Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 17 January 2024

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Title:	**Mental Health Act in OUHFT Annual Report**

Status:	**For Discussion**
History:	**Annual Report presented to TME on 14 December 2023** **Contemporaneous monthly reporting of this data is included in the Directorate Quality Report**

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Confidential:	**No**
Key Purpose:	**Performance**

Executive Summary

1. The Mental Health Act in Oxford University Hospitals NHSFT: How well has the Trust met CQC requirements[1] when providing care for patients detained under the Mental Health Act.
2. This report concerns use of the Act during the period from 1 July 2022 to 30 June 2023.
3. The Trust is a nationally recognised leader in integrating mental and physical healthcare. Governance of the effective use of the Mental Health Act (MHA) is key to ensure integrated services that are compliant with Care Quality Commission policy. This is the sixth annual review of use of the MHA by the Trust.
4. Annual audit and reporting, with contemporaneous monitoring of MHA use are essential components of governance that uphold the Trust's accountability, and drive improvements in the quality of care provided under the Act by the Trust.
5. For consistency and ease of reading, albeit against grammatical convention, all numbers are written as numerals.
6. Key findings of the 2023 audit are as follows:
   - The MHA was used on 30 occasions during the period: 10 patients were detained under section 2 (assessment order), one of whom was later detained under section 3; 6 patients were detained under section 3 (treatment order); There were 14 uses of section 5(2) (emergency holding order);
   - 1 patient detained was under 18 years of age (section 2);
   - None of the detained patients were transferred to the Trust using section 19;
   - All detained patients were discharged from the Trust within the statutory time limit;
   - None of the detained patients appealed their detention;
   - No patients died during their period of detention;
   - 100% of patients entitled to receive their rights (detained under section 2 or 3) had documentation to record the receipt of the relevant information;
   - 63% (10) of detained patients required restraint. None of the restrained patients were aged under 18;
   - Risk assessment was documented for 100% (16) of detained patients in this period.
7. Capacity to consent to treatment under the MHA was documented for 100% of detained patients in this period.
8. Patient and carer involvement in care planning were 100% and 60% of cases respectively.

9. 13% of detained patients had minor errors in documentation or process, a reduction from 83% in the previous reporting period, highlighting the importance of the MHA administrator role.
10. Closer working with the Oxford Health Mental Health Act office has been achieved through the establishment of regular meetings with their staff and AMHP leads.

Recommendations

11. The Trust Board is asked to:

- Review the Trust MHA activity and targets for improvement detailed in the action plan provided in Appendix 1 (table 2) in one year's time;
- Consider that delivery of actions plans will be the responsibility of the MHA lead as a member of the Psychological Medicine directorate's governance team;
- To be aware of the impact on OUH of challenges in Psychiatric care across the county, in particularly Eating Disorders Services;
- Be aware that the internal OUH MHA policy is due to expire in August 2024 and is in the process of being reviewed and updated.

Mental Health Act in OUHFT Annual Report

1. Purpose

1.1. To evaluate the legal compliance and quality of care the Trust is providing to patients requiring compulsory treatment for mental illness.

2. Background

2.1. The Mental Health Act 1983 (amended 2007) authorises compulsory treatment of patient for a mental disorder, enabling the delivery of essential treatment to severely ill patients.

2.2. The Trust is registered with the Care Quality Commission (CQC) to provide assessment or medical treatment for persons detained under the Mental Health Act 1983.

2.3. The majority of patients to whom the MHA applies are admitted to psychiatric hospitals. Some patients may require medical or surgical treatment alongside psychiatric treatment, for which they must be admitted to an acute hospital.

2.4. Whilst such patients constitute a minority of patients admitted to this Trust, it is essential to comply with legislation to ensure patients are protected and provided with their statutory safeguards.

3. Monitoring and Evaluation

3.1. The Trust Psychological Medicine Service maintains a contemporaneous, secure database of patients detained under the Act.

3.2. For each patient on the MHA patient database from 1 July 2022 to 30 June 2023, MHA statutory paperwork and clinical records were audited against the Trust's MHA policy and internally-set standards of practice (in turn based on the MHA Code of Practice).

