Bradford District Care
NHS Foundation Trust

Agenda Item
23.4

Mental Health Legislation Committee

Annual report

1 April 2022 to 31 March 2023

Contents

1 Period covered by the report

The report covers the period from 1 April 2022 to 31 March 2023.

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 2022/23. 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 Office of the Chief Executive and the Chair of the Trust, 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.

In March 2022, the strategic objectives to be included in the BAF were refreshed in line with the Chief Executive's in year priorities. These remain aligned to the high-level strategic priorities of the Trust – Best Place to Work, Best Quality Care, Healthy and Possible and Seamless Access but describe the key areas of focus for 2022-23.

The Lead Executive for each strategic objective reviews their specific objective(s) and the risk(s) associated with it and updates the controls and assurances associated with those risks on a monthly basis. Any organisational high risks linked to the BAF strategic objectives are also identified in the BAF summary with relevant narrative where a risk has changed or been archived for the relevant committee to view.

There are no Strategic Objectives aligned to the Mental Health Legislation Committee

The Committee still reviews the summary of 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.

Coronavirus Pandemic and effect on the Committee work.

The Committee continued to meet throughout the pandemic during 2022/23, but all meetings were held on Microsoft Teams. The emphasis moved to exception reporting, rather than detailed discussions, as Coronavirus pressures and controls eased and systems to manage any outbreaks worked effectively.

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 July 2022.

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

4 Meetings of the group / committee

The Committee met on six occasions. The dates were: 26 May 2022, 21 July 2022, 22 September 2022, 24 November 2022, 26 January 2023 and 23 March 2023.

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 (NED). All meetings in the period were quorate.

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

Substantive Members:

Name:	Position:	26 May 22	21 July 22	22 Sept 22	24 Nov 22	26 Jan 23	23 Mar 23	Total
Simon Lewis	Non-Executive Director (Committee Chair)	X	✓	✓	✓	✓	✓	/6
Alyson McGregor, MBE	Non-Executive Director (Committee Deputy Chair)	✓	X	✓	X	✓	✓	/6
Carole Panteli	Interim Trust Chair (until August 22) and Non-Executive Director	✓	X	X	✓	✓	✓	/3
Andrew Chang	Non-Executive Director		✓					1/1
Linda Patterson	Non-Executive Director (Trust Chair)						X	
Therese Patten	Chief Executive						X	
Dr David Sims	Medical Director	X	✓	✓	X	✓	✓	/6
Phillipa Hubbard	Director of Nursing, Professions and Care Standards	✓	X	X	X	✓		/6
Tafadzwa Mugwagwa	Interim Chief Operating Officer (until Sept 2022)	✓	✓	✓				3/3
Kelly Barker	General Manager MH Care Group (until Sept 22) Interim Chief Operating Officer (from October 22)	X	✓	X	✓	✓	✓	/6

*Mrs Panteli continued as Acting Trust Chair role until August 2022.
*Mr Tafadzwa left the Trust in September 2022
*Mrs Barker changed roles from General Manager. Mental Health Care Group in October 2022 to take on the Interim Chief Operating Officer role

Others in Attendance :

Name:	Position:	26 May 22	21 July 22	22 Sept 22	24 Nov 22	26 Jan 23	23 Mar 23	Total
Dr Suresh Bhoskar	Consultant Psychiatrist	X	X	X	✓	X	X	1/6
Simon Binns	Mental Health Legislation and Care Programme Approach Lead	✓	✓	✓	✓	✓	✓	6/6
Sue Grahamslaw	Corporate Business Manager (Committee Secretariat) (left March 2023)	✓	✓	✓	✓	✓		5/5
Fran Stead	Trust Board Secretary (Observer in Nov 24) In attendance from Jan 2023				✓	✓	✓	3/3
Helen Robinson	Deputy Trust Secretary / Corporate Governance Manager (attendance up to and including item 10)	✓	✓	X	X	X	X	2/6
Keith Double	Involvement Partner	✓	✓	✓	X	✓	✓	6/6
Karan Essien	Involvement Partner	X	X	✓	✓	✓	✓	4/6
Chrissie Freeth	Associate Hospital Manager		✓		✓		✓	3/3
Ruby Bhatti OBE	Associate Hospital Manager	✓		✓		✓		3/3
Joanne Tiler	Mental Capacity Act Clinical Lead	✓	X	✓	✓	✓	✓	5/6
Teresa O'Keefe	Mental Health Act Advisor	✓	X	✓	✓	✓	X	4/6
Dr Anita Brewin	Head of Psychological Therapies	✓		X	✓	✓	✓	4/5
Chris Dixon	Head of Nursing – Mental Health		✓	X				1/2
Baljit Kau Nota	Local Authority Social Worker	✓	X	X	X	X	X	1/6
Adbul Karim	Local Authority Social Worker	✓	X	X	X	X	X	1/6
Chris Hunt	Head of Kaizen Promotion Office (KPO)		✓	✓	X	X	X	2/5
David Gibson	Compliance & Governance Manager, Estates & Facilities							1/1
Thabani Songo	Operations Service Manager – Adult Inpatient Service		✓					1/1
Chioma Obasi	Operational Support Manager			✓				1/1
Carly Driscoll	Carer Experience & Involvement Manager				X	X	X	0/3
Grainne Eloi	Interim Director of Nursing, Professions and Care Standards				X			0/1
Cathy Schofield	Allied Health Professions Lead (Observer)	✓						1/1
Susan Francis	Staff Governor (non-clinical) (Observer)				✓			1/1
Zahir Irani	Governor (Appointed Bradford University)						X	0/1

6 Reports made to the Trust Board

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

Date of meeting: 26 May 2022

Key escalation and discussion points from the meeting
Alert:
• No items to escalate
Advise:
• Terms of Reference were approved -key change of exec lead for the committee to Medical Director from joint leads between COO and Medical director. • Although V& A reducing on wards focus needed and will be given on self-harming • In line with the principle of no force first, incidents of restrictive practices under review
Assure:
• The committee were assured that plans are in place to ensure performance across the dashboard with high levels of compliance on the training dashboard - Mental Capacity Act Training compliance is 96.12% and reduction in violence and aggression on wards • Sexual safety pilot on Heather ward successful and now being rolled out to all wards • The committee was assured that plans are progressing to recruit sufficient Associate Hospital Managers to fulfil this vital role • Development of app to monitor and govern use of blanket restrictions
Risks discussed: • National data suggests BDCFT is a high user of restrictions. Suggested that this references difference in data quality and local comparisons of like for like data are being sought.
New risks identified: • Concern re return to no smoking policy(driven by national policy) and impact on ward atmosphere, behaviour and restrictions. Historically linked to increase in AWOL and V&A incidents. Proactive steps to be taken to ensure risks are minimised.

Report completed by:
Alyson McGregor, MBE
Committee Chair and Non-Executive Director
26th May 2022

Date of the meeting: 21.07.22

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
• The Committee **("C")** agreed that no issue required urgent escalation.
Advise:
• C asked the team to consider (for the next meeting) whether additional information could be presented in relation to the **ethnicity** of service users subjected to restrictive practices (in the way that their sex is currently). • C was presented with – and scrutinised – the outcome and learnings from an interesting (anonymous) management-led survey (going beyond the scope of the annual national staff survey) into **"what does is it really feel like to work on these wards"**. The evidence indicated that: (a) staff welcomed this; (b) local management and leadership really matters to staff and can (when it is engaged, open and effective) make a big difference (including to their overall job satisfaction); (c) while there are some areas of outstanding practice, there are clearly some issues which require action (with further engagement being progressed). C would welcome an update, in 6 months, in relation to the same. • C heard and tested evidence in the context of a useful report, from management, regarding the "searching of patients and their property". Among other things, C noted evidence of a rise, on inpatient wards, of AWOL, the possession/use of **illicit substances**, and **self-harm**. Although the headline figures re incidents of violence and aggression had dropped, C heard that that could well be significantly **under-reported**. C would like a further report, in 12 months. It also asked for more granular information in some areas: e.g. in relation to reported sexual abuse/behaviour (which appeared, to C, to be too wide a category to enable C to properly understand the level of seriousness of such incidents). • It may be worth noting that attendance at this meeting, from a few regular attendees, was a little down – that is not a particular concern at this point, however, and C was quorate and effective in terms of the range/quality of input.
Assure
• C was grateful for the continuing input from its **involvement partners**: one was able to attend in person and made a significant contribution to the meeting; another made some excellent points and challenges in writing. • C continued (and shall continue) its innovative and progressive work, using the **"Care Trust Way"** change management methodology, with a specialist "coach", to seek ways to further improve its effectiveness. Ideas were discussed and developed, including for example in relation to further encouraging "the voice" of service users (perhaps through the engagement of an "advocate"). • C was presented with – and reflected upon – some interesting (further and ongoing) work and thoughts from the excellent **"Positive & Proactive Group"**.

Its findings and views were helpful to C and, among other things, provided further assurance in relation to the wider body of evidence it has to draw on.

- C obtained assurance re progress in relation to **"Hospital Managers"** (and was grateful for the continued engagement and contribution of this important group of people), most obviously in terms of a successful recruitment round and some additional support provided by the Trust. C shall continue to review whether this group has sufficient support.
- C scrutinised – as ever – the data and evidence regarding the use of **restrictive practices** within the Trust. It was satisfied that the now relatively long-term trend of relatively low and declining use of such practices had been maintained during the most recent period, on the evidence before it.
- C obtained assurance that (carefully considered and constructive) **feedback** had been provided to the government, on behalf of the Trust, regarding the consultation re changes to the Mental Capacity Act with regard to the creation of Liberty Protection Safeguards (formally DoLS).
- Various other matters – including some more administrative matters – were progressed or dealt with, appropriately, within the meeting.

Risks discussed:

- Board assurance framework and strategic organisational risk register noted/discussed.

Report completed by: Simon Lewis, NED, Chair of MHLC
Date: 31.07.22

Date of the meeting: 22.09.22

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert:

- There is a relatively significant issue regarding the timely production of **reports/ documents** for mental health tribunals and hospital manager meetings. Performance, which was already relatively weak, has declined further. Part of the problem appears to be that the Trust's (small) Mental Health Act team is and has been under some considerable resource pressure (running at around 20-50% capacity, in practice, due to long-term absence/capability issues). Additionally: other parts of the Trust and/or external stakeholders appear unable and/or unwilling to prioritise this (important) work to the extent required. The Committee **("C")** took the view that the Board, given some potential risks arising from the issue, needs to consider an intervention to: (a) provide a longer-term solution to the MHA team's resourcing issue (short-term resourcing options having been tried and, due to the nature of the work, been ineffective); and (b) to promote stronger compliance with the requirement to assist in the production of such documentation in other relevant parts of the trust.

