

Mental Health Legislation Committee

Annual report

1 April 2019 to 31 March 2020

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1 Period covered by the report

The report covers the period from 1 April 2019 to 31 March 2020

2 Introduction

The Mental Health Legislation Committee (Committee) has been formally established by the Board of Directors as one of its sub-committees. It is authorised to seek and obtain evidence of assurance on the effectiveness of the Trust's mental health legislative systems and processes, and the quality of the services provided.. The Committee will monitor and report to the Board on the effectiveness of these systems and processes. The Committee's key objectives are to seek assurance that:

- systems and processes are effective, and wherever possible evidence-based
- the quality of services provided is good and continuously improving
- the experience of people using Trust services is good and continuously improving.

The Committee also seeks to:

- monitor, review and report to the Board on all the above; highlighting assurances received and risks to assurance identified
- receive relevant mental health legislation update for information and assurance.

This report covers the work the Committee has undertaken at the formal meetings held during 2019/20. It seeks to assure the Board on the work it has carried out and the assurances it has received, and to demonstrate that it has operated within its Terms of Reference.

Secretariat support is provided by the Executive Support Team, who work with the Mental Health Legislation and Care Programme Approach Lead in relation to agenda planning; minutes; managing cumulative action logs; and general meeting support.

Assurance

The Committee receives assurance from the Executive Director members of the Committee and from the subject matter experts who attend the meetings as required dependant on the agenda items being discussed.

Assurance is provided through written reports, both regular and bespoke, through critical challenge by members of the Committee and by members seeking to validate the information provided through wider knowledge of the Trust; specialist areas of expertise; attending Board of Directors', and Council of Governors' meetings; visiting services, talking to staff, and observing operational meetings at the Trust as required.

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of

the effectiveness of those controls. The Committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the Committee or to commission further information where there was a lack of assurance (actual or perceived). These are:

- SO 1.1: if demand exceeds capacity, then service quality, safety and performance could deteriorate; and
- SO 2.1: if regulatory standards are not met, then we will experience intervention from regulators and/or damage our public confidence

The Committee reviews the BAF at each meeting prior to it being presented to the Board.

A revised Dashboard has been in operation since late 2019 for the Committee as part of an internal pilot. The Dashboard is now designed to accord with statistical process control measures thereby aligning with the Care Trust Way (as our quality improvement [QI] methodology). To reduce the risk of data saturation and enhance attention to detail, exception or outlier data are highlighted; and an easy to follow colour-coded legend allow readers to quickly ascertain which data have improved, deteriorated, require a watching brief or are in a steady state. Additionally, accountabilities for each item of activity/data are made explicit. Narrative data accompanies quantitative data to identify risks, challenges, and actions.

The individual high-level Dashboards, tailored to each Board sub-committee, collectively form a Data Pack that is presented to the Board of Directors. A key aim is for the Data Pack to inform strategic decision making by providing clarity on the impact of operational decisions in the context of ongoing development of the Trust's QI methodology. The revised system was approved by the Board of Directors on 26 March 2020 and has subsequently been rolled out throughout the remaining Board sub-committees.

The Committee has responded as a result of the COVID-19 pandemic to ensure that business continuity remains as appropriate for the Committee. Formal reports on the Trust's business continuity plans for all corporate governance meetings have been presented to the Board of Directors. The Board formally agreed to establish standing items on each corporate governance meeting for: COVID-19 Update; and Management of Deferred Items. COVID-19 runs accordingly as a theme through the agenda items being discussed in Committee meetings.

3 Terms of Reference

The Terms of Reference (TOR) underwent a major restructure in March 2020 to bring them into line with revised content devised by Corporate Governance.

The updated TOR were ratified by the Trust Board in April 2020.

The Committee had not undertaken an effectiveness review in this period, having concentrated on implementing the actions developed by an external review from

Humberside NHs Foundation Trust in April 2018, some of which had 2 year implementation time frames.

Terms of Reference for information are attached at **Appendix 1**

4 Meetings of the group / committee

The Committee met on six occasion; 5 of them as standard meetings and one in March 2020 using Microsoft Teams (because of COVID-19 lockdown restrictions). The dates were: 23 May 2019; 18 July 2019; 19 September 2019; 21 November 2019; 23 January 2020; and 24 March 2020.

5 Membership of the committee and attendance at meetings

The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive directors. All meetings in the period were quorate.

Attendance at meetings for substantive members and those in attendance were as follows:

Name	23/5/19	18/7/19	19/9/19	21/11/19	23/1/20	24/3/20	Total
Substantive members							
Non-Executive Director (Chair) - Carole Panteli	✓	✓	✓	✓	X	✓	5/6
Non-Executive Director - Zulfi Hussain MBE	✓	✓	✓	✓	✓	✓	6/6
Non-Executive Director - Simon Lewis	✓	✓	✓	✓	X	✓	5/6
Non-Executive Director and Trust Chair - Cathy Elliott						✓	1/1
Non-Executive Director - Andrew Chang					✓		1/1
Chief Operating Officer - Patrick Scott	x	✓	✓	✓	✓	✓	5/6
Medical Director - David Sims	✓	X	✓	✓	✓	✓	5/6

	23/5/19	18/7/19	19/9/19	21/11/19	23/1/20	24/3/20	Total
Others in attendance							
General Manager/Deputy Director of Nursing Professions and Care Standards – Grainne Eloi, left MHLC after 23/1/20	✓	X	✓	X	X		2/5

Director of Nursing, Professions and Care Standards – Phil Hubbard					X		0/1
Assistant General Manager/General Manager – Kelly Barker, joined MHLC 19/9/19			X	X	✓		1/3
Interim Head of Quality Governance – Louise Hussain, left MHLC after 18/7/19	✓	✓					2/2
Deputy Director of Risk, Compliance and Nursing – Jenny Wilkes, joined MHLC 19/9/19			X	✓	X		1/3
Head of Quality Governance and Patient Safety – Beverley Bray, covered for J Wilkes on 23/1/20					✓		1/1
Corporate Governance Manager – Fran Limbert, joined MHLC on 19/9/19			✓	✓	X	✓	3/4
MHL and CPA Lead – Simon Binns	✓	✓	X	✓	✓	✓	5/6
Mental Health Act Advisor – Teresa O’Keefe	✓	✓	✓	✓	✓		5/5
Mental Capacity Act Clinical Lead – Joanne Tiler	✓	✓	✓	✓	✓		5/5
Consultant Psychiatrist (Section 12 approved) – Dr Shubra Singh, left MHLC after 19/9/19	X	X	X				0/3
Consultant Psychiatrist (Section 12 approved) – Dr Suresh Bhoskar, joined MHLC on 21/11/19				X	✓		1/2
Consultant Psychiatrist (Section 12 approved) – Dr Abdul Qayyum, joined MHLC on 23/1/20					X		0/1
Approved Mental Health Professionals Manager – Kate O’Leary	X	X	X	✓	X	X	1/5
Associate Hospital Manager – Chrissie Freeth	X			✓			1/2
Associate Hospital Manager – Ruby Bhatti			✓		X		1/2
Council of Governors Representative – Sid Brown	✓		✓	✓			3/3
Patient Experience Lead – Isla Skinner	X	X	X	X	X		0/5

6 Reports made to the Trust Board

At each of the Committee meetings, the following areas were reported up to the Trust Board:

Mental Health Legislation Committee meeting, 23 May 2019

The Committee was made aware of the report from CQC reviewing long term segregation in LD services and noted how under-reported autism appeared to be. The Acting Medical Director agreed to work with key professionals and report back on implications for BDCFT in September.