3.3. Reference to the Trust's policy has not been included in this evaluation, as this has been done previously and there has been no subsequent alteration in policy. The policy is due for renewal in 2024.

3.4. These are internally-derived standards as no nationally-set standards for acute trusts are available: Annual surveys of MHA in England and Wales undertaken by the CQC involve mental health trusts, though some comparable standards are considered here. In October 2020, the CQC have published a report on how people's mental health needs met in acute hospitals, and how can this be improved. This included the use of the MHA in acute hospitals. This may shape future standards and policy[2].

3.5. This review distinguishes two types of standards: Some are essential for lawful use of the Act; such that sub-standard care may invalidate the detention and confer unlawful detention by the Trust, e.g. administration of statutory MHA forms. Other standards are recommended for good practice but failure to meet them does not invalidate the detention.

3.6. **KLOE:** This evaluation is based on the Care Quality Commission's (CQC) key lines of enquiry (KLOE) approach to service evaluation: Is the service **safe; effective; caring; responsive; well-led?**

Safe?

3.7. Detained patients may require physical or chemical restraint with associated risk of accidental harm. It should therefore only be used if there are no better options.

3.8. Frequency of restraint alone is not an indicator of quality care.

3.9. A death under the MHA is not necessarily a sign of poor practice for a patient who is acutely unwell. Nevertheless, patients who die whilst under the MHA must have their cases referred to the coroner and CQC. This is a statutory safeguard for all patients under the MHA.

3.10. Risk assessment and management are core components of clinical care, especially so for patients whose risks are high enough to warrant compulsory detention management under the MHA.

Effective?

3.11. Capacity to consent to treatment alone is not a criterion for detention under the MHA. However, assessing and monitoring capacity to consent is key to promoting patient autonomy, as emphasised in the 'overarching principles' of the Code of Practice. Its importance is reflected in the priority given to it by the CQC.

3.12. Every patient detained under the Act must have a named clinician allocated to them who is responsible for all care delivered under the Act. Currently in the Trust this is a Consultant Psychiatrist. The responsible clinician (RC) is a statutory role and must be available 24 hours a day. During office hours, the RC role will be allocated to the Trust psychological medicine service consultant psychiatrist with the most appropriate expertise for that patient's needs. Out-of-hours, RC cover is provided by a weekly on-call system of psychological medicine service consultants.

3.13. There is overlap between the MHA and the Mental Capacity Act 2005. To mitigate uncertainty among clinicians Trust guidance states that where both acts are applicable in the emergency setting, the MCA should be used first. Where the MHA emergency order section 5(2) is used, a psychiatric opinion should be sought to ensure the correct application and administration

of statutory paperwork. Anticipated changes to MHA legislation in the near future may improve this.

Responsive?

3.14. The Trust must ensure the particular needs of patients are provided for.

3.15. The Code of Practice explicitly focuses on children and young people and people with special needs owing to learning disabilities and autistic spectrum disorders.

3.16. Ensuring the privacy, dignity and safety of patients detained under the MHA is a statutory duty of providers.

Caring?

3.17. One of the core purposes of the MHA is to protect patients from unlawful enforced treatment. The MHA provides safeguards for all detained patients and informing patients of their entitlements is a statutory duty of all providers (section 132 MHA).

3.18. Patient and carer involvement in care planning is an overarching principle of the MHA, with the aim of promoting patient autonomy despite the need for compulsory care. This is an obligation of the RC. This issue is also increasingly a focus of recent CQC MHA monitoring reports.

3.19. Referral to the independent mental health advocate (IMHA) is a safeguard for patients who do not have advocacy through family, friends or carers. This is an opt-in facility under the Act. OUH policy makes this an opt-out facility, to maximise access to this safeguard for patients detained in a hospital in which the Act is seldom used.

Well Led?

3.20. This criterion refers to oversight of the MHA, to ensure accountability and quality of the care delivered under the Act.

3.21. It includes correct administration of statutory paperwork, provision of statutory rights to patients (especially appealing against one’s detention) and staff training.

