Bradford District Care
NHS Foundation Trust

MENTAL HEALTH LEGISLATION COMMITTEE MEETING

23rd May 2019

Paper Title:	Mental Health Legislation Annual Report 2018/19
Lead Director:	Patrick Scott, Chief Operating Officer
Paper Author:	Teresa O'Keefe, Mental Health Act Advisor
Agenda Item:	**17**
Presented For:	Assurance
Paper Category:	Governance & Compliance

Executive Summary:

In the Autumn of 2017, the government ordered a review of the Mental Health Act. The final report was published in December 2018, an outline of this was presented to the Committee earlier this year. We now await further progress as to what changes may come about as a result.

This report provides a summary of the Committee's activity for 2018/19 and details of Executive and Non-Executive attendance at Committee meetings.

It contains details of unannounced CQC ward visits in 2018/19 and outlines the key themes and how these are actioned.

It provides a summary of activity for the frequently used Sections of the Mental Health Act 1983. It draws upon local data covering Bradford and Airedale. It also provides information on the sections of the Act used in the Bradford Royal Infirmary and the Airedale General Hospital, since we have Service Specifications set up to monitor compliance on their behalf.

The use of Section 2 has continued to rise since the Supreme Court Judgement in 2014 and is now close to three times 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 each of the following years. There has been a very slight drop this year, which could be due to a number of professionals preferring to use DoLs for some patients who are lacking in capacity but compliant with their treatment plan.

Comparisons with national data would have little value in this report and is therefore not included, 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 in the 2017/18 period following a new system recently introduced therefore the figures published show a dramatic decrease in the use of detentions.

National data for 2018/19 has not yet been published, however, in 2017-18 there were 49,551 new detentions under the Mental Health Act recorded, but the overall national totals will be higher as not all providers submitted data. Trend comparisons are also affected by improving data quality. For the subset of providers that submitted good quality detentions data in each of the last three years, it is estimated there was an increase in detentions of 2.4 per cent from previous year.

There has been a continuous rise in tribunal activity over the last 9 years, but a steady slow drop in hospital manager activity over the same period. The drop in hospital manager activity is due the priority that has to be given to the appeals received for mental health tribunal hearings as there are statutory timeframes that must be followed for the tribunals. The MHA officers often have difficulty in setting a hospital manager appeal prior to any tribunal 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 55% of all cases heard by them.

Recommendations:
That the Committee: • **Approves** this report subject to any minor amendments • **Records** that report provides assurance against the marked Regulatory Requirements

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**	**X**
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	X

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	X
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	

Equality Impact Assessment :
n/a

Mental Health Legislation Annual Report

1 The work of the Committee during 2018/19

The Mental Health Legislation Committee met on the following occasions:

- 19 April 2019
- 19 July 2018
- 10 October 2018

At this point, one of recommendations made by Humberside Non-Executive ‘s Report into the work of the Committee came into effect and the meeting changed to a 2-monthly cycle of dates commencing:

- 22 November 2018
- 24 January 2019; and
- 21 March 2019

2. Non-Executive and Executive attendance at Committee

Name	Role	19/4/18	19/7/18	10/10/18	22/11/18	24/1/19	21/3/19	Total
Zulfi Hussain	Chair until 21/3/19	✓	X	✓	✓	✓	✓	5/6
Carole Panteli	Chair from 22/3/19					✓	X	1/2
Gerry Armitage	NED	✓	✓ (chair)	X	X			2/4
Simon Lewis	NED					✓	X	1/2
Mike Smith	Trust Chair	✓	✓	✓	✓		✓	5/5
Brent Kilmurray	Chief Executive						✓	1/1
Patrick Scott	Chief Operating Offcier						✓	1/1
Andy McElligott	Medical Director	✓	✓	✓	✓	X	✓	5/6
Debra Gilderdale	Director of Nursing	X	✓	✓	X	✓		3/5

3. Items reported to Trust Board

The following summaries highlighted the items reviewed at each Committee and in turn reported to Trust Board

3.1 Meeting on 19 April 2018

At the request of the Trust Chair and Medical Director, two NEDs from Humberside Trust were invited to observe the Committee, with a view developing a set of improvement and development recommendations. Following the formal meeting, they met with Exec and Non-Exec members, plus a wide selection of In Attendance staff. Their report would be considered at Committee and Board once available.

Section 17 Leave
Dr Clare Stephenson, Consultant Psychiatrist then provided feedback regarding Section 17 leave arrangements across low secure services. Dr Stephenson highlighted a number of issues/ambiguities with the Section 17 leave form which were impacting on the effective completion of this.

CQC ACTION PLAN
The Committee noted publications produced by CQC and highlighted the importance of reviewing these and considering the resultant implications of development identified on the work of the MHLC.

INTERNAL AUDIT REPORT
The Committee received a copy of the report into the quality of MHA Administration processes. The report provided significant assurance, with some correlation between findings in this report and CQC findings.

MHA CQC Review Visits
The MHLC reviewed reports on recent CQC Mental Health Act Review Visits. Since the last report there had been one unannounced visit to the Assessment and Treatment Unit. In addition, CQC reports and Provider Action Statements had been received for Maplebeck (male), Ashbrook (female), Bracken Ward and Assessment and Treatment Unit

CPA AUDIT UPDATE
The Committee reviewed a summary of the results of the CPA Peer Review audit carried out in February and March 2018.The overall compliance had improved, with an increase to 82.10% in February/March 2018, compared to 71.63% in September 2017.

COMMITTEE DASHBOARD Q4
The integrated performance report showed a good performance with achievement of the majority of indicators

MENTAL CAPACITY ACT AND DOLS
The Mental Capacity Clinical Lead presented the quarterly update of the Mental Capacity Act training and other updates.

REVIEW OF BLANKET RESTRICTIONS
The Committee was provided with details of a new procedure which had been developed to ensure front-line clinical staff on wards understood what constituted a restriction and how to assess and apply as appropriate.

