Executive Summary

This report describes how the Mental Health Act 1983 and the Mental Capacity Act 2005 have been used in the Trust in 2015/16. It also draws on internal and external assurance sources to establish areas of compliance and non-compliance with both pieces of legislation: the Trust was found not to have suitable arrangements in place for obtaining and acting in accordance with the consent of people or, where that did not apply, for establishing and acting in accordance with people’s best interests. This report presents the forward plan as agreed by the Mental Health Law Committee for 2016/17.

Recommendations to the Board

The Board of Directors is requested to:

- RECEIVE and ACCEPT this report for the information of the Board;
- AGREE to the recommendation that Mental Health Act and Mental Capacity Act is included in the Trusts future mandatory Training programme; and
- RATIFY the MHL priorities for the coming year (2016/17).

Trust Strategic Priorities Supported by this Paper

Excellence

- Continually improve the quality and safety of service delivery, service user experience and improving outcomes.
- Delivering the highest level of quality and financial performance.
Risk Implications
This report highlights the risk of legal challenge arising from issues around implementing aspects of the Mental Health Act 1983 and the Mental Capacity Act 2005 as well as from the under-resourcing of the Mental Health Act administrative function.

Legal and Compliance Implications
This report highlights areas where the Trust’s practice is not in line with the Mental Health Act 1983 and the Mental Capacity Act 2005.

Finance Implications
This report makes recommendations for the training of all staff on capacity and consent provisions and identifies issues with the resources allocated to the Mental Health Act administrative function.

Single Equalities Impact Assessment
N/A

Requirement of External Assessor/Regulator
The Trust finds itself in breach of CQC regulations, which it is duty bound to resolve or an enforcement notice might be issued.
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Introduction

This annual report provides the Board with assurance that it is carrying out its duties under the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA) with due care and diligence. The report covers the period from April 2015 to 31 March 2016 and examines the data and activity in relation to the Trust’s duties and responsibilities under the MHA and the MCA as well as external and internal assurance sources.

Regular changes in mental health case law and legislation have a continuous impact on services. The Trust is committed to embed those, to comply with the law and to model best practice for the community we serve. However it is recognised that embedding those changes into clinical practice takes time and that bringing staff, service users and carers with us is key. For this reason, this report will demonstrate areas of progress and areas which will be developed in the coming year.

The monitoring of compliance with Mental Health Law is overseen by the Trust’s Mental Health Law Committee which was re-launched in February 2015 and was chaired by Sarah Charles, Non-Executive Director. Sarah’s tenure ended in November 2015 and the MHL committee would like to extend its thanks to Sarah for her diligence and leadership.

The membership of the group has been revised and now includes a service users’ representative, a carer, local authority partners, Associate Hospital Managers and representation from the Divisions.

In March 2015, the Trust appointed a Mental Health Law Manager and a Mental Capacity Act Lead/Deputy Mental Health Law Manager, who are responsible for providing leadership and strategic overview on the MHA, MCA and Human Rights Act 1998. These posts have been invaluable in creating robust systems with which the Trust can fulfil its responsibilities in relation to Mental Health law.

The MCA Lead in particular has made significant inroads to assessing awareness of MCA throughout the whole organisation and designing and delivering training materials on how to test capacity, record Consent to treatment and understand our responsibilities in relation to Deprivation of Liberty Safeguards.

The Mental Health Law Hub

The MHL Hub was created in March 2015. The purpose of the Mental Health Law Hub (MHL Hub) is to:

- share information regarding the Mental Health Act 1983 (MHA), the Mental Capacity Act 2005 (MCA), the Deprivation of Liberty Safeguards (DoLS), the Human Rights Act 1998 and associated legislation/case law with the whole Trust;
- provide expert legal advice and guidance in relation to MHA and the MCA(DoLS) to staff, service users and carers; and
- provide a comprehensive administration service in relation to MHA and Deprivation of Liberty Safeguard (DoLS) administration services for the whole Trust.

The structure and the achievements/challenges for the MHL Hub are covered in Appendix 2.
1. **Use of the Mental Health Act 1983**

1.1 **National context – Detentions in Hospital and the use of Community Treatment Order**

**Detention in Hospital**

In 2014/15 period, according to HSCIC, there were a total of 58,399 detentions under the Act, an increase of 5,223 (or 10%) compared to 2013/14 (53,176) and compares to a 6% rise during 2013/14 and a 4% rise during 2012/13.

On the 31 March 2015 there were a total of 25,117 people subject to the MHA. Of these, 19,656 were detained in hospital. This is an increase of 1,586 (or 6.7%) detained compared to 31 March 2014 and an increase of 4,179 (or 20.0%) compared to the 31 March 2011.

**Community Treatment Orders (CTO)**

In the 2014/15 period according to HSCIC, 4,564 CTOs were issued this is an increase of 130 (or 3%) compared with the same period in 2013/14.

On the 31 March 2015 there were 5,461 people subject to CTO. This is an increase of 96 (or 2%) on the previous snapshot on the 31 March 2014.

The chart below shows the trend of increasing detentions under the MHA between 2009/10 and 2014/15:

![Detentions under the MHA - National Data](chart.png)

*Source: Health and Social Care Information Centre*

*Note: Detentions under the MHA figures exclude: short term detention order (Sections 4, 5(2), 5(4), 135 and 136; Detentions following the use of Section 135; Detentions following recalls from conditional discharge; Section 136 uses in custody suites.*

---

1.2 Detentions under the Mental Health Act – Trust Data

In 2015/16 period, according to the KP90 submissions for Camden and Islington NHS Foundation Trust\(^2\), there were a total of 1,811 admissions to hospital sites within the Trust.

Compared to the same period in 2014/15 there was an increase in admissions to Trust sites of 155 (or 9%). The total number of formal admissions under the MHA was 715, an increase of 209 (or 39%) and the total number of informal admissions was 1,142, a decrease of 97 (or 5%) compared to the same period in 2014/15.

On the 31 March 2016 there were a total of 318 people subject to the MHA. Of these, 153 were detained in hospital. Compared to the 31st March 2015 there has been a decrease of 8 (or 3%) in the number of formal admissions under the MHA to Trust sites.

The following chart shows the trend of admissions to Trust sites under the MHA between 2009/10 and 2015/16:

![Admissions to C&I Hospital Sites](chart)

*Source: KP90 Returns*

Whilst the national figures refer to the period 2014/15 we can see that there is a general trend showing a year on year increase in the number of detentions since 2011. Nationally this an average increase of 6% however in the Trust, there has been an increase of 39%, which is just over 6 times the national average.

A number of factors might explain the difference between local and national trends in terms of formal admissions, including:

- Higher volume of referrals of patients not previously known to services; and
- Multiple admissions of same patients.

However, we need to better understand the reasons as to why the number of admissions in the trust is so much higher than the national average. This analysis will form part of the MHL Annual report for 2016/17.

The Mental Health Law Monitoring Committee will continue to monitor both local and national trends in the coming year as well as underlying reasons. The Trust is also an active member of the Pan-London MHA Managers Network, which is in the process of benchmarking detention data.

\(^2\) C&I Dashboard> MHA Reports> KP90 Submissions
1.3 The Mental Health Act Dashboard
The Mental Health Act dashboard has been developed in the last year to ensure that data is collected in respect of the change from Rio to Carenotes. The dashboard is a useful tool to capture activity in relation to the use of the MHA and is part of our Quality Assurance Framework and performance monitoring such as:
- KP90 returns;
- MHA Sectioned Patients in the period;
- MHA – CTO, Recall and Revocations; and
- MHA Formal Vs Informal admission.

The dashboard will be used by the Mental Health Law Monitoring Group to monitor the trust’s use of both the MHA and the MCA. Work is planned in 2016/17 to ensure the Trust can record the following:
- improving on the data we capture in respect of Equality and Diversity characteristics;
- CTOs by Division;
- MCA figures (Test for capacity & Best Interests; and
- Deprivation of Liberty Safeguards.

1.4 Use of Community Treatment Orders (S17a) – Trust Data
Community Treatment Orders (CTOs) allow patients with a mental disorder to live in the community whilst still being subject to powers under the Mental Health Act. The power of recall allows the Responsible Clinician (RC) to bring a CTO patient back to hospital if they think they have become unwell again.