The Committee was provided with a very informative presentation on Specialist InPatient services. The presentation highlighted issues with Delayed Transfers of Care on ATU and shared positive service user involvement strategies such as: #We are Thornton.

MCA – online training for staff in certain staff groups had been developed to increase awareness for those not requiring face to face training. This would include Admin, Nursery Nurses amongst others. (positive news). Training for frontline staff would need to be revised later this year in response to new Liberty Protection Safeguards coming into force in Spring 2020.

Section 117 Aftercare audit highlighted the need for staff in key groups to work more closely together to ensure responsibilities are understood and clearly recorded in service user care plans.

Mental Health Legislation Committee meeting, 18 July 2019

The Committee acknowledged the work that had taken place to support colleagues to undertake the Mental Capacity Act mandatory training programme, with compliance at 84.6% with a plan to reach 90% by December 2019. The Committee agreed that the online learning tool for the Mental Capacity Act would be shared with Board members.

The Committee Chair outlined work underway to refine the Committee's performance dashboard. A development session on the Mental Health Act had also been presented to the Committee. It was agreed that the presentation would be shared with Board members.

A second development session for the Mental Health Committee would be organised. Details of the session would be shared with Board members.

Mental Health Legislation Committee meeting, 19 September 2019

1. Mental Capacity Act compliance: the Committee received a presentation on the findings from an internal Mental Capacity Act audit of in-patient wards undertaken in June 2019. They noted that the objective of the Audit was to examine whether capacity assessments, etc, were properly being conducted at appropriate points. The Trust works to nine different guideline standards which formed the criteria for how the audit results would be scored against, with the target standard being 100% for each of the nine standards.

The Committee noted that the audit involved a sample of service users across 13 different mental health in-patient wards and involved 57 people. The findings were captured into three different areas:

- 1) where a service user is admitted formally, a mental capacity assessment should be completed at the point of admission;
- 2) where a decision that warrants an assessment is needed it should be carried out on that basis; and
- 3) where it is found that a service user does not have capacity to make a decision, a best interest meeting should take place.

The Committee heard from the Mental Capacity Act Lead on Compliance against each of those areas. It was noted that only 17% of informal patients that required a mental capacity assessment on admission had one undertaken. Low compliance was found in other areas, too.

The Committee members were very concerned about the low compliance rate as this is a regulatory matter as well as a quality and safety issue.

It was suggested by the Chief Operating Officer (COO) and agreed by the Committee that a “rapid improvement” approach would be taken commencing as soon as possible, led by the COO and the operational teams. The MCA Lead has already implemented a programme of training and awareness raising sessions with ward staff. The wider approach would support her ongoing efforts.

2. Associate Hospital Manager Recruitment: The Committee received feedback from the Hospital Manager representative. It was noted that the Trust has unfortunately lost a number of Hospital Managers and therefore the time commitment on the remaining 16 (which is the lowest number the Trust has ever had) will become unsustainable. Whilst hearings have, to date, proceeded as planned, it was noted that an effective recruitment drive needs to be undertaken promptly. The recruitment drive will be discussed, as soon as practicable, with the Trust’s new Chair, Cathy Elliott, as these are Chair appointments.

3. CQC MHA Compliance inspections: Findings from the Care Quality Commission routine Mental Health Act compliance inspections were presented. The Assessment and Treatment Unit within the Learning Disability Service had received positive feedback from inspectors with no actions identified as part of the inspection. The unit is to be congratulated on this achievement.

The Mental health legislation forum has been tasked with reviewing CQC compliance reports to coordinate responses and actions as well as updating the MHLC at each Committee meeting.

The Committee discussed performance metrics including the data presented within the Integrated Performance Dashboard. As part of the discussions it was noted that the Trust was seeing a rise in the number of service users detained under the Mental Health Act within an Acute setting. The Committee have tasked the Mental Health Legislation Forum to undertaking a review and advising the Committee at the next meeting.

A paper was presented that highlighted the internal audit report from May 2019 on Mental Health Care Plans and Mental Health Care Records. The Committee noted that the “significant assurance” had been found within this area noting the Trust has effective and robust controls in place over the processes used to establish, review and maintain mental health care plans and care records for service users on CPA. The report noted that there is appropriate governance in place which provides assurance over the quality of those service user care plans and care records and appropriate actions identified in an action plan to address CQC findings. This is being implemented in an effective and efficient manner.

Mental Health Legislation Committee meeting, 21 November 2019

The Committee received an update on progress made on Mental Capacity Act (Act) training for Trust colleagues. A series of development actions had been identified following findings from an internal audit on compliance and application of the Act across all inpatient wards in June 2019. The Committee received assurance that progress

made against identified improvement work was progressing well against the pre-expected trajectory. They heard from the lead for this workstream who outlined the supporting governance framework for monitoring progress made against the action plan, and how good practice was being co-produced with the services. The Committee noted a 40% increase in compliance, (rising to 54%) for Mental Capacity Act assessment completion has risen, and improvements of 33% with the best interest decision making since September 2019. The importance of embedding this work was noted along with how daily lean management techniques for performance monitoring was being used to support delivery. It was noted that an audit on this workstream would take place 2 December 2019.

From reviewing the performance dashboard the Committee noted an upward trend since July 2019 for both an increase in the use of full physical interventions and a mirrored rise in the use of rapid tranquilisation across a number of acute inpatient wards. The date presented was to 30 September 2019, with a further update for October's data expected on 25 November 2019 to review whether the trend had continued to increase. The Committee noted the increase in acuity in the wards and that the data had been reviewed by the Positive and Proactive Steering Group prior to presentation to Committee. The Medical Director and Chief Operating Officer agreed to provide a rapid review of the data for October and would provide a verbal update at the Board of Directors meeting on 28 November 2019.

Mental Health Legislation Committee meeting, 23 January 2020

Associate Hospital Manager recruitment has been very successful with 6 new people coming on board in January and February (after all required checks are completed)

MCA audit will be repeated in April, if stable then audit cycle move back to 6 monthly

Changes to MHLC Terms of Reference were agreed in readiness for re-approval in March

Assurance received:

Significant improvement in MCA compliance

CPA audit also provided strong assurance of effective management of care

Items to escalate:

Incident reporting data outside of Q3 report (new) raised by Medical Director: Notification of Under 16 Admission to acute wards for 9 days. 1 episode of full intervention. Being treated as a Serious Incident investigation. Local Authority to be involved

Mental Health Legislation Committee meeting, 24 March 2020

The Board were presented with and re-approved the Terms of Reference for the Mental Health Legislation Committee.

This meeting was held via Microsoft Teams and only members were present, with the Corporate Governance Manager and MHL & CPA Lead in attendance to present items on behalf of other authors.

Joint meetings between this Committee and the Quality and Safety Committee

In addition, there were three joint meetings between this Committee and the Quality and Safety Committee, held on: 23 April 2019; 12 August 2019 and 9 December 2019.

The first meeting was set to assure both Committees that appropriate and swift action was being taken in response to the Trust receiving a Section 29A Warning Notice from the Care Quality Commission (CQC). The joint meeting received high level action plans from services and officers from the Trust were held to account to verify, line by line that progress to address the issues raised was being made.

The meeting in August was used to receive further assurance that each of the identified workstreams were on track, completed and closed, or still in need of development and support.