MENTAL HEALTH ACT ANNUAL REPORT
The Annual Report was accepted and would be presented in full to the Trust Board in May 2018

COMMITTEE BUSINESS CYCLE
It was agreed that issues highlighted through internal Audit reports should be shared with relevant Committees and this should become a standing item on the agendas.

MENTAL HEALTH LEGISLATION FORUM
The minutes from the Mental Health Legislation Forum held in February and March 2018 had been circulated for information and summarised key points were discussed

3.2 Meeting on 19 July 2018:

CQC ACTION PLAN
The Deputy Director of Quality Improvement introduced the report which was now produced in a new format with clear themes and co-ordinated actions and reiterated key points within it.

REVIEW OF THE MHLC REPORT FINDINGS
The Committee received the report prepared by the Humberside NEDs. All 10 recommendations contained within the report had been widely agreed and accepted by Trust Board and MHLC.

MENTAL CAPACITY ACT:
The MCA Clinical Lead presented the Annual Report on MCA activity and training, which provided assurance in relation to the implementation of the MCA

COMMITTEE DASHBOARD Q1
The integrated performance report showed a good performance with achievement of the majority of indicators at 30 June 2018

REVIEW OF COMMUNITY TREATMENT ORDERS (CTOs)
The Committee received a report outlining the use of CTOs. The paper described 2 patient journeys detailing how they ended up on a CTO, who was involved and how it's use was kept under review.

MENTAL HEALTH LEGISLATION FORUM
The minutes from the meetings held on 26 April 2018 and 7 June 2018 had been circulated for information with summarised key points:

ASSOCIATE HOSPITAL MANAGERS GROUP
The minutes from the AHM meeting held on 4 June 2018 had been circulated for information and it was noted that the successful recruitment of 7 further hospital managers had taken place

3.3 Meeting on 18 October 2018:

CQC ACTION PLAN
The Improvement Quality Programme board had been disestablished. IT department were working on personalised care plan issues. Recent feedback from the CQC visit to the Oakburn Ward highlighted concerns regarding restrictive practices. Consequently blanket restrictions and interventions would be subject to a more thorough review.

MHLC PERFORMANCE REVIEW PROGRESS
Of the 10 recommendations a number had been completed. The Mental Health Legislation Forum to be strengthened and would be considered at a meeting on 7 November. The work plan had been updated and contained a number of new additional items for review by the Committee. The Committee would be meeting on a bi-monthly basis, commencing in November.

MENTAL HEALTH LEGISLATION FORUM
A review of the DOLs applied for was currently being undertaken. Training would also be delivered to consultants and nurses regarding the recent DOLs ruling, including regular guidance and support to staff on the Dementia Assessment Unit regarding DOLs practice.

ASSOCIATE HOSPITAL MANAGERS GROUP
Members had received an electronic copy of the updated MHA Policy and Procedures. 6 new hospital managers were now in post making a total of 21.

MENTAL CAPACITY ACT UPDATES
Training dates had been set until the middle of 2019 with additional bespoke sessions timetabled.

CQC MENTAL HEALTH ACT REVIEW VISITS REPORT
The report and reiterated key points from within it regarding the CQC Mental Health Act compliance visit to Oakburn Ward

COMMITTEE DASHBOARD
The integrated performance report showed a good performance, with achievement of the majority of indicators at 30 September 2018. Stretched target for levels were not breached

3.4 Meeting on 22 November 2018

MENTAL CAPACITY UPDATES
The report highlighted actions being taken to increase Mental Capacity compliance levels. A business case was being developed to increase the working hours for the MCA Lead; and appoint an additional staff member to work on staff bank to deliver training. Non-compliant areas would be targeted and work with managers to increase this.

CQC ACTION PLAN
The report detailed how the action plan had been updated and submitted to the CQC. A gap analysis of the action plan has also been undertaken. Since the paper had been distributed, the action plan had been condensed to make it more user friendly;

COMMITTEE PERFORMANCE REVIEW
A number of actions had been completed. The Trust's legal advisers had provided training to doctors and this had been well attended. Adding medical expertise on the Committee was being considered and, in the meantime, a section 12 doctor was a member. The Trust had recently appointed two new NEDs. Simon Lewis (a Barrister with Human Rights experience) joined the Trust on 19 November and would be joining the Committee. Carole Panteli (a former senior clinician within the NHS) had also been appointed and would be joining the Committee.

SECTION 117 AFTERCARE AUDIT UPDATE
The audit had now been undertaken twice yearly for a number of years. Two standards had achieved 100% compliance and two had achieved over 90% compliance; The results were generally positive and the Commissioners had not provided any adverse feedback;

CQC MENTAL HEALTH ACT REVIEW VISITS REPORT
Since the Committee last met, an unannounced visit had taken place to Heather Ward.

MENTAL HEALTH ACT HALF YEAR REPORT
The report highlighted that the use of Section 2 had continued to rise since the Supreme Court Judgement in 2014 and was now close to three times the pre-2014/15 level. The use of Section 3 rose in 2014/15 by approximately 50% following the Cheshire West judgement, and had remained high over each of the following years.

3.5 Meeting on 24 January 2019:

COMMITTEE PERFORMANCE REVIEW
Work was continuing with strengthening MHLC. The Committee welcomed two new Non-Executive Directors Carole Panteli and Simon Lewis. Mrs Panteli would take over as Chair of the Committee from its next meeting in March 2019.

MENTAL HEALTH LEGISLATION FORUM
The Forum had moved from 6 weekly meetings to 2 monthly. The meeting scheduled to take place in December 2018 was unfortunately cancelled and the next meeting would be taking place on 11 February 2019.

ASSOCIATE HOSPITAL MANAGERS GROUP
A review of Hospital Manager expenses had taken place. The Trust provided a slightly higher than average payment and therefore the rates would remain same this year.

MENTAL CAPACITY ACT UPDATES
Training compliance had increased from 50% in July to 68% in December 2018. A second trainer had commenced to work on staff bank training which had resulted in the double amount of training available for 2019.

