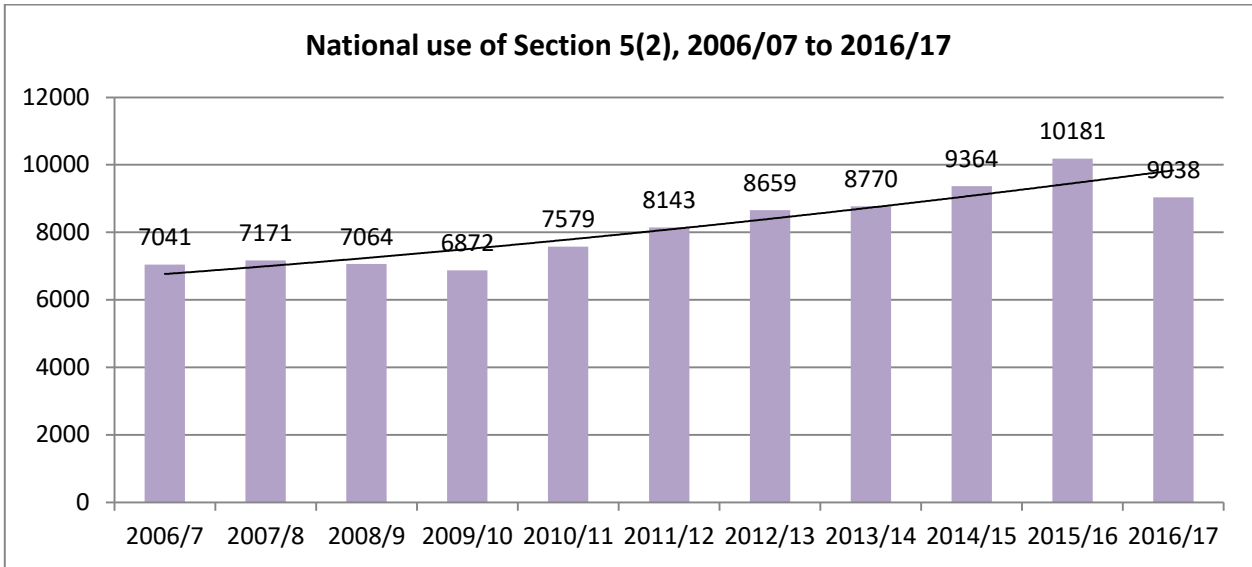
8.2 **Section 5 (2)**

Section 5(2) is a section that allows for the detention of a person already in hospital for up to 72 hours. It is designed to provide the time required to complete a Section 2 or 3 when the person wishes to leave hospital before the necessary arrangements for these sections can be made.