The meeting December heard that the majority of workstreams had been implemented and that actions had moved on to sustaining the progress made.

7 The work of the committee or group during the year 1 April 2019 to 31 March 2020

Throughout the year, the Committee has received updates and assurance on a number of areas. These included

Review of the Performance Dashboard at every meeting, with refinement of data presented to give a clear picture of compliance with Mental Health Legislation and to give challenges back to operational services, where questions, such as restrictive practices arose and needed further assurance
Presentation on Specialist In-Patient Services

The Section 117 Aftercare Audit was presented twice, with presentations from senior clinical staff on how compliance can be improved

Care Programme Approach Audit was presented twice with evidence of strong compliance across services

Receipt and Scrutiny of Section Papers demonstrated great care was being taken to ensure any correctible error are being addressed immediately, and where errors

fundamentally invalidate the detention of a patient, they are immediately re-graded to informal and advised of their right to leave

Timeliness of Reports to Hospital Managers and Tribunals outlined how professionals were required to provide reports in a time-limited process and that overall compliance was better than seen 12 months previously

Mental Capacity Act Progress Updates were presented at every meeting. There were key actions for operational services to improve compliance against a set of MCA standards and with significant additional input from the MCA Lead, services had made huge improvements in both observed levels of understanding amongst frontline staff and accurate recording of assessments of capacity.

Mental Health Act Annual Report to Trust Board highlighted another busy year up to 31 March 2020 and the full activity report is attached at Appendix 2.

8 Conclusion

The Chair of the Mental Health Legislation Committee would like to assure the Board that the Committee worked hard to fulfil its Terms of Reference during 2019/20. The Board is asked to recognise how the Committee supports the ongoing continuous improvement journey both at the Trust and on its own effectiveness.

The Committee adds value by maintaining an open and professional relationship with officers of the Trust and it has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues, risks, or learning. Organisational learning drives this Committee and is one of its core values; further improvements will be made to advance this critical aspect of quality and safety.

Members of the Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

21 May 2020

Carole Panteli
Non-Executive Director and Chair of the Mental Health Legislation Committee

Simon Binns
Mental Health Legislation and Care Programme Approach Lead

Mental Health Legislation Committee

Terms of Reference

Version:	12
Approved by:	Mental Health Legislation Committee
Ratified by:	Board of Directors
Date approved:	24 March 2020
Date ratified:	30 April 2020
Job title of author:	Mental Health Legislation and Care Programme Approach Lead and Corporate Governance Manager and Deputy Trust Board Secretary
Job title of responsible Director:	Non-Executive Director and Chair of the Mental Health Legislation Committee
Date issued:	1 May 2020
Review date:	March 2021
Frequency of review:	Annual
<p>Amendment Summary:</p> <p>1: Terms of Reference transferred onto the new Trust terms of reference template as supported by the Care Trust Integrated Governance Guide</p> <p>3: section 1, updated the member and attendee list</p> <p>2: section 2, expanded to recognise regular attendees and their role in the Committee, and that Governors are invited to attend to observe the Committee meetings</p> <p>3: section 3, expanded to include guidance on deputies, and action as a result of a non-quotate meeting</p> <p>4: section 4, to include the Committee's responsibility to provide assurance and escalation to the Board of Directors, and a standing item on voting arrangements for the Board sub-committees</p> <p>5: section 5, expanded in the powers, establishment and cessation for the Committee</p> <p>6: section 6, to include the Trust's new values</p> <p>7: section 7, diagram that shows the Board of Directors meeting structure</p> <p>8: section 8, expanded to include the duties of the Chair</p> <p>9: section 9, expanded to include the requirement of an annual effectiveness review</p> <p>10: scheduled of deputies now include in-line with the good practice articulated in the Care Trust Integrated Governance Guide.</p>	

1 Name of Committee

Mental Health Legislation Committee.

2 Composition of the Mental Health Legislation Committee

Members: full rights

Title	Role in the group / committee
Non-Executive Director	Committee Chair
Non-Executive Director	Additional Non-Executive member
Non-Executive Director	Additional Non-Executive member
Chief Operating Officer	Executive lead with day-to-day responsibility for operational delivery of services. Assurance and escalation provider to the Mental Health Legislation Committee.
Medical Director	Executive lead for medics. Assurance and escalation provider to the Mental Health Legislation Committee.
Chair of the Trust	Additional non-executive member (attendance at meetings will be dependent on the agenda items being discussed).
Chief Executive	Accountable Officer (attendance at meetings will be dependent on the agenda items being discussed).

Any Executive and Non-Executive Director can attend a Board sub-committee meeting because of the position that they hold. When carrying out this duty they will assume full member rights.

In addition, the following individuals will attend each meeting:

- Deputy Director of Risk, Compliance and Nursing
- Corporate Governance Manager and Deputy Trust Board Secretary
- General Manager, Mental Health Care Group
- Associate Hospital Manager
- A Doctor approved under Section 12 of the Mental Health Act (1983)
- Mental Capacity Act and DOLS Clinical Lead (Also a DOLS Best Interest practitioner)
- Mental Health Legislation and Care Programme Approach Lead
- Mental Health Act Advisor
- Approved Mental Health Professionals Manager
- Involvement Friends.

In addition to anyone listed above, the Chair of the Committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

2.1 Governor Observers

The Committee welcomes and encourages governors to attend its meetings. The role of a Governor at Board sub-committee meetings is to observe the work of the Committee. The Governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe Non-Executive Directors appropriately challenging the Executive Directors for the operational performance of the Trust. At the meeting the Governor observer(s) will be required to declare any interest they may have in respect of any of the items to be discussed.

3 Quoracy

Number: The minimum number of members for a meeting to be quorate is three, two of whom must be Non-Executive directors. Attendees do not count towards quoracy. If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by one of the other Non-Executive directors.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal “acting up” arrangements.

A schedule of deputies, attached at appendix 1a, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 Meetings of the Committee

Frequency: The Committee will meet at least six times a year.

Urgent meeting: Any member of the Committee may request an urgent meeting.

Minutes: The Committee Secretariat will be provided by the Executive Support Team.

Assurance and Escalation Reporting: The Chair of the Committee will provide an update of key issues arising from the meeting to the next Board of Directors meeting.

Voting: It is at the discretion of the Chair of the meeting to call a vote during a meeting. When voting, decisions at meetings shall be determined by a majority of the votes of the Executive and Non-Executive Directors present and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

5 Authority

Establishment: The Committee is a sub-committee of the Board of Directors and has been formally established by the Board.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Committee is a standing Board sub-committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually.

