

Mental Health Act Statistics, Annual Figures 2016/17: Background Data Quality Report Experimental Statistics

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Introduction

This document is a background data quality report for the Mental Health Act Statistics, Annual Figures 2016/17 publication.

This publication can be downloaded from the NHS Digital website at:

<http://digital.nhs.uk/pubs/mha1617>

This publication contains the official statistics about uses of the Mental Health Act ('The Act') during 2016/17. Under The Act, people with a mental disorder may be detained in hospital in the interests of their own health or safety, or for the safety of others. They can also be treated in the community but subject to recall to hospital when necessary for assessment and/or treatment under a Community Treatment Order (CTO).

In previous years, this publication series has been sourced from the KP90 data collection. These data returns were made by organisations in England that are registered to provide Mental Health Services and make use of the Mental Health Act 1983 legislation. These include high security psychiatric hospitals as well as other NHS service providers and independent hospitals. The data were submitted as aggregate data items for each provider via the KP90 collection, which collected this data for the last time in 2015/16.

For 2016/17, this publication was primarily sourced from the Mental Health Service Data Set (MHSDS), an administrative data source which contains record-level data about the care of children, young people and adults who are in contact with NHS-funded mental health, learning disabilities or autism spectrum disorder services¹. Organisations submit data to the MHSDS on a monthly basis and this publication is an annual view of Mental Health Act data compiled from those monthly submissions.

For acute hospitals which are not in scope for MHSDS but do make use of The Act, a separate aggregate collection was set up this year. Data from the 'Annual uses of the Mental Health Act 1983 in English acute trusts' (Acute) collection therefore contribute to the 2016/17 figures². This was approved as a temporary collection method pending the introduction of a new Emergency Care Data Set, which will record uses of The Act in hospital emergency departments.

The change in data source allows us to:

- a) **Better meet user needs**, as it supports more detailed analysis of uses of The Act, incorporating patient demographics and details of their pathways through services. The aggregate collection did not support such detailed analysis.
- b) **Reduce burden**, as the MHSDS is sourced from routine flows of administrative data. The burden of collection is reduced as organisations do not have to complete a bespoke annual return specifically for the Mental Health Act.

Further information about the MHSDS is available at:

<http://content.digital.nhs.uk/mhsds>

¹ Methodological Change Notice published at: <http://content.digital.nhs.uk/pubs/methchanges>. Also see 'Accuracy and Reliability' section of this document for further details of methods used.

² Further information on the Acute collection is available at: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/annual-uses-of-the-mental-health-act-1983-in-english-acute-trusts-mha-acute>

Data quality reports are produced as part of each monthly MHSDS publication, providing detailed information on coverage, validity and integrity of the data. These reports can be accessed via the landing page at:

<https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics>

Purpose of this document

This document aims to provide users with an evidence-based assessment of the quality of the statistical output of the Mental Health Act Statistics 2016/17 publication by reporting against the nine European Statistical System (ESS)³ quality dimensions and principles.

In doing so, this meets our obligation to comply with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics⁴, particularly Principle 4, Practice 2 which states:

“Ensure that official statistics are produced to a level of quality that meets users’ needs, and that users are informed about the quality of statistical outputs, including estimates of the main sources of bias and other errors and other aspects of the European Statistical System definition of quality”.

For each dimension this section describes how this applies to the publication. We will continue to provide clear and comprehensive information about the methods used in our analysis and the quality of the data to assist users in interpreting our reports.

In addition, as the publication is now compiled from administrative data this document also references and signposts to further information about the assurance of the MHSDS. Quality assurance of administrative data is an ongoing, iterative process to assess the data’s fitness to serve their purpose. More information about the ongoing assurance of MHSDS monthly submissions can be found in the Data Quality section of the Executive Summary in the Mental Health Services Monthly Statistics publication⁵.

These statistics have been assessed as Medium Risk and Medium Profile in accordance with the UKSA Administrative Data Quality Assurance Toolkit⁶ and this document also highlights appropriate activities relating to the following UKSA assurance practice areas:

1. Operational context & administrative data collection
2. Communication with data supply partners
3. QA principles, standards and checks applied by data suppliers
4. Producer’s QA investigations & documentation

A summary of these can be found in Appendix 3.

³ <http://ec.europa.eu/eurostat/web/european-statistical-system>

⁴ <https://www.statisticsauthority.gov.uk/archive/assessment/code-of-practice/code-of-practice-for-official-statistics.pdf>

⁵ <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics>

⁶ https://www.statisticsauthority.gov.uk/wp-content/uploads/2015/12/images-qualityassurancetoolki_tcm97-44368.pdf

In addition, this document contains background information about the Mental Health Act including changes to Mental Health law, which will be of interest to readers who are not already familiar with The Act.

Background information about The Mental Health Act

People can be admitted to hospital for the treatment of mental health problems on either a voluntary basis as 'informal' patients, or on a compulsory basis as 'formal' patients. Formal patients are within the scope of this publication; they have been admitted to hospital on a compulsory basis under The Mental Health Act 1983 (known as being 'detained' or 'sectioned'). See the 'Links to related statistics' section of the main report for further statistics on informal patients.