CQC MENTAL HEALTH ACT REVIEW VISITS REPORT
Since the Committee last met, an unannounced visit had taken place to Fern Ward on 26 November 2108. The report of the visit had recently been received and the main findings revealed:

- Blanket restrictions, no previous policy.
- Care planning
- Systm1 and impact on services

CQC ACTION UPDATE
The MHLC was asked to consider reviewing the Terms of Reference for the Positive and Proactive Steering Group (Completed) There will now be regular reports to Committee on restrictive practices.

3.6 Meeting on 21 March 2019:

FEEDBACK FROM AUDIT COMMITTEE
A Compliance Group was being established which would include the monitoring of MCA training; this would be reported into the Quality & Safety Committee. The Chair confirmed MCA training would be discussed at Board on 28 February to conclude where it would best be monitored.

MH LEGISLATION COMMITTEE PERFORMANCE REVIEW
The Committee agreed to invite the Trust Solicitor from Hempsons to speak to the Committee as soon as possible to examine the MHA and improvement to the Committee. It was envisaged that this would take around 2 hours and it was imperative that a clear steer was provided to the Solicitor.

MENTAL HEALTH LEGISLATION FORUM
Supreme Court in November 2018 referring to Section 37/41 for patients with conditions amounting to use of DOLs. The Consent to Admission and Treatment form (CTAT) in SystmOne required amendment. Hospital Managers had requested that consultants be required to type renewal documentation as opposed to hand writing.

PRESENTATION ON ACUTE IN-PATIENT SERVICES
This was a new agenda item to enable Services to present an update on oversight and scrutiny.

MENTAL CAPACITY ACT AUDIT AND PROGRESS UPDATE
The report highlighted actions being taken to increase Mental Capacity compliance levels. Training compliance had increased from 50% in July 2018 to 74.6% in February 2019 and on target to reach 80% by June 2019.

COMMITTEE DASHBOARD, Q3 FOR 2019
The new stretched target of 98% was not breached on Q1, Q2 or Q3. Ethnicity Information showed the first full dataset drawn information based on ethnicity definitions used in SystmOne.

CQC ACTION UPDATE
Inspections had highlighted issues around segregation and blanket restrictions.
- Core inspections had taken place in:
- Older Persons Community Mental Health Team
- Forensics
- Acute In-patients
- Crisis Services
- Older Persons In-patient Services
- Recent visit to MHA Office; no CQC feedback received to date.

TERMS OF REFERENCE REVIEW AND RE-APPROVAL
It was agreed to present the TOR to the April Trust Board meeting following the updated amendments: The addition of the Interim Head of Quality Governance;

the addition to specific areas of responsibility of oversight of restrictive practices; and the addition of the General Manager, Mental Health Care Group.

The Code of Practice to the Mental Health Act provides statutory guidance in relation to the medical treatment of patients suffering from a mental disorder. At 37.11 the Code states: "*The organization (or individual) concerned should put in place appropriate governance arrangements to monitor and review the way that functions under the Act are exercised on its behalf. Many organisations establish a Mental Health Act steering or scrutiny group especially for this task. Ideally such forums should have representation from the Board."*

This report outlines some of the key activity under the MHA in the financial year 2018/19 to provide assurance to the Board that those exercising the functions under the Act do so appropriately and lawfully.

1. Introduction

1.1 This report provides the Committee with an overview of Mental Health Act activity for the period 1st April 18 to 31st March 2019.

2. The Work of Associate Hospital Managers

2.1 All Non-Executive Directors (NEDs) of the Trust Board, are in fact "hospital managers" within the meaning of the MHA, however due to other commitments, this is not required. 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".

2.3 Following a number of resignations due to other commitments the number of hospital managers over the last year had dropped to only 16. This number was not sufficient to maintain balanced panels. Following a successful recruitment drive, the Trust was able to appoint in July five new hospital managers, bringing the numbers back up to a more acceptable level of 21. All received initial training and observed a number of hearings before commencing their role as full panel members. They, along with the existing hospital managers continue to be supported in their role by the MHA Advisor.

3 Outcome of Managers Hearings

3.1 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; this latter reason is the majority of the case heard.

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 CTO client does not turn up for appointments, although they can be formally recalled for this purpose. Following receipt of the statutory report to order renewal a hospital managers meeting is convened.

3.2 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 service 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 either the responsible clinician or the care co-ordinator 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.

3.5 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 small 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 materialize as actual hearings.

4 Hospital Manager Hearings and Renewals Activity

4.1 There were a total of **60 Appeals** and **138 Renewals** being lodged with hospital managers a total of 198 cases.

4.2 In total 111 appeals and renewals were heard (15 appeals and 96 renewals).

4.3 Of the 15 appeals heard, 12 (80%) were not upheld and 3 (20%) was discharged.

4.4 Of the 96 renewals heard, 90 (94%) were renewed, 4 (4%) were discharged and 2 (2%) were adjourned

4.5 Combining the outcome rate of all manager hearings, i.e. 111 heard, with 7 clients discharged, the discharge rate is 6%.

4.6 Nearest relatives exercising their right to order the discharge of their relative has remained relatively high at 27 for the year. Of these 15 were regraded to informal status by the RC, 5 were barred, 3 lapsed, 1 the relative withdrew, and 3 proved not to be valid requests. Of the 3 that lapsed, one was due to the client being AWOL, one was a clinical decision, and one lapsed in error.

Of the 5 cases that were barred only one had a hospital manager hearing and this resulted in no discharge.

The Code of Practice requires hospital managers to consider barring orders only if deemed appropriate. Of the 4 cases where the managers did not consider the barring

order, this was due to 2 where the nearest relative had felt under duress to make the request, one where the RC made the patient informal before a hearing could take place and one case where, following discussion with the RC, the nearest relative decided to allow the RC to make the decision relating to discharge.