6 Role of the Committee

a. Purpose of the Committee

The overall aim of the Committee is to monitor, review and report to the Board the adequacy of the Trust's processes to support the operation of mental health legislation.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Committee

In carrying out their duties members and attendees of the Committee must ensure that they act in accordance with the values of the Trust, which are:

- we care
- we listen
- we deliver.

b. Duties of the Committee

The Committee's key objectives are to:

- monitor, review and report to the Board of Directors on all aspects of mental health legislation
- receive assurances against Care Quality Commission (CQC) inspection action plan and routine CQC related activity
- be assured that there are systems, structures and processes in place to support the operation of mental health legislation, within both inpatient and community settings and ensure compliance with associated codes of practice and recognised best practice
- be assured that our care and treatment in the Trust embraces the core values of current mental health legislation and protects service users and the community of which they are members

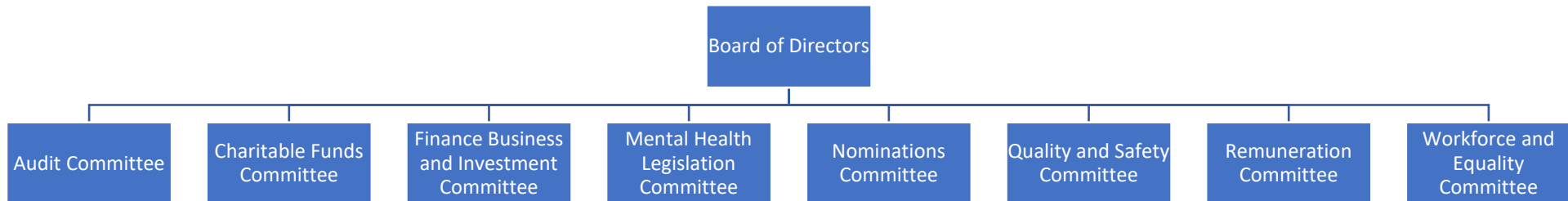
- be assured that the Trust has in place and utilises appropriate policies and procedures in relation to mental health legislation and to facilitate the publication, distribution and explanation of the same to all relevant staff, service users and manager
- be assured that Associate Hospital Managers and appropriate staff groups receive guidance, education and training in order to understand and be aware of the impact and implications of all new relevant mental health associated legislation
- to consider opportunities, challenges and requirements of our local place and regional health care systems and partnerships
- supporting the Trust's continuous improvement journey, both internal and external learning will be considered by the Committee. This will be within the remit as set out in the terms of reference and supporting work plan for the Committee who will be acting as an agent of the Board of Directors.

In particular the Committee shall review the adequacy of:

- the implementation and performance of operational arrangements in relation to mental health legislation through quarterly dashboard reporting of key performance indicators
- oversight of restrictive practices through the dashboard, exception reporting and a summary of actions taken by the Positive and Proactive Steering Group
- reports from inspecting authorities and the development of action plans in response to recommendations
- progress against any other action plans and any risks identified within the Corporate Risk Register relevant to mental health legislation
- analysis and information reports in relation to the use of the Mental Health Act and to make recommendations in response to findings
- the schedule of powers and responsibilities of the Associate Hospital Managers, including those powers and responsibilities delegated to officers of the Trust
- information provided to Associate Hospital Managers of their legal duties and appropriate training to support their duties under mental health legislation
- the process of recruitment, induction, appraisal and development of Associate Hospital Managers (through the Trust Chair and Chair of the Mental Health Legislation Committee)

- implementation and requirements of any new and amended mental health legislation, establishing groups to undertake detailed implementation work as required
- the provision of adequate guidance, information, education and training on mental health legislation to staff, service users, carers and other stakeholders
- joint working arrangements around the use of mental health legislation with partner agencies, notably including local authorities, other NHS commissioners and providers, and the police.

7 Relationships with other groups and committees



The Committee does not have any sub-committees. It is linked to the Trust’s operational groups as an assurance receiver and provides a route of escalation to the Board of Directors.

8 Duties of the Chair

The Chair of the Committee shall be responsible for:

- agreeing the agenda in partnership with the Chief Operating Officer
- directing the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the secretariat and checking the draft minutes
- ensuring the agenda is balanced and discussion is productive
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

9 Reviews of the terms of reference and effectiveness

The terms of reference shall be reviewed by the Committee at least annually and be presented to the Board of Directors for ratification.

It will be the responsibility of the Chair of the Committee to ensure that it carries out an assessment of effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The Chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

10 Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	Deputy (by job title)
Non-Executive Director Chair	Another Non-Executive Director
Non-Executive Director	Another Non-Executive Director
Non-Executive Director	Another Non-Executive Director
Chief Operating Officer	General Manager
Medical Director	Associate Medical Director

Attendee (by job title)	Deputy (by job title)
Deputy Director of Risk, Compliance and Nursing	Head of Quality Governance and Patient Safety
Corporate Governance Manager	Director of Corporate Affairs
General Manager – Mental Health Care Group	Assistant General Manager – Mental Health Care Group
Mental Health Legislation and Care Programme Approach Lead	Mental Capacity Act Lead Mental Health Act Advisor

Appendix 2

MENTAL HEALTH LEGISLATION COMMITTEE
ANNUAL ACTIVITY REPORT
1 APRIL 2019 TO 31 MARCH 2020**Executive Summary:**Review of the Mental Health Act

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 a White Paper outlining the proposed changes.

However, due to the Covid-19 pandemic the Covid-19 Act came into force in 2020 and with it came potential changes to the MHA. However, the MHA changes would not be enacted unless there was a National need and to date this has not been the case. Amendments that could be enacted outlined in the Act are: the possible use of only one medical recommendation for section 2 and section 3; extensions to the time permitted under Sections 135 and 136, and sections 5(4) and 5(2). Further amendments were outlined in relation to MHA Court Orders and measures were outlined allowing RCs to authorize treatments that would normally be authorized by a second opinion doctor (SOAD) from the CQC.

Whilst none of the above have been needed nationally, various other changes became necessary.

Changes due to Covid-19 restrictions

The **Mental Health Tribunal** (MHT) stopped all preliminary medical examination of patients prior to a tribunal. They also advised that they would not hear any appeals or referrals from patients in the community. Face to face tribunals were stopped and initially conducted via telephone. These proved problematic, and the tribunal moved to conducting hearings via video. Many difficulties in both methods ensued and are still being addressed.

The **CQC** stopped inviting patients to clinics (usually held in the hospital) in order to authorize treatments for both in patients and community patients. Instead, they now request information to be emailed to them by the MHA office and take telephone contact of professionals should they need to discuss issues. Certificates then follow electronically rather than via the post.

It was agreed that **hospital managers** would not consider appeals if the patient had a right to appeal to a tribunal. All renewals would be considered by way of a paper renewal. Panels are sent reports and patients are encouraged to also submit their views. These are considered and any questions they have are sent to the Chair who then forwards these to the MHA Advisor and on to the professionals. Responses are sent back to panel members who consider all they have read and make a decision based upon the information before them. This method has proved successful in the circumstances.

Digital signatures were approved on statutory documentation.

Approval was sought and given to allow Trust doctors to satisfy the requirement to “**personally examine**” a patient through **video communication** where necessary, enabling many aspects of the MHA to continue without detentions lapsing. These included for the renewal of community treatment orders, renewal of section 3, recommendation for section 3 where the patient was already on the ward, and authorizing treatment under the MHA.

Summary of Mental Health Act activity

The report 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** took a sharp rise following the Supreme Court Judgement in 2014 and is now more than three times the pre 2014/15 level.

The use of **Section 3** rose by over 50% initially, and this higher level has remained consistent over each of the following years.

There has been a marked increase in the use of **Section 136** and commentary is included as to how this is being addressed.

There has been a slight drop in **tribunal activity** over the past 3 years, following a steady increase prior to this. We believe this could be due to a faster turnaround of patients within the hospital and the change to the in patient model where the consultants are now on the wards daily.

Whilst there had been a steady drop in **hospital manager appeals** over the last 9 years this was just beginning to be addressed in order to ensure patients’ rights were upheld and this year saw a 60% increase over the previous year of appeal cases being heard.

The number of **hospital manager renewals** considered remain almost the same over the last 4 years, with hearings relating to Community Treatment Orders (most of which are CTO renewals, representing 39% of all cases heard by them.