Advise:

- There is an ongoing issue regarding the (availably, suitability and quality of) **physical space** in which (tribunal and associate hospital manager) hearings are conducted, especially as in-person hearings become the default option again, and especially in light of COVID-safety concerns. At Airedale, specifically: in the short-term, a room often usually used for "relaxation" by service users will be used instead, for (on average) one or two afternoons a week, for hearings. While an alternative space for relaxation will be provided, the proposed arrangement did not appear to C to be a good long-term solution. An action was agreed to consider any better longer-term alternative options.

- C received some feedback about how isolating/depressing it can feel, personally, as a mental health service user, to be in an **out-of-area service**.

- There was a combined **CQC** mental health act visit to the Airedale Centre for Mental Health – the outcome is unknown, as yet, but C will be updated in due course. It was noted that, unusually, CQC visited all three wards at the site – it is possible that a similar approach may be repeated at Lynfield Mount.

Assure

- C was again grateful for the continuing input from its **involvement partners**: they made useful contributions and offered important insights in relation to several matters.
- C scrutinised – as it always does – the data and evidence regarding the use of **restrictive practices** within the Trust. It was further satisfied, on the evidence, that the increasingly long-term trend of relatively low and declining use of such practices has been maintained during the most recent period. Heather and Oakburn appear to have been the worst-performing wards over the longer-term: but, notably, Oakburn appears, since March 2022, to have been able to transform its performance – it appeared to C that lessons could be learned from what appears to be its marked improvement.

- The majority of the newly appointed **associate hospital managers** have progressed, effectively, through an induction programme and are well-positioned to act in the role.

- Ongoing strong performance regarding many **metrics** covered in the "dashboard". **Training compliance**, for example, is in a relatively good place.

- C was updated on compliance regarding **consent to admission and treatment**. Most wards have showed progress and/or maintained a strong position (Heather and Oakburn appeared to be among those wards not performing as strongly as others, but the evidence was not in a form from which confident conclusions could be drawn).

- C analysed feedback from its members following a recent **survey**: the feedback was generally positive with some areas for improvement.

- Various other matters – including some more administrative matters – were progressed or dealt with, appropriately, within the meeting.

Risks discussed:

- Board assurance framework and strategic organisational risk register noted/discussed.

Report completed by: Simon Lewis, NED, Chair of MHLC
Date: 22.09.22

Date of meeting: 24.11.22

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
• The Committee **("C")** did not think any matters required a formal "alert".			
Advise:			
• Other comparable trusts have had similar issues re **timeliness of reports/documents** re tribunal and "hospital manager" hearings. Our service levels are more ambitious than some. Consideration to be given to the most appropriate service levels. • An **involvement partner** shared some concerns from other service users about their own personal experiences as service users. Interim COO agreed to follow up, with a view to understanding more, taking any appropriate action, and reporting back to C. • A judge (of a tribunal hearing) requested an alternative **room for a hearing**, on the basis that the allocated room was considered unsuitable. • C was updated that, following the specific escalation/alert raised by C in its previous report, there had been some positive discussions, and a proposal for **additional resource** was in the process of being submitted.			
Assure:			
• The **dashboard data** was considered/scrutinised. • C received a useful update (on matters such as "low holds", use of force generally, and some work regarding sexual safety) – which helped C to "triangulate" data – from the **Positive and Proactive Forum**, which continues to do some excellent work. • C discussed, and obtained reasonable assurance in relation to, an update re recent **CQC monitoring visits** and the action plan in response to CQC feedback. • C considered an interim report re the **Mental Capacity Act** (focused on the inpatient audit and improvements).			

• C discussed the half-year report re the Mental Health Act activity. C asked for some further information, within future iterations, re benchmarking, if available. • The meeting was observed by at least one member of staff for developmental purposes. C remains keen to be open and transparent in its work, and to encourage and support career progression.
Decisions / Recommendations:
• Approved report re Hospital Managers. • Approved half-year report re Mental Health Act activity (subject to a matter relating to "gender descriptors" being reviewed). • Approved outline plan re Audit Items.
Risks discussed: • Board assurance framework and strategic organisational risk register noted/discussed.
New risks identified: • Nothing material at board level

Report completed by:

Simon Lewis
Committee Chair and Non-Executive Director

23.12.22

Date of meeting: 26.01.23

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
• The Committee **("C")** did not think any matters required a formal "alert".			
Advise			
• Good/useful update from the **Associate Hospital Managers** on matters including: (a) changes to the way decisions are given, orally, to service users, following remote hearings on MS Teams; (b) provision of laptops for hearings; (c) agreement on revision to the target for papers to be ready in advance of hearings (from 3 days to 2) and for that to be monitored; (d) increase in number of face-to-face hearings; and (e) a sufficient understanding of good practice regarding data retention. • **Involvement partners** raised a couple of matters: (a) potential barriers to service users being involved in research programmes; (b) the definition/application of "ethnic minorities" term.			

- Helpful update on the **draft mental health bill**, its development and likely scope.

Assure

- The **dashboard data** was considered/scrutinised. Performance generally in line with expectations in key areas (e.g. "sections" considered to be free from errors, data regarding training, use of restrictions/interventions, etc). While there was a dip in training performance data, that was explained by changes in the pool of those requiring training (to include more "bank" workers).
- C received another useful update – helping C to "triangulate" data – from the **Positive and Proactive Forum** – no overall rise in incidents – positive feedback re new role/appointment (PTU lead) – ongoing emphasis on being ambitious re continuous improvement in this important area. Satisfactory explanations provided regarding the use of 2 prone restraints in the relevant time period.
- **Mental Capacity Act** update report provide and noted. Completed audit results expected to be presented to "Clinical Board" next month and then, to C at its next meeting.
- While it could not be ruled out, no material adverse impact was expected, in the coming period, on issues relevant to C, from (a) Covid-19 or (b) industrial action.

Decisions / Recommendations

- **Associate Hospital Managers** report approved.
- Previous minutes approved.

Risks discussed:

- Board assurance framework and strategic organisational risk register noted/discussed.

New risks identified:

- Nothing material at board level

Report completed by:

Simon Lewis
Committee Chair and Non-Executive Director

28.02.23

Date of meeting: 23 March 2023

Report to the: Board of Directors

Key escalation and discussion points from the meeting			
Alert	**Action (to be taken)**	**By Whom**	**Target Date**
1. C did not consider any matter arising from the meeting to require a formal alert – but note 2, below, in particular.			
Advise:			
2. Medical Director raised a recent issue and requested the Board be informed. **14-year-old** ("P") arrived in 136 Suite**.** Following review, P did not meet criteria to be further detained under Mental Health Act. P was, however, held another week, on the order of a judge. The Trust worked with ICB and Local Authority to identify a placement (making strong representations); but very few national placements available in the East of England. Next potential placement, in Bradford, was on 03.04.23. By then, P would have spent 2 weeks in the suite. Highlights the difficult position for young people with complex conditions, in Bradford, re high-intensity Local Authority beds. In addition, there was an adverse impact on the Trust's ability to provide 136 "places of safety".			
3. Restrictions in relation to **restraints on female patients** down, significantly, in January; but full restraints, on females, relatively high in February. The new lead in this area is undertaking a "deep dive" to assess and consider necessary action (C will be kept updated). Exploration, within C, regarding causal/contributory factors. Further, C suggested that an audit, conducted 18 months or so ago, about the time of day when incidents tend to occur, be repeated.			
4. Mental health legislation **training metrics** showed a slight drop in some areas; but still above target and C was satisfied that the drop was due, primarily, the introduction of additional (bank) staff and impact of half-term holidays.			
5. C reflected on the committee **effectiveness data**/feedback.			
6. C continued to seek, and receive, useful feedback from **involvement partners**. One interesting point raised related to the risks associated with **AI** (artificial intelligence) and the Trust's approach to managing the same.			
7. C's **Chair** has been appointed part-time judge of the mental health tribunal. This should assist the work of C. He will, of course, not sit on hearings at the Trust (to avoid a conflict of interest).			

Assure:

8. Positive feedback from Associate **Hospital Managers** representative regarding the provision of laptops for hearings. Challenges made, by C, about management of security risks in face-to-face hearings – partial assurance obtained (e.g. about systems in place) – agreement that risks be considered further at next AHM meeting.

9. Core data within the **Dashboard** in line, broadly, with expectations.

10. Regarding the **Mental Capacity Act**: (a) weekly audits working well; (b) coaches embedded in wards; (c) clinical audit results are positive. C challenged that "best interest assessments" appeared, still, to be a relatively difficult area; C was told that further training would be provided.

11. 1 unannounced **CQC** Mental Health Act monitoring visit occurred this period, on Clover Ward PICU. Action statement not yet received; but generally positive feedback provided. Some actions anticipated. C told that the Trust's team is being pro-active in relation to this and more generally with CQC. Trust response to be submitted by 12.04.23.

Decisions / Recommendations:

12. C approved:

    (a) The annual review of C's "terms of reference", including the amendments proposed within it.
    (b) C's annual review document, making some additions (e.g. to emphasise the importance placed on the engagement of involvement partners in C's work).
    (c) C's interim workplan.

Risks discussed:

- See above.

New risks identified:

- N/A

Report completed by:
Simon Lewis
Committee Chair and Non-Executive Director
03.05.23

7 The work of the committee or group during the year 1 April 2022 to 31 March 2023

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.

Mental Health Act Monitoring Reviews by the Care Quality Commission changed during to the Pandemic and had moved to a remote review system in 2020. This continued into 2021, however in 2022 the CQC picked up their pace and re-introduced “in-person” reviews. The Committee were presented with updates from each visit. Some visits required no actions, others had recommendations and the Committee were assured that through the local In Patient QUOPs meetings, any areas requiring follow-up were being actioned.

The Committee was given assurances that how Interpreter services are accessed and how the Service level Agreement meetings between the Head of Equality and Work Experience and Enable” managers have ensured that issues of training, development and the quality of interpreters provided to the Trust are kept under close review.

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. Overall compliance had been affected by staff shortages within the MHA Department and providing reports with a greater window than was actually needed (reports were circulated 3 days prior to a hearing. Across the region the average was 2 days. We have implemented that time window locally too). Now that window has been reduced compliance has improved and eased the pressure on the MHA Dept.

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 2023 and the 12-month activity report is attached at **Appendix 2**.

8 Annual Effectiveness Review Summary

The online Mental Health Legislation Committee Effectiveness Review survey was circulated by the Corporate Governance Team to members and attendees of the Mental Health Legislation Committee on 25 January 2023 for completion by 3 February 2023.