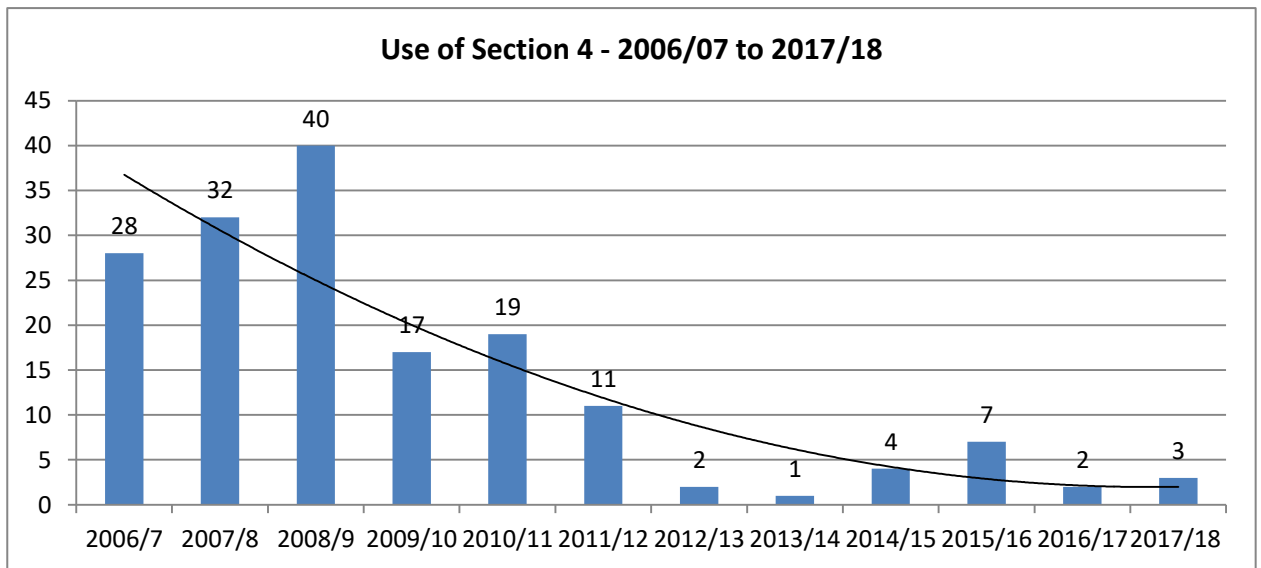
Comments

The use of Section 5(2) has dropped steadily over the past four years. Again this is likely to be due to the impact of the Cheshire West judgement and most patients already coming into hospital under the Mental Health Act.



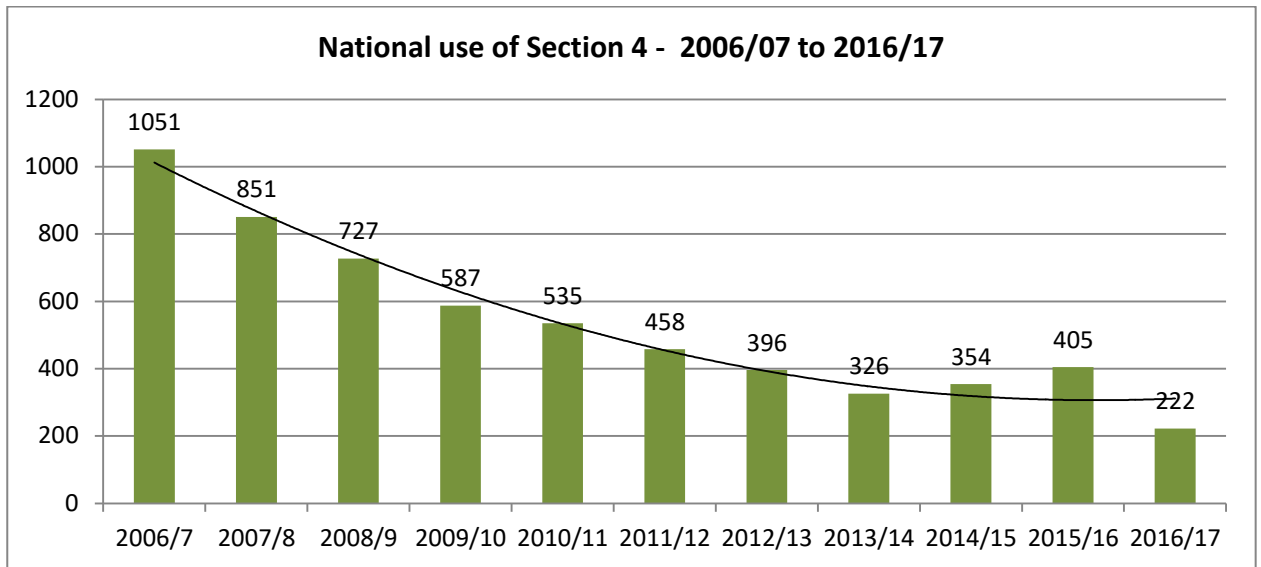
8.3 Section 4

Section 4 is a section that allows a person to be admitted from the community and detained in hospital for up to 72 hours. It may be applied when an AMHP want to place a person under Section 2 or 3 but are unable to get two doctors as required and the person needs to be admitted urgently.