4.6 Hospital Managers Appeals and Renewals Activity Summary Table for past 9 years

Requests rec'd	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Appeals	212	201	207	120	105	118	107	63	60
Renewals	65	91	125	138	152	168	131	138	138
Total rec'd	**277**	**292**	**332**	**258**	**257**	**286**	**238**	**201**	**198**
Not Heard	**134**	**147**	**165**	**114**	**99**	**75**	**107**	**86**	**87**
Re-grade Prior by RC	55	66	66	43	50	37	49	37	45
Withdrawn	27	32	34	13	11	9	17	6	5
Other Reasons*	52	49	60	58	38	29	41	43	37

***Other reasons manager hearings not heard include:**

Regraded informal by Tribunal prior (2)
CTO terminated (12)
Discharged onto CTO (3)
Unable to set in timeframe (8)
No RC available (1)
Lapsed (5)
Put on DoLs (4)
CTO revoked (2)

Outcome of cases heard

Appeals	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Heard	**102**	**104**	**65**	**39**	**40**	**40**	**36**	**12**	**15**
Denied	84	86	50	32	31	34	28	11	12
Adjourned	10	7	2	1	1	0	0	0	0
Discharged	8	11	13	6	8	6	8	1	3
Renewals									
Heard	**32**	**41**	**102**	**105**	**118**	**126**	**95**	**109**	**96**
Renewed	19	37	98	101	110	118	95	108	90
Adjourned	7	1	2	0	2	1	0	0	2
Discharged	6	3	2	4	6	7	0	1	4

5 Mental Health Tribunals

5.1 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 materialize as actual Tribunal hearings.

5.2 Tribunal activity – numbers received remain close to that of the previous 3 years, though the numbers actually resulting in a hearing has reduced by a small number over the same period due to more patients being discharged by the RC prior to the hearing taking place.

5.3 Of the 402 requests processed, 215 were heard and 187 were not heard. The large number of cases not heard could indicate a thorough MHA assessment by the professionals having taken place in the weeks prior to the hearing, which resulted in 134 (71%) 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 46 (34%) 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.

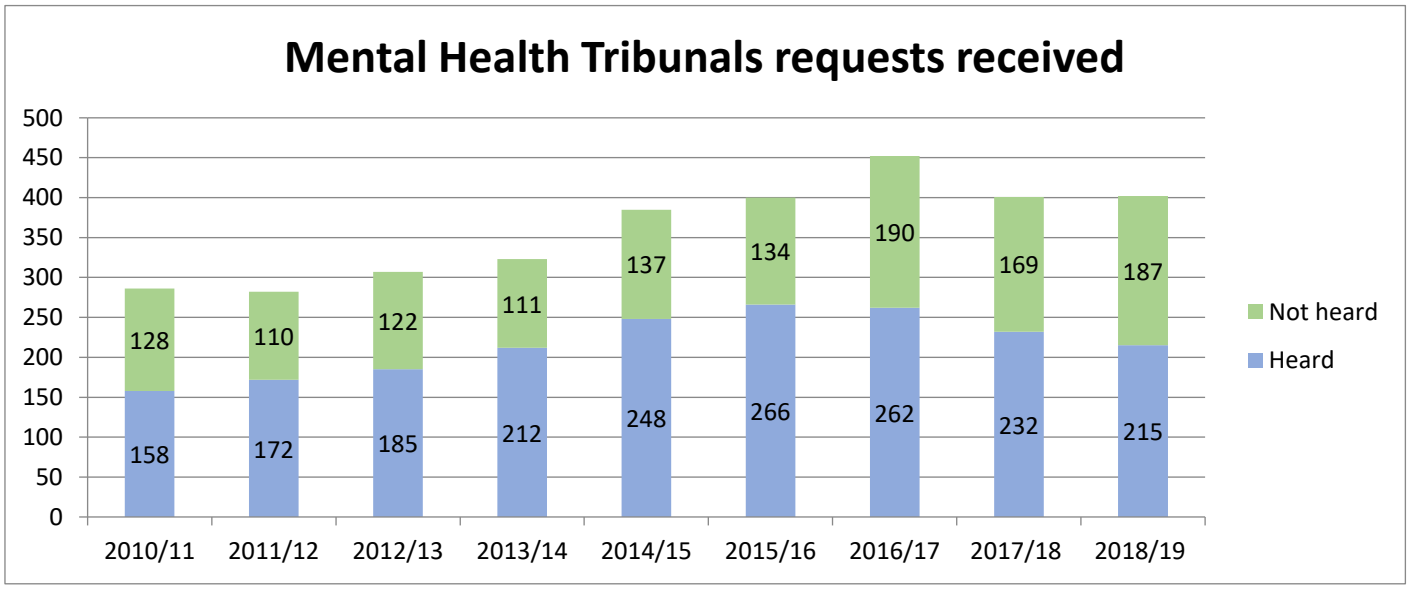
Of the 215 heard, there were 184 (85%) not discharged, 18 (8%) discharged, 13 (7%) adjourned. Of the 18 discharged 5 of these were restricted cases and 13 non restricted

Of the 202 non restricted Sections 2, 3 or CTO cases heard (which compare to the type of sections that hospital managers hear) 13 (6%) were discharged.

Of the 13 restricted cases heard, 5 (38%) were discharged. This is not a surprising result as the RC has no power to discharge a restricted patient when well, the only authority to discharge is through the tribunal with the approval of the MOJ.