The survey comprised a set of standard questions on a satisfaction rating scale, some of which were relevant to all Board Committees and some which were specific questions related to the Mental Health Legislation Committee's Terms of Reference. Most questions were based on the satisfaction rating scale but there was opportunity for respondents to provide additional feedback at various points in the survey.

Approximately half of those asked to complete the survey responded (9 out of 21) – a similar response rate as 2022.

Top-line results indicate that the Committee is considered to work effectively.

There have been improvements since last year in the following areas:

- The format, content and timeliness of reports;
- Time for discussion and debate on the papers when that have been presented.

The facility for providing additional feedback was used by some people which enriched the data with constructive comments and suggestions, including areas where further work should be considered, such as:

- *Committee Operation*: Review of the discussions that had taken place within the meeting – whilst it is acknowledged this happens at the end of the meeting, it may be helpful to summarise at other points.
- *Committee Membership*: training of new members to assist them in performing their roles effectively – especially in the role of Hospital Managers; ensuring members have sufficient knowledge of the Trust to identify and challenge key risk areas.
- *Terms of Reference*: Awareness and understanding of Trust's policies and procedures as these are approved at subgroups, rather than at Committee level. This ties in with the suggestion of improved training of new members.

However, attention was also drawn to some Committee strengths which continued to be:

- The feeling of support and inclusivity;
- Feeling able to participate and subsequently being listened to in meetings;
- The flexibility of the agenda to ensure pertinent items are given due attention;
- Effective communication with the Board.

It should be noted that these strengths align with the Trust values of We Care, We Listen, We Deliver.

Full details of the findings were presented to the committee at the meeting on 23 March 2023

9 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 2022/23. 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

5 May 2023

Simon Lewis
Non-Executive Director and Chair of the Mental Health Legislation Committee

Mental Health Legislation Committee

Terms of Reference 2022-23

Version:	14
Approved by:	Mental Health Legislation Committee
Ratified by:	Board of Directors
Date approved:	26 May 2022
Date ratified:	14 July 2022
Job title of author:	Mental Health Legislation and Care Programme Approach Lead, and Corporate Business Manager
Job title of responsible Director:	Non-Executive Director and Chair of the Mental Health Legislation Committee
Date issued:	
Review date:	31 March 2023
Frequency of review:	Annual

Amendment Summary:

- Change of Executive Lead for Committee to Medical Director from joint leads between Medical Director and Chief Operating Officer. (Section 2)
- Addition of section relating to Executive and Non-Executive Director posts being filled on an interim basis and they will be Committee members for the duration of their interim post (Section 2)
- Minor change to title of Corporate Business Manager (losing reference to interim status)
- Change to Committee Secretariat support from Executive Support Team to Corporate Governance Team (Section 4)
- Reference to receiving updates from Positive & Proactive Steering Group and Associate Hospital Managers Group added under Section 7
- Change to Chair agreeing agenda with the Medical Director rather than the Chief Operating Officer (Section 8)

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
Medical Director	Executive lead for Committee. Assurance and escalation provider to the Mental Health Legislation Committee.
Chief Operating Officer	Executive with day-to-day responsibility for operational delivery of services. 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.

There may be occasions where the Executive and Non-Executive Director posts have been filled on an interim basis. Where this arrangement is in place, the interim post holder will be considered a member of this group for the period they hold the interim position.

In addition, the following individuals will attend each meeting:

- 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
- Corporate Business Manager
- Involvement Friends

Suggested additional attendees:

- Head of Nursing, Mental Health (Joint Chair of Positive & Proactive Steering Group)
- Head of Psychological Therapies (Joint Chair of Positive & Proactive Steering Group)

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 Corporate Governance 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

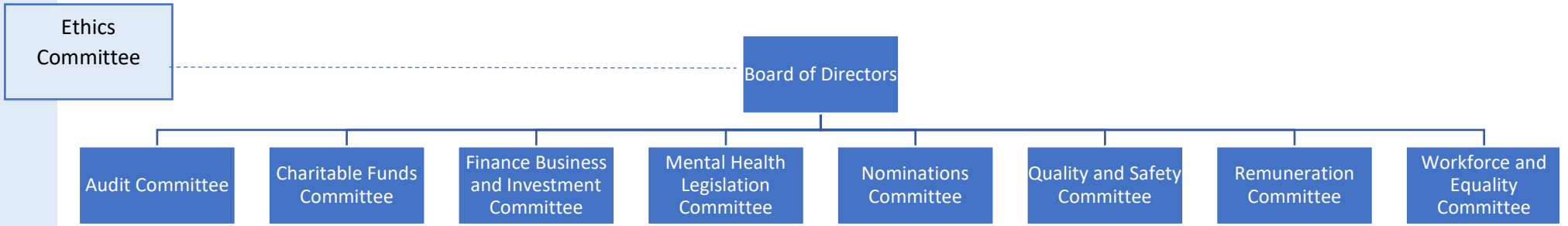
- the process of recruitment, induction, appraisal and development of Associate Hospital Managers (through the Trust Chair and Chair of the Mental Health Legislation Committee)

- 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 (and in addition it receives updates from the Positive and Proactive Steering Group and the Associate Hospital Managers Group) 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 Medical Director
- 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)
Corporate Business 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
Head of Nursing, Mental Health	Head of Psychological Therapies
Head of Psychological Therapies	Head of Nursing, Mental Health

Appendix 2

Mental Health Act activity report 01/04/2022 to 31/03/23

1. Introduction

1.1 This report provides the Committee with an overview of Mental Health Act activity for the period 1st April 2022 to 31st March 2023.

1.2 Review of the Mental Health Act

Following the Independent Review conducted by Simon Wessely and published in **December 2018**, the government published a White Paper in **January 2021**. The White Paper set out the government's response to reform mental health legislation, responding to the Independent Review. Substantial changes to the Act were suggested based on the following four principles:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- the person as an individual – ensuring patients are viewed and treated as individuals

Following publication of the White Paper, the government consulted widely to understand the views of service users, clinicians, carers, and people with lived experience of treatment under the Act. The Trust responded to the consultation which closed in **July 2021**.

The response to the consultation was published in **August 2021**. In its introduction, it stated: "*The government and NHS England and Improvement (NHSEI) are delivering the most ambitious programme to transform mental health care that England has ever known.*

We remain committed to legislate so that patients suffering from mental health conditions, who may require care under the Mental Health Act, have greater control over their treatment and receive the dignity and respect they deserve."

On **27th July 2022** the MHA Reform Bill was published. It took forward recommendations from the White Paper, but not all of them. Some of the proposed changes to the current Act are outlined below:

- Detention criteria more complex and excludes LD and autism
- Detention criteria require "serious harm may be caused…."
- Shorter S3 detention reduced to 3 months, renewed for 3 months, then 6 months, then yearly
- Tightening of treatment provisions. 2nd opinion required for capable refusing patients. No S62 for urgent ECT.
- Referral to tribunal after 3 months for S2, S3 and CTO
- IMHAs for informal patients
- Nominated person chosen by patient replaces nearest relative and has more rights

A joint committee of the Lords and Commons published its report on the Draft Bill on **19th January 2023.**

The report welcomed the Draft Bill but suggested that proper resourcing and implementation will be crucial. The report recommended the creation of a Mental Health Commissioner to oversee the direction of travel for the reforms monitoring outcomes and supporting cultural change. It recommended that CTOs be abolished for Part 2 patients (those discharged for Section 3). It welcomed the provision for statutory Care and Treatment plans and recommended that all patients have a statutory right to make advance choice documents. The changes recommended were designed to strengthen the Draft Bill. A further response from the government is expected before the end of the next session of parliament, i.e. early April 2023.

We aim to keep the Committee updated as and when further details are published.

1.3 The Covid-19 Act and Covid-19 restrictions – ending of restrictions

The Covid-19 Act came into force in 2020 and with it came potential changes to the MHA. However, none of these have been implemented as they were not deemed a national necessity.

However, throughout the Pandemic, both the Mental Health Tribunal and Hospital Managers conducted all hearings remotely. This ended on 1st October 2022 when patients were given a choice as to whether they wished to have their hearing as face to face, or remotely via video. In the last five months there has been a gradual return of face to face hearings.

While solicitors have returned to seeing their patients on the ward or in the community, they no longer request to attend the hospital to access the patients notes on SystmOne. These are sent electronically together with the reports prepared for the hearings.

The CQC Second Opinion Doctors (SOADs) also continue to request SystmOne notes electronically, rather than attending the MHA office. Certificates are sent to the MHA office via email making use of digital signatures, rather than sending them through the post.

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, they are not required to sit as panel members. Although a number of NEDs had agreed to observe two hearings every year to give assurance to the Board, this had not occurred during the pandemic. Nonetheless, any NED would be welcome to observe a hearing whether they are conducted remotely via Microsoft Teams or in person at one of the hospitals. Patient hearings are heard by Associate Hospital Managers, usually simply referred to as “hospital managers”.

2.3 As numbers of available hospital managers dropped towards the end of 2021 and being unable to have the usual open evening to recruit new members, existing hospital managers were asked for recommendations. From these we were able to invite applications and ultimately interview and recruit 5 new hospital managers in June 2022. These new hospital managers are now fully embedded into the role and receive ongoing support from both the MHA Advisor and their colleagues on the panel.

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 (the renewal) relate to the majority of cases 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 members 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. These are shown in the figures below as "not heard".

4 Hospital Manager Hearings and Renewals Activity

4.1 There were a total of **30 Appeals** and **109 Renewals** being lodged with hospital managers a total of 139 cases.

4.2 In total **92 hearings** took place (**12 appeals and 80 renewals**).

4.3 Of the 12 appeals heard, 9 were denied, 3 was discharged

4.4 Of the 80 renewals heard, 79 were renewed and 1 was discharged.

4.5 Combining the outcome rate of all manager hearings, i.e. 92 heard, with 3 clients discharged, the discharge rate is just over 3%.

4.6 Hospital Managers Appeals and Renewals Activity Summary Table for past 11 years

Requests rec'd	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Appeals	207	120	105	118	107	63	60	53	59	67	30
Renewals	125	138	152	168	131	138	138	136	121	131	109
Total rec'd	**332**	**258**	**257**	**286**	**238**	**201**	**198**	**189**	**180**	**198**	**139**
Not Heard	**165**	**114**	**99**	**75**	**107**	**86**	**87**	**71**	**103**	**95**	**47**
Re-grade Prior by RC	66	43	50	37	49	37	45	34	48	47	22
Withdrawn	34	13	11	9	17	6	5	5	10	13	2
Other Reasons*	60	58	38	29	41	43	37	32	45	35	23

Appeals	**2012/13**	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Heard	**65**	**39**	**40**	**40**	**36**	**12**	**15**	**25**	**36**	**24**	**12**
Denied	50	32	31	34	28	11	12	19	28	21	9
Adjourned	2	1	1	0	0	0	0	0	3	0	0
Discharged	13	6	8	6	8	1	3	6	5	3	3
Renewals											
Heard	**102**	**105**	**118**	**126**	**95**	**109**	**96**	**96**	**103**	**85**	**80**
Renewed	98	101	110	118	95	108	90	90	101	81	79
Adjourned	2	0	2	1	0	0	2	1	1	1	0
Discharged	2	4	6	7	0	1	4	5	1	3	1

***Other reasons not heard include:**

CTO terminated (7)
Placed on CTO (3)
CTO recalled or revoked (3)
No renewal document (1)
Patient AWOL (2)
Technical issues (1)
Transferred out (1)
No panel/professionals available (4)
Discharged prior by NR order (1)

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 12 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 since the peak 6 years ago. This could be as a result of patients being discharged more quickly from hospital.