The Mental Health Act 1983 ('The Act') is the main Act of Parliament covering the care and treatment of people with mental health problems. It sets out how and when a person can be admitted, detained and treated in hospital without consent. In order to apply it, certain professionals must agree that this must be done because the health or safety of the individual, or that of other people, is at risk. The individual must be considered to have a 'mental disorder'; the definition of this term was broadened as a result of The 2007 Act.

Mental health law is about balancing the need to detain people in order to protect them or other people from harm and the need to respect peoples' human rights and autonomy⁷. Whilst the application of The Act means that a person loses certain rights (such as their liberty and refusal of treatment), it also sets out other rights, such as a right of appeal and help from an advocate, and free aftercare once released from certain Sections of The Act. These are outside the scope of data collections made as part of this release but more information can be found in the Code of Practice for the Mental Health Act⁸.

The various Parts and Sections of The Act have different purposes, durations and other features but the majority of Sections used to detain patients fall under Parts II and III of The Act, which respectively cover 'civil Sections' and 'forensic Sections' (those applied under Criminal Law). More information about individual uses featured in the report is provided in the Metadata file.

Changes to Mental Health law

The Mental Health Act 2007 made some major amendments to the existing 1983 Act. These included the introduction of Community Treatment Orders (CTOs), which came into effect in November 2008 and replaced Supervised Discharge. They allow people who meet the criteria to be treated in the community rather than under detention in hospital and were intended to address the problem of 'revolving door' patients (those that end up being repeatedly detained in hospital), although a person does not need to have been readmitted in order to be placed on a CTO. Information about the use of CTOs was introduced in the 2008/09 annual publication.

⁷ Ian Hall and Afia Ali: Changes to the Mental Health and Mental Capacity Acts: implications for patients and professionals: <http://pb.rcpsych.org/content/33/6/226.full>

⁸ Code of Practice: Mental Health Act 1983: <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

The Mental Health Act and the Mental Capacity Act

The Mental Capacity Act allows, among other provisions, the restriction of freedom for individuals who do not have capacity to agree to decisions regarding their freedom, finances, and choices about health assessments, treatment and visitors.

The 2007 Mental Health Act made changes to the Mental Capacity Act 2005 including the introduction of Deprivation of Liberty Safeguards (DoLS) from 2009 which are used to deprive a person of their liberty.

Information about DoLS applications under the Mental Capacity Act is not included in this publication; these data are published separately by NHS Digital. The 2015/16 annual publication is available at:

<http://content.digital.nhs.uk/pubs/mentcap1516annual>

There is no legal framework required for restriction of liberty of individuals who are not detained in hospital under the Mental Health Act (those people either not subject to the Mental Health Act or on a CTO or Guardianship order).

Where a person lacks capacity, the Mental Capacity Act should usually be used in preference to the Mental Health Act to admit and detain a person in hospital for treatment, provided the person doesn't object to or resist the admission or treatment. The Mental Health Act is required if the deprivation of liberty in hospital is to give treatment for mental disorder and the treatment could not otherwise be given because of a valid and applicable advance refusal or refusal from a welfare attorney.

Deprivation of liberty orders are applied for by the responsible care home or hospital and are authorised (or not) by the responsible supervisory body⁹. The safeguards are intended to ensure that this is only done when it is in the best interests of the individual and also to provide a framework to determine whether a deprivation of liberty is already occurring for existing cases, and whether or not this is appropriate, as well as reviewing or monitoring existing arrangements.

⁹ Following the dissolution of PCTs in 2013 as a result of the 2012 Health and Social Care Act, all Deprivation of Liberty orders are made by Local Authorities. Prior to this, orders for persons in social care settings were managed by Local Authorities and those for persons in health settings were managed by Primary Care Trusts (PCTs).

Data Quality Assessment

Relevance

The degree to which the statistical product meets user needs in both coverage and content.

This publication is the source of official statistics about uses of the Mental Health Act in England. It presents counts of new detentions under the Mental Health Act which occurred during the annual reporting period, broken down into sections and scenarios, and also the number of people detained under The Act at the year-end. It also includes counts of short term orders and Community Treatment orders.

The data are primarily sourced from the MHSDS which is the key source of national information about the use of NHS-funded mental health, learning disabilities and autism services. In order to ensure that the relatively small number of uses of The Act that occur in acute hospitals are also covered by this publication, a separate aggregate collection provides information from such hospitals. Data from both sources are included in this publication.

This publication does not cover uses of Section 136 where the place of safety is a police cell. The 2016/17 data are due to be published by the Home Office on 26th October 2017 and will be available at the following page:

<https://www.gov.uk/government/collections/police-powers-and-procedures-england-and-wales>

Content of this publication

This publication includes the following statistical outputs:

- A summary report containing key findings and signposts to further information
- This Background Data Quality Report
- Excel Data Tables containing aggregate counts of detentions and people detained under The Act, in the same format as previous years
- Interactive data visualisations using Microsoft Power BI which illustrate variations in uses of The Act across different groups and also information about coverage
- Machine-readable CSV data file which includes the data in the Excel tables at national level and additional information at sub-national level (based on high-level measures presented in the Excel Tables)
- Metadata document describing the measures in the publication and explaining how they have been derived from record-level administrative data.