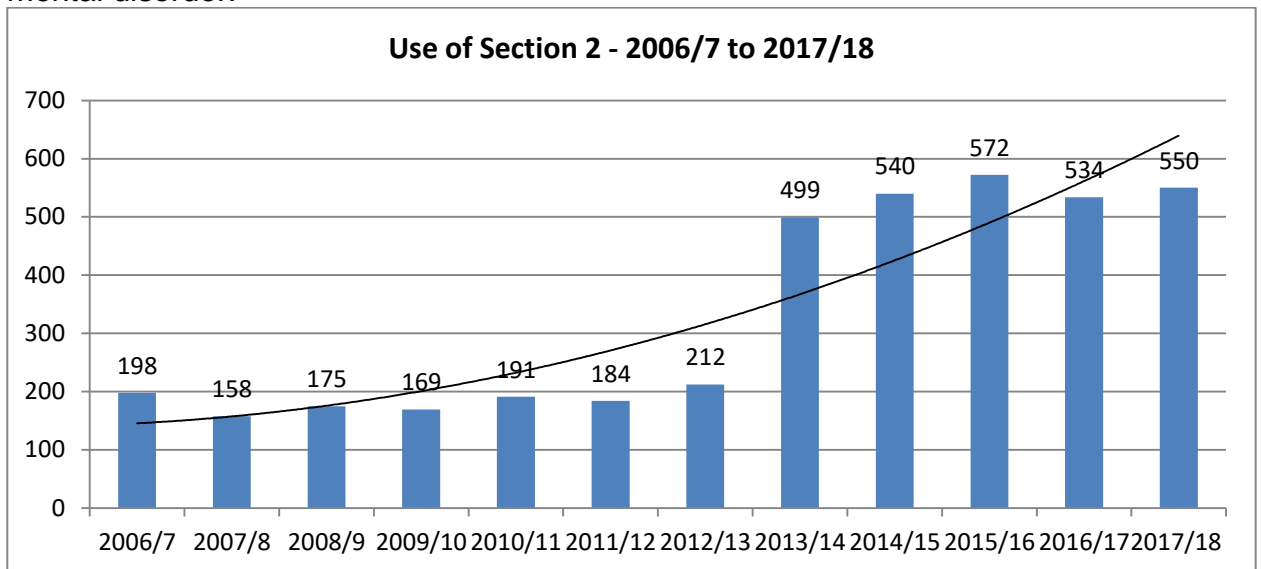
Comments

The use of Section 4 has remained low for the past six years. This appears to indicate a more ready supply of doctors available to make the second medical recommendation required for a Section 2 or Section 3.



8.4 Section 2

This section gives the power to detain and treat a person in hospital for up to 28 days. It is used for the assessment of people who have, or are believed to have a mental disorder.