As a snapshot on the 31 March 2016 there were a total of 165 people subject to a CTO within the Trust. Compared to the 31 March 2015 this represents an increase of 8 (or 3%). In 2015/16 period, according to the KP90 submissions, there were a total of 151 new CTOs made within the Trust. Compared to 131 in 2014/15 representing there was an increase of 20 (or 15%).

The table below shows the number of new Community Treatment Orders (CTO) made in the trust over the past 6 years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of CTO's Made in the Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>91</td>
</tr>
<tr>
<td>2010/11</td>
<td>118</td>
</tr>
<tr>
<td>2011/12</td>
<td>132</td>
</tr>
<tr>
<td>2012/13</td>
<td>134</td>
</tr>
<tr>
<td>2013/14</td>
<td>127</td>
</tr>
<tr>
<td>2014/15</td>
<td>131</td>
</tr>
<tr>
<td>2015/16</td>
<td>151</td>
</tr>
</tbody>
</table>

Source: KP90 Returns- Dashboard
Note: National figures for 2015/16 are not available at time of writing

The historic figures from 2009-2015 presented here are different to those reported in the MHL Annual Report 2014/15. The sources of the figures from the 2014/15 report were unobtainable at the time of writing the
Nationally there has been a 2.9% increase in the number of CTOs being made in 2015/16 compared with 2014/15 but an increase of 15% within C&I.

As seen in the following table the mean average increase in CTO’s being made across London in 2015-16 was 16%. The findings from other London Trusts are as follows:

<table>
<thead>
<tr>
<th>London Trust</th>
<th>Number of CTOs Made</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden &amp; Islington</td>
<td>131 151</td>
<td>15%</td>
</tr>
<tr>
<td>Barnet Enfield &amp; Haringey</td>
<td>97 100</td>
<td>3%</td>
</tr>
<tr>
<td>South West London &amp; St Georges</td>
<td>103 104</td>
<td>1%</td>
</tr>
<tr>
<td>West London Mental Health Trust</td>
<td>78 91</td>
<td>17%</td>
</tr>
<tr>
<td>Central &amp; North West London NHS Foundation Trust</td>
<td>107 155</td>
<td>45%</td>
</tr>
</tbody>
</table>

The Mean average increase within London Trusts 16%

However, despite the comparable benchmarking with other neighbouring Trusts, C&I needs to determine the underlying causes of this significant increase in the use of CTO and to lay out the clinical rationale for using CTOs along with the benefits and dis-benefits Trusts use of CTO.

There are only two possible ways to end a CTO:

- Revocation – RC exercise their power to recall patient to hospital and end the CTO. It effectively places the individual back on the Treatment Section\textsuperscript{4} they were on prior to the CTO being put in place.
- Discharge – Section 23 authorises the discharge from CTO and the service user is no longer subject to the MHA and is a reflection of their journey of recovery.

The table below shows the number of CTO discharges and revocations made in the Trust over the past 7 years:

The number of CTOs ending decreased by 7 (or 9%) between 2014/15 and 2015/16. This decrease in the number of CTOs ending has an impact on the overall number of service

\textsuperscript{4} Mental Health Act Section 3, 37 or 47
users subject to a CTO within the Trust at any one time and explains the increase in the snapshot figures of service users subject to CTO.

1.5 The Approved Mental Health Professional (AMHP) Duty Service
The Trust provides an AMHP service for Camden, and for Islington. The service is responsible for undertaking Mental Health Act assessments of individuals referred to them. During 2015/16 there was one duty manager who provided cover for both teams, while a second post was planned to recruit to. The AMHP service is run via a rota and draws social workers who are specially trained as AMHPs from across the mental health teams in all Divisions and also from adult social care.
The full AMHP Duty Service reports for each borough can be found in the appendices of this document. The respective reports are prepared and presented to each borough separately hence their contents (how and what they monitor) is different based upon the demography of each borough. In 2016/17 the AMHP services will look at why the two borough work differently based upon their demography.
In summary across the boroughs of Camden and Islington the total number of Mental Health Act assessments in 2015/16 was 1252 this in an increase of 23% (or 225) on the previous year.
One of the objectives of the AMHP service for the 2016/17 period will be to ensure that ethnicity codes are in line with national recording systems and to be able to better capture accurately the ethnicity of those who use the service.

1.6 Associate Hospital Managers
Associate Hospital Managers (AHMs) are lay people, who are appointed by the Trust to review the cases of detained and Community Treatment Order (CTO) patients. Their role and powers derive from the Mental Health Act 1983 and are set out in detail in the Code of Practice. Their main function is in undertaking ‘Managers Hearings’ which consider if a patient’s detention in hospital or CTO status should be lifted.

1.6.1 Governance
The Convenor of Associate Hospital Managers is appointed by the Trust Chairman and chairs the AHM group. The AHM Group meets every quarter to with the remit to consider issues of good practice, raising standards and receiving training. The AHM Group reports to the Mental Health Law Committee.
In addition the Convenor of the AHMs is an active member of the London Mental Health Act Network, which brings together non-executive directors, Lead Associate Hospital Managers (AHMs) and Heads of Mental Health Act Departments with key active roles in leading and shaping the implementation of the Mental Health Act provisions applicable to AHM panels within mental health trusts and private providers based in London and the South East for mutual support through development and change.

1.6.2 Volume of Hearings and Priority Areas
There were 130 Associate Hospital Managers hearings listed in 2015/16. A managers hearing is generated in 1 of three ways:

- **Renewal Hearing** – When a patients detention in hospital or Community Treatment Order is renewed
- **Appeal** - When a patient appeals to the Hospital Managers for discharge from Section or Community Treatment Order
- **Barring** – When a Responsible Clinician Bars a nearest relatives application for discharge.

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5 MHA Sections 3, 37 and 47
With regards to the number of hearings which took place in 2015/16 in all cases the use of the Mental Health Act was upheld.

We were unable to provide figures for the number of hearings in the previous MHL Annual report (2014/15). We are therefore unable to comment on any trends within the Trust. AHM activity figures are however captured on-going and we will be able to a comparison in the next MHL annual report (2016/17). The breakdown across the 4 quarters is as follows:

The number of hearings dropped by 17 between Q2 and Q3. This is a direct result of the decreased level of qualified MHA staff in the MHA offices.

**AHM Hearing Backlog & Risks to the Trust**

In order to meet the requirements of the MHA in relation to the lawfulness of detention and treatment as well as meeting the requirements of the First Tier Tribunal (Mental Health) the MHL Hub has struggled to list AHM hearings and a backlog in excess of 40 renewal hearings had built up as of 31 March 2016 at Highgate Centre for Mental Health. Going into the 2016/17 this poses the largest risks to the Trust as this backlog could continue to grow until the level of experienced staff in the MHA office increases.
2. Use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

2.1 National Context

The Supreme Court found, in the case of Cheshire West\textsuperscript{6} in March 2014, that any person, residing in a hospital or care home, who is under \textit{continuous supervision and control and not free to leave}\textsuperscript{6} is being deprived of their liberty. This has lowered the threshold of what constitutes a deprivation of liberty and has had the effect of increasing the number of applications for Deprivation of Liberty Safeguards (DoLS) made nationally from 13,000 to 113,000 representing 872% increase.

2.2 DoLS Figures for Camden and Islington NHS Foundation

There were no DoLS figures available for the Trust in the year 2014/15 for comparison. There were 24 DoLS applications in the year 2015/16. Applications from the SAMHs service dominate the number of applications made by the Trust. The Acute Inpatient settings were from Dunkley (3) which has LD beds and Jade (1). The SAMH Inpatient setting was Garnet (4) and Pearl (1) and the 15 applications from the Residential / Nursing Home setting came from Stacey Street.

<table>
<thead>
<tr>
<th>Percentage of DoLS applications Granted</th>
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<tbody>
<tr>
<td>DoLS Not Granted</td>
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<tr>
<td>DoLS Granted</td>
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The reasons for the DoLS applications not being granted were as follows:

- DoLS office rejected as patient was ‘primarily receiving treatment for mental disorder’ and therefore Mental Health Act was deemed more appropriate
- Residents discharged from
- Admin error i.e. Incorrect DoLS application form completed or form submitted to incorrect DoLS office

As a result of these we will be aiming in the coming year to ensure that 80% of all DoLS applications are granted. This will be done by ensuring the admin errors are reduced and that further training is provided to staff to identify when MHA should be considered prior to considering making a DoLS application.