5.4 Tribunal Activity for the past 9 years is shown below:

	Year:								
	2010/11	**2011/12**	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Requests rec'd	**286**	**282**	**307**	**323**	**385**	**400**	**452**	**401**	**402**
Not Heard	**128**	**110**	**122**	**111**	**137**	**134**	**190**	**169**	**187**
Re-grade by RC	64	53	74	54	84	89	123	107	122
Re-grade by AHM	0	6	11	6	2	4	3	0	3
Withdrew	40	41	29	32	30	26	43	48	46
Transferred	11	4	7	10	8	3	3	0	1
Adjourn/Re-listed	6	4	1	9	8	6	10	1	5
Placed on CTO	5	0	0	0	0	1	0	0	0
*Other reasons	2	2	0	0	5	5	*8	*13	*10
***Other reasons tribunal not heard:** CTO lapsed or terminated (9) + Patient not eligible (1)									
Outcome of case heard									
Heard	**158**	**172**	**185**	**212**	**248**	**266**	**262**	**232**	**215**
Not Discharged	137	160	163	196	212	237	237	205	184
Discharged	16	9	12	9	23	20	19	24	18
Adjourned	5	3	10	7	9	5	6	2	13
Other	0	0	0	0	4	4	0	0	0

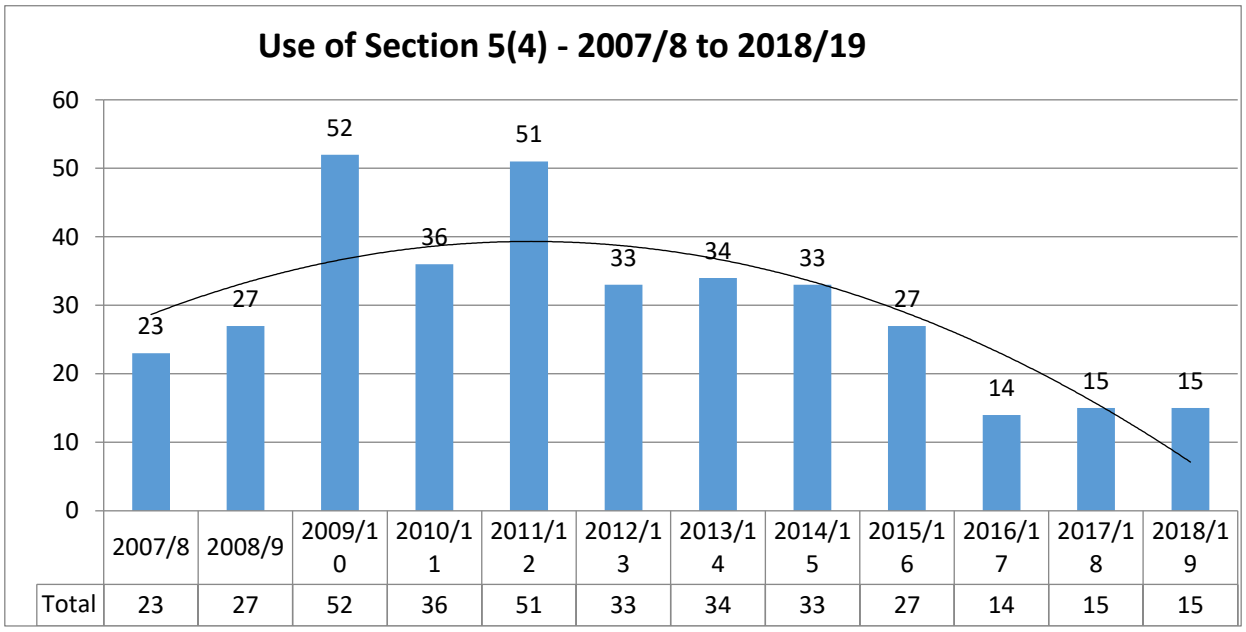


6 Activity data for key sections

Detailed below is the MHA activity for BDCFT. The national data is not shown in this report as a comparison as the 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.

6.1 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.



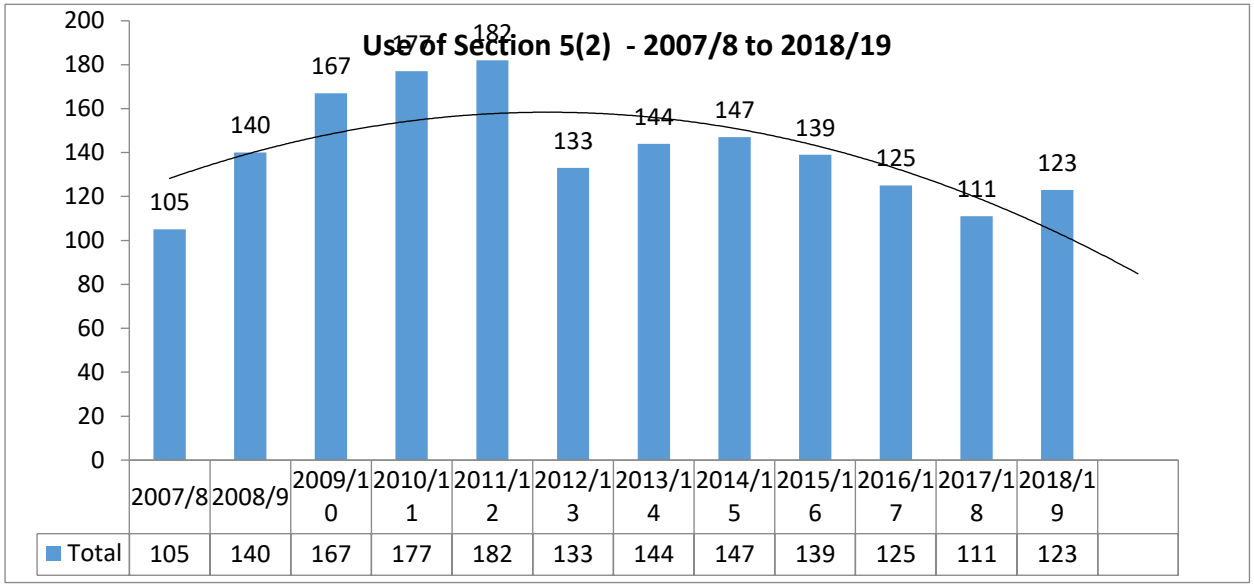
	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	23	27	52	36	51	33	34	33	27	14	15	15

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.

6.2 **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.