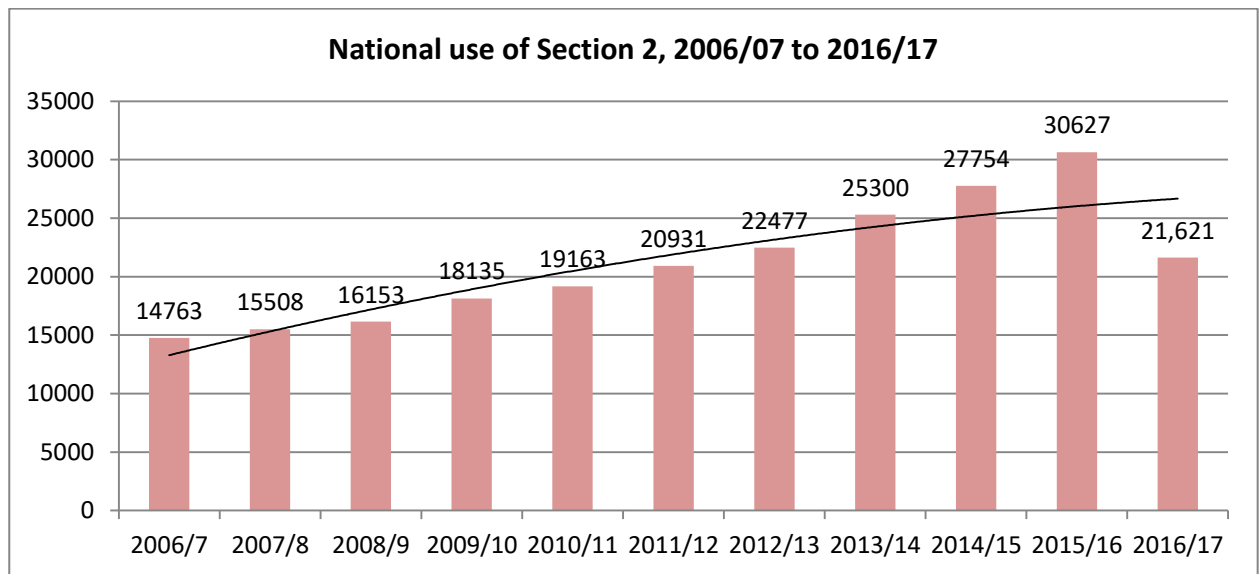


Comments

The use of Section 2 has, over the last five years remained at more than twice the pre 2014/15 level. This is directly as a result of the Supreme Court ruling which defined “deprivation of liberty” as applying to anyone who was under continuous supervision and control and not allowed to leave. The new definition defined more inpatient service users as being deprived of their liberty, which then had to be authorised, either, under the Deprivation of Liberty safeguards or, under the Mental Health Act or under the. Professionals within BDCFT and the Local Authority have viewed that the Mental Health Act is the most appropriate legislation to authorise a deprivation of liberty for the clients within a hospital setting who are suffering from a mental disorder.

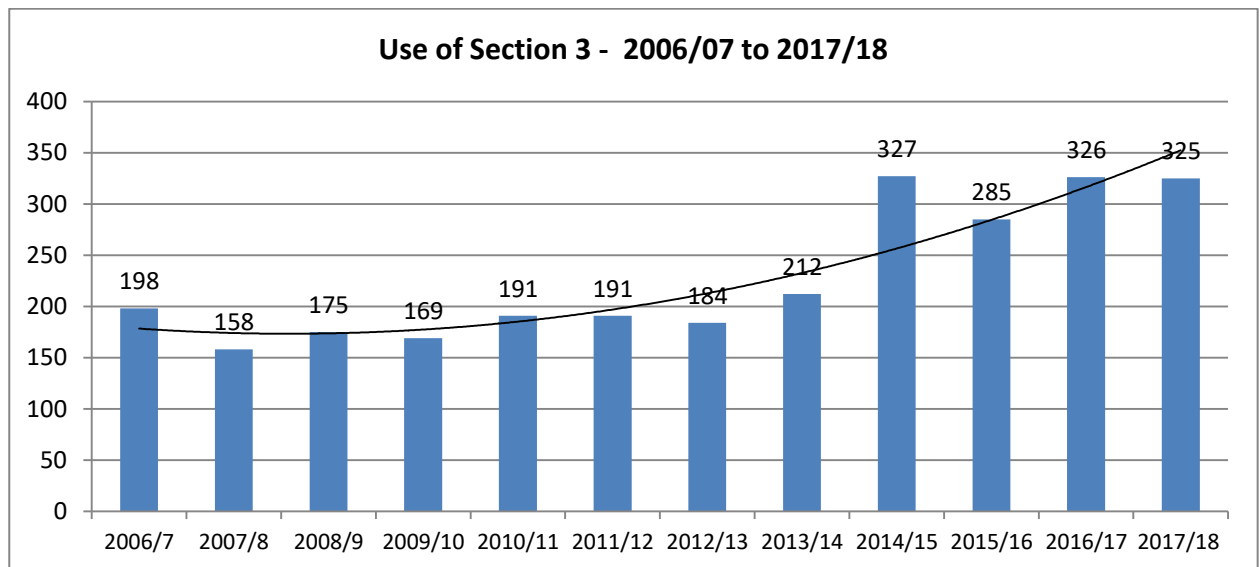
The Act allows professionals some discretion as to which power they use in certain cases where the client is compliant but lacks the capacity to agree to the care and treatment, although the choice should be guided by the Code of Practice

requirement that the least restrictive option must be considered. In addition, professionals appear to view Section 2 as the most appropriate initial power of detention, rather than Section 3, even for well-known clients.