\textsuperscript{6} [2014] UKSC 19 - P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council (Respondent)
2.3 Mental Capacity Act Leadership in the Trust
A Mental Capacity Lead/Deputy Mental Health Law Manager was appointed in March 2015.
with responsibility for:
- Implementing the recommendation of the CQC inspection in relation to mental health
  law;
- Overseeing the administration of the Mental Capacity Act 2005, Deprivation of Liberty
  Safeguards, other associated legislation, case law and statutory guidance;
- Acting as the point of expertise within the Trust providing support and guidance to
  clinicians on all aspects of the Mental Capacity Act 2005 and Deprivation of Liberty
  Safeguards within the framework of the Mental Health Law Hub;
- Representing the Trust at any relevant national or regional meetings/networks in
  relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

This post still has considerable portfolio of work to accomplish, and although there is very
steady progress and it will be possible to achieve, it would be extremely helpful if funding for
this post caught up to provide this security.

2.4 MCA & DoLS Training
In March 2015 an external organisation was appointed to provide training on the MCA and
DoLS since this was required for the whole Trust. An external provider delivered
’Implementing the MCA’ training in the Summer / Autumn 2015. The training consisted of a
full day course for registered staff and a half day for non-registered staff. The Trust has set
a target of 80% of staff to have completed the MCA & DoLS mandatory Training.

The mandatory training session forms part of the MCA & DoLS awareness induction session
for all new staff to the Trust. It covers Trust policy for assessing and recording Capacity,
Best interests and making referrals for DoLS. It is a 35 minute session. The areas covered
by the mandatory training are incorporated into more in depth MCA DoLS training courses
such as:
- Informed Consent to Staying on the Ward following discharge from MHA;
- Implementing the MCA within mental health services (Full and Half Day);
- Introduction to MCA/MHA for Junior Doctors;
- Introduction to MCA/MHA for New Nursing Staff; and
- MCA & DoLS Demonstration Session.

We commenced the mandatory training in April 2015 and the compliance with our 80%
target are represented below:
Whilst we have made great headway in reaching the 80% target we have not yet reached it and need to train a further 318 staff in order to meet it. At the end of Q4 the Trust was at 61% (or 722 members of staff). We aim to meet the 80% (or 1040 member of staff) target by Q2/Q3 of 2016/17 period. The immediate feedback from the CQC of their visit in February 2016 highlighted concerns about level of awareness and training in relation to both the MCA and MHA. The MHL proposes that both MHA and MCA form part of the Trusts Mandatory Training programme in 2016/17.
3. External Assurance Sources

3.1 Care Quality Commission MHA Monitoring Visits

The CQC conducted a provider level inspection to the Trust in February 2016. The provider action report and the rating are not expected to be received until summer 2016 so will be addressed in the 2016/17 MHL Annual report.

The CQC conduct Mental Health Act monitoring visits as a way of assessing the service we provide. On the day of the visit the CQC provide verbal feedback which is followed up with written report highlighting their finding and what actions the Trust need to take. The Trust must then produce a respond. In July 2015 the Mental Health Law Manager produced April visits use of the Mental Health Act is monitored by the Care Quality Commission (CQC). The CQC conducted a total of 10 MHA monitoring visits to the following trust wards in 2014/15:

- Dunkley Ward (28/04/2015);
- Jade Ward (05/05/2015);
- Malachite Ward (17/06/2015);
- Montague Ward (01/07/2015);
- Pearl Ward (20/07/2016);
- Rosewood Ward (07/08/2015);
- Coral Ward (17/09/2015)
- Garnet Ward (06/10/2015);
- Laffan Ward (25/11/2015); and
- Opal Ward (20/01/2016).

The table below sets out the issues identified by the CQC on their ward visits:

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<td>Care Plans</td>
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<tr>
<td>Section 132 Rights</td>
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<td>!</td>
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<td>□</td>
<td>!</td>
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<td>!</td>
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<tr>
<td>Tribunals and hearings</td>
<td>NI</td>
<td>NI</td>
<td>NI</td>
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<td>NI</td>
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<td>Leave of absence</td>
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<tr>
<td>Transfers</td>
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<td>Control and security</td>
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<tr>
<td>Consent to treatment</td>
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<tr>
<td>General Healthcare</td>
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</tr>
</tbody>
</table>

□: No issue identified
! : Issue identified
NI: Not inspected

The top three issues identified are:
- Care plans: patients' views were not adequately reflected and copies were not always shared with patients;
- Section 132 rights: evidence was found of attempts being made on the admission day to explain their rights to patients but, when unsuccessful, little evidence could be found of further attempts being made in a timely fashion;
- Consent to treatment: patients’ consent to treatment was not sought and capacity to consent to treatment was not tested prior to first administration of treatment.
Responses to the findings of each report and action plans have been duly returned to the CQC. According to our Quality Assurance Framework, action plans are stringently monitored by the Mental Health Law Committee. The Mental Health Law Manager and Mental Capacity Act Lead also participate in Quality Assurance Reviews to check the implementation of action plans. They also work closely with Ward Managers and Consultants on improving skills and knowledge of mental health law.

In October 2015 the Acute Division started piloting the admin-led monitoring group and which tracks on a weekly basis the wards compliance against S132 rights and consent to treatment. We are hoping to see improvements in these areas in the coming year.
4. Internal Assurance Sources

4.1 Clinical Audits

The following audits were undertaken in the by the Mental Health Law Hub:

- Informed Consent for Voluntary Admission - This identified risks to the Trust with regards to the potential unlawful deprivations of liberty of Informal inpatients who lacked capacity to consent for admission. A summary of the finding of this audit can be found in Appendix 6.
- Consent to Treatment Provided under the MHA – This identified that the Trust was not fully compliant with the requirements of the MHA Code of Practice with regards to Consent to Treatment requirements of the Code. A summary of the finding of this audit can be found in Appendix 7.

4.2 Mental Health Law Committee

The Mental Health Law Committee has met regularly 2015/16.

The role of the Committee is:

- To have oversight and scrutiny of all issues related to Mental Health law relevant to the services and duties delivered by the Trust and its Local Authority partners.
- Using internal and external legal expertise, to advise the Trust on issues related to the application of law in Trust practice, with a view to contributing towards improved risk management and service user experience.
- To provide assurance to the Board, the governing body and partners, on the appropriate and effective administration and application of mental health law in practice and adherence to best practice guidance.
- To uphold and protect the rights of service users.

The existing Non-Executive Director chair of the Committee stood down after their term had finished. A new Non-Executive Chair was appointed and commenced in the autumn of 2015. Further to this, Service Users and Carers are also Board Members. The Committee will meet 4 times in 2015/16. Four groups will report directly to the Committee:

- AHM Group
- Mental Health Law Policies and Procedure Group
- Mental Health Law Monitoring Group
- Mental Health Law Training Group

All four groups are due to convene and to agree their terms of reference in 2015/16.

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7 Informal In-Patient is someone who is not subject to the Mental Health Act
5. **Conclusion**

As demonstrated earlier in this document the newly formed MHL Hub has completely reviewed and overhauled the systems and identified what is required for the trust to fulfil its obligations under the MHA and MCA and started to create new structures and tools to achieve this, which has been a major piece of work. The Hub has also faced a number of serious staffing challenges in 2015/16 which have been met by using additional staff through NHSP and training them to ensure they are properly inducted into the service as quickly as possible and equipped to fulfil the administrator roles. This has required considerable dedication and effort on behalf of the whole team. In addition the managers have kept all stakeholders informed of staff changes and ensured there has been clear communication to minimise the impact these changes in staffing might have on services. It has been a credit to the team that they have made significant improvements and there is now more robust governance through the Mental Health Law Committee, and many freshly reviewed policies and procedures. There is greater monitoring of the MHA & MCA and in relation to training the Trust is now in a much healthier position of having 60% of staff compliant with mandatory training on MCA. The team are committed and in the coming year recognise there is more work to do.