Definitions

The units of measure used in this publication remain the same as in previous years although the method for producing them has changed:

- Detentions under the Mental Health Act 1983, by legal status
- Uses of Short Term Detention Orders under the Mental Health Act 1983
- Uses of Community Treatment Orders
- Uses of section 2 and section 3 of the Mental Health Act 1983
- People subject to the Mental Health Act 1983 on 31st March 2017

All these measures are counts of events (uses of The Act e.g. detentions, uses of short term detention orders) except the last measure, which is a count of people.

Counts of these measures are presented by type of provider at England level as in previous years. Using the MHSDS administrative data source has made it possible to add further breakdowns including age, gender and ethnic group. Detentions, uses of section 136 and CTOs are therefore also presented as rates per 100,000 population. For detentions, the rates are also presented by Sustainability and Transformation Partnership (STP) areas, to meet the need for monitoring of The Act at this new NHS administrative geography.

The methods used to calculate the measures in this publication has changed this year, due to the change in the way the figures are sourced and produced. This change and the reasons for the change were announced in the 2015/16 publication, via the special feature 'Mental Health Act Statistics: Improved reporting to support better care'¹⁰ and are also described in an Announcement of Methodological Change¹¹.

The figures are now produced from referral and patient-level information rather than from aggregate numbers submitted by individual hospitals. The new method produces these statistics from analysis of individual changes in legal status and the sequence of hospital admissions recorded for each person in the MHSDS. Essentially the information is derived by re-using data collected in the course of delivering patient care, rather than from aggregate numbers submitted to a bespoke data collection.

All providers registered to use the Mental Health Act are required by law to keep records of uses of The Act. This is done using official forms, so definitions of terminology and local record-keeping are well established and records are liable to inspection by the Care Quality Commission in its regulatory role. However, the change in data source means that the route for supplying information for national monitoring of The Act has changed. Details of arrangements for data collection and submission are provided in the Completeness section below. Further information about the logic used to construct individual measures is provided in the Metadata file.

¹⁰ <https://files.digital.nhs.uk/publicationimport/pub22xxx/pub22571/inp-det-m-h-a-1983-sup-com-eng-15-16-spec-feat.pdf>

¹¹ <http://content.digital.nhs.uk/pubs/methchanges>

Experimental statistics

The data in this publication are marked as **experimental statistics**¹² and may be subject to further change as we develop our statistics. The classification of experimental statistics is in keeping with the UK Statistics Authority's Code of Practice¹³. Experimental statistics are new official statistics that are undergoing evaluation. They are published in order to involve users and stakeholders in their development, and as a means to build quality at an early stage. The UK Statistics Code of Practice states that "effective user engagement is fundamental to both trust in statistics and securing maximum public value..." and that as suppliers of information, it is important that we involve users in the evaluation of experimental statistics.

Meeting user needs

NHS Digital has made the following changes to this publication to better meet user needs:

- **Change in data source:** the use of more granular referral-level data allows NHS Digital to perform new analyses of the data that were not possible from the aggregate KP90 collection. This includes presenting rates of detention by age, gender and ethnicity. Over time, additional insights will be gained from further investigations of the data.
- **Publishing information about uses of The Act more frequently:** several measures are included in the 'Monthly Data' CSV file in each Mental Health Services Monthly Statistics publication (see Appendix 1 for further details).
- **Improved reporting in this publication:** we have changed the format of the summary report and improved the clarity of explanations. Additional Excel tables are provided this year which provide rates of detention by age, gender and ethnicity. Additionally, we have produced Microsoft Power BI reports this year, allowing users to access interactive data visualisations.

As this is the first annual publication from the MHSDS data, we will continue to work with stakeholders to further extend our reporting on uses of The Act.

Completeness

We have assessed completeness at three levels:

1. Have all eligible organisations submitted data to MHSDS?
2. Have the organisations that use The Act included this information in their submissions?
3. Is the data submitted about The Act complete? For example, does it cover all relevant hospital sites and services and all required elements of The Act (e.g. uses of section 136 as well as uses of CTO)? Have monthly data been submitted consistently and at the expected volumes?

¹² https://gss.civilservice.gov.uk/wp-content/uploads/2016/02/Guidance-on-Experimental-Statistics_1.0.pdf

¹³ See Assessment Report for this publication series, released by the UK Statistics Authority in October 2014: <https://www.statisticsauthority.gov.uk/publication/statistics-about-inpatients-formally-detained-in-hospitals-under-the-mental-health-act-1983-and-patients-subject-to-supervised-community-treatment/>

Completeness: Have all eligible organisations submitted data to the MHSDS?

Not all organisations are yet submitting data about The Act in the MHSDS. NHS Acute Trusts were allowed to submit summary data to a separate Acute collection this year. For the purposes of assessing that all eligible providers who use the Mental Health Act submitted data in 2016/17, we have also drawn on comparisons to providers that submitted data to the KP90 collection in 2015/16.