5.3 Of the 334 requests processed, 166 were heard and 168 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 92 (55%) of the cases not heard being discharged from Section or from CTO prior to the hearing. Another factor relating to cases not being heard was the 42 (25%) cases relating to clients withdrawing their requests. This can either by due to the patient satisfied with their progress and are willing for the discharge decision to be made by their own RC, or the solicitor advising them that they would have a better chance at being discharged if they allowed more time for their mental health to improve.

Of the 166 heard, there were 149 (90%) not discharged, 15 (9%) discharged, 2 (1%) adjourned.

A breakdown of the 15 discharged is as follows:

11 (7%) of the 155 Civil sections heard (Sections 2, 3 or CTO) were discharged by the tribunal, whereas just over 3% of hearings before a hospital manager panel were discharged.

5 (45%) of the 11 cases restricted by the Ministry of Justice (MOJ) were discharged.

In the last financial year, we reported that 7% of patients were discharged by the tribunal for civil sections and 6% for the hospital manager panels.

Neither the hospital managers nor the RCs have the authority to discharge the restricted cases, the MH Tribunal is the most common route for discharge, and occasionally, a discharge is authorized directly from the MOJ.

5.4 Tribunal Activity for the past 11 years is shown below:

	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020/ 21	2021 /22	2022/23
Requests rec'd	**307**	**323**	**385**	**400**	**452**	**401**	**402**	**398**	**363**	**340**	**334**
Not Heard	**122**	**111**	**137**	**134**	**190**	**169**	**187**	**176**	**177**	**168**	**168**
Re-grade by RC	74	54	84	89	123	107	122	114	97	98	87
Re-grade by AHM	11	6	2	4	3	0	3	2	3	3	4
Withdrew	29	32	30	26	43	48	46	38	35	19	42
Transferred	7	10	8	3	3	0	1	4	5	3	3
Adjourn/Re-listed	1	9	8	6	10	1	5	3	16	16	17
Placed on CTO	0	0	0	1	0	0	0	0	1	0	2
*Other reasons	0	0	5	5	*8	*13	*10	15	*20	29	13

Heard	**185**	**212**	**248**	**266**	**262**	**232**	**215**	**222**	**186**	**172**	**166**
Not Discharged	163	196	212	237	237	205	184	194	165	146	149
Discharged	12	9	23	20	19	24	18	24	15	15	7
Adjourned	10	7	9	5	6	2	13	4	6	11	2
Other	0	0	4	4	0	0	0	0	0	0	0

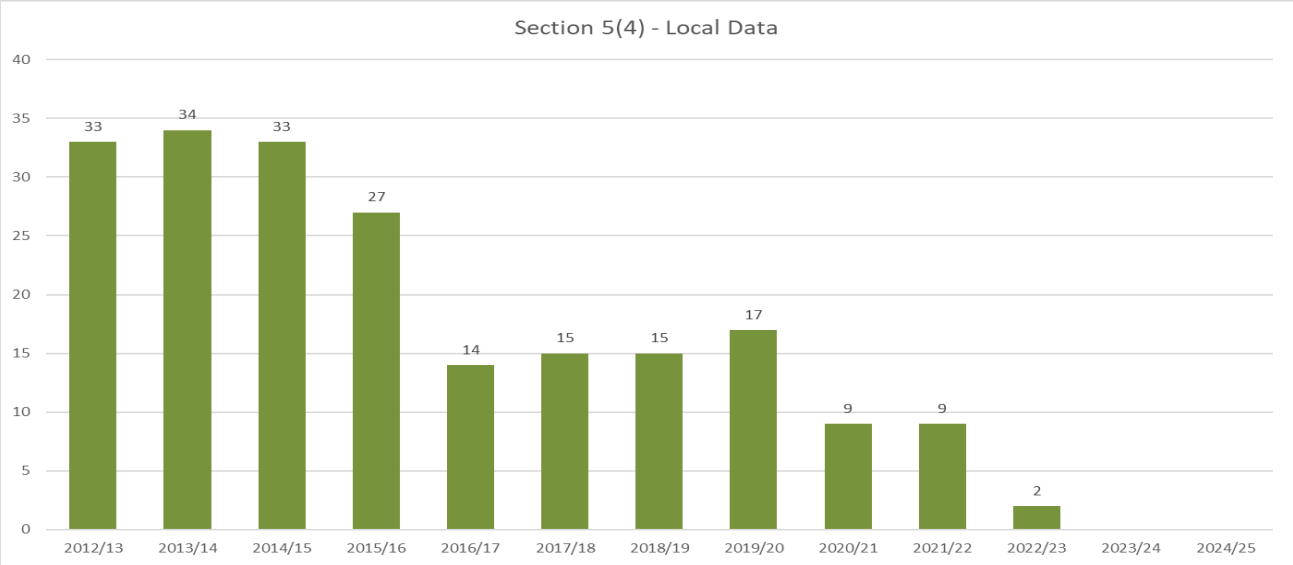
CTO terminated (5)
Patient unwell (1)
Patient AWOL (1)
No jurisdiction (2)
CTO revoked (1)
Patient deceased (1)
Previous discharge by MOJ (2)

6 Activity data for key sections over an 11 year period

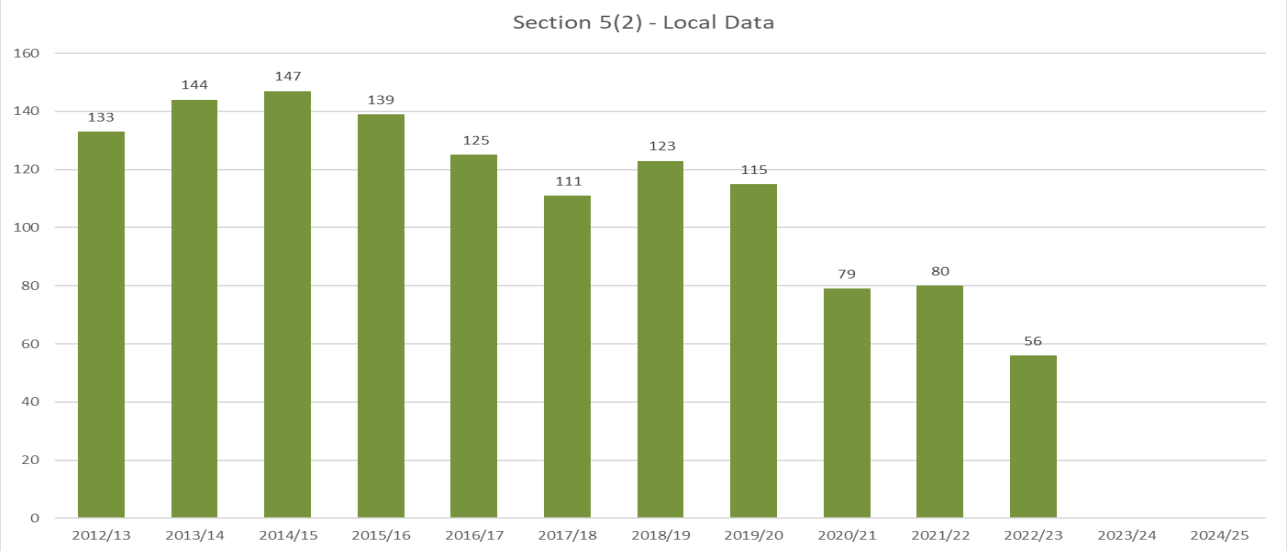
	2012 /13	2013 /14	2014 /15	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020/ 21	2021 /22	2022 /23
Section 5(4)	**33**	**34**	**33**	**27**	**14**	**15**	**15**	**17**	**9**	**9**	**2**
Section 5(2)	**133**	**144**	**147**	**139**	**125**	**111**	**123**	**115**	**79**	**80**	**56**
Section 4	2	1	4	7	2	3	2	5	1	1	1
Section 2	212	499	540	572	534	550	600	590	569	517	522
Section 3	184	212	327	285	326	325	306	331	311	271	310

Detailed above is the MHA activity for BDCFT over the last 11 years. A brief explanation of the five section types indicated above is shown below with some commentary.

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. The figures indicate a continued drop in use over the last ten years. This is likely to be due to the fact that most patients are now admitted under Section due to the Cheshire West ruling of 2014 with less informal admissions and very thorough assessments of capacity prior to admission.

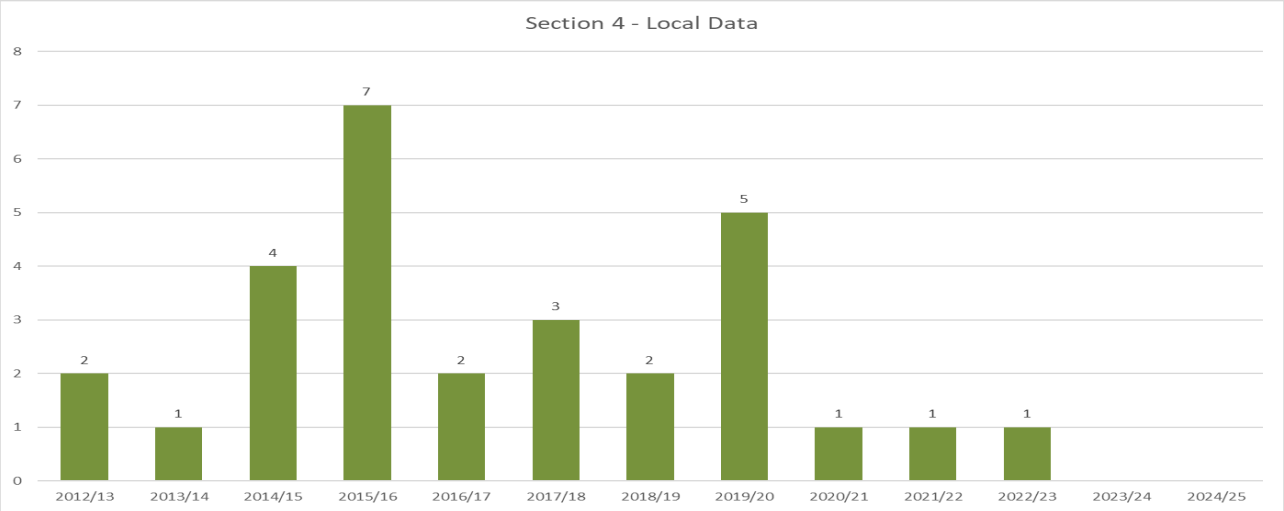


Section 5 (2) is a section that allows for the detention of a person already in hospital for up to 72 hours. It is designed to provide the time required to complete a Section 2 or 3 MHA assessment when the person wishes to leave hospital before the necessary arrangements for these sections can be made.