3.22. The H3 form is a statutory form which records the detention of the patient in hospital and is signed by the ward’s nursing coordinator on behalf of the hospital managers. Its importance in ensuring lawful detention of a patient is reflected in correct completion being evaluated here.

3.23. Aftercare planning with local authorities is a statutory duty for trusts to provide for patients detained under section 3 and who are soon to be discharged from hospital (section 117 MHA).

3.24. Use of the MHA in the emergency department (ED; including patients in the emergency assessment unit under the care of an ED consultant) requires particular attention. Patients in ED who require psychiatric attention are under the care of the Emergency Department Psychiatric Service, a service provided by Oxford Health NHSFT. The Trust's MHA policy [2] remains applicable. The Trust's Standard Operating Procedure remains applicable. The MHA paperwork for patients assessed in the ED but subsequently detained to other Trusts is scrutinised by the Mental Health Act Office for Oxford Health NHSFT.

3.25. Sections 2, 3 and 5(2) are not applicable in ED (though this is a likely future change with the planned amendments); a patient must be admitted to an inpatient ward to be detained under the MHA. It is common, however, for patients in ED to be assessed to determine whether they require compulsory hospital admission under the MHA.

3.26. When a person in a public place is behaving in such a way to cause concern that he or she is suffering from an acute mental illness, the police are able to detain them to bring them to a 'place of safety' for psychiatric assessment to determine if the patient needs to be compulsorily admitted into hospital. This police power is provided by section 136 MHA. In Oxfordshire, the majority of such patients are brought to Littlemore (psychiatric) Hospital. If a patient under section 136 is also suspected of having an urgent physical health problem, the police may bring them to ED. In this case, the patient may be assessed under the MHA in ED or the police may take them to Littlemore once they have been treated by an ED physician. This occurs once or twice per month.

3.27. Oversight of use of section 136 in ED in OUH is through the Oxfordshire Partnership in Practice meeting (not OUH psychological medicine governance). This is a multi-agency forum involving ED leads, Thames Valley Police, South Central Ambulance Service and Oxford Health NHSFT (OH). Psychological Medicine governance and MHA leads meet with the OH clinicians working in ED and managers of the Approved Mental Health Practitioners (AMPH) Service, to oversee this interface.

3.28. The Coronavirus Act 2020 was passed in March 2020. It made possible temporary changes to the way clinicians could use the MHA, in an emergency. It did not prove necessary to use these changes and the Act was withdrawn in October 2023.

4. Findings

4.1. In the period 1 July 2022 to 30 June 2023 30 OUH patients were detained under the MHA: 10 patients were detained under section 2 (assessment order), one of whom was later then detained under section 3. 6 patients were detained under section 3 (treatment order).

4.2. There were 14 uses of section 5(2) (emergency holding order). This was an increase from 6 last year.

Safe?

4.3. The proportion of detained patients where restraint was used has increased. Accepting the small sample size in this audit, this increase may reflect better documentation of restraint but also the increase in eating disorders patients admitted to the Trust who may require restraint in order to be safely fed.

4.4. The documentation of specific risk assessment and plan has remained at 100%

4.5. No deaths occurred under detention during this period.

Effective?

4.6. Documentation of patient capacity has improved from 95% to 100%. Previous low performance was due to documentation discrepancies between clinicians, as capacity is not directly related to the use of the MHA and is assumed to be retained. However, its assessment is in the Code of Practice that guides clinicians in their use of the MHA.

4.7. The increase in average length of stay of detained patients has persisted. This almost certainly reflects the increase in number of eating disorder patients who have frequently been severely medically unwell, and for whom identifying a specialist psychiatric bed has been increasingly challenging. The longest stay was 64 days. This is a national problem and not one OUH clinicians can influence directly. We continue to work with colleagues in Oxford Health to address this issue.

4.8. The MHA is used in a wide range of speciality wards, reflecting that all OUH divisions treat highly complex patients with combined mental and physical health care needs. This reaffirms the need for a ‘trust-wide’ approach to the application of the MHA.

Responsive?

4.9. No patients with a primary diagnosis of learning disability or autism were detained.

4.10. The one child detained during this period was aged 16.

4.11. There were no complaints about the care of patients whilst detained.

4.12. Incidents occurring whilst patients are detained under the MHA would be reported on Ulysses however there were no such issues during this time period.