Although we know that not all eligible organisations are submitting data to the MHSDS, there are difficulties in correctly identifying all those organisations that should do so. This is particularly the case in the independent sector, which includes a large number of small organisations. Organisational change including mergers and changes in registration makes it difficult to maintain a complete list of all eligible healthcare providers. In 2015/16, eight independent service providers accounted for 90 per cent of detentions in this sector. Seven of the eight providers submitted MHSDS data in 2016/17. In terms of completeness although there are many small ISPs that have not returned data in 2016/17, it is the quality of that submitted by the large organisations that has a greater impact on completeness.

All NHS Trusts that previously submitted KP90 and were eligible to submit data to MHSDS made MHSDS submissions during 2016/17. But not all of them included information about The Act in their submissions (see next section).

NHS Digital is working with partners, including NHS England, NHS Improvement and the Care Quality Commission (CQC) to ensure that all eligible organisations submit data to the MHSDS.

Information about organisations submitting data to the MHSDS is included in the monthly publication 'Mental Health Services Monthly Statistics'. The Excel Data Quality Report for March 2017 Final data¹⁴ includes this data for the annual period covered by this publication.

Table 1 shows that the number of organisations submitting data about their mental health services to MHSDS data rose from 85 in April 2016 to 99 in January 2017 but fell to 97 in March 2017.

Table 1: Number of organisations submitting MHSDS data, by month, 2016/17

Month	Apr-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar-2017
Number of organisations	85	91	91	93	93	92	94	94	94	99	97	97

Source: *Mental Health Services Monthly Statistics, March 2017*

Completeness: Have the organisations that use The Act included this information in their submissions?

See also: Slide 8 in the summary report

Not all organisations required to submit MHSDS will make use of The Act, so the number of organisations eligible to submit MHSDS is greater than the number registered to use the Mental Health Act. In addition, acute NHS Trusts that are out of scope for MHSDS can submit data via the Acute collection.

¹⁴ <http://www.digital.nhs.uk/catalogue/PUB30000>

The majority of uses of the Mental Health Act in health services occur in specialist mental health, learning disability and autism services, including those commissioned by the NHS but provided by Independent Sector Providers (ISPs). These organisations are mandated to submit MHSDS in accordance with the information standard¹⁵ published under section 250 of the Health and Social Care Act 2012.

For the purposes of assessing that all eligible providers who use the Mental Health Act submitted data in 2016/17, we have also drawn on comparisons to providers that submitted data to the KP90 collection in 2015/16.

To assess the completeness of data about uses of The Act, we have grouped providers into three categories. This reflects the different contribution each group makes to these statistics and the different issues affecting data quality. These groups are:

- **NHS Mental Health and Learning Disabilities Trusts** – most uses of The Act occur in these settings and these providers are required to submit data to the MHSDS.
- **Acute Trusts** – a large number of organisations which each typically account for a small number of uses of The Act, if any. These organisations are eligible to submit data to the Acute collection but not to the MHSDS.
- **Independent Service Providers** – a large number of organisations typically providing inpatient services including some secure settings likely to provide services for detained patients. These providers are required to submit data to the MHSDS. There is a wide variation in the size and capacity of ISPs and these are not all registered with the NHS Organisation Data Service (ODS) service in a way that supports consistent identification.

Table 5 of the Data Tables reflects this grouping.

Table 2 shows that the number of organisations submitting Mental Health Act data is lower in this first year using the new data sources than last year under the KP90 collection. The number of detentions for each group is also provided to illustrate the contribution of each group to the annual totals.

The number of ISPs presented in Table 2 excludes a group of smaller independent providers from 2015/16 which were shown as 'other' ISPs in Table 5 last year. In 2015/16 data was collected from 225 independent sector hospitals. This includes 33 hospitals that were not reported separately in last year's CSV file as they either had no ODS code and/or represented very small numbers of detentions. These providers were aggregated into an 'other' group and accounted for 95 people detained on 31st March 2016.

In 2016/17, one provider, Birmingham Children's Hospital NHS Foundation Trust (RQ3), submitted data to both the MHSDS and Acute collections (reflecting the different services provided). In Table 2 below and Table 5 of the Data Tables, this provider is only shown under MHSDS totals and not under Acute.

In 2015/16, 172 providers submitted data to the KP90, compared to 128 providers submitting Mental Health Act data to either the MHSDS or Acute collections in 2016/17. Compared to last year, organisational coverage was best amongst NHS Mental Health & Learning Disabilities providers and lowest amongst Independent Service Providers (ISPs). The majority of ISPs that submitted data to KP90 last year did not submit data about The Act to MHSDS.

¹⁵ <http://content.digital.nhs.uk/isce/publication/SCCI0011>

Table 2: Number of organisations submitting data about the Mental Health Act, by provider type, 2015/16 and 2016/17

	Number of submitters		Number of detentions	
	2015/16	2016/17	2015/16	2016/17
All organisations	172	128	63,502	45,864
NHS Providers	126	114	56,594	43,050
Mental Health and Learning Disabilities Trusts	63	60	54,921	41,268
Acute Trusts	63	54	1,673	1,782
Independent Providers	46	14	6,908	2,814

Source: KP90 2015/16, MHSDS, Acute 2016/17

Appendix 2 contains detailed breakdowns of organisation-level data which are intended to assist users in a more detailed interpretation of completeness in 2016/17. These tables include lists of:

- Organisations that submitted 12 months' Mental Health Act data to the MHSDS in 2016/17
- Organisations that submitted fewer than 12 months' Mental Health Act data to the MHSDS in 2016/17
- Organisations that submitted data to the Acute collection in 2016/17
- Organisations submitting data to KP90 in 2015/16 but not submitting data about The Act to either MHSDS or the Acute collection in 2016/17
- Organisations submitting data about The Act in 2016/17 that did not submit data to KP90 in 2015/16.