**Priorities for 2016/17:**

- To present the gaps and areas where improvement is required in the Trust to the Senior Leadership team for discussion and a commitment from operations and all to help resolve them.
- MH Law hub to then select an area that requires an improvement, for example S:132 rights and consent to treatment and pilot an intervention with a specific team/ward.
- Review the structure of the Mental Health Law Hub to ensure that the staffing capacity is able to meet the demands of the service, and the Trust is able to consistently fulfil its legal obligations to the MHA and MCA in a timely fashion.
- Devise MHA admin guidance and explore new tools that might support MHA admin staff, and create standardised systems across the Trust.
- Creation of MHL Champions and/or other suitable leads as identified by the Divisions to ensure staff across the trust are equipped with relevant MHL knowledge and skills relevant to their role.
- Explore new income generating opportunities through SLAs with other Trusts in relation to MHA admin and Training.
- Continue with robust programme of auditing MHA and MCA area.
- Develop and strengthen AHM appointments, recruitment and appraisal systems.
- Ensuring that Carenotes can provide reports around the use of the MCA and DoLS
- Develop a programme to monitor the use of advocacy across the Trust.
- Work closely with the MHA/MCA task and finish group in the Acute division to resolve issues reported in CQC MHA monitoring visits (Recording of Section 17 leave, 132 Rights and consent to treatment).
Appendix 1

Trust’s Associate Hospital Managers List 2014/15

Lady Butterworth
Tony Bowyer
Margaret Giller
Brian Haley
Norman Hamilton
Paul Jacques
Kathleen Lee
Petra Leseberg
Peter Nevins
Alistair Nimblette
Fiona Ng
Maria Oladapo
Pamela Ormerod
Susan Plowden
John Rahman
Jennifer (Jenny) Seres
David Uzosike
Jeremy Walker
Roberta Wetherell
Appendix 2

List of those consulted with in order to prepare the Mental Health Law Annual Report 2015/16

Patrick Vernon  (Chair of the MHL Committee)
Claire Johnston  (Head of Nursing & People)
Deborah Wright  (Head of Social Care & Social Work)
Philippa Dawson  (Acting Deputy MHL Manager / MCA Lead)
Suzanne Joels  (Consultant Psychiatrist & Clinical Director SAMH)
Jenney Seres  (Associate Hospital Managers)
Roger Small  (Service Users Rep)
David Hamilton  (AMHP Duty Lead Islington)
Caroline Spencer  (AMHP Duty Lead Islington)
Aisling Clifford  (Associate Director – Acute Division)
Ian Griffiths  (Divisional Clinical Director)
Karen Jones  (Matron)
Ann Jumawan  (Matron)
Margaret Adedeji  (Matron)
### Appendix 3

<table>
<thead>
<tr>
<th>Band 8b</th>
<th>Band 7</th>
<th>Band 6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Duties</strong></td>
<td><strong>Overview of implementation of Mental Health Law (i.e. MHA 1983 and MCA 2005) at Trust level</strong></td>
<td><strong>Review Mental Capacity Act policies</strong></td>
</tr>
<tr>
<td></td>
<td>• Devise Mental Health Act policies + responsible for MHL policies review schedule</td>
<td>• Devise Mental Capacity Act recording tools</td>
</tr>
<tr>
<td></td>
<td>• Devise and deliver Mental Health Act training programme</td>
<td>• Deliver Mental Capacity Act training programme</td>
</tr>
<tr>
<td></td>
<td>• Devise Mental Health Act Monitoring Plan and implement effective MHA monitoring</td>
<td>• Monitor use of Mental Capacity Act</td>
</tr>
<tr>
<td></td>
<td>• Provide MHA legal advice as and when required</td>
<td>• Provide MCA legal advice as and when required</td>
</tr>
<tr>
<td></td>
<td>• Represent the Trust at LMHAN Network and other MHL related forums</td>
<td>• Represent the Trust at London MCA Network and other MCA related forums</td>
</tr>
<tr>
<td></td>
<td>• Line management of Band 7 Deputy Mental Health Law manager/MCA Lead and Band 6 MHL Coordinator</td>
<td>• Line management of MHA admin staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deputise for MHL Manager when absent</td>
</tr>
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<table>
<thead>
<tr>
<th>Band 5</th>
<th>Band 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of Duties</strong></td>
<td><strong>Ensuring functions of the office are completed managed</strong></td>
</tr>
<tr>
<td></td>
<td>• Receiving &amp; Scrutinising section papers</td>
</tr>
<tr>
<td></td>
<td>• Delegating appropriate tasks to Band 4</td>
</tr>
<tr>
<td></td>
<td>• Assisting Band 4 in their responsibilities</td>
</tr>
<tr>
<td></td>
<td>• Providing cover for Band 4</td>
</tr>
<tr>
<td></td>
<td>• Handling legal queries of beyond level of Band 4</td>
</tr>
<tr>
<td></td>
<td>• Developing skills of Band 4 Ensuring</td>
</tr>
<tr>
<td></td>
<td>• Writing to patients, Nearest Relatives and carers regarding information about the MHA</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

| Band 6 | | | **Provide patients, relatives and carers with information on their rights under the MHA 1983 + devise tools to facilitate this** |
| | | | • Liaise with IMHA service |
| | | | • Liaise with Associate Hospital Managers re appointment, training needs, honorarium |
| | | | • Monitor use of MHA 1983 |
| | | | • Liaise with Recovery College |
Appendix 4

Camden AMHP Duty

Camden AMHP Duty Service 2015/16
Total number of assessments: 668

Introduction
Camden Approved Mental Health Professional Duty service operates from Monday to Friday from the First Floor, East Wing, St. Pancras Hospital. It is co-located with the Islington AMHP service and the AMHP management team, which includes the AMHP training manager. The duty administrator provides support to both services.

During 2015/16 there was one Duty Manager that covered both Camden and Islington AMHP Duty Teams. However in April 2016 a new Duty Manager was recruited for Islington so there is currently a Duty Manager in both Camden and Islington. There is also an AMHP Lead/service manager responsible for the overall service.

The service is run via a rota and draws AMHPs from across the mental health teams and also adult social care. The aim is to have three AMHPs on duty per day, undertaking both planned and emergency work across the borough. There are currently 27 warranted Camden AMHPs available for the rota (not including the two AMHP managers). Overall this is 2 AMHPs less than a year ago. We have trained 2 AMHPs neither of which were able to join the rota, 1 is on maternity leave and 1 has left the trust. Three AMHPs are no longer available due to maternity leave, long term sickness and no longer being warranted, however we have gain 1 AMHP who has transferred from the Islington rota to the Camden rota. We currently are unable to rota 3 AMHPs per day. Also it should be noted that although we have 4 staff going for AMHP training this September they are unlikely to be warranted until the spring of 2017 at the earliest. We will also lose 2 AMHPs who are leaving the trust in the summer and 1 AMHP will reduce their commitment to the rota due to undertaking a new role.

The volume of work is widely variable. On a day to day basis the number of assessments completed can range from 0 to 8. There are approximately 13 assessments per week up from 9 a week last year. It is estimated that 15% these assessments required planned police assistance, which is the percentage as last year. However, a number of assessments do not actually take place as the person is assessed prior to the planned date or sometimes the assessment is cancelled. We have undertaken a number of assessments where we have called the police as an emergency. We will record these more accurately as well as the number of warrants applications.

This year we have started to gather information on the number of assessments that were not completed. There were 63 assessments that were not completed out of the 668 assessments. The reasons for the AMHP not being able to complete include for community assessments the service user not being at home when the assessment was not undertaken and for immediate assessments in accident and emergency departments and police stations when a bed cannot be identified in a timely manner and the assessment is passed to EDT to be completed. Due to the high number of police assisted assessments, a duty AMHP attends court approximately 1-2 times a week to obtain S.135 warrants.

Community Treatment Order recommendations and revocations should be undertaken within teams but are sometimes completed by AMHP duty where there are no AMHPs available. Guardianships and Nearest Relative displacements are also allocated within teams. Where the team does not have an AMHP, this work has to be negotiated with another team’s AMHP. There have been no Guardianships in Camden in the last year.