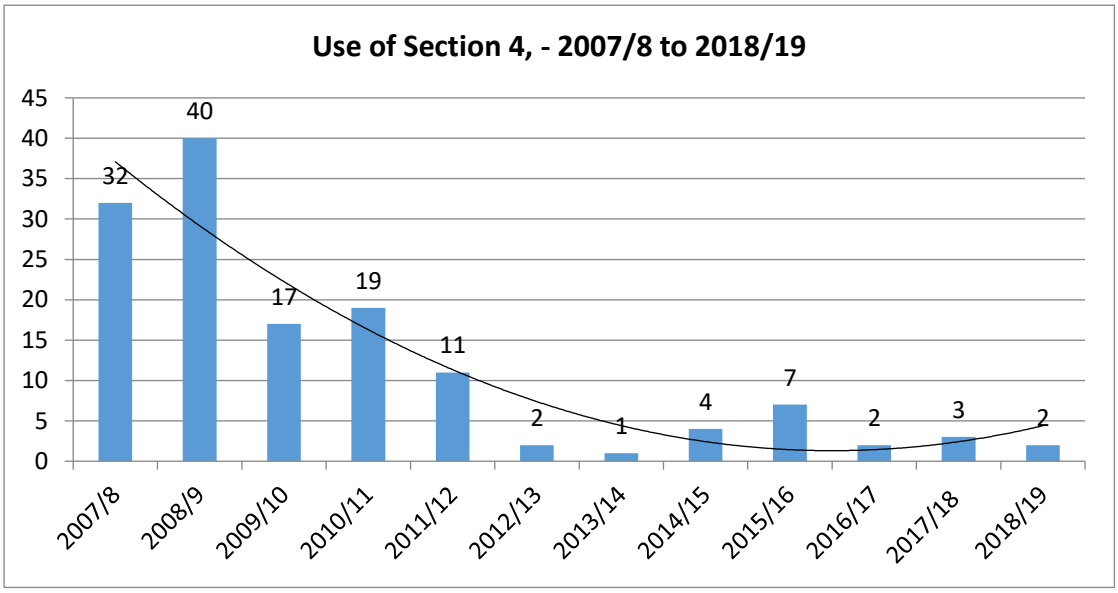
	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	105	140	167	177	182	133	144	147	139	125	111	123

Comments

The use of Section 5(2) has peaked again this year following a steady drop since 2014/15. This is not of concern as the admitting professionals must consider the least restrictive option in regard to admission. If the service user has capacity and is agreeing to admission, it would not be lawful or appropriate to use the MHA. If there is a deterioration in the patient's mental health and they are wanting to leave and would pose a risk to themselves or others, it is appropriate for the doctor to consider a holding power under section 5(2) and to arrange for a full MHA assessment to be carried out.

6.3 **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 wants 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.

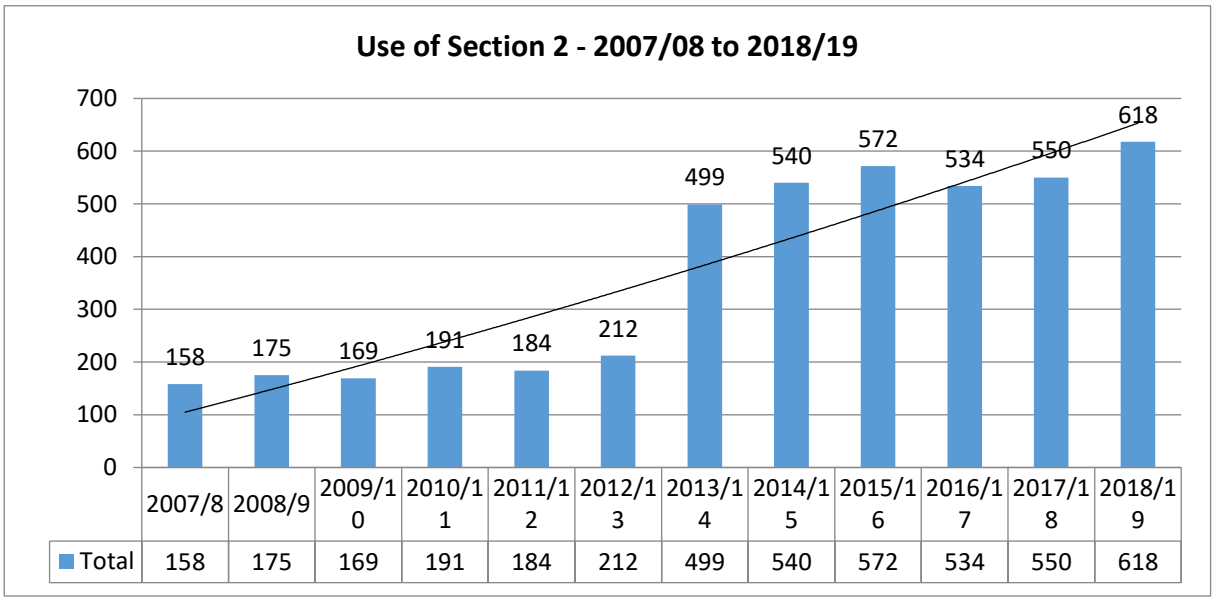


Comments

The use of Section 4 has remained low for the past seven 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.

6.4 **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.