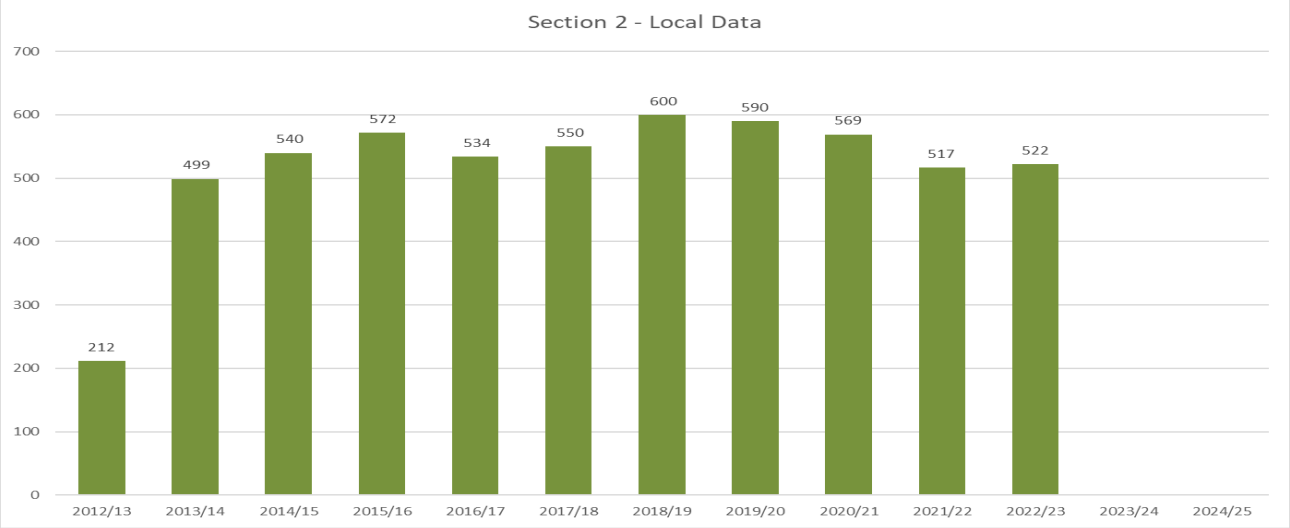
There has been a steady drop in use for the last five years. The admitting professionals must consider the least restrictive option in regard to admission. The 5(2) is only used when there is a change in presentation in the patient's mental health later in the delivery of their care. If the patient is 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) whilst arranging for a full MHA assessment to be carried out.

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.



The use of Section 4 has remained low for the past eight years and in fact has only been used once in each of the last 3 years. This is excellent as it appears to indicate a ready supply of doctors available to make the second medical recommendation required for a Section 2 or Section 3.

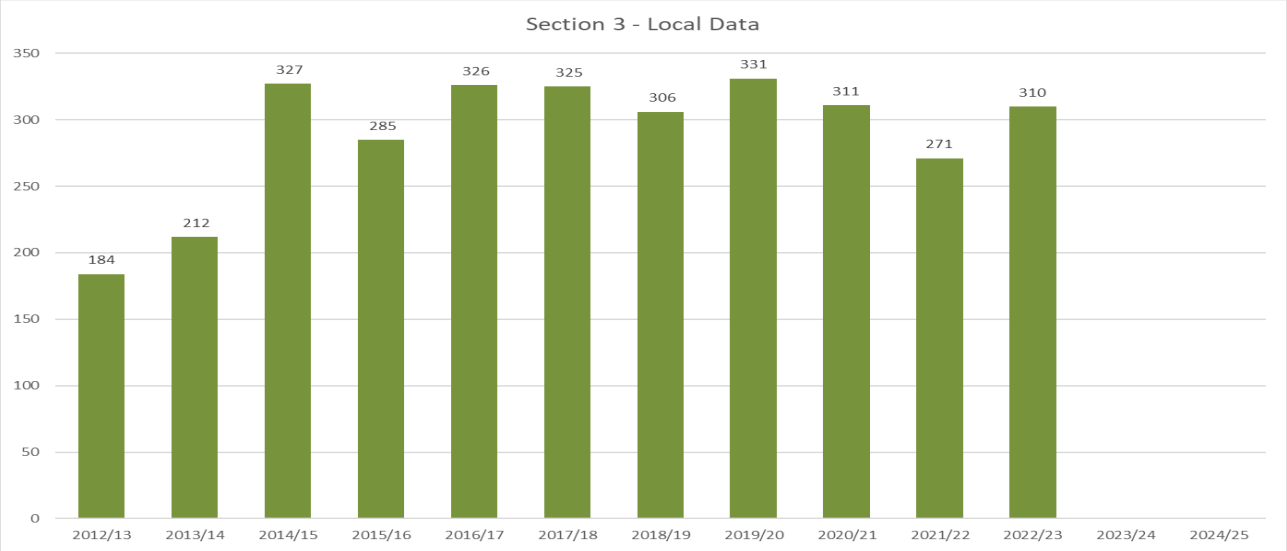
Section 2 gives the power to detain and treat a person in hospital for up to 28 days. It is used for the assessment of people who have, or are believed to have, a mental disorder.



The use of Section 2 has dropped each year for the last five years. In this financial year the figure of 522 cases is a small drop on previous years. These figures however do not include data for those patients placed out of area. This information is not available at the present time. If that data had been available, the figures for patients detained under section 2 in from our district would be different.

Regarding 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.

Section 3 gives the power to detain and treat a person in hospital for a period of up to six months and can be renewed.



After a drop in the previous two years, the number detained of 310 in this financial year is a small increase and took us back to levels seen in 2020/21. Again, unfortunately we do not have the data for those patients occupying an out of area bed. This may have shown a different picture.

6.1 New sections per month

	Numbers of new detentions received	April 22	May 22	June 22	July 22	Aug-22	Sep-22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	***Total***
	Section 5(4)	0	0	2	0	0	0	0	0	0	0	0	0	**2**
	Section 5(2)	4	7	11	1	2	3	7	6	5	1	6	3	***56***
	Section 4	0	0	0	0	0	0	1	0	0	0	0	0	***1***
	Section 2	34	48	39	50	39	33	51	42	42	47	43	54	***522***
	Section 3	24	24	28	14	34	21	21	35	29	31	25	24	***310***
	Sections: 35, 36, or 38	0	0	0	0	1	0	0	1	0	0	0	0	**2**
	Section 37	0	0	1	0	0	0	1	1	0	0	0	0	**3**
	Section 37/41	0	1	1	1	0	1	1	1	2	0	0	1	**9**
	Section 47/49 + 48/49	1	1	0	0	0	0	0	0	1	0	0	1	**4**
	New CTOs in Month	4	8	2	5	2	2	5	6	2	4	5	5	**50**
	Total per month	**67**	**89**	**84**	**71**	**78**	**60**	**87**	**92**	**81**	**83**	**79**	**88**	**959**

6.2 Section 136 information

Section 136 Data	Place of Safety used Total	LMH	ACMH	Police	AGH/ BRI	Outcome Terminated	Informal Ad	Regrade S2/S3	CTO Recall	Transfer	Age Profile 0-17	18-30	31-45	46-59	60+	Male	Female	Not given	Total
April 22	**16**	4	10	1	1	10	2	4	0	0	0	8	4	2	2	8	8	0	**16**
May 22	**13**	0	10	2	1	3	3	7	0	0	0	4	4	5	0	9	4	0	**13**
June 22	**15**	1	12	1	1	8	2	5	0	0	0	8	3	3	1	8	6	1	**15**
July 22	**12**	2	10	0	0	6	2	4	0	0	0	7	2	3	0	8	4	0	**12**
Aug 22	**12**	2	10	0	0	4	1	7	0	0	0	9	2	1	0	7	4	1	**12**
Sept 22	**11**	3	6	0	2	5	0	5	1	0	1	6	4	0	0	5	6	0	**11**
Oct 22	**7**	0	6	0	1	5	0	2	0	0	0	4	3	0	0	3	3	1	**7**
Nov 22	**13**	1	11	0	1	8	1	4	0	0	0	5	3	5	0	8	5	0	**13**
Dec 22	**9**	2	4	2	1	7	0	2	0	0	0	3	5	1	0	6	3	0	**9**
Jan 23	**11**	1	7	0	3	7	4	0	0	0	0	8	2	1	0	5	6	0	**11**
Feb 23	**3**	0	3	0	0	0	0	3	0	0	1	1	1	0	0	2	1	0	**3**
Mar 23	**8**	1	5	0	2	4	1	3	0	0	1	5	2	0	0	3	5	0	**8**
Total	**130**	**17**	**94**	**6**	**13**	**67**	**16**	**46**	**1**	**0**	**3**	**68**	**35**	**21**	**3**	**72**	**55**	**3**	**130**

Use of the Section 136 suites to detain Section 2 patients

During the 12 months of this report the Section 136 suites at Lynfield Mount and the Airedale Centre have been used on more than 65 occasions to detain patients under section 2 of the MHA whilst waiting for an available bed. This figure may be an under-estimate as it is not always clear for those patients subsequently detained to our hospitals whether they were previously in the 136 suites prior to being given a bed on a ward. The use of the S136 suite to detain patients has clearly meant that the suites designated to take clients under S136 are not available, many patients therefore being diverted to local A&E facilities. We are currently working with staff at the A&E facilities at both BRI and AGH to set up systems whereby accurate data can be produced. As an example, the police have advised that in the first two months of this year 27 patients were taken to BRI under S136 for assessment, our records had only indicated one individual in that two month period.

The impact on the MHA department is that papers relating to patients detained under Section 2 in the 136 suites have to be processed immediately, amendments obtained speedily, and papers uploaded to S1 in order that scanned papers can be sent when the patient is transferred out of hours. Once the transfer has taken place a great deal of chasing is required to obtain the statutory accepting document from the new hospital. Original papers then have to be posted out the next working day. The process continues in reverse when a local bed is located, and the patient is transferred back.