The AMHP managers offer advice and support to all AMHPs regardless of whether their work is within teams or as part of the duty service.
Data
The total number of Mental Health Act assessments undertaken during the year 2015/6 was 668, although there may be an element of under reporting. Over the previous 5 years Camden AMHP duty has seen a downward trend in the number of assessments carried out in a year. (481 in 2014/15; 524 in 2013/14; 535 in 2012/13; 539 in 2011/12; 587 in 2010/11). However this year has seen a great increase in the number of assessments, this is in line with other London boroughs including Islington that have been reporting an upward trend.

Public health data suggests the diagnosed prevalence of serious mental illness (SMI) in Camden is 1.3%, which is significantly higher than the London and England averages. It is the third highest in England. 25% of adults with SMI have Bipolar Disorder and 75% schizophrenia. Prevalence is 83% higher in the most deprived areas of the borough.

We do not know how many people are new residents or are transitory.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Borough</td>
<td>Year</td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
</tr>
<tr>
<td>Camden</td>
<td>2014/2015</td>
<td>39</td>
<td>51</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>2015/2016</td>
<td>43</td>
<td>48</td>
<td>51</td>
</tr>
</tbody>
</table>
**Gender**

Out of the total number of assessments, 42% are women and 58% are men. Last year we assessed almost the same number of men as women, this year we have assessed significantly more men than women in every quarter.

**Number of AMHP Assessments [Camden Only] in Qtr. per Gender - 01 April 2015 to 31 March 2016**

![Gender Chart]

**Age**

**Number of AMHP Assessments [Camden Only] in Age Band - 01 April 2015 to 31 March 2016**

![Age Chart]

<table>
<thead>
<tr>
<th>Age</th>
<th>&lt;18</th>
<th>16-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65-74</th>
<th>75+</th>
<th>Unknown</th>
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</thead>
<tbody>
<tr>
<td>No.</td>
<td>16</td>
<td>74</td>
<td>141</td>
<td>147</td>
<td>135</td>
<td>72</td>
<td>45</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>2.5%</td>
<td>11%</td>
<td>21%</td>
<td>22%</td>
<td>20%</td>
<td>11%</td>
<td>7%</td>
<td>5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

It has been requested if information can be provided for under-18s as this more appropriately identifies CAMHs service users. The spread of the age range of those being
assessed demonstrates the diversity of needs and also the skills and knowledge required to undertake AMHP work in Camden.

The Camden age profile is very similar to that of the rest of London but relatively younger than England with significantly greater proportions of younger adults aged between 25 and 40 years. Camden’s population is expected to rise to 246,100 by 2023, an increase of 8.5%. People aged 45 years and over are expected to account for the largest rise between now and 2023. In terms of percentage increase, the highest increase is expected in those aged 75+, numbers in this age group are expected to increase by 30% (3,500 people) (Reference: LBC Joint Strategic Needs Assessment). Serious mental illness affects a greater proportion of men than women aged 18 and over (1.8% compared to 1.3%). The prevalence of diagnosed serious mental illness increases in people aged 35 years and over, with 45-54 year olds experiencing the highest prevalence (Public Health Intelligence report).

### Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>%</th>
<th>% 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian / Asian British</td>
<td>46</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Black / Black British</td>
<td>145</td>
<td>21.5%</td>
<td>20%</td>
</tr>
<tr>
<td>Mixed Background</td>
<td>40</td>
<td>6%</td>
<td>4%</td>
</tr>
<tr>
<td>Not Known</td>
<td>19</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>27</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>60</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>White</td>
<td>331</td>
<td>49.5%</td>
<td>58%</td>
</tr>
</tbody>
</table>

Broad ethnic groups have been reported as Camden’s population is very diverse and there are many smaller groups which are 1% of the total number. However, it would be useful to identify which groups are greatest in number if particular populations are increasing. These figures are drawn from Rio. It should be noted that these categories are sometimes not self-defined.

Of the total number of those assessed, almost half of those assessed were from ‘white’, 21.5% from ‘black’ and 7% from ‘Asian’ ethnic groups. 6% were described as ‘mixed’ heritage and 9% ‘other ethnicities’. These are similar numbers to last year but with slightly more people coming under the ‘other’ group, ‘black’ service users and slight decrease in the
percentage of ‘Asian’ service users. There has been almost a 10% decrease in the number of ‘white’ service users that we assessed. It would be interesting to see a breakdown of the figures for ‘white’ service users in terms of country of origin to see the effect of EU migration. According to the Camden Public Health Intelligence report on ‘serious mental illness’ (June 2013), the incidence of psychiatric illness is observed to vary across ethnic groups. Nearly 35% of Camden’s overall population is estimated to be from a black minority ethnic group background. Black ethnicities count for the highest prevalence of SMI, particularly black men. The highest recorded prevalence is 4.8% in black men and 2.7% in black women. Evidence also suggests that Black Caribbean and Black Africans have a higher incidence of common adult mental health disorders, e.g. anxiety, depression and phobias. The same can be said of the White Irish community (Reference: JSNA). 22% of Camden’s residents are from the non-British, white community. The figures we report here are only those who have been subject to a Mental Health Act assessment. A more detailed analysis is required to compare this with the ethnicity of those subject to CTOs, S.136 as well as the breakdown of the likelihood of informal or formal admission for different ethnicities and the population of the inpatient and crisis services.

**MHAA by Service User’s Team**

Of those assessed, the largest percentage (27%) was not under the care of any local mental health services or adult social care at the time of the assessment (compared to 26% last year). This figure remains very high and warrants further investigation. 12% were from out of area which also continues to be high, although in Camden it appears that EDT are now picking up greater numbers of assessments for those who live elsewhere. It should also be noted that the Focus homeless team often work with people who belong to another area and this is not differentiated in these figures. Both South and North R&R teams account for a significant percentage. EIS account for the next largest percentage at 11% and Focus at 4%. CAMHs were 1% compared to 3% last year.

**MHAA by Service Users Team**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Social Care</td>
<td>1</td>
</tr>
<tr>
<td>AOT</td>
<td>29</td>
</tr>
</tbody>
</table>
Outcomes

74% of those assessed were admitted formally under the Mental Health Act compared to 83% last year. This figure should always be reasonably high if filtering and consideration of alternatives is rigorously considered prior to a Mental Health Act assessment taking place. 4.5% were admitted informally. However, 10% (it was 9% last year) of those assessed were
not admitted (and it is not detailed that a community alternative was put in place), which suggests there are a number of people who should not have been referred for assessment. It would be useful to understand this figure in more detail so that we can try to reduce this. 3% had a community alternative and it is likely that this figure is higher but it has not been clearly documented by AMHPs on their reports. We need to have clearer information on the use of crisis teams and houses as alternatives to admission and also how often these services refer for a mental health act assessment. There were no Section 4s.

This year we have started to collect figures for assessment not complete. There were almost 10% of assessments that we were unable to complete. The main reason for not being able to complete an assessment was that either the person was not at home when we assessed in the community or for assessments in A&E or police stations there was no bed identified in a timely manner at the end of the assessment so an application could not be completed.

**Police Waits**

Camden police are one of the few boroughs who still organise attendance at Mental Health Act assessments via a centralised events office. We have a very good relationship with the events team and work to prioritise together. They have also been short staffed over the last year however which can delay assessments. Previously the majority of assessments took place between 0-10 days. However this year only 40% of assessments took place within 10 days of the police risk assessment being sent. Those over 20 days are delays for specific reasons usually, such as repeated attempts. In the last year, we have contributed to the development of a pan-London protocol for Mental Health Act assessments involving the police. The Magistrates courts have also contributed as the process of obtaining warrants can be bureaucratic. We are working with local police to support teams to be better able to prepare and submit the information that the police need to carry out assessments.