Mental Health Legislation Annual Report 2019/20

1. Introduction

- 1.1 This report provides the Committee with an overview of Mental Health Act activity for the period 1st April 2019 to 31st March 2020.

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 The Trust recruited six new hospital managers in 2019 bringing the total to 22. This gives sufficient numbers available to make up panels for patient appeals and reviews. New members are invited to observe at least two hearings prior to sitting as a panel member, and are always teamed up with two experienced members.
- 2.4 At the request of the Committee, hospital managers were asked to provide a brief pen portrait, which we hope will give the Committee some assurance that members are carefully chosen from a variety of backgrounds and skill sets. The pen portraits will be submitted to the Committee of 21st May 2020.

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 **53 Appeals** and **136 Renewals** being lodged with hospital managers a total of 189 cases.
- 4.2 In total **121 hearings** took place (**25 appeals and 96 renewals**).
- 4.3 Of the 25 appeals heard, 19 (76%) were denied and 6 (24%) were discharged.
- 4.4 Of the 96 renewals heard, 90 (94%) were renewed, 5 (5%) were discharged and 1 (1%) was adjourned.
- 4.5 Combining the outcome rate of all manager hearings, i.e. 121 heard, with 11 clients discharged, the discharge rate is 9%.
- 4.6 Nearest relatives exercising their right to order the discharge of their relative has remained relatively high at 26 for this financial year. Of these 8 were regraded to informal status by the RC, 12 were barred, 1 lapsed in error, 3 the relative withdrew, and 2 proved not to be valid.

Of the 12 cases that were barred only 5 had a hospital manager hearing. These hearings resulted in only one being discharged. This would indicate that the RCs consider very carefully the extra criteria needed before barring the request which the hospital managers upheld.

The Code of Practice requires hospital managers to consider barring orders only if deemed appropriate. Of the cases where the managers did not consider the barring order, this was due to a number of reasons. One case not heard was because the nearest relative had felt under duress to make the request; one case was because the nearest relative was displaced under Section 29 by the Court as unsuitable to act in this capacity; and a number of cases where the RC made the patient informal before a hearing could take place due to an improvement in the patients' presentation.

4.6 Hospital Managers Appeals and Renewals Activity Summary Table for past 10 years

Requests rec'd	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Appeals	212	201	207	120	105	118	107	63	60	53
Renewals	65	91	125	138	152	168	131	138	138	136
Total rec'd	277	292	332	258	257	286	238	201	198	189
Not Heard	134	147	165	114	99	75	107	86	87	71
Re-grade Prior by RC	55	66	66	43	50	37	49	37	45	34
Withdrawn	27	32	34	13	11	9	17	6	5	5
Other Reasons*	52	49	60	58	38	29	41	43	37	32

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

CTO terminated (22)

Lapsed (2) – 1 x whilst patient abroad + 1 x patient didn't attend review appointment

Section 29 extension by Court (1)

Placed onto CTO (1)

Hospital Manager diary error (1)

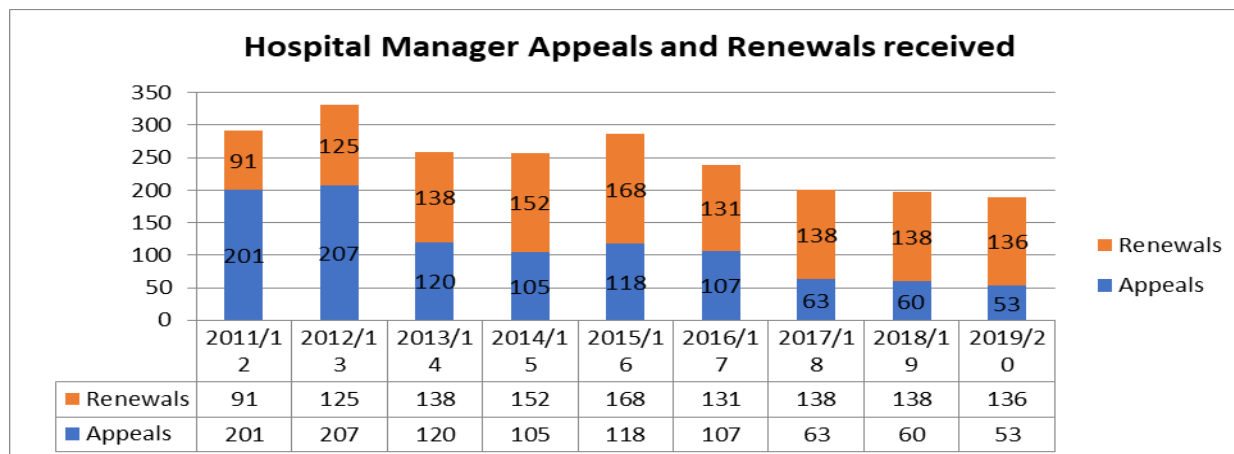
No care co-ordinator attended (2)

Discharged by MHT prior (2)

Unable to set due to RC availability (1)

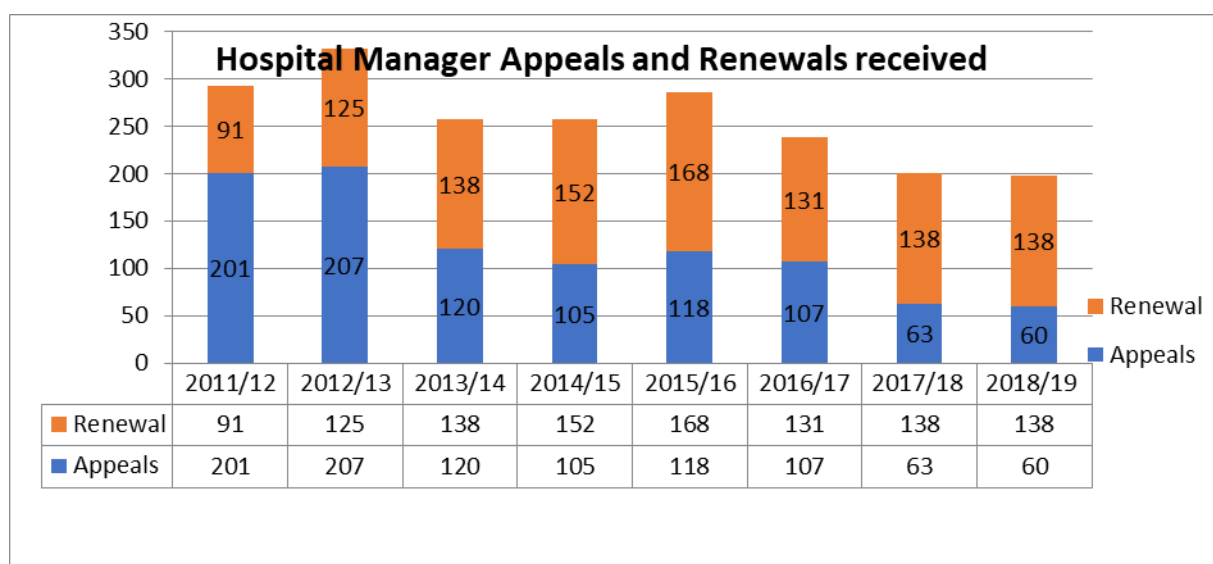
Outcome of cases heard

Appeals	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Heard	102	104	65	39	40	40	36	12	15	25
Denied	84	86	50	32	31	34	28	11	12	19
Adjourned	10	7	2	1	1	0	0	0	0	0
Discharged	8	11	13	6	8	6	8	1	3	6
Renewals										
Heard	32	41	102	105	118	126	95	109	96	96
Renewed	19	37	98	101	110	118	95	108	90	90
Adjourned	7	1	2	0	2	1	0	0	2	1
Discharged	6	3	2	4	6	7	0	1	4	5



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. Both the numbers received and the numbers heard have dropped slightly in the last 4 years. This could be as a result of patients being discharged more quickly from hospital.