Caring?

4.13. The documentation of patients being provided with their rights (section 132) remains at 100%. We have recognised that patient rights are a priority for CQC inspections at other trusts, and so have enhanced the OUH process to include documentation of why patients may have not been able to receive their rights, plus a record of further attempts to explain them.

4.14. Patient and carer involvement in care planning under the Act has improved significantly over the last few years. Patient involvement has increased from 40% to 74% to 100%, and continues at 100% this year. Carer involvement has increased each year but dropped slightly this year to 88%. In the remaining cases there were individual specific reasons why carers were not involved (patients not having family or not wanting family involved).

4.15. Two patients were referred for advocacy with an IMHA (12.5%). There is no target for referral. Consideration and crucially documentation of advocacy has dropped slightly from 100% to 88%. A previous low finding of 17% in the 2018-2020 audit was likely attributable to many factors, including clinicians failing to document referral being considered if it was later decided it was not required. Also, IMHA providers remain external to OUH and the time to access them may exceed the length of the detention or admission to OUH often due to transfer to a psychiatric bed.

Well Led?

4.16. We have trained an existing member of the administrative staff to lead on the administration of the MHA documents, and to take on additional responsibilities. This member of staff completed a Mental Health Law and Practice Certificate via the University of Northumbria, graduating in December 2023. This investment and training have allowed for contemporaneous monitoring of the quality of our MHA use in OUH, and they have contributed significantly to the enhancement in our MHA process. The Psychological Medicine Service also has an operational services manager, who can undertake additional administrative oversight of MHA use.

4.17. Correct completion, receipt and scrutiny of statutory MHA paperwork are essential for lawful detention of patients. Errors risk invalidating a patient’s detention; unlawful detention for which the Trust would be liable.

4.18. The correct use and presence of the H3 form, that registers the patient’s detention to OUH, has remained at 100%.

4.19. The rate of MHA paperwork being scrutinised promptly remains at 100%.

4.20. 100% of the expected statutory paperwork was identified at audit. This is now predominantly received and entirely stored electronically. There was an occasion where documents were completed in the old paper format and left on the ward. This did not invalidate the detention.

4.21. There were no ‘non rectifiable errors’ detected on document scrutiny. There was just one incident of ‘minor error’ on MHA paperwork that was identified when papers were scrutinised. This sort of minor error is rectifiable and does not affect the patient’s detention. Historically there have been errors in using the OUH systems for MHA activity as detailed in the SOP. These have been promptly identified and rectified by the MHA administrator and have not impacted on the legality of the detention.

4.22. We continue to report MHA activity monthly in the directorate quality reports. MHA activity and any related incidents or errors are discussed monthly at the Psychological Medicine governance meeting, and with the full psychiatric team at the monthly team meeting.

4.23. We have established a regular internal MHA meeting to review errors and problems with our scrutiny process. The MHA administrator also now meets with the MHA office in Oxford Health, and Oxfordshire AMHP leads on a monthly basis.

4.24. No patients required Section 117 after care planning.

4.25. No patients appealed their section during the period.

4.26. No international transfers.

4.27. Training is currently up to date for all key staff groups involved in the use of the MHA. All consultant psychiatrists are in date with specialist training to act as RC for detained patients. Diary alerts are now implemented to prompt psychiatrists to make early arrangements to refresh their training as needed.

4.28. The SOP for using the MHA patient database has been updated.

4.29. A new SOP is being created to facilitate the correct arrangements for tribunals to be held in OUH.

4.30. The memorandum of understanding around provision of Associate Hospital Managers (AHMs) between OUH and Oxford Health NHSFT needs to be renewed.

5. Conclusions

5.1. The Trust's use of the MHA has been legally compliant. Where there have been errors, these have been identified and rectified appropriately.

5.2. The quality of the service provided to detained patients continues to improve. This has been a result of multiple enhancements to the way we administer and monitor MHA use in the trust. The expansion and now contemporaneous use of our data collection process, the introduction of an EPR form that the new MHA administrator ensures has been completed by the patient's RC, and closer working with Oxford Health and the AMHP service continue.