Amongst NHS Mental Health and Learning Disabilities providers, the following providers submitted data to MHSDS, but are not yet submitting data about The Act:

- Isle of Wight NHS Trust (R1F)
- Leicestershire Partnership NHS Trust (RT5)

Amongst independent providers, missing data about The Act from The Huntercombe Group (which recorded 440 detentions in 2015/16), has the greatest impact on independent sector totals in 2016/17.

Further details of the specific data quality issues encountered by organisations trying to submit Mental Health Act data can be found in the 'Provider Feedback' section of the monthly Data Quality reports.

Completeness – Are the data submitted about The Act complete?

See also: Slide 9 in the summary report

Not all organisations are yet submitting data about The Act to the MHSDS. Amongst those organisations that did submit data, some of the data are not complete.

Our assurance processes looked both at the submission of data across the 12 months of the reporting year and used comparisons with the snapshot count of patients subject to The Act at 31st March (as shown in Table 5 in the Data Tables) to assess the completeness of submissions. Users interested in reviewing monthly data volumes can explore organisation-level counts on the 'Provider-level coverage' in the Microsoft Power BI reports provided as part of this publication. Please note that there is no direct relationship between the number of records submitted in any one, or all, of these tables and the measures presented in this publication, which are derived from a combination of these items.

Some of these organisations are submitting uses of The Act for only some of their sites and the Provider Feedback section of the monthly Data Quality reports highlights specific providers where these have been identified during the year.

As part of monthly MHSDS publications, national and organisation level data quality measures are shown that validate a selection of key data items by provider. The Excel 'Data Quality Report' Excel file in each monthly publication contains a variety of data quality information relevant to the Mental Health Act:

- **Provider Feedback:** This worksheet includes a qualitative summary of any data quality issues, by provider, resulting from validation and investigation of each month's data by NHS Digital and the provider.
- **Coverage:** This worksheet shows the number of records submitted each month by organisation and also by MHSDS table. This is a useful resource for users due to the high volume of detailed information it contains. The March 2017 Final Data Quality Report¹⁶ contains this information for the full 12 month period covered by this report.
- **Validity Count / Percentage:** These worksheets include, for each organisation, the numbers and proportion of records which have 'valid', 'other', 'default', 'invalid' and 'missing' values. This includes the Mental Health Act measure 'MHS-DQM07 Mental Health Act Legal Status Classification Code'.

The 'Data Quality CSV' file in each monthly publication also includes the number of records submitted by each organisation for the measure 'MHS-DQM07' in machine-readable format.

Table 3 shows the number of providers submitting data to the 'MHS401: Mental Health Act Legal Status Classification Code' data table for each month in 2016/17. During this period, the number of submitters rose from 61 to 72 before declining to 70 in March 2017. Coverage in both the NHS and independent sectors rose during the period.

¹⁶ https://files.digital.nhs.uk/excel/7/h/mhsds_data_quality_measures_march_2017_refresh.xls

Table 3: Number of organisations submitting any records to Table MHS401 (Mental Health Act Legal Status Classification Period), by month and organisation type, 2016/17

	Apr-2016	May-2016	Jun-2016	Jul-2016	Aug-2016	Sep-2016	Oct-2016	Nov-2016	Dec-2016	Jan-2017	Feb-2017	Mar-2017
All	61	65	65	68	69	67	71	72	71	72	72	70
NHS	54	56	56	57	57	55	58	59	59	59	60	58
ISP	7	9	9	11	12	12	13	13	12	13	12	12

Source: Monthly MHSDS Data Quality Reports (Data Quality Measure MHS-DQM07)

To support providers in making accurate monthly submissions to the MHSDS, NHS Digital provides feedback at different stages in the data flow (including reports at the point of submission). These include detailed Data Summary Reports about coverage, volume, code validity and data consistency.

For each monthly reporting period, providers have the opportunity to make an initial 'primary' submission which can be updated with a 'final' submission the following month. Where there are concerns about data quality, NHS Digital contacts providers directly so that any issues with local data extraction processes can be addressed for a future submission. Where issues have been identified in a primary submission, this process allows organisations to correct them in a subsequent final submission. Note that these checks are currently limited to key elements of the dataset.

NHS Digital is working together with NHS England, NHS Improvement and the Care Quality Commission to drive up organisational coverage and data quality in the MHSDS. As well as ongoing efforts with individual providers, NHS Digital has also published detailed implementation planning guidance¹⁷. The Care Quality Commission (CQC) also monitors the use of The Act, including the keeping of records about its use by service providers.

Accuracy & Reliability

Accuracy is the proximity between an estimate and the unknown true value. Reliability is the closeness of early estimates to subsequent estimated values.