	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Total	158	175	169	191	184	212	499	540	572	534	550	618

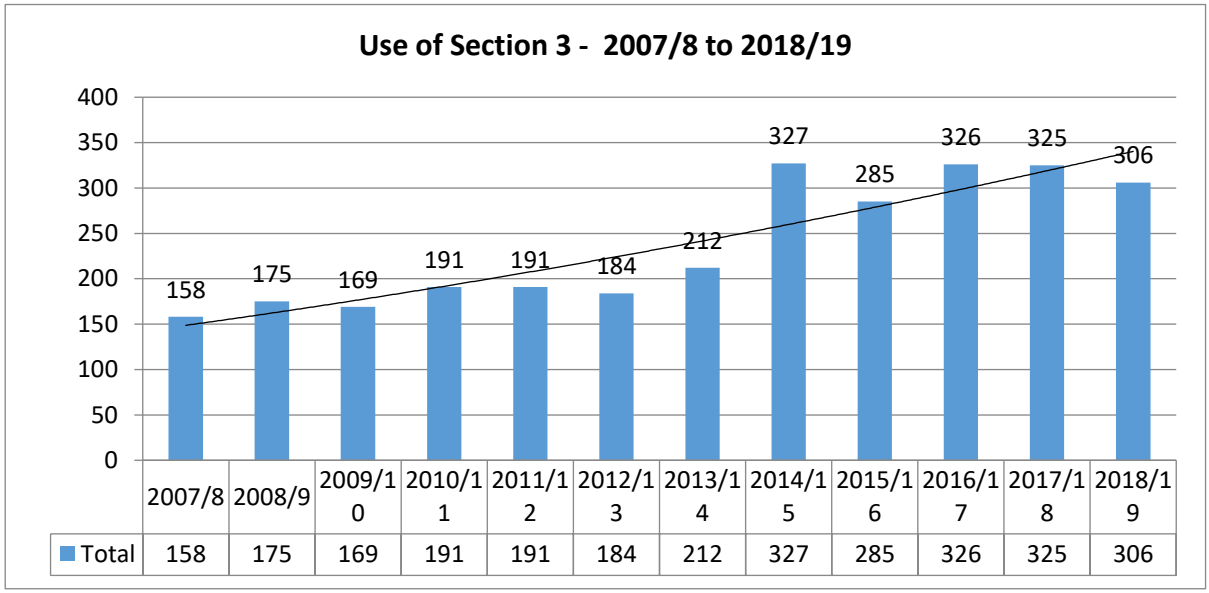
Comments

The use of Section 2 is now at an all time high and has continued to rise over the last 6 years and is now almost three times the pre 2013/14 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 authorized, either, under the Deprivation of Liberty safeguards or, under the Mental Health Act. Professionals within BDCFT and the Local Authority have generally viewed that the Mental Health Act is the most appropriate legislation to authorize 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 patient 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.

6.5 **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 a high level over the following years. This increase shows an excellent understanding by all professionals, on current legislation, with the only patients now informal being those with capacity and whom we would allow to leave, should they so choose.

There has however, been a slight drop this year, which could be due to some of the patients who would have moved from a section 2 to a section 3 previously, being placed under the Deprivation of Liberty (DoLs) safeguards instead.

6.6 New sections per month

	Numbers of new detentions received	April 18	May 18	June 18	July 18	Aug-18	Sep-18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	March 19	Total
	Section 5(4)	1	2	0	2	1	0	2	2	0	1	3	1	**15**
	Section 5(2)	13	7	9	9	8	9	20	7	9	9	11	12	**123**
	Section 4	1	0	0	0	0	0	0	0	1	0	0	0	**2**
	Section 2	53	54	50	54	41	54	48	50	57	50	45	62	**618**
	Section 3	27	28	27	28	27	16	32	26	35	17	2	34	**299**
	Section 36	1	0	0	0	0	0	1	0	0	0	0	0	**2**
	Section 37	0	0	0	1*	0	*1	1	1	0	1	1	0	**6**
	Section 37/41	1	2	1	1	1	0	0	1	1	1	0	1	**10**
	Section 47/49	0	0	1	0	0	0	0	2	0	0	1	0	**4**
	Section 48/49	0	0	0	1	0	0	0	0	0	0	1	0	**2**
	New CTOs in Month	4	3	5	4	3	2	2	3	0	4	5	5	**40**
	Total per month	**101**	**96**	**93**	**100**	**81**	**82**	**106**	**92**	**103**	**83**	**69**	**115**	**1121**

6.7 Section 136 information

Section 136 Data	Place of Safety used Total	LMH	ACMH	Police	Other	Outcome Terminated	Informal Ad	Regrade S2/S3	CTO Recall	Transfer	Age Profile 0-17	18-30	31-45	46-59	60+	Male	Female	Total
April 18	19	12	6	0	1	11	2	6	0	0	1	6	6	5	1	**8**	**11**	**19**
May 18	25	14	11	0	0	17	0	7	0	1	2	6	12	5	0	**12**	**13**	**25**
June 18	23	7	16	0	0	10	4	9	0	0	0	13	7	3	0	**10**	**13**	**23**
July 18	21	14	7	0	0	12	3	6	0	0	0	4	11	3	3	**11**	**10**	**21**
August 18	17	12	5	0	0	12	0	5	0	0	1	6	6	4	0	**11**	**6**	**17**
Sept 18	25	10	14	0	1	13	1	11	0	0	2	6	8	8	1	**12**	**13**	**25**
Oct 18	**31**	**17**	**14**	**0**	**0**	**13**	**3**	**15**	**0**	**0**	**2**	**12**	**11**	**6**	**0**	**18**	**13**	**31**
Nov 18	**18**	**13**	**4**	**0**	**1**	**9**	**1**	**8**	**0**	**0**	**1**	**4**	**7**	**4**	**2**	**9**	**9**	**18**
Dec 18	**21**	**12**	**9**	**0**	**0**	**15**	**1**	**5**	**0**	**0**	**0**	**10**	**5**	**4**	**2**	**10**	**11**	**21**
Jan 19	**14**	**11**	**3**	**0**	**0**	**10**	**1**	**3**	**0**	**0**	**1**	**6**	**4**	**3**	**0**	**9**	**5**	**14**
Feb 19	**21**	**13**	**8**	**0**	**0**	**9**	**5**	**7**	**0**	**0**	**1**	**12**	**5**	**3**	**0**	**8**	**13**	**21**
Mar19	**18**	**4**	**14**	**0**	**0**	**8**	**1**	**8**	**0**	**1**	**0**	**6**	**7**	**5**	**0**	**12**	**6**	**18**
Total	**253**	**139**	**111**	**0**	**3**	**139**	**22**	**90**	**0**	**2**	**11**	**91**	**89**	**53**	**9**	**130**	**123**	**253**

Analysis of Section 136 data for the period 01.04.18 to 30.09.18:

There has been a steady increase in the use of Section 136 over the last 3 years. There were 253 Section 136 episodes in this period, an average of 21 per month.