Analysis of Section 136 data for the period 01.04.22 to 31.03.23:

Whilst there had been a steady increase in the use of Section 136 until 2020/21 its use has dropped sharply over the last two years. Clearly the blocking of the S136 suites with detained patients will have had an impact on these numbers. The number of occasions when service users were brought to our facilities in the last 12 months was 111 (plus 19 taken to other facilities outside the Trust) followed a similar pattern to the 156 Section 136 episodes in the previous 12-month period.

In regard to the 19 taken to other facilities our records show that 13 of these were taken to A&E at either Airedale or Bradford. (Note however our comment above in relation to not having accurate data at present as to the use of A&E for S136 assessments.

The Street Triage team have continued to work with the police during this time, supporting them and where appropriate directing clients away from the necessity to arrest and detain under Section 136.

Numbers of S136s received in previous years:
130 in 2022/23
156 in 2021/22
340 in 2020/21
328 in 2019/20
253 in 2018/19
197 in 2017/18
177 in 2016/17

Analysis of data for this financial year:

- 13% (17) came to Lynfield Mount Hospital.
- 72% (94) came to Airedale Centre for Mental Health.
  15% (19) came to an alternate Place of Safety

Outcomes:

- 52% (67) of S136s were terminated
- 35% (46) were admitted under Section 2
- 12% (16) were admitted informally
- 1% (1) was CTO recall

Gender Profile:

- 55.4% (72) were male
- 42.3% (55) were female
- 2.3% (3) not given

Age Profile:

- 2.5% (3) were aged under 18
- 52% (68) were aged 18-30
- 27% (35) were aged 31-45
- 16% (21) were aged 46-59
- 2.5% (3) was aged 60 and over

6.3 Community Treatment Orders (CTOs)

Since the introduction of CTOs in 2008, we have had an average of 52 new CTOs each year. Hospital managers are required to consider renewal of section 3 and renewal of CTO in addition to any appeals received. This year 45% of hearings were to consider Community Treatment Orders.

2

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 – Mar19	April 19 – March 20	April 20 - March 21	April 21 – March 22	April 22-March 23
New CTOs	54	45	51	62	53	64	55	40	53	45	49	50
CTO Hearings to HMs	25	63	65	61	72	60	66	61	48	59	50	41
Section hearings to HMs	45	98	74	90	92	71	55	50	73	80	64	51
Total HM hearings	**74**	**167**	**143**	**158**	**169**	**131**	**121**	**111**	**121**	**139**	**114**	**92**
% CTO hearings	34%	38%	45%	39%	42%	46%	55%	55%	39%	42%	44%	45%

The amount of activity in relation to CTOs is considerable:

Each new CTO client needs a certificate authorizing treatment within one month and thereafter needs reviewing at least six monthly. During the 12 month period of this report, 53 certificates of urgent treatment (Section 64G) were issued whilst awaiting a 2nd opinion (SOAD); 22 certificates were issued by the SOADs (CTO11); and 50 certificates were issued by the RCs (CTO12s) where the patient was consenting and had the relevant capacity. All this needs careful monitoring by the MHA Officers.

A number of clients will need to be recalled. The length of time of 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. There were 11 clients recalled for treatment and allowed to return home.

Revocation: An additional 16 clients were recalled but were too unwell to return to the community and therefore had their CTO revoked following a MHA assessment. 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.

Termination: Clients are also taken off CTO as soon as they no longer need the provisions of the Act to keep them well, this is known as the CTO being terminated. In the period of this report 22 clients on CTO had their CTO terminated, 21 by the RC and one following by a panel of hospital managers. This shows that the guiding principle outlined in the MHA Code of Practice (the least restrictive option) is being considered throughout the client's delivery of care.

7. Use of Deprivation of Liberty Safeguards

Applications for DOLs have only been made on only 9 occasions in the period of this report. This is a positive change from higher numbers in previous years as the MHA not only provides more safeguards for patients within our hospitals, but the qualified staff are much more familiar with the legislation that applies.

However, when the Liberty Protection Safeguards (LPS) come into force, the situation could change again if LPS is found suitable for more of our compliant patients who lack the relevant capacity to be admitted informally. We await the new Code of Practice and guidance before we can establish as to whether this might be the case or not.

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 of the MHA.

MHA Activity at Bradford Royal Infirmary:

Use of Section 5(2) - 25
Use of Section Two - 33
Use of Section Three – 4

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, currently via Microsoft Teams.

Training provided: This has been put on hold since the Covid-19 Pandemic but will be resumed as soon as requested by the general hospital. However, the team is available for support and advice during normal office hours and training can resume as soon as the hospital requests it.

MHA Activity at Airedale General Hospital:

Use of Section 5(2) – 14
Use of Section Two – 12
Use of Section Three – 2

The figures above represent the papers received by the MHA Department. The quarterly meetings have not taken place since the start of Covid restrictions.

Training provided: This has been put on hold since the Covid-19 Pandemic but will be resumed as soon as requested by the general hospital. However, the team is available for support and advice during normal office hours and training can resume as soon as the hospital requests it.

Timeliness of reports to Hospital Manager Hearings and Mental Health Tribunals

In order for panels to have sufficient information before them to make a sound and balanced judgement and come to a lawful decision they need written reports in advance of the hearing. Timescales have been set by both the tribunal and hospital managers. Timescale for tribunal reports is 3 weeks after the appeal is received, and for hospital managers it is at least 2 clear working days in advance of the hearing.

We were looking to achieve an improvement upon previous findings submitted in September 22, when full sets of reports to hospital managers were sent on time in 26% of cases and full sets of reports to the Mental Health Tribunal were sent on time in 58% of cases.

It is to be pointed out that when one or two of the reports are received late the MHA officers send what have been received on time, hence, even in the cases where full sets were not sent on time, panel members would receive what reports had been received.

If reports are not received on time to the First Tier Mental Health Tribunal, then the Upper Tier Tribunal has the power to impose sanctions including fines of up to £500 and ultimately a prison sentence. None of these sanctions have been imposed upon BDCFT. In addition, prior to such measures being taken the First Tier Tribunal may issue an Order to Answer. Again, no such Orders have been received.

In every case where a professional has advised that they have been unable to comply with the timeframe given by the Tribunal, the MHA officers have completed a “Case Management Request” asking for an extension. When the extension is granted, we receive a Direction Notice giving a new timeframe. In every case an extension has been authorised and that extension complied with. This report considers the report to be late if the professional has not been able to comply with the original timeframe.

Results - Hospital Manager hearings:

In the three months of January 2023 to March 2023, the hospital managers considered **17 cases.**

Of these 12 full sets of reports (71%) were sent on time. This is a marked improvement on the quarter previously reported on where only 26% full sets of reports were sent on time.

The result in September 2020 was 78%.
The result in February to April 2021 was 56%
The result in December 21 to February 22 was 46%
The result in June to August 22 was 26%

There were 5 cases (29%) where the full set of reports were not sent on time. The following reasons were identified:

- One occasion the reports had been uploaded by relevant professionals but were not sent out on time due to staffing shortages in the MHA Department.
- Two cases were due to the social report being furnished late
- One case was due to the doctor and nurse furnishing the report late
- One case was due to the RC furnishing the report late

Results - Mental Health Tribunals:

Reports are to be sent to the tribunal within 3 weeks of receipt of the appeal or referral and this can often be that reports are required for a hearing that does not take place for a further 4 to 6 weeks.

In relation to section 2 hearings, these must be sent to the tribunal within 24 hours of the hearing. As section 2 hearings have to take place within 7 days of the request, professionals only get between one and five days to submit their report.

In the three months of January 2023 to March 2023 the Mental Health Tribunal considered **44 cases.**

Of these 29 full sets of reports (66%) were sent on time. This is an improvement on the quarter previously reported on.

The result in September 2020 was 68%.
The result in February to April 21 was 64%
The result in December 21 to February 22 was 73%
The result in June to August 22 was 58%

There were 15 cases (34%) where the full set of reports were not sent on time. The following reasons were identified:

- 3 cases were due to just the doctor furnishing the report late
- 5 cases were due to just the social report being furnished late
- 4 cases were due to just the nursing report being furnished late
- 1 case was due to the doctor and social report being furnished late
- 1 case was due to the doctor and nursing report being furnished late
- 1 case was due to the doctor, social report and nursing report being late

Conclusion and actions taken

We are pleased that the actions taken have resulted in a really good improvement in relation to the hospital manager hearings, who agreed in January 2023 to reduce the timeframe required for receipt of reports from 3 working days to 2 working days. This has contributed to an improvement from 26% compliant in the previous reporting period to 71% compliant in the period of reporting.

There has also been a small improvement in compliance in relation to reports to the Mental Health Tribunal, from 58% compliance in the previous reporting period to 66% compliance in this period of reporting.

These results will again be shared and discussed in Adult and Older People's QUOPs and Medical Council meeting to further raise awareness and creation of local actions if needed.

The MHA Department initiated a number of improvements following work with the KPO team just over a year ago. These include sending out weekly PIPA lists to all wards advising of imminent deadlines. This has proved extremely helpful for professionals' awareness of impending deadlines.

Scrutiny of section papers

This report outlines the responsibilities upon the Trust to ensure that all patients sectioned under the MHA are lawfully detained.

For this purpose, qualified nurses, on behalf of the hospital managers are responsible for formally receiving and accepting the detention papers by completion of statutory forms. The MHA officers are responsible for the administrative scrutiny, and four consultants on a rotational basis are responsible for medical scrutiny to ensure that the medical content is sufficient to warrant detention.

This report provides evidence of the findings following scrutiny and the actions taken where appropriate under Section 15 of the MHA to have amended any papers that contain minor errors capable of rectification; and what steps are taken if papers are found to be fundamentally defective and incapable of rectification.

The period for scrutiny covered in this report is 01.01.23 to 31.03.23.

The Code of Practice to the MHA and the Reference Guide to the MHA outline guidance in relation to the receipt and scrutiny of MHA documents.

Regulations say that applications for detention under the Act must be delivered to a person who is authorized by the hospital managers to receive them.

People who sign applications and make the supporting medical recommendations must take care to comply with the requirements of the Act. People who act on the authority of these documents should also make sure that they are in the proper form, as an incorrectly completed or indecipherable form may not constitute authority for a patient's detention.

There is a distinction between receiving admission documents and scrutinizing them. For these purposes, receipt involves physically receiving documents and checking that they appear to amount to an application that has been duly made (since that is sufficient to give the managers the power to detain the patient). Scrutiny involves more detailed checking for omissions, errors and other defects and, where permitted, taking action to have the documents rectified after they have already been acted on.