Methodology

As explained in the 2015/16 publication¹⁸, from 2016/17 these statistics about uses of the Mental Health Act are primarily produced from referral-level information sourced from the MHSDS rather than from aggregate numbers submitted by individual providers to the KP90 collection.

Therefore these statistics are now derived from administrative data, which are produced in the course of delivering patient care, rather than from a bespoke aggregate collection. Their use for statistical purposes is secondary. Using this referral-level data allows a much greater range of analysis to be produced, including new breakdowns, for example by age or ethnic group, and for different patient pathways (for example, those on an Early Intervention

¹⁷ <http://content.digital.nhs.uk/mhsds/spec>

¹⁸ See the 'Improved reporting to support better care' special feature in the 2015/16 publication: <http://content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-spec-feat.pdf>

Pathway, or those who enter the services via a crisis pathway). It supports analysis or repeat detentions for individual patients within and across reporting periods.

The MHSDS contains 48 data tables¹⁹, only some of which are required to produce the measures in this publication. These tables include:

- MHS001: Master Patient Index (provides the age, gender and ethnicity for each person, enabling analysis by these characteristics)
- MHS401: Mental Health Act Legal Status Classification Period (provides details of detention periods for people detained under The Act)
- MHS404: Community Treatment Order (provides details of CTO periods)
- MHS405: Community Treatment Order Recall (provides details of periods where a person on a CTO was recalled to hospital for treatment under section 17a)
- MHS501: Hospital Provider Spell (provides details of periods in hospital). Please note that each record has an associated referral in table MHS101: Service or Team Referral and that data cannot be submitted without an associated referral.

NHS Digital has developed methods for accurately producing counts of the specific scenarios that are monitored in the official Mental Health Act statistics, by analysing individual changes in legal status and the sequence of hospital admissions recorded for each person in the MHSDS. From this information, the number of uses of individual sections of The Act can be determined.

Therefore whilst the methodology can accurately produce counts of events with a high degree of accuracy from the data source, issues with completeness affect the accuracy of outputs produced using these methods.

The metadata file contains further details including definitions for measures included in this publication and technical descriptions of the constructions used to produce these measures from the data sources.

Sources of error and bias

The main source of error and bias in these statistics is the completeness of the MHSDS data (see 'Relevance' for a summary of these issues). At national level, this results in a downward bias to counts and any derived rates.

Therefore although we are presenting the same measures as in previous years, due to missing data the 2016/17 figures are not directly comparable to those published in previous years.

The impact of coverage issues on the reliability of individual figures varies according to what is being counted and at what level the data are being used. The following general guidance to bias in this publication is provided alongside detailed guidance below for each Excel table:

Counts of events (such as new detentions) are understated in these statistics due to shortfalls in coverage (also see 'Relevance'). Counts of events at sub-national level are also understated, but to varying degrees, depending on the completeness of the data in each

¹⁹ This is based on MHSDS Version 1. Also see the MHSDS Technical Output Specification at: <http://content.digital.nhs.uk/mhsds/spec>

area. This publication includes the first breakdowns of detentions by Sustainability and Transformation Partnership (STP) areas (Table 1d in the Data Tables). As an aggregate data collection, the KP90 did not support further analyses by geography. However, counts of detentions and associated rates by STP areas are each affected by coverage and completeness issues to a different extent. Please note that these breakdowns are based on the patient's place of residence, not place of treatment, and therefore do not reflect treatment that occurs away from the area of residence. A further source of downward bias is that this detailed analysis can only be produced from the record-level MHSDS data; information is submitted as aggregate figures to the Acute collection so cannot be used for these purposes.

Counts of people detained (see Table 5) are particularly affected by missing data from Independent Service Providers (ISPs). Due to the type of services they provide, ISPs tend to have longer stay patients and these are more likely to be picked up in a snapshot end of the year count than those detained for shorter periods of time. Therefore missing data from ISPs will have a greater impact on the count of people detained (Table 5) than for new detentions (Table 1). This is because the count of people detained at the end of the period will include not only some people detained in the current reporting year, but also in hospital as a result of continuing detentions that commenced in earlier periods.

Population-based rates for age, gender and ethnicity are derived using counts of events. Therefore they are also understated due to the numerator (the number of events) being incomplete whilst the denominator (population) is complete (based on either Census data or ONS estimates of the complete figures). There is an additional downward bias resulting from records where a valid age, gender or ethnicity could not be obtained. However, completeness for these fields is good in the MHSDS and the counts used are shown in each Excel table. A further source of downward bias is that this detailed analysis can only be produced from the record-level MHSDS data; information is submitted as aggregate figures to the Acute collection so cannot be used for these purposes.

Although we cannot know whether the missing data causes bias in term of age, gender or ethnicity, we can segment the data that we did receive to see if there are large variations in characteristics. We can compare demographic information for NHS and independent providers that did submit data to see if there are large variations in age, gender or ethnicity which could result in bias to derived rates, due to variations in completeness across these types of providers.

Table 4 shows the counts for age, gender and ethnicity split between NHS and Independent Sector providers. These counts show that despite the differences in services provided, the percentage splits of gender, age and ethnicity are broadly similar across NHS and Independent Sector providers and as such we believe the calculated rates of detention are reliable.