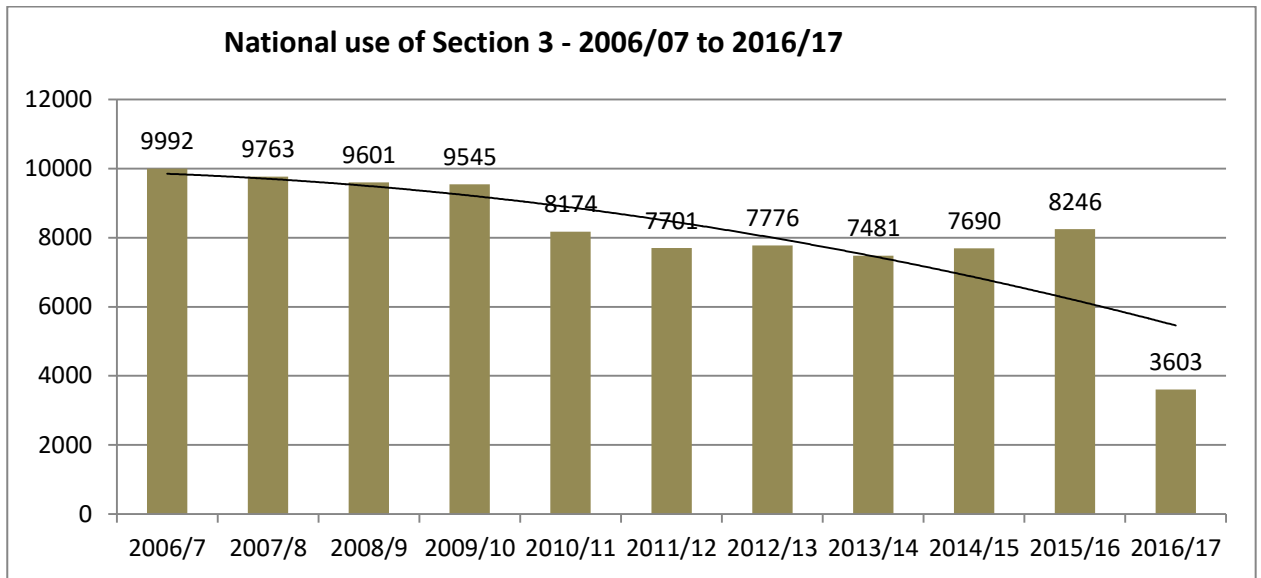
8.5 Section 3

This section gives the power to detain and treat a person in hospital for a period of up to six months and can be renewed.



Comments

The use of Section 3 rose in 2014/15 by approximately 50% following the Cheshire West judgement, and has remained at the higher level over the following four years. This increase shows an excellent understanding by all professionals, on current legislation, with the only clients now informal being those with capacity and whom we would allow to leave, should they so choose.



8.6 New sections per month

	Numbers of new detentions received	April 17	May 17	June 17	July 17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
	Section 5(4)	2	1	0	2	1	1	0	0	1	1	2	4	15
	Section 5(2)	6	11	9	8	14	7	8	10	11	9	7	11	111
	Section 4	1	0	1	0	0	0	0	0	0	0	1	0	3
	Section 2	34	71	46	31	38	47	46	51	46	49	41	50	550
	Section 3	25	21	40	20	25	26	34	25	25	35	23	26	325
	Section 36	0	0	1	0	0	1	1	0	0	0	0	0	3
	Section 37	0	0	1	2	0	0	0	0	0	0	0	0	3
	Section 37/41	0	1	0	2	1	0	1	1	1	1	0	0	8
	Section 47/49	0	0	0	0	0	0	1	0	0	0	0	0	1
	Section 48/49	0	0	1	0	0	0	0	0	0	1	0	0	2
	New CTOs in Month	6	7	3	4	3	2	0	8	10	5	3	4	55
	Total per month	74	112	102	69	82	84	91	95	94	101	77	95	1,076