5.3. Future plans include continuing to build on our attempts to optimise patients safeguards and rights including the provision of IMHA and CQC information at the point of detention.

5.4. The summary of findings (table 1) used to develop an action plan (table 2) are provided in Appendix 1.

6. Recommendations

6.1. The Trust Board is asked to:

- Review in one year the Trust's MHA activity and the action plan detailed in Appendix 1.
- Confirm that delivery of the listed actions plans will be the responsibility of the MHA lead as part of the Psychological Medicine Service directorate's governance team.
- To be aware of the impact on OUH of challenges in Psychiatric care across the county, in particularly Eating Disorders Services;
- Be aware that the internal OUH MHA policy is due to expire in August 2024 and is in the process of being reviewed and updated.

References

1. CQC Report from the Assessment of mental health services in acute trusts programme: 'How are people's mental health needs met in acute hospitals, and how can this be improved'? October 2020 https://www.cqc.org.uk/publications/themed-work/assessment-mental-health-services-acute-trusts
2. Oxford University Hospitals NHS Foundation Trust's Mental Health Act 1983 Policy

Appendix 1: Summary of Findings and Action Plan

Table 1 – Summary of Findings

Quality	Practice 2015-17	Practice 2017-18	Practice 2018-20	Practice 2020-21	2021-22	2023-23	Target
SAFE							
Deaths	0	0	0	0	0	0	N/A
Restraint	26%	63%	4%	27%	37%	63%	N/A
Risk Documentation	not audited	38%	77%	100%	100%	100%	100%
EFFECTIVE							
Capacity documentation	68%	63%	70%	100%	95%	100%	100%
Compulsory assessment (Sec 2) & treatment orders (Sec 3)	Sec 2 12 Sec 3 6	Sec 2 6 Sec 3 1	Sec 2 14 Sec 3 13	Sec 2 19 Sec 3 2	Sec 2 10 Sec 3 9	Sec 2 10 Sec 3 6	N/A
Sec 2 & Sec 3 By Directorate	AGM 10 Surg 3 Gastro 1 Traum 1 Renal 1 Neuro 2	AGM 3 OCE 3 Neuro 3	AGM 7 Gastro 5 Paeds 3 Trauma 1 Renal 2 Neuro 7 Sp Surg 2	AGM 7 Gastro 2 CHOX 5 OCE 1 Neuro 4 Surg 1	AGM 11 Gastro 3 CHOX 2 Trauma 2 Surg 1	AGM 9 CHOX 1 Trauma 3 ICU 1 Surg 1 Neuro 1	N/A
Mean Average Length of stay (in days) under MHA	7	10	16	10	20	19	N/A
Named Consultant as RC	100%	100%	100%	100%	100%	100%	100%
Discharged in statutory time limit	100%	100%	100%	100%	100%	100%	100%
Section 5.2 Emergency Holding Order	3	2	15	9	6	14	N/A
Sec 5.2 used in 'working hours'	30%	50%	73%	66%	50%	43%	N/A

Quality	Practice 2015-17	Practice 2017-18	Practice 2018-20	Practice 2020-21	2021-22	2023-23	Target
EFFECTIVE							
Sec 5.2 use by Directorate	AGM 1 Resp 1 ID 1	Surg 1 Neuro 1	AGM 7 Neuro 1 CSS 1 Womens 2 Paeds 1 Surgery 2 ID 1	AGM 4 Gynae 1 AICU 2 Trauma 1 Onc 1	AGM 5 ICU 1	AGM 5 ENT 1 Gastro 1 ICU 2 Neuro 1 Plastics 1 Surgery 1 Trauma 2	N/A
Psychiatry Involvement	100%	100%	100%	100%	100%	93%	100%
RESPONSIVE							
Gender Equality	Male 6 Female 15	Male 4 Female 5	Male 13 Female 14	Male 6 Female 14	Male 7 Female 12	Male 4 Female 10 Non-Binary 2	N/A
Ethnicity	W-B 14 W-O 2 W-I 1 B-B 1 Asian 1 N-S/K 2	W-B 6 Asian 1 N-S/K 2	W-B 32 BB 1 B 1 Mixed 1 Other 5 Not stated 2	W-B 11 W-O 3 O 2 Mx 4	WB – 18 WO – 1	WB- 14 B-O- 1	N/A
Children	0	2	5	5	3	1	N/A
LD, ASD	0	0	0	0	0	0	N/A
CARING							
Patient Rights	76%	100%	74%	100%	100%	100%	100%
Patient involvement in care planning	79%	40%	74%	100%	100%	100%	100%
Consideration of carer involvement in care planning	N/A	38%	81%	95%	100%	100%	100%
Referral to IMHA documented	58%	20%	17%	100%	100%	88%	100%
DOLS considered	N/A	N/A	N/A	35%	37%	31%	N/A