<table>
<thead>
<tr>
<th>Patient borough</th>
<th>Waiting time days</th>
<th>Q1</th>
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<th>Q3</th>
<th>Q4</th>
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<tr>
<td>Camden</td>
<td>[0-5] days</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>5.26</td>
<td>6.90</td>
<td>4.76</td>
<td>16.00</td>
</tr>
<tr>
<td></td>
<td>Number of Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[6-10] days</td>
<td>9</td>
<td>12</td>
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</tr>
<tr>
<td></td>
<td>%</td>
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<tr>
<td></td>
<td>[11-15] days</td>
<td>3</td>
<td>9</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>15.79</td>
<td>31.03</td>
<td>33.33</td>
<td>32.00</td>
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<tr>
<td></td>
<td>Number of Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>[16-20] days</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>10.53</td>
<td>6.90</td>
<td>23.81</td>
<td>12.00</td>
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<td>Number of Patients</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>More than 20 days</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>21.05</td>
<td>13.79</td>
<td>9.52</td>
<td>20.00</td>
</tr>
<tr>
<td></td>
<td>Number of Patients</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>25</td>
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<td>100.00</td>
<td>100.00</td>
<td>99.99</td>
<td>100.00</td>
</tr>
</tbody>
</table>

**Other issues:**

LAS waits – all London have experienced waits for LAS attendance. On occasion they have not been able to provide any transport within four hours. They do not transport outside
London and sometimes do not prioritise attending police stations. This year LAS have commissioned the use of their non-emergency ambulances to support with transportation of mental health patients for planned assessments in the community. This has meant that we are now able to book ambulances in advance and are confident that they will turn up on time to assessments and be ready to transport patients to hospital.

Beds – we have had a number of occasions when there have been long waits for beds and where beds have not been identified prior to a planned assessment. In addition, where Camden patients are placed out of borough, Camden AMHPs have to travel further to undertake assessments, sometimes this can be outside London.

Policies – both the Approval Policy and Operational policy have been updated.

**EDT**

Annual: 2015/16

Last year’s figures in brackets.

MHAAs 534(488) of which 239(208) were from out of borough, 10(21) were foreign nationals

Outcomes were 239(229) x S2, 26(35) x informal admissions, 126(136) x no application, 133(60) could not be completed 11(12) were referred to CRRTs, 2(5) were medically admitted (MCA), 2(3) were transferred on 136, 2(3) were CTO recalls, 2xS3

Of out of borough referrals, 46(34) were Barnet, 25(23) were Brent, 21(19) were Westminster, 13(15) were Hackney 12(6) were Haringey and 15 were Lambeth (-)

As you can see we were unable to complete 25% of the MHAAs referred, almost entirely due to the lack of a bed by 9am. This is probably an underestimate, as on some occasions, particularly at weekends we completed the assessment after EDT shift was finished

**Conclusion**

This year saw a dramatic increase in the number of assessments undertaken in Camden. A significant percentage of service users assessed were not in contact with services at the time of referral. This report demonstrates that AMHPs in Camden are required to be highly skilled in order to respond to the high number and diversity of assessments.

There is however a problem with the level of staffing in Camden. At the moment given the currents AMHPs commitment to the ROTA we are able to fill 112 spaces of a 120 spaced 8 week ROTA. This does not include AMHPs taking holidays. So often we are only have 2 AMHPs on ROTA. We are using some locum AMHPs to fill some of the shifts at the moment but this is not necessarily sustainable. In the longer term we may need to consider AMHPs committing more time to AMHP Duty however there would need to be an agreed reduction in the amount of work that they needed to do for their teams. Another option could be to employ a full time AMHP on duty which would mean that AMHPs would have to commit less time from their teams to come onto duty.

The information for this report is derived largely from the dashboard. However, there remain data quality issues in both the accurate inputting and the information drawn from Carenotes. The presentation, accessibility and accuracy require further work to ensure the dashboard provides easily available reports that demonstrate all AMHP activity. Further work is required to ensure the dashboard is accurate and provides the reports that demonstrate all AMHP activity. To this end from July this year we will be collecting new information that should help to give us a more accurate picture of activity in Camden.

This year we will report EDT figures alongside AMHP duty. We also aim to collect data for all duty activity such as the number of warrants and the number of referrals as well as non-duty activity such as CTO recommendations and revocations. We will also report information on ethnicity, gender and outcome comparisons.
Islington AMHP Duty

Islington AMHP Duty Service 2015/16
Total number of assessments: 564

1. Introduction

Islington Approved Mental Health Professional Duty service operates from Monday to Friday from the First Floor, East Wing, St. Pancras Hospital. It is co-located with the Camden AMHP service and the AMHP management team, which includes the AMHP training manager. One duty administrator provides support to both services and a locum 0.5 admin is also currently in post.

Due to the volume of work in both boroughs and the recommendation from the AMHP Review last year a dedicated duty manager for Islington was successfully recruited and started in post on 11th April 2016.

The service is run via a rota and draws AMHPs from across the mental health teams and also adult social care. The aim is to have three AMHPs on duty per day, undertaking both planned and emergency work across the borough. There are currently 23 warranted Islington AMHPs available for the rota reduced from 26 last year. 2 AMHPs retired, two left, there was a change of job role for 2 other AMHP’s but Islington have gained 3 AMHP’s who have recently got warranted and have 2 AMHP candidates about to start training in September 2016. Another person has started from another borough but we are not including them as the new Islington AMHP duty manager has had to come off the AMHP duty rota. They won’t be warranted until next year and we know of another AMHP who has just gone on long term sick leave. We currently are unable to rota 3 AMHPs per day.

The volume of work is widely variable. On a day to day basis the number of assessments completed can range from 0 to 8. There are approximately 10 assessments per week. It is estimated that 12.5% of these assessments required planned police assistance. However, a number of assessments do not actually take place as the person is assessed prior to the planned date or sometimes the assessment is cancelled. We have undertaken a number of assessments where we have called the police as an emergency. We will record these more accurately as well as the number of warrants applications.

This report includes only completed assessments and therefore does not include the referrals that do not result in a completed assessment or repeated attempts. Due to the high number of police assisted assessments, a duty AMHP attends court approximately once a fortnight to obtain S.135 warrants (we often get three S135 warrants at the same time).

Community Treatment Order recommendations and revocations should be undertaken within community teams but are sometimes completed by AMHP duty where there are no AMHPs available. Guardianships and Nearest Relative displacements are also usually allocated within teams. Where the team does not have an AMHP, this work has to be negotiated with another team’s AMHP. There have been no NR displacements but one application was lodged and the legal proceedings went into this year but the patient in question was subsequently discharged.

The AMHP managers offer advice and support to all AMHPs regardless of whether their work is within teams or as part of the duty service.

2. Data

The total number of Mental Health Act assessments undertaken during the year 2015/16 was 564 compared with 536 in 2014/2015. In common with most other boroughs this is an increase on previous years. An element of this used to be a data recording issue as three years ago data was not collected properly as Islington was not a centralised service but this would no longer be a contributory factor. The table below shows a substantial increase between February and March 2016.
Islington has the highest prevalence of people diagnosed with serious mental illness in London at just less than 1.5% which is significantly higher than London and England averages (QOF, 2011/12). Around 20% of people over 18 diagnosed with a psychotic disorder have bipolar disorder and the remaining 80% are diagnosed with psychoses, including schizophrenia. A significant number of people suffer from depression, the highest in London.

Out of the total number of assessments, 44% are women and 56% are men (compared to 50:50 last year). Every quarter shows more men assessed than women.
It has been requested if information can be provided for under-18s as this more appropriately identifies CAMHs service users. The spread of the age range of those being assessed demonstrates the diversity of needs and also the skills and knowledge required to undertake AMHP work in Islington.