8.7 Use of Section 136

Section 136 Data	Place of Safety used					Outcome					Age Profile						N/K	Total
Apr-17	12	6	6	0	0	4	3	5	0	0	1	3	4	4	0	0	0	12
May-17	22	9	13	0	0	13	1	8	0	0	1	7	7	7	0	0	0	22
Jun-17	16	7	8	1	0	8	2	6	0	0	0	6	7	3	0	0	0	16
Jul-17	14	9	5	0	0	12	1	1	0	0	0	10	4	0	0	0	0	14
Aug-17	17	7	9	0	1	6	5	6	0	0	0	6	6	4	1	0	0	17
Sep-17	18	14	4	0	0	13	2	3	0	0	0	9	7	2	0	0	0	18
Oct 17	20	10	10	0	0	9	4	7	0	0	0	7	8	2	3	0	0	20
Nov 17	14	6	7	1	0	11	0	3	0	0	2	4	8	0	0	0	0	14
Dec 17	12	9	1	2	0	7	1	4	0	0	0	0	11	1	0	0	0	12
Jan 18	18	11	7	0	0	7	4	7	0	0	1	7	7	2	1	0	0	18
Feb 18	17	13	3	1	0	10	2	4	0	0	2	6	3	4	2	0	0	17
March 18	17	8	9	0	0	13	1	4	0	0	1	6	5	4	1	0	0	17
Total																		

Analysis of Section 136 data for the period 01.04.17 to 31.03.18:

There were 197 Section 136 episodes in this period, average 16 per month, slightly up on the average of 15 for the last financial year.

- 55% (109) came to Lynfield Mount Hospital;
- 42% (82) came to Airedale Centre for Mental Health;
- 2.5% (5) sent to a police station
- 0.5% (1) other place of safety

Outcomes:

- 57% (113) of S136s were terminated
- 30% (58) were admitted under Section 2 or Section 3
- 13% (26) were admitted informally
- 53% (105) were male
- 47% (92) were female

Age Profile:

- 4% (8) were aged under 18
- 36% (71) were aged 18-30
- 39% (77) were aged 31-45
- 17% (33) were aged 46-59
- 4% (8) was aged 60 and over

8.8 Community Treatment Orders (CTOs)

Since the introduction of CTOs in 2008, we initially saw a steady increase in numbers, but this levelled off after the first few years. The most notable impact on the introduction of CTOs has been on the numbers of CTO appeals and renewals heard by hospital managers. The chart below shows that, a large proportion of cases heard by hospital managers (49%), are to consider Community Treatment Orders.

Period (1 April to 31 March)	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
New CTO's	14	29	35	54	45	51	62	53	64	55
CTO Hearings to HMs				25	63	65	61	72	60	29
Section hearings to HMs				45	98	74	90	92	71	30
Total HM hearings				74	167	143	158	169	131	59
% CTO hearings				34%	38%	45%	39%	42%	46%	49%

9. Care Quality Commission (CQC) Mental Health Act Inspection visits

The CQC have the right to visit our services at any time for the purposes of reviewing patient care and compliance with Mental Health Legislation requirements. In 2017/18 CQC inspectors visited nine wards. Analysis of these visits form a separate report.

07.06.17	Baildon ward	Unannounced
07.06.17	Ilkley ward	Unannounced
22.06.17	Clover ward (PICU)	Unannounced
05.09.17	Dementia Assessment Unit	Unannounced
27.11.17	Step Forward Centre	Unannounced
12.12.17	Bracken ward	Unannounced
14.12.17	Maplebeck ward	Unannounced
15.12.17	Ashbrook ward	Unannounced
26.02.18	Assessment & Treatment Unit	Unannounced