Table 4: Detentions by gender, age and ethnicity, 2016/17, by provider type

	<i>Number</i>			<i>Percentage</i>		
	All	NHS	Independent	All	NHS	Independent
Gender						
Male	22,716	21,151	1,565	52%	51%	56%
Female	21,291	20,048	1,243	48%	49%	44%
Age						
15 and under	322	234	88	1%	1%	3%
16-17	722	532	190	2%	1%	7%
18-34	13,845	12,690	1,155	31%	31%	41%
35-49	11,294	10,557	737	26%	26%	26%
50-64	8,317	7,923	394	19%	19%	14%
65 and over	9,533	9,283	250	22%	23%	9%
Ethnicity						
White	31,004	29,207	1,797	75%	75%	73%
Mixed	1,224	1,132	92	3%	3%	4%
Asian	2,928	2,816	112	7%	7%	5%
Black	4,549	4,337	212	11%	11%	9%
Other	1,629	1,373	256	4%	4%	10%

Source: MHSDS

Table 5 below provides detailed guidance on bias and issues specific to each of the Excel Data Tables (table continues on next page).

Table 5: Sources of errors and bias, by Data Table, 2016/17

Data Tables	NHS providers	Independent sector providers
Tables 1a, b, c	<p>Downward bias to numbers and derived rates:</p> <p>Counts of detentions in these tables are affected by missing monthly submissions and by incomplete data.</p> <p>The figures for 'Detentions following revocation of CTO' were affected by variability in the way providers recorded the Section 3 that preceded the CTO and was renewed on revocation. This is considered to be a recording issue.</p>	<p>Downward bias to numbers and derived rates:</p> <p>Because this sector has historically reported a small proportion of new detentions, gaps in submissions affect the national counts less than missing NHS data (downward bias).</p>
Table 1d	<p>Downward bias to numbers and derived rates:</p> <p>Geographical rates are affected in varying ways by missing NHS providers in each area and this means that comparisons between areas may not be valid. All areas are likely to be affected to some extent but the following missing providers will particularly impact figures for local areas:</p> <ul style="list-style-type: none"> • South Essex University Partnership • Cumbria Partnership • Isle of Wight 	<p>Downward bias to numbers and derived rates:</p> <p>Since the large independent sector organisations have hospitals in different areas and take patients from all over the country, gaps in data from these organisations will result in a more evenly spread impact than missing NHS providers.</p>
Tables 2a, b, c	<p>Downward bias to numbers and derived rates:</p> <p>Most uses of section 136 occur in the NHS so this has the greatest impact on the figures. Where patients are not referred to a Mental Health service after discharge from the s136, local system issues mean these may not be included in MHSDS submissions. This is a known issue that increases the shortfall caused by gaps in submissions.</p>	<p>Downward bias to numbers and derived rates:</p> <p>This is affected by gaps in submissions but has less impact on uses of section 136 as we are not aware of ISPs being used as a Place of Safety by the police.</p>

Tables 3a, b, c	<p>Downward bias to numbers and derived rates:</p> <p>Whilst the total number of new Community Treatment Orders (CTOs) recorded is similar to previous years, variation in reporting of preceding and subsequent uses of The Act may require further investigation and the figures are affected by recording issues. Although data submitted in Table MHS404 indicated CTOs ending with a revocation, this number did not tally with uses of section 3 that could be identified as a detention following revocation (Table 1). We also understand that some organisations had trouble flowing the 'parent' records (in Table MHS401) for each CTO, including the previous section and this reduces the reliability of reporting on preceding legal status. Data for one provider (Lancashire Care NHS Foundation Trust (RW5)) was excluded from the CTO counts due to significant data quality issues.</p>	<p>Downward bias to numbers and derived rates:</p> <p>CTOs are not often started in ISP organisations and so gaps in ISP submissions affect these measures less than missing data from NHS providers.</p>
Table 4	<p>Downward bias to numbers:</p> <p>Most of these figures are also in Table 1 and are subject to the issues shown above. As in Table 3 the record level data shows some new scenarios, not previously collected.</p>	<p>Downward bias to numbers:</p> <p>Most of these figures are also in Table 1 and are subject to the issues shown above. As in Table 3 the record level data shows some new scenarios, not previously collected.</p>
Table 5	<p>Bias varies by provider:</p> <p>The bias varies by provider, as data may be complete, incomplete or missing.</p> <p>Comparisons with previous year's figures at provider level shown in Table 5 of the Data Tables are a useful measure of completeness for 2016/17 as the number of people that can be detained is limited by capacity. However local knowledge (for example about ward closures or mergers) may be required to interpret large changes.</p>	<p>Bias varies by provider:</p> <p>The bias varies by provider, as data may be complete, incomplete or missing.</p> <p>The sector makes a greater contribution to these figures as people detained in specialist services on criminal justice sections (longer duration) are likely to be in the sector.</p> <p>Comparisons with previous year's figures at provider level are a useful measure of completeness for 2016/17 as the number of people that can be detained is limited by capacity. However the sector is subject to frequent change and local knowledge will be required to interpret large changes.</p>

Accuracy of statistics for prior periods: duplicate recording of detentions

Analysis of the record-level MHSDS data during the production of these statistics has revealed new insights which suggest that the number of detentions may have been overstated in previous years. This section summarises these insights and their implications for previously published data. As these are new insights, they may require further investigation.