5.3 Of the 398 requests processed, 222 were heard and 176 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 114 (65%) 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 38 (22%) 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 222 heard, there were 194 (87%) not discharged, 24 (11%) discharged, 4 (2%) adjourned. A breakdown of the 24 discharged is as follows:

- 7 were Section 2s
- 6 were Section 3s
- 4 were CTOs
- 7 were Section 37/41 restricted by the MOJ

As 20 of the 222 cases were restricted cases and 7 of these were discharged it means the discharge rate for restricted cases was 35%.

Of the remaining 202 cases heard that were not restricted 17 were discharged which relates to 8%

It is difficult to give an exact comparison of discharge rates by hospital managers as opposed to those discharged by the Mental Health Tribunal (MHT), however, if we exclude the restricted cases (where the RC has no power to discharge) then the hospital managers discharged 9% of cases whereas the MHT discharged 8% of cases.

Whilst it is still not an exact comparison, it relates to the same section types, i.e. sections 2, 3, 37 and CTO which both bodies consider. Both bodies consider appeals from these section types, however, the MHT also consider cases referred to them which the hospital managers don't and the hospital managers consider renewals which the MHT don't.

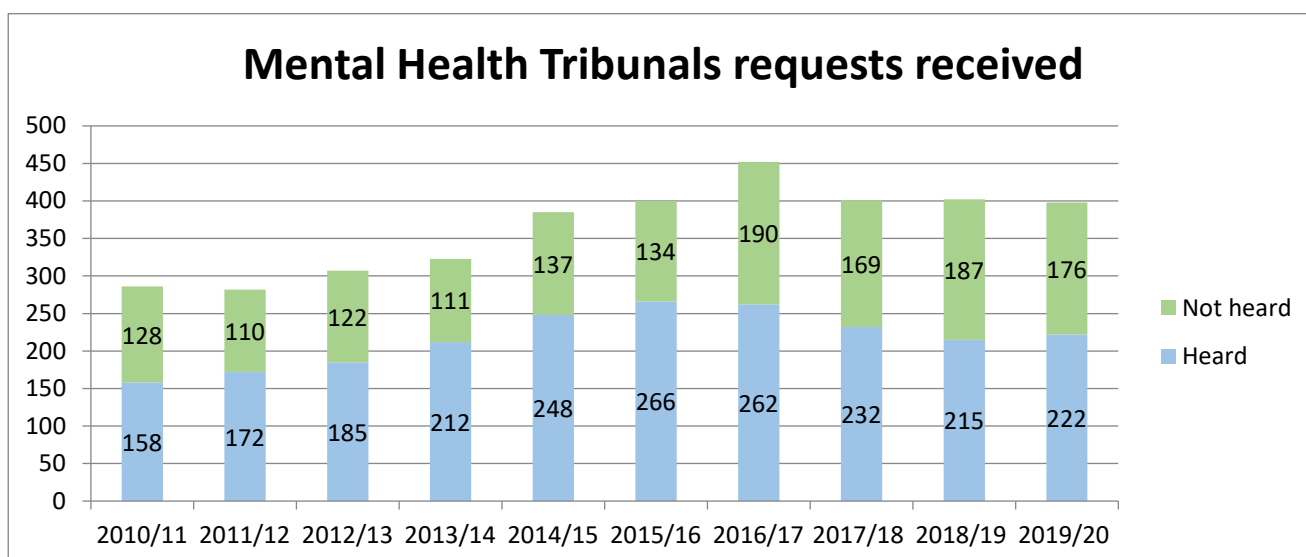
5.4 Tribunal Activity for the past 10 years is shown below:

	Year :									
	2010 /11	2011 /12	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20
Requests rec'd	286	282	307	323	385	400	452	401	402	398
Not Heard	128	110	122	111	137	134	190	169	187	176
Re-grade by RC	64	53	74	54	84	89	123	107	122	114
Re-grade by AHM	0	6	11	6	2	4	3	0	3	2
Withdrew	40	41	29	32	30	26	43	48	46	38
Transferred	11	4	7	10	8	3	3	0	1	4
Adjourn/Re-listed	6	4	1	9	8	6	10	1	5	3
Placed on CTO	5	0	0	0	0	1	0	0	0	0
*Other reasons	2	2	0	0	5	5	*8	*13	*10	15

***Other reasons tribunal not heard:**
CTO terminated (2)

Outcome of cases heard

Heard	158	172	185	212	248	266	262	232	215	222
Not Discharged	137	160	163	196	212	237	237	205	184	194
Discharged	16	9	12	9	23	20	19	24	18	24
Adjourned	5	3	10	7	9	5	6	2	13	4
Other	0	0	0	0	4	4	0	0	0	0

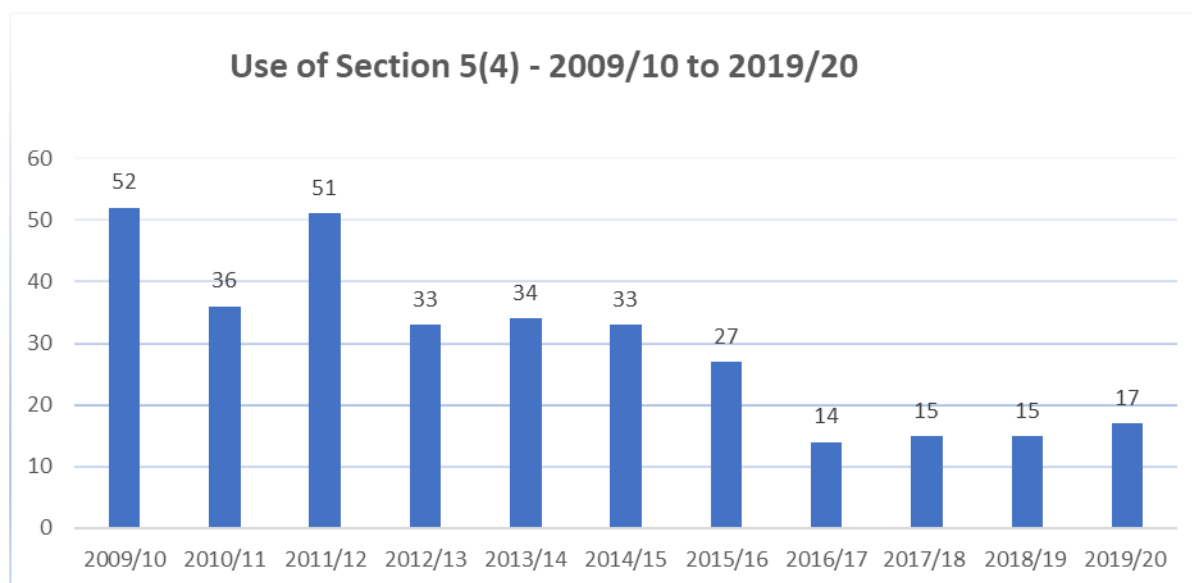


6 Activity data for key sections

Detailed below is the MHA activity for BDCFT

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.