Quality	Practice 2015-17	Practice 2017-18	Practice 2018-20	Practice 2020-21	2021-22	2023-23	Target
WELL LED							
117 After care plans	100%	N/A	N/A	N/A	N/A	N/A	N/A
Appeals	0	0	1	2	5	0	N/A
Staff training	100%	100%	100%	100%	100%	100%	Annual for: Duty& Ops Managers Psych Med admin Cons. Psychs
H3 form	89%	100%	100%	100%	100%	100%	100%
Documents scrutinised on time	90%	89%	100%	100%	100%	100%	100%
All paperwork present	90%	89%	100%	100%	100%	100%	100%
No ‘non rectifiable’ Errors on Forms	86%	87%	98%	100%	95%	100%	100%
Monthly activity reporting	100%	89%	35%	100%	100%	100%	100%

Table 2 – Action Plan

Objective	Recommendation	Action	Date for completion	Notes
SAFETY				
Improve the detail and clinical relevance of risk assessments completed for detained patients	Ensure use of EPR proforma is at 100%	Feedback to all psychiatrists who may act as RC at consultant meeting	Immediately	
EFFECTIVENESS				
Review the trusts' policy of using the MCA where both MHA and MCA could be applicable		Identify training for MHA lead and administrators that addresses this specifically and liaise with MHA leads at other large acute trusts	2024	
Ensure SOP followed re. informing psychological medicine of 5(2) detentions	Alert junior doctors in induction	Liaise with educational lead in psychological medicine reincorporating this to psychological medicine induction	End 2024	
CARE				
Increase inclusion of carers in care planning, and ensure this is also documented, to 100%	Reiterate importance of IMHA referral to clinicians using MHA. Better documentation of current good practice will further improve our performance in line with CQC recommendations	Annual review of MHA policy with all Section 12 doctors in PMS Specific teaching for new PMS clinicians about MHA use in OUH To be done by MHA lead	2024 Within the initial 'shadowing' phase of induction	Present this report at next internal consultant meeting

Objective	Recommendation	Action	Date for completion	Notes
WELL LED				
To identify 100% of errors on MHA documentation and correct within one working day	The timely scrutiny of MHA paperwork has led to improvements and should be enhanced further to minimise risk to the trust of illegal detentions	Contemporaneous feedback to colleagues of any errors To be done by MHA administrator and MHA lead	Immediate effect	The AMHP and the independent doctors will not be OUH employees, and assessments frequently take place out of hours
To maintain annual teaching for relevant clinicians	Clinicians will need to be updated regarding policy, audit standards and audit results to understand expectations To ensure ward guidance and SOP are familiar to relevant staff groups	Annual MHA teaching with Psychiatrists and Section 12 approved trainees. To be done by MHA lead Duty manager training to be updated by MHA administrator (RL)	August 2024	
To identify future key indicators of good practice in line with CQC guidance, and ensure policy and SOPs are aligned to this	Consideration should be made of likely future measures of quality and good integrated working. These may include demonstrating least restrictive practice and the use of advanced directives	Review of SOP and MHA patient database To be done by MHA lead and Administrator	August 2024	MHA policy is due for review in 2024
Consider including information about section 17 leave related MHA work (i.e. patients transferred for acute care) and also about use of the MHA in the ED in future reports	This will be discussed with the Consultant Psychiatrist and team leads in EDPS	MHA lead	Dec 2024	