The numbers of adults with mental health conditions is expected to increase over the next 15 years. There are likely to be approximately an extra 5,500 cases in Camden and Islington, based on population growth estimates. Common Mental Disorders will make up the majority of the increase, but the number of people with dementia will see the largest percentage increase.
change. In the long term, it is predicted that the number of people with dementia will double by 2050 with the fastest percentage growth expected amongst people aged 85 and over. Based on current estimates of population change, and the proportion of children living in social housing remaining constant, the number of children with any mental health condition Camden is likely to decrease by 0.4% by 2030, as the number of children resident in the borough falls (13 fewer children with a mental health condition). Conversely, Islington’s population aged 5-16 will grow in that time. In 15 years there could be an additional 570 children diagnosed with a mental health condition living in Islington (3,760 in total). (Healthy Minds, Healthy lives: Widening The Focus on Mental Health. Camden and Islington Annual Public Health Report 2015)

Ethnicity

<table>
<thead>
<tr>
<th>ETHNICITY</th>
<th>Asian / Asian British</th>
<th>Black / Black British</th>
<th>Mixed Background</th>
<th>Not Known</th>
<th>Not Stated</th>
<th>Other Ethnic Groups</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>22</td>
<td>161</td>
<td>11</td>
<td>20</td>
<td>34</td>
<td>29</td>
<td>287</td>
</tr>
<tr>
<td>%</td>
<td>4%</td>
<td>28.5%</td>
<td>2%</td>
<td>3.5%</td>
<td>6%</td>
<td>5%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Last year, 49% of those assessed were White British which was the highest percentage. This year the figure is 51% followed by Black British at 28.5%. These two groups remain the two main ethnic groups. Asian/Asian British at 4% White – any other background at 17%, Black African at 13% and Asian British at 7%. Broad ethnic groups have been reported as Islington’s population is very diverse and there are many smaller groups which are 1% of the total number. However, it would be useful to identify which groups are greatest in number if particular populations are increasing. These figures are drawn from Rio. It should be noted that these categories are sometimes not self-defined.

Islington has an ethnically diverse population: less than half (48%) of residents describe themselves as White British, which is slightly higher than the London average (45%) and much lower than the England average (80%). Islington’s population has become more diverse since 2001, when 57% of Islington residents described themselves as White British. This was slightly lower than London (60%) and again much lower than England (87%). There are however, differences in prevalence of Common Mental Disorders by ethnic group. People of all White backgrounds are significantly more likely to be diagnosed with CMD than all adults (16% compared to 15% in Camden; 18% compared to 17% in Islington). Of the
major ethnic groups, prevalence of CMD is significantly higher than average among White British (20% in Camden and 21% in Islington), White Irish (23% in both boroughs) and Black Caribbean adults (18% in Camden and 17% in Islington) which is represented in our figures. Furthermore, in Camden, Black women are significantly more likely to be diagnosed (16%) than women in general (14%). In both Camden and Islington, the Asian and Chinese populations are significantly less likely to be diagnosed than the average (9% for both boroughs). (Healthy Minds, Healthy lives: Widening The Focus on Mental Health. Camden and Islington Annual Public Health Report 2015)

MHAA by Service User’s Team

Of those assessed the largest percentage (28%) were not under the care of any local mental health service at the time of referral (the same percentage as last year). This figure is high and warrants further investigation. The next highest is North Islington R&R (14%) and then Out of area assessments, which have increased significantly from last year’s figure. These assessments will mostly be from Whittington A&E, Tolpuddle police station, British Transport police and the prisons. One of the two local prisons has recently closed but as we do not complete very many assessments in prisons this should not have a major impact on the figures.

<table>
<thead>
<tr>
<th>Service User’s Team</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOT</td>
<td>26</td>
</tr>
<tr>
<td>Community Rehab</td>
<td>27</td>
</tr>
<tr>
<td>EIS</td>
<td>56</td>
</tr>
<tr>
<td>None</td>
<td>158</td>
</tr>
<tr>
<td>North Islington RR</td>
<td>82</td>
</tr>
<tr>
<td>Out of Area</td>
<td>61</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>17</td>
</tr>
<tr>
<td>SAMH</td>
<td>32</td>
</tr>
<tr>
<td>South Islington RR</td>
<td>56</td>
</tr>
<tr>
<td>Any other teams</td>
<td>49</td>
</tr>
</tbody>
</table>
Outcomes
These figures are broadly similar to last year. 77% of those assessed were admitted formally (compared to 76% last year and the year before). This figure should always be reasonably high if filtering and consideration of alternatives is rigorously considered prior to a Mental Health Act assessment taking place. There were more Section 2s than Section 3s which is now the usual pattern nationally. There were no Section 4s. 5% were admitted informally which is almost the same as last year. However, 8% of those were assessed and not admitted nor a community alternative recorded which is slightly lower than last year.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Support</td>
<td>8</td>
</tr>
<tr>
<td>Crisis team</td>
<td>8</td>
</tr>
<tr>
<td>CTO</td>
<td>11</td>
</tr>
<tr>
<td>Informal</td>
<td>30</td>
</tr>
<tr>
<td>No action/No admission</td>
<td>45</td>
</tr>
<tr>
<td>S.2</td>
<td>247</td>
</tr>
<tr>
<td>S.3</td>
<td>189</td>
</tr>
<tr>
<td>Not completed</td>
<td>24</td>
</tr>
<tr>
<td>S136 discharge</td>
<td>2</td>
</tr>
</tbody>
</table>
### Police Waiting Times

#### 2015/2016

<table>
<thead>
<tr>
<th>Patient borough</th>
<th>Waiting time days</th>
<th>Q1</th>
<th></th>
<th>Q2</th>
<th></th>
<th>Q3</th>
<th></th>
<th>Q4</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Patients</td>
<td>%</td>
<td></td>
<td>Number of Patients</td>
<td>%</td>
<td>Number of Patients</td>
<td>%</td>
<td>Number of Patients</td>
<td>%</td>
</tr>
<tr>
<td>Islington</td>
<td>[0-5] days</td>
<td>1</td>
<td>7.69</td>
<td>2</td>
<td>10.53</td>
<td>6</td>
<td>28.57</td>
<td>3</td>
<td>13.64</td>
</tr>
<tr>
<td></td>
<td>[6-10] days</td>
<td>2</td>
<td>15.38</td>
<td>4</td>
<td>21.05</td>
<td>2</td>
<td>9.52</td>
<td>8</td>
<td>36.36</td>
</tr>
<tr>
<td></td>
<td>[11-15] days</td>
<td>3</td>
<td>23.08</td>
<td>4</td>
<td>21.05</td>
<td>4</td>
<td>19.05</td>
<td>4</td>
<td>18.18</td>
</tr>
<tr>
<td></td>
<td>[16-20] days</td>
<td>1</td>
<td>7.69</td>
<td>4</td>
<td>21.05</td>
<td>5</td>
<td>23.81</td>
<td>1</td>
<td>4.55</td>
</tr>
<tr>
<td></td>
<td>More than 20 days</td>
<td>6</td>
<td>46.15</td>
<td>5</td>
<td>26.32</td>
<td>4</td>
<td>19.05</td>
<td>6</td>
<td>27.27</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>13</td>
<td>99.99</td>
<td>19</td>
<td>100.00</td>
<td>21</td>
<td>100.00</td>
<td>22</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Compared to 2014/15’s figure of 64%, 62.5% of assessments in 2015/16 were not competed within 10 days. Compared to 2014-2015 when 31% waited for more than 20 days in 2015/16 the percentage has lowered to 28%.

**Strategies to resolve long wait for police assistance.**

A year ago dedicated Sergeants were allocated to the four Islington clusters reducing the waiting times. An Islington duty manager has been appointed and is currently building good working relationships with the police to facilitate quicker response times to the requests for community based MHA assessments.

**Other issues:**

LAS waits – from mid-April the new LAS Net transport system started in Camden and Islington. This has already proved to be a great success in reducing the waiting times for transport, particularly for community based MHA assessments. Unfortunately the booking system is currently unable to assist with police stations and A&E transportation but this can be reviewed in the future.

Beds – Unfortunately the lack of beds remains a major issue, with a high number of patients having to wait for over 24 hours for a bed in A&E and police stations. This situation is currently being addressed by the trust.

S136 data - following the guidelines set out in the paper London’s S136 Care Pathway from 1 July 2016 specific data will be obtained to ensure that there is no more than 4 hours between when the Psychiatric Liaison Team contacts the Camden or Islington AMHP service and the time of the MHA assessment for S136s. (The MHA assessment can only be completed if a bed has been located).
Islington EDT provisional figures for 2015-2016 are 283 assessments and 174 admissions. In comparison, the previous year EDT completed 190 assessments and admitted 120 people. This means in the last year there have been approximately 49% more MHA assessments completed by Islington EDT, but the rate of ‘conversion’ from assessment to detention stayed relatively level at 63% in 2014/15 and 61% in 2015/16.

This figure does not take account of all the MHA assessments EDT were contacted about but they could not start because no beds were available.