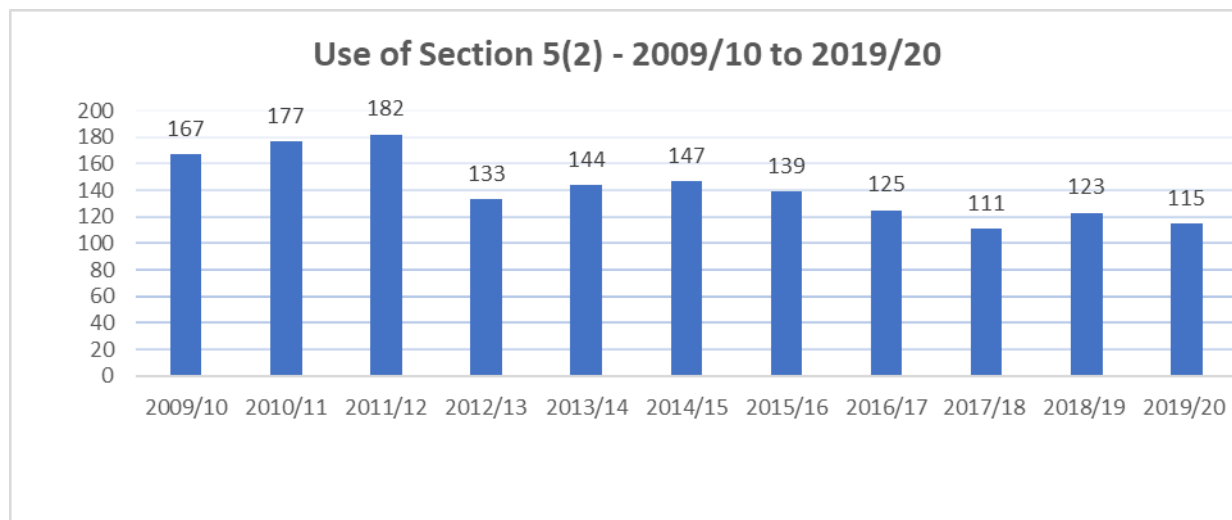


Comments

Although there has been a slight projected increase this year, the use of Section 5(4) overall remains relatively low in comparison to years prior to 2016/17. 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.

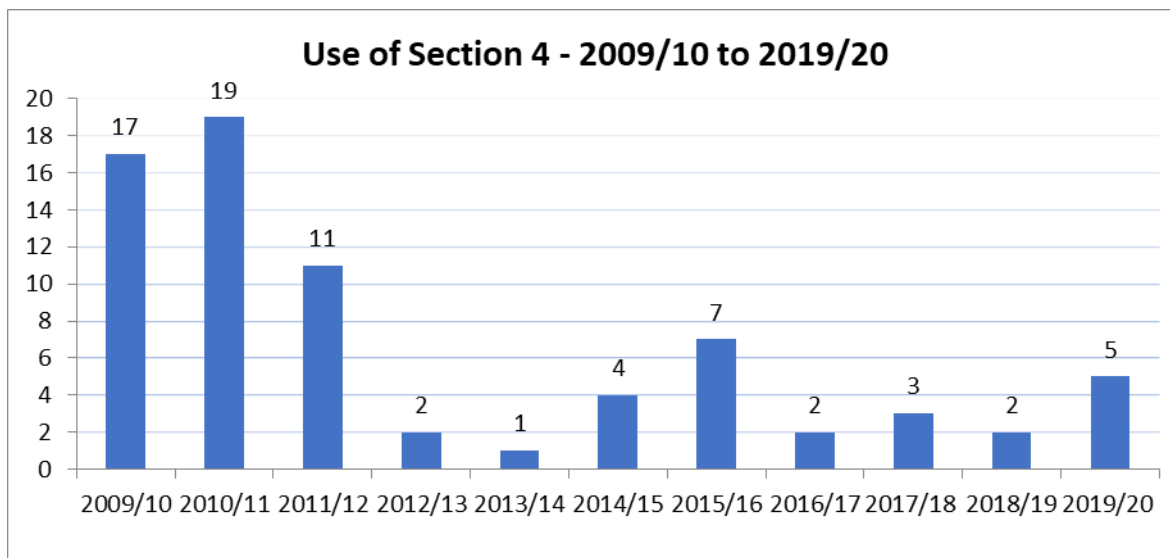


Comments

The use of Section 5(2) has dropped slightly in the years since 2014/15. The admitting professionals must consider the least restrictive option in regard to admission. The 5(2) is used when there is a change in presentation in the patient's mental health later in the delivery of their care. If the patient is 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.