This compares to 197 in 2017/18, 177 in 2016/17, and 167 in 2015/16.

- 55% (139) came to Lynfield Mount Hospital;
- 44% (111) came to Airedale Centre for Mental Health;
- 1% (3) other place of safety

Outcomes:

- 55% (139) of S136s were terminated
- 36% (90) were admitted under Section 2 or Section 3
- 9% (22) were admitted informally
- 51% (130) were male
- 49% (123) were female

Age Profile:

- 4% (11) were aged under 18
- 36% (91) were aged 18-30
- 35% (89) were aged 31-45
- 21% (53) were aged 46-59
- 4% (9) was aged 60 and over

6.8 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 (55%), are to consider Community Treatment Orders.

Period	Nov 08-Mar 09	Apr 09-Mar 10	Apr 10-Mar 11	Apr 11-Mar 12	Apr 12 – Mar 13	Apr 13 – Mar 14	April 14-Mar 15	April 15-Mar 16	April 16-Mar 17	April 17-Mar 18	April 18 – Mar19
New CTO's	14	29	35	54	45	51	62	53	64	55	40
CTO Hearings to HMs				25	63	65	61	72	60	66	61
Section hearings to HMs				45	98	74	90	92	71	55	50
Total HM hearings				**74**	**167**	**143**	**158**	**169**	**131**	121	111
% CTO hearings				34%	38%	45%	39%	42%	46%	55%	55%

Whilst the number of new cases over the last 8 years has ranged between 40 and 64 new cases, we have on average at any one time between 60 and 70 clients in the community subject to CTOs. The amount of activity in relation to CTOs is vast, each new CTO client needs a certificate authorizing treatment within one month. A number of clients will need to be recalled, this applied to 28 clients in this financial year. The length of time of the stay on the ward under recall can't exceed 72 hours without the consultant taking action, which can be either, to allow the client to return to the community, to allow the client to remain informally on the ward, but still subject to the CTO rules, or to revoke the order.

I the last year, 13 of the 28 recalled clients had their recall ended within 72 hours and returned to the community and 15 had their CTOs revoked, meaning they were back on the previously suspended section 3. For each client whose CTO is revoked, the MHA officers must refer them for a Mental Health Tribunal and ensure that there is new authority immediately to treat in hospital – no 3 month rule applies.

Clients are taken off CTO as soon as they no longer need the provisions of the Act to keep them well. In this period 21 clients had their CTOs terminated due to improved insight and an improvement in their mental health.

7. Use of Deprivation of Liberty Safeguards

Fifteen new Deprivation of Liberty Safeguard (DoLs) applications were made in the 12 months of this report, as opposed to only one in the previous period last year. This appears to be a new development. Many of these clients had first been detained under a Section 2 quite appropriately and were placed on a DoLs when their presentation settled in order to avoid use of Section 3. It appears to have been used mainly for clients who would otherwise be ready for discharge but were awaiting a suitable placement.

Because of this change in practice each DoLs case was investigated independently to ensure the requests were appropriate and all were found to be so.

8. Use of the MHA in the general hospitals

The Care Trust has Service Specifications with both ANHSFT and BTHFT in relation to the administration, scrutiny and training under the MHA.

Any patients in these hospitals who are placed on Section 5(2) doctors' holding power, or Sections 2 or 3 of the MHA, will be scrutinized by the MHA officers at BDCFT.

<u>MHA Activity at Bradford Royal Infirmary:</u>

Use of Section 5(2) - 50
Use of Section Two - 7
Use of Section Three – 1

Monitoring and compliance: Each section is scrutinized by the MHA officers to ensure compliance with the Act and amendments called for and received where needed. All section 5(2)s are checked for outcome of MHA assessments within the 72 hour time frame. Meetings take place on a monthly basis between the MHA Advisor and an officer from BRI's Risk Department.

Training provided: Four training session are provided each year by the MHA Advisor

<u>MHA Activity at Airedale General Hospital:</u>

Use of Section 5(2) – 13
Use of Section Two – 12
Use of Section Three – 2

Monitoring and compliance: Each section is scrutinized by the MHA officers to ensure compliance with the Act and amendments called for and received where needed. All section 5(2)s are checked for outcome of MHA assessments within the 72 hour time frame. Meetings take place on a quarterly basis between the MHA Advisor and relevant senior staff at director level at AGH.

Training provided: Four training sessions are provided each year by the MHA Advisor

8. 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 the period of this report, the CQC inspectors visited 6 wards.

Date	**ward**	**Visit type**
25/07/18	Oakburn ward	Unannounced
22/10/18	Heather ward	Unannounced
22/11/18	Fern ward	Unannounced
22/01/19	Dementia Assessment Unit (DAU)	Unannounced
28/01/19	Thornton ward	Unannounced
29/01/19	Clover ward (PICU)	Unannounced

The key themes arising from the six unannounced visits that took place in the last financial year were as follows:

- Concern regarding a number of blanket restrictions
- Patients not receiving copies of their care plans or evidence of involvement by them
- Evidence lacking in regard to reading of rights under Section 132
- Evidence lacking in regard to patients' awareness of right to an IMHA
- Patients not receiving copies of their Section 17 leave
- Evidence lacking in regard to thorough assessments of capacity

The CQC issue a report on their findings following each visit and provider action statements are submitted back to the CQC outlining what actions will be taken to address the issues raised by the CQC. These provider action statements are monitored via the wards' Quality and Safety forum and within the business unit's collective Quality and Safety forum. Additionally, CQC reports and provider action statements are shared across business units to promote cross learning and joint improvement where applicable.