Our analysis of the MHSDS data has shown that where patients are transferred between hospitals whilst subject to The Act, the same uses of The Act may be recorded in two places, leading to a potential double counting of uses. It suggests that there was some double-counting of this type in previous years where providers submitted aggregate figures to the KP90. This means that detention figures for previous years may have been overstated.

Transfers between hospitals may occur for a variety of reasons including moving patients to hospitals to receive specific services or as part of bed management practices.

Both hospitals involved in the transfer have a legal duty to record the use of the Act and it is likely that this has led to some double counting in previous years where both hospitals recorded the detention in their KP90 return. There may have been further levels of duplication where more than two hospitals were involved in a patient's care.

NHS Digital has developed methods for ensuring that each use is only counted once in the analysis of MHSDS data; this is because the data shows where the same use of The Act has been recorded by more than one provider and we count each use where it originally occurs – and further occurrences can be identified as transfers whilst the patient was 'on section'. This count of transfers is not part of the existing time series but we believe it provides important context (transfers 'on section' were not recorded in the KP90 collection).

Using the record level MHSDS, our analysis of 2016/17 data shows that in addition to the 25,474 detentions that occurred at the point of admission, a further 7,091 admissions occurred where the patient was transferred from another provider whilst already detained ('transferred on section'). In previous years, we believe that some of these transfers were submitted as new detentions on admission to hospital.

Although we can derive the number of transfers on section using MHSDS for 2016/17, we do not know to what extent this double counting occurred in previous years as 'transfers on section' were not included in the KP90 collection.

Accuracy of statistics for prior periods: composition of detentions on and following admission to hospital

These statistics have always shown detentions that occurred on admission to hospital separately to those that followed admission (See Table 1a in the Data Tables). Since both the date and time of events are recorded in the MHSDS, we are able to accurately classify detentions based on the date and time of hospital admission and change in legal status. We can therefore identify detentions that occurred following admission to hospital but on the same day.

When we compare the 2016/17 figures for 'detention on admission' to 'detention following admission', we have noted that the proportion of 'detentions following admission' is higher than in recent years (38.3 per cent of all detentions in 2016/17 compared to 27.0 per cent in 2015/16).

If both the admission and detention occurred on the same day, we believe that some providers may have recorded these as 'detentions on admission' in the KP90. It suggests that some of the 'detentions on admission' recorded in previous years actually occurred following admission to hospital.

Coherence and Comparability

Comparability is the degree to which data can be compared over time and domain. Coherence is the degree to which data that are derived from different sources or methods, but refer to the same topic, are similar.

Time series data are presented as part of these statistics, as in previous years. However due to the change of data source this year and the issues of accuracy identified above, it is not possible to make direct comparisons to prior years. However we have produced some more nuanced analysis to assist users in understanding the differences observed in the number of detentions compared to previous years.

Change in data source

The change in data source follows the recommendation in the Secretary of State's Fundamental Review of Returns 2013 that the KP90 collection would be retired once the same information could be produced from administrative data sources.

The scope of the administrative data source has gradually increased from covering only NHS mental health services for adults, to including Independent Sector Providers in 2011 together with changing the format to permit analysis of individual uses of The Act, adding learning disability services in 2014 and, with introduction of Children and Young Peoples' services and the MHSDS in January 2016, coverage of children and adolescents.

This means it now covers the majority of services where The Act is used. A small number of uses of The Act occur in NHS acute hospitals each year and remain out of scope for MHSDS so this information was collected separately in a separate return. Although the number of uses of the Mental Health Act that occur in these settings is small, data are required to provide a full national picture at least once a year. Services should be delivered in the least restrictive setting possible and this cannot be monitored without information about uses of detentions and other sections of The Act. This includes any changes in the way The Act is used, particularly use of Section 136 in Accident and Emergency departments.

Comparisons between statistics from KP90 and MHSDS

As the new MHSDS-based analysis counts the same events as were previously produced using the KP90 collection, in theory it is possible to compare outputs from both data sources. However, at present the high-level numbers are not comparable to those produced in previous years due to organisational coverage and any local issues with supplying comprehensive, accurate data via the MHSDS.

Therefore the 2016/17 statistics shown in the Data Tables, produced from the MHSDS, should not be directly compared to those produced from the KP90 collection in previous years.

Estimating the change in detentions from 2015/16 to 2016/17

We can use the new insights noted in the 'Accuracy and Reliability' section to produce an estimate of the change in detentions between 2015/16 and 2016/17.

These insights suggest that the level of detentions were overstated in previous years, due to double-counting in the KP90 collection. In 2016/17, data were incomplete, so we cannot make a direct comparison between these periods.

To estimate the change in detentions between 2015/16 and 2016/17, we have analysed the data submitted by a smaller group of providers. We have not attempted to estimate the true level of detentions in 2015/16 or 2016/17, as this would require additional investigations into

the elements of double-counting, coverage and