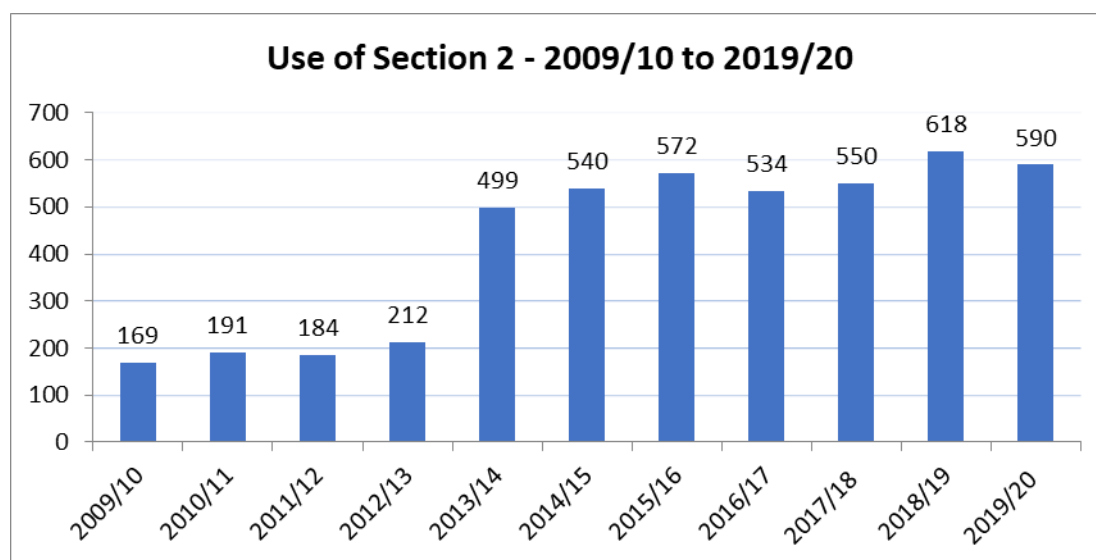


Comments

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



Comments

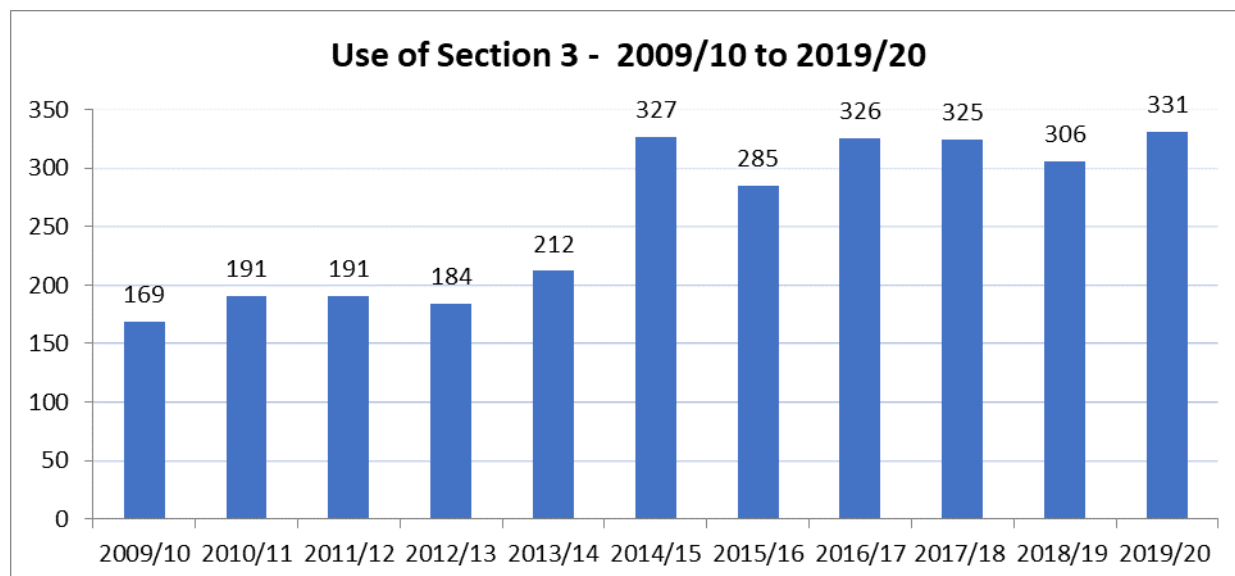
The use of Section 2 has remained at a high level since its sharp increase in 2013/4. This is directly as a result of the Supreme Court ruling which defined “deprivation of liberty” as applying to anyone who was under continuous supervision and control and not allowed to leave. This definition defined 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 regard to the choice professionals sometimes have as to whether Section 2 or Section 3 is the most appropriate, the AMHPs, who are responsible for making the applications, generally 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 over 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.

In addition to use of the MHA to authorize a deprivation of liberty, there have this year also been 21 patients subject to the Deprivation of Liberty Safeguards (DoLs). Each of these patients had previously been subject to a Section 2 of the MHA, but once settled, a DoLs became the most appropriate option rather than a Section 3.

6.6 New sections per month

	April 19	May 19	June 19	July 19	Aug-19	Sep-19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	March 20	Total	
Numbers of new detentions received														
Section 5(4)	1	2	2	0	1	3	3	1	0	1	2	1	17	
Section 5(2)	16	9	10	10	14	9	12	5	4	7	9	10	115	
Section 4	0	0	0	0	0	1	1	1	0	1	0	1	5	
Section 2	48	56	50	55	61	55	48	43	40	51	41	42	590	
Section 3	29	23	27	17	31	26	40	29	30	27	29	23	331	
Sections: 35, 36, or 38	0	0	0	0	0	0	0	1	0	0	0	0	1	
Section 37	1	1	0	0	0	0	0	0	0	0	1	0	3	
Section 37/41	0	2	3	1	1	0	1	0	1	2	1	1	13	
Section 47/49 + 48/49	1	0	1	1	0	1	0	1	1	1	0	0	7	
New CTOs in Month	9	4	4	4	8	2	2	6	5	5	2	2	53	
Total per month	105	97	97	88	116	97	107	87	81	95	85	80	1135	

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 19	16	6	10	0	0	9	2	4	0	1	0	4	4	5	3	9	7	16
May 19	26	11	15	0	0	13	2	11	0	0	0	10	8	6	2	10	16	26
June 19	26	4	22	0	0	14	1	10	0	1	0	11	9	5	1	17	9	26
July 19	27	10	17	0	0	17	2	7	1	0	0	11	9	6	1	12	15	27
Aug 19	28	12	16	0	0	16	2	10	0	0	2	13	7	4	2	16	12	28
Sept 19	20	9	11	0	0	10	3	7	0	0	1	8	3	5	3	7	13	20
Oct 19	40	23	17	0	0	28	3	9	0	0	0	15	16	6	3	20	20	40
Nov 19	28	16	12	0	0	20	1	7	0	0	2	14	8	3	1	15	13	28
Dec 19	30	12	18	0	0	23	3	4	0	0	1	14	7	7	1	13	17	30
Jan 20	37	23	14	0	0	28	2	7	0	0	1	17	13	3	3	15	22	37
Feb 20	25	9	16	0	0	20	3	2	0	0	1	7	10	6	1	18	7	25
Mar20	25	11	14	0	0	16	5	4	0	0	2	11	8	4	0	12	13	25
Total	328	146	182	0	0	214	29	82	1	2	10	135	102	60	21	164	164	328

**Analysis of Section 136 data for the period
01.04.19 to 31.03.20:**

There has been a steady increase in the use of Section 136 over the last few years. There were 328 Section 136 episodes in this financial year, an average of 27 per month.

This compares to:

328 in 2019/20
197 in 2017/18
177 in 2016/17
167 in 2015/16

- 45% (146) came to Lynfield Mount Hospital;
- 55% (182) came to Airedale Centre for Mental Health;

Outcomes:

- 66% (214) of S136s were terminated
- 25% (82) were admitted under Section 2 or Section 3
- 9% (29) were admitted informally
- 50% (164) were male
- 50% (164) were female

Age Profile:

- 3% (10) were aged under 18
- 41% (135) were aged 18-30
- 31% (102) were aged 31-45
- 18% (60) were aged 46-59
- 7% (21) was aged 60 and over

Comments:

Due to the increase in the number of section 136s, a plan was agreed between the police force and the Mental Health Trust to develop a system of jointly working and signposting service users away from the use of section 136 where it is safe to do so.

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 (39%), are to consider Community Treatment Orders.

Period	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 – Mar 19	April 19 – March 20	
New CTOs	54	45	51	62	53	64	55	40	53	
CTO Hearings to HMs	25	63	65	61	72	60	66	61	48	
Section hearings to HMs	45	98	74	90	92	71	55	50	73	
Total HM hearings	74	167	143	158	169	131	121	111	121	
% CTO hearings	34%	38%	45%	39%	42%	46%	55%	55%	39%	

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 36 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.

In the last half year year, 20 of the 36 recalled clients had their recall ended within 72 hours and returned to the community and 16 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 22 clients had their CTOs terminated due to improved insight and an improvement in their mental health.

7. Use of Deprivation of Liberty Safeguards

Twenty-two new Deprivation of Liberty Safeguard (DoLs) applications were made in this financial year.

This compares to:

22 in 2019/20
15 in 2017/18
1 in 2016/17
None in 2015/16

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.

The appropriateness of each DoLs case is monitored by the MCA Clinical Lead.

It is to be noted that DoLs regime is due to be replaced by the new Liberty Protection Safeguards (LPS), though the proposed start date for this of 1st October 2020 is likely to be extended.

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.

MHA Activity at Bradford Royal Infirmary:

Use of Section 5(2) - 40
Use of Section Two - 24
Use of Section Three – 5

The use of Section 2 in the BRI has increased significantly as this compares to only 7 cases in the full year in 2018/19. This is believed to be due to difficulty in obtaining a mental health bed at the time of the MHA assessment.

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 sessions are provided each year by the MHA Advisor.

MHA Activity at Airedale General Hospital:

Use of Section 5(2) – 20

Use of Section Two – 7

Use of Section Three – 4

The use of Section 5(2) has increased to 20 occasions, compared to 13 in the previous period last year; however, the numbers are still relatively small and of no concern.

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.