Islington not only has a busy police station (Tolpuddle) but also Highbury Magistrates court diversion, Pentonville prison (HMP Holloway has closed this year) and Brewery Road British Transport Police. These all generate referrals for Mental Health Act assessments. Court Diversion is currently largely covered by an Islington AMHP seconded to BEH Liaison and Diversion service. These assessments are not recorded in this report. (Location of assessments would be important data to collate for future reports.)

Policies – both the Approval Policy and Operational policy have been updated.

Conclusion
Overall the number of completed Mental Health Act assessments continues to rise in Islington. This may in part, be due to better data recording but will also reflect increasing numbers of assessments that most boroughs are experiencing. A significant percentage of service users assessed were not in contact with services at the time of referral. This report demonstrates that AMHPs in Islington are required to be highly skilled in order to respond to the high number and diversity of assessments.

Positive steps forward have been the introduction of the Net ambulance service to reduce the time waiting for transport at community based MHA assessments and also the introduction of specific cluster Sergeants to help co-ordinate police assistance at community based MHA assessments.

The information for this report is derived largely from the dashboard. However, there remain data quality issues in both the accurate inputting and the information drawn from Care notes. The presentation, accessibility and accuracy require further work to ensure the dashboard provides easily available reports that demonstrate all AMHP activity. As part of this process the Camden and Islington AMHP managers and Shilpa Nairi, the AMHP training manager have all recently met with a member of the IT department to increase our ability to collate appropriate data and statistics to inform policy and help develop efficacy of data. In future, this will include the number of warrants and the number of referrals as well as non-duty activity such as CTO work.
Appendix 6

Informed Consent for Voluntary Admission Audit

Quality Assurance reviews conducted in March 2015 by the Deputy MHL Manager / MCA lead found that an area of risk to the Trust was the status of Informal patients on wards. In light of the case of ‘Cheshire west’, which lowered the threshold of what is deemed deprivation of liberty, for patients who lacked capacity must be under either the MHA or a Deprivation of Liberty Safeguard. A rolling programme of training was delivered on all wards, CRT, psych liaison services and a system was put in place to monitor voluntary admissions to wards. A new form was devised to record that patients who were agreeing to Voluntary admission were provided with sufficient information and that they had capacity to consent to Voluntary admission.

Progress notes

Out of the 18 informal admissions the patients consent to voluntary admission was recorded 9 times. Of these 9 the following was found:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent was obtained at the point of admission</td>
<td>4</td>
<td>44%</td>
</tr>
<tr>
<td>That sufficient information was given to the patient about nature and purpose of the admission/stay</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Acknowledgement of the patients capacity recorded or evidence of the test for capacity</td>
<td>5</td>
<td>55%</td>
</tr>
</tbody>
</table>

Whilst consent was only obtained on admission for 4 patients it was recorded for 5 further patients after admission as follows. 1 day (frequency =2), 2 days (frequency=1), 3 days (frequency = 1) and 9 days (frequency=1).

Identifying Risks to the Trust

Of the 18 informal admissions there were 5 instances where the Trust could potentially be challenged around the legal authority patient’s admission or stay in hospital.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal Inpatients where the records say the patient has consented but notes reflect there are doubts about their capacity to consent</td>
<td>2</td>
<td>11%</td>
</tr>
<tr>
<td>Informal Inpatients where there is no evidence that they have consented to admission and there is evidence they are being deprived of their liberty without legal authority.</td>
<td>3</td>
<td>17%</td>
</tr>
</tbody>
</table>

Findings

There was no evidence that the form for staff to record the consent and capacity of patients to be admitted voluntarily was used during the first fortnight of its implementation.

The absence of the form or sufficient documentation in the patient’s records is a risk to the Trust and there are instances that constitute the unlawful deprivation of liberty of service users.
Appendix 7

Consent to Treatment Provided under the MHA Audit

The audit results show that the Trust is not fully compliant with the requirement to:
- seek consent and assess capacity prior to first administration of treatment as per CoP 24.41 (78.95% compliant overall);
- seek consent and assess capacity at the end of the three month period of treatment without consent as per CoP 25.17 (84.21%) and;
- communicate the results of the SOAD visit to the patient as per CoP 25.66 (52.63%).

The Trust is exposed to the risk of legal challenge in all of the three above areas.

When capacity to consent to treatment prior to first administration is assessed, the recording is decision specific in 84.21% of cases but follows the functional test in 47.37% of cases only and includes evidence in 10.53% of cases only.

When capacity to consent to treatment at the end of the three month period of treatment without consent is assessed, the recording is decision specific in 94.74% of cases but follows the functional test in 63.16% of cases only.

It is interesting to note that the capacity assessment seems to be better documented in relation to consent to treatment at the end of the three month period of treatment without consent than it is in relation to consent to treatment prior to first administration of treatment.

The results suggest that only 52.63% of patients are informed of the SOAD’s reasons following a SOAD visit. On some wards no evidence could be found of this statutory responsibility being ever discharged or of the reasons why it was not.
Mental Health Law Hub Summary
In March 2015 the team consisted of:

| Corporate (HQ) | Mental Health Law Manager (Band 8b) |
|               | Deputy Mental Health Law Manager (Band 7) |
|               | Mental Health Law Coordinator (Band 6) |

| Administration | Highgate Mental Health Centre | 2 X Band 5 Mental Health Act Officers (1 of whom was NHSP) |
|               | 1 X Band 4 Mental Health Act Assistant (NHSP) |

| The Huntley Centre | 1 X Band 5 Mental Health Act Officers |
|                   | 1 X Band 4 Mental Health Act Assistant (NHSP) |

A summary of duties of the MHL Hub staff can be seen in appendix 3. Over the last 12 months the MHL Hub has achieved:

- Full governance through the MHL committee and sub-groups
- Comprehensive administration of the MHA
- New income generation from SLA with UCL in order to provide MHA administration
- New income generation for providing training to external Trusts for MHA admin staff and clinical staff (UCL and Whittington Health)

And created/delivered

- administration services for monitoring the use of DoLS
- MHL News Letter
- a range of Information Leaflets for staff, Service Users and Carers (in relation to The MHL Hub, The Mental Capacity Act, Voluntary Admission, Advance planning
- Key MHL policies in view of the introduction of the new MHA code of Practice and also the implementation of the MCA (DoLS)
- A stall at the C&I Family Fun Day
- MHL Administrators Training program for new MHA staff
- MHL Training Plan (covering MHA and MCA(DoLS)
- Level 1 MCA(DoLS) Training to 60% of clinical staff
- Assessment forms for Carenotes for Test for Capacity and Best Interests
- Assisted the Carenotes implementation team to create new functions for the management and recording of the MHA and DOLs
- Assisting with the promotion of the new Independent Mental Health Advocate (IMHA) service in Camden
- Co-produced and delivered MHL related training with the Recovery College

There have been some concerns during the course of the year that the administration of the MHA has not been consistent. This has been due to a number of challenges faced by the MHL Hub (how the MHL Hub mitigated the risks is in brackets):

- Loss of 2 member of experienced staff from the administration team (NHSP staff subsequently recruited to these posts)
- Difficulty in recruiting new staff with suitable MHA experience (MHA admin training package was created for new staff induction, Training delivered by Corporate staff)
- Long Term administration staff sickness (cover provided by corporate staff)
• **Complaints** from the First Tier Tribunal- Mental Health due to turnover of staff and (MHA admin training package was created for new staff induction, Training delivered by Corporate staff, communicating changes with Tribunal, cover provided by corporate staff)

• **Concern raised by the CQC** in relation to MHA and MCA knowledge of clinical staff across the whole Trust *(Mandatory Training plan for clinical staff on MHA and MCA is being considered)*

• **Concerns raised by Clinical staff** in relation to MHA office at Highgate *(MHA admin training for new staff, communicating changes with clinical teams, cover of MHA admin roles by Corporate staff)*

• **Concerns raised by Associate Hospital Managers** in relation to creation of back-log of Managers Renewal Hearings *(MCA Lead provided cover in an attempt to tackle this)*

• **Unable to complete all planned audits** due to the cover required in MHA offices *(Two key audits were identified and completed that covered key areas Capacity & Consent and Deprivation of Liberty)*.

The MHL Hub is considering what might be needed as increase in resource to ensure that the Trust is able to consistently fulfil its legal obligations to the MHA and MCA in a timely fashion.