Hospital managers have formally delegated their duties to receive and scrutinize admission documents to MHA officers and qualified mental health or learning disability nurses.

A checklist for the guidance of people delegated to receive documents, to help them detect those errors which fundamentally invalidate an application and which cannot be corrected at a later stage in the procedure have been produced and are available to all relevant staff.

Documents are scrutinized for accuracy and completeness and to check that they do not reveal any failure to comply with the procedural requirements of the Act in respect of applications for detention. Medical recommendations are also scrutinized by a number of senior consultants, who have appropriate clinical expertise to check that the reasons given appear sufficient to support the conclusions stated in them.

If admission documents reveal a defect which fundamentally invalidates the application and which cannot, therefore, be rectified under section 15 of the Act, the patient can no longer be detained on the basis of the application. Authority for the patient's detention can be obtained only through a new application (or, in the interim, by the use of the holding powers under section 5 if the patient has already been admitted to the hospital). The patient is advised and the nursing staff complete an incident report.

This paper outlines the findings following scrutiny of 214 section papers received in the period 01/01/23 to 31/03/23, these comprised of 134 section 2 papers and 80 section 3 papers.

- 117 section papers contained no error – 45%
- 97 section papers contained one or more error – 55%

- 33 errors (34%) were made by AMHPs
- 22 errors (23%) were made by doctors
- 37 errors (38%) were made by nurses
- 5 (5%) were delayed receipt of papers

96 papers were capable of rectification under Section 15 of the MHA. One paper was found to be unlawful as the two medical recommendations did not comply with the timeframe of being no more than 5 days between when each of the doctors had assessed the patient.

The errors capable of rectification were all minor including spelling of names or addresses, incorrect postcodes, wording that did not apply, not having been deleted, or incorrect dates having been input on the papers. On occasion we are unable to contact a professional in a timely manner to make the necessary amendments. In these cases the "de minimis" principle is noted on the scrutiny sheet with the MHA officer signing to authorize this.

Whilst all but one of these errors were minor, it is nonetheless very time consuming getting hold of professionals to make the necessary amendments.

We would like the Trust to consider an alternative available option, which is the submission of documents through a recognised portal, which it is purported, could reduce errors by over 90%.

12. Care, Education and Treatment Reviews (CETRs) 01/4/22 to 31/03/2023

April 2022

Inpatient:
1. DS

Community:
2. PN

CTRs Cancelled - 0

Outcomes from CTR

1. Social worker to liaise with RC, regarding the optimum point to undertake an assessment of capacity to consent to future accommodation, care and support. the care coordinator to liaise with colleagues in order to identify a GP surgery, close to the proposed future accommodation. A further CTR should be scheduled prior to mid July 2022.

2. The current safeguarding enquiry should continue, but should include failings of the provider to support attendance for health checks; the individual's access to his possessions (books) being restricted; the use of restraint that is out with the PBS plan; and a prolonged delay in seeking lawful authorisation for a potential deprivation of liberty, to which the individual likely lacked capacity to consent to. The care coordinator should liaise with the social worker leading the current safeguarding enquiry. This should then include consideration of the use of restraint and issues regarding its necessity and proportionality. This may well require close scrutiny of daily care records.
The care coordinator should liaise with the domiciliary care provider to ensure an annual health check is completed. This should include consideration of known health issues.
The social worker needs to rapidly update the individualised service specification, in keeping with advice from the individual's sister and healthcare professionals. This should then be used as the basis of seeking and commissioning a bespoke package of care and support.
The care coordinator should continue to visit frequently, and on the basis of discussions with the wider MDT, the social worker and the individual's sister, should advise the current support team regarding additional support and communication with the individual, with regard to the transition.
The panel would support the day service provider's intent to offer an increased number of sessions. They felt that in view of the forthcoming trauma associated with a change of accommodation, care and support, the day service represents a protective factor. The psychologist should keep under review, the need for bereavement support.

May 2022

Inpatient:
3. MW

Community: 0

CTRs Cancelled - 0

Outcomes from CTR
The assistant psychologist should take further action to monitor the fidelity of staff responses against the PBS plan. This might usefully include critical incident analysis. She should also review the incident of March 11th, where records could be construed as indicated that unplanned punitive contingencies, potentially at odds with the MHA Code of Practice, were used. She should report back on this, to the case manager from the CCG.

The RC should ensure that nursing staff are directed to update the Health Action Plan and ensure that nursing staff are directed to update the Hospital Passport. Should they need clarification regarding the required standard, they should be asked to liaise with the case manager from the CCG. Nursing staff should be directed by the RC, to develop a care plan which explains how bowel habits are to be monitored and any support required to maintain healthy bowel habits.
The case manager from the CCG, to request early allocation of a new social worker.
The SaLT should develop and introduce suitably accessible materials explaining the role and function of the court of protection and liaise with nursing staff to ensure planned care, correctly aligned to the individual's communication needs.

June 2022

Inpatient: None

Community:
1. DA

CTRs Cancelled:
- RN – Not enough information
- JA – Consent issue

Outcomes from CTR
- Arrangements should be made, for the individual to have ad hoc (and/or or planned) short breaks in a self-catering setting, with support workers.
- Within the context of CPA, the care coordinator should revisit this proposal, in order to identify and offer the individual potential opportunities.

- Care coordinator to encourage completion of the communication assessment and ensure the findings inform both current care and support and planning for the future.

- Care coordinator to liaise with the specialist epilepsy service to understand issues relating to both the incidence and impact of epilepsy and non-epileptic attacks. The findings should inform care and support and potentially, plans for the future.
- The care coordinator review to current risk, crisis and contingency plans.
- The OT should seek to collate and describe what is already known about the individual's sensory needs including assessments that have been undertaken at the specialist autism day service.
- Through the CPA process, the care coordinator to liaise with the day services manager, review their records and ensure a correct alignment to wider clinical records.
- The social worker to complete reassessment of need.
- The social worker and CCG should liaise, with a view to commissioning an independently facilitated Life Plan. This alongside the local authority's assessment of need, should then inform the development of a service specification.
- Social worker to meet with the individual's mother, to hear the nature of her concerns and determine what action is required.
- The care coordinator and social worker to liaise with the individual's family to review/reassess carers assessment.

August 2022

Inpatient:

4. RN
5. CR

Community:

6. JA

CTRs Cancelled - 0

Outcomes from CTR

- RN

Route cause analysis to be undertaken. Specialist supervision to be arranged for care coordinator. the care coordinator to review all past clinical records and update care plans and risk assessments. nursing staff to ensure that the individual's husband is provided with copies of care plans for comment / contribution. nursing staff from the hospital, should liaise with the individual's husband and agree contacts with the named nurse and be advised of arrangements whereby he can readily access the nurse in charge. nursing staff should liaise with the individual's husband to ascertain his preferences for being notified of any incident where restraint, of any form, is used. Care coordinator to contact GP to ensure LD health checks. The panel requested that a medical examination be sought, by nursing staff, on the day of the CTR, with the outcome being reported back to the family the same day and immediately following the CTR, the outcomes of urine testing be ascertained and fed back to the family the same day.

within the Care Act assessment potential day time resources should be explored as well as where reliable sources of appropriate domiciliary support within the home.

clinical records to be amended with immediate effect re power of attorney however the RC also committed to raise the matter with colleagues and senior managers, such that the matter could be routinely enquired about during routine admission processes.
nursing staff to record and share (the same day) n '7 day plan of actions and agreement'.
The case manager from the ICB agreed to raise this at the next MDT, to determine how reasonable adjustments could be made such that the individual's daughter could be more actively involved in supporting her mother.

The panel noted that the local authority safeguarding team and CQC had been notified of concerns and therefore were satisfied that internal findings would be subject to external scrutiny. No further actions were therefore recommended.

- CR

Section 17 leave plan and authorisation to be updated. Clinical Lead for the Dementia Assessment Unit to liaise with the RC, to ensure any restrictive escorting requirements are necessary and proportionate. Ensure flexible use of section 17 leave both to support engagement in preferred, activities; and to help re-orientate and prepare the individual for discharge.

The panel felt that the care coordinator should liaise with colleagues from the learning disability team, the dementia assessment unit and the acute trust urology team, with a view to practitioners engaging in facilitated peer group supervision.

Health Action Plan to be revised. The case manager from the ICB, with support from the care coordinator, should liaise with the hospital team, the learning disability team and the care home to ensure appropriate provision for aftercare, and transition planning.

Liaison needed with the individual's sister to ensure her input and support for transition planning, discharge and aftercare.

- JA

Nature and reason for expenses from care provider to be explained to family. crisis and contingency plans to be reviewed. Referral to SALT. Care coordinator to update health action plan and liaise with GP for reasonable adjustments to address unmet health needs. Service spec to be completed to include care coordinator and family views. CPA meeting to be held and to review CPA Care plans. Consideration should be given, to commissioning the involvement of voluntary sector providers of assertive community support to people who sleep rough. The social worker should seek clarity regarding the current advocacy role and share this information with the Care Coordinator. the advocate should be involved in discussions of current care and support and in planning for the future. Care Act Advocate referral to be made.

September 2022

Inpatient:
AI

Community:
NL

CTRs Cancelled - AI

Outcomes from CTR
NL - care coordinator should liaise with the psychology service to update re wider concerns.
Investigations and enquiries are evolving and ongoing; the possibility of a 'victimless prosecution' had not been ruled out, given the individual's habit of backtracking on disclosures. They agreed that MARAC provided an appropriate process by which to share emerging details which may usefully inform safety plans; It is essential that the current Care Coordinator is fully engaged in this process. Safety/management plan to be shared with care coordinator as a matter of urgency.

The care coordinator should seek regular safeguarding supervision, with regard to this case. The care coordinator should liaise with colleagues from her trust, the CCG case manager and any involved professionals from the learning disability team in the individual's area of residence, to ensure that senior managers in all agencies are aware of the nature and complexity of current risks.

social worker from the funding authority should liaise with counterparts in the individual's area of residence, to identify potential local providers of tenancies and support. The social worker from the placing local authority should explore how a personal assistant role could usefully be introduced. This should include consideration of the skills, support and operating protocols within which the personal assistant would work.

The social worker and care coordinator should liaise to ensure multiagency planning meetings are reinstated as soon as possible. These to run in parallel to the ongoing MARAC process. The care coordinator should consider whether it would be in line with local policy to host these within a CPA context.
The social worker should seek to contact the individual's father in order to appraise him of the current situation as well as to hear his concerns and thoughts regarding future support.

October 2022

Inpatient: DS

Community: 0

CTRs Cancelled: 0

Outcomes from CTR

- Increase community support staff visits _ ICB Case Manager Responsible
- The case manager from the ICB should liaise with the individual's family and her colleagues, in order to ensure ICB representation at key planning meetings
- Social worker and case manager to liaise re security screen and any fitting cost
- Further CTR December

November 2022

Inpatient:

1. HI
2. MW
3. JC

Community:

1. NS

CTR's Cancelled - None

Outcomes from CTR

- HI

Formulation needed
Quick Read Summary to be produced
PBS plan to be reviewed and updated and to be informed by functional assessment and formulation
Care Act Assessment to be completed
Service Spec to be completed
Liaison with family and nursing staff regarding introductions to the new baby

- MW

SALT to review and update communication guidelines
Hospital passport and Health Action Plan to be updated

- JC

Care coordinator to progress recommendations from previous CTR
ICB to visit ward and review care plans
Social worker to liaise with housing providers to secure accommodation
Care Act Assessment to be completed
Close observation and compassionate support to be ensured, MDT review with regards to introduction of more specialist support.

- NS

Health needs assessment and health action plan required
Liaison with GP regarding need for specialist epilepsy and/ or neurology services
Liaison with nursing/psychiatry to monitor and review psychotropic medications
Access to be sought to the persons full history then produce a risk assessment in conjunction with other specialists

Needs assessment to be produced and liaison with housing departments
Care Act Advocate required
Liaison with YP keyworker service

Planned for next 6 months - 11

December 2022

Inpatient:
DS

Community:
LP
ST
BJ

CTR's Cancelled - None

Outcomes from CTR
DS

- As discussed, the case manager from the ICB to meet weekly with hospital staff, community staff and the individual's family, to monitor implementation of the agreed transition plan and agreed prompt remedial actions, in response to any deviation from the plan.
- community service manager to liaise with hospital staff and the individual's family in order to introduce a checklist of areas where staff needed to be confident and competent, prior to discharge. Support to achieve these should then be agreed in weekly planning meetings.
- the registered manager should look to notify the hospital MDT of the date of commencement of 7-day support. This should be as early as possible during January 2023.#
- The case manager from the ICB (in consultation with the family) and managers from the community provider, and hospital staff, need to meet urgently, to review transition plans and agree an action plan.
- As discussed the RC should liaise with the hospital MDT to ensure a social story explaining the process is developed and shared with all involved.
- The individual's parents offered to support any recruitment/selection processes to ensure the 'right staff' are employed.
- Early follow up CTR date to be identified
- Any introduction to the individual's natural father could be an emotional experience and his support needs should be taken into account. The RC agreed to discuss further with the individual's mother, the individual's social worker and the adoption agency social worker, to consider how to support, around any future contact.

LP

- In seeking to handover lead responsibility to the local Community Mental Health Team, the IHTT psychiatrist should draw attention to the need for a functional skills assessment by an occupational therapist, once the individual's mental state is stable. The findings of this may warrant update of the Care Act Assessment and so, liaison with the social worker will be important.
- The panel noted that the individual's mental health is at an early stage of assessment and that there have been prolonged periods within minimal contact with services, meaning that history has been difficult to discern. In seeking to handover lead responsibility to the local Community Mental Health Team, the IHTT psychiatrist should draw attention to the need for a formulation, based on a full review of health and social care records, as well as presenting features, to be recorded.
- As discussed, the IHTT should flexibly extend their involvement, by way of a reasonable adjustment, until there has been a full handover to the CMHT and opportunity for introductory visits by the new, incoming, care coordinator.
- The panel concurred with the view of the IHTT psychiatrist, that alongside CMHT involvement, there should be liaison from a specialist practitioner from the learning disability health practitioner, until such a time as the individuals needs are more fully understood, especially with regard to comprehensively reviewing the health history and determining the need for reasonable adjustments, in relation to both physical and mental health. The DSR coordinator should draw the panel's recommendation to the attention of the relevant service manager.
- The DSR coordinator should request of the relevant learning disability team manager, that an allocated healthcare practitioner should comprehensively review the primary care record to accurately determine past history and presenting needs. A health action plan should then be prepared.
- The IHTT psychiatrist should draw to the attention of the incoming CMHT psychiatrist, the need to review medication history on the basis of primary care records.
- Pressing need to secure accommodation. Social worker to keep under review the individual's support needs, as the clinical picture and its longer term implications become clearer.
- As agreed during the CTR, the social worker, with the individual's agreement, should refer to a care act advocate.

ST

- The consultant psychiatrist to liaise with the family and the care coordinator, to understand their concerns and monitor / assess appropriately. He should liaise with the epilepsy service, with a view to jointly reviewing and considering medication management, and should liaise with the care coordinator, to agree a process by which a mental state examination can promptly be undertaken, when it is recognised that mood disturbances suggest a seizure to be imminent.

- The care coordinator to ensure a functional assessment of behaviours of concern is undertaken, which includes consideration of past history and specialist clinical assessments and leads to a revised PBA plan.

- the care coordinator to update the risk assessment and review past history and speak at length with family member, in order that a complete risk history can be compiled and predictors of risky behaviour identified.#

- The social worker to liaise with the care coordinator and seek to urgently visit and gain assurances that any use of restraint is fully recorded and always necessary and proportionate. Should this not be the case, she should seek advice regarding escalation of concerns. Also in liaison with the MDT to develop the service specification, with a view to identifying an appropriate service.

BJ

- The manager of the Intensive Support Team to liaise with the care coordinator, to ensure that that the wider assessment, includes a review past records and liaison with family members, in order to understand the nature of past episodes of disturbed behaviour. Also to ensure OT, SaLT and psychology assessments are completed and that a formulation to developed and recorded.
- The manager of the IST should liaise with the care coordinator, to ensure historic records are reviewed and a behavioural assessment is undertaken, alongside assessments by allied health professionals, psychology and psychiatry. The findings should be integrated into a PBS plan.
- The IST manager should alert the care coordinator, to the need to review past primary care records in order to identify ongoing health needs and strategies by which these can be met. In liaison with the manager of the supported living service, the Health Action Plan should be updated, as required and to ensure that all risk assessments are updated in line with the outcomes of current and ongoing assessments. They should liaise with the care coordinator, to ensure the individual's mother is fully involved and regularly updated regarding ongoing assessments.

Planned for next 6 months: 8

January 2023

Inpatient:
PC
DT

CTR's Cancelled - 1 (Mental Health)

Outcomes from CTR

PC
Report not received

DT

- The RC and MDT should negotiate with the individual to agree a goal of increasing periods of leave to 4-5 times per week, within 6 months.
- OT to ensure care plans reflect the need for 1 weeks' notice for offsite, non-routine activities.
- The MDT to consider relaxing the nature of supervision, during section 17 leave, within the terms of the current authorisation, for routine activities.
- The case manager from the ICB, should liaise with senior managers to determine how a communication assessment can be accessed, in a timely manner, from partner organisations within the ICS. Also to liaise with the individual's mother to understand the nature of difficulty she experiences with visiting her son in hospital and whether any additional support can be provided.

Planned for next 6 months: 8

February 2023

Inpatient:
DS
YK
CR (Mental Health)
FM (Mental Health)

Community:
LS

CTR's Cancelled - 0

Outcomes from CTR
DS

- The care coordinator should liaise with the individual's mother to determine how best she can support the training of future support staff.
- Social worker to liaise with LA MCA team re optimal timing of capacity assessment.
- Social worker, ICB and OT to review costed timetable and identify components eligible for funding as well as where the individual will be required to self-fund. Deficits to be discusses and action plans to address within transition/discharge meetings.
- Hospital and community OT and the individual's mother re development of pictorial resources available to the individual post discharge

- The Chief Operations Officer, from the community provider should liaise with the individual's mother re opportunities for her to meet the proposed team of support staff. In the event that she feels any have interactional styles that would mitigate against them forming positive relationships with her son, the Chief Operations Officer should explore other staffing solutions.

YK – Report not received.

CR
As MH, report not received

FM
As MH, no report received

LS

- Care coordinator to oversee review and update of PBS plan, Health Action Plan and Hospital Passport
- Guidance re safe eating and drinking should be reviewed as part of respiratory pathway
- As discussed, the care coordinator should discuss the individual's needs regarding catheter care with the GP and the local continence nurse.
- Care coordinator to liaise with physiotherapy to review and advise re moving and handling plans, wheelchair neds, access of raise and reclining seats and commode. OT support if necessary.
- Care coordinator and advocate to discuss if she wishes to change her social worker.

Planned for next 6 months: 8

March 2023

Inpatient:
RB (Mental Health)
FM (Mental Health)
Community:
NL (Learning Disabilities)

CTR's Cancelled - 1

Outcomes from CTR

1. A formulation is required and to take account of the diagnosis of autism. Care plans to be reviewed to remove any suggestion of a diagnosis of Learning Disability. Further assessment report should be clear on this. RC to make a referral for a communication assessment by a therapist with a specialism in autism

Once completed:
prepare a full service specification in consultation with the individual, the hospital MDT and the ICB case manager. To include details of how introductions and transitions should be managed. To include SALT recommendations.
Care coordinator to explore accommodation options in line with service spec.
The RC should seek legal advice regarding the current position and specifically whether parole board licence restrictions, can authorise a deprivation of liberty.

2. The RC should refer for a communication assessment by a Speech and Language Therapist, to understand needs associated with receptive and expressive communication and to ensure these are taken account of, within care plans.

the RC will continue to liaise with the individual and review with a view to maintaining effective symptom control whilst minimising adverse effects. This will include attention to potential metabolic effects.
The forensic psychology assessment should proceed and include formulating offending risks such that any post-discharge offender management issues can be taken fully into account.
the care coordinator should seek to liaise with the individual's parents, to determine use of independent interpreter services.
The RC should discuss with the individual and seek permission to liaise with his legal representatives, in order to gain a correct understanding of the current position and related future processes and seek legal consultation via the hospital providers' lawyers, in order to ensure and up to date understanding of the legal position and to minimise any risks that deportation proceedings inhibit the capacity of the hospital to deliver its obligations under the Mental Health Act.

3. Social worker needs to review MARAC meeting records in order to determine whether there are any outstanding issues and actions.

The social worker, with support from her manager, should seek to engage flexibly with the individual, in order to maintain a trusting relationship, such that the individual feels confident in the case that she needs urgent assistance, and also that she can monitor soft signs of risk and to seek intermittently, to involve the community nurse.
The complexity of safeguarding issues, both historic and potentially going forward, are such that the community nurse should seek regular safeguarding supervision through the Trust.
The panel noted the Homeless Outreach Project in the individual's hometown have a proven track record of supporting individuals, flexibly, who present with similar life circumstances. The social worker should liaise with the service manager to determine whether the team can assist, advise or sign post to equivalent teams in the area where the individual currently stays.

Planned for next 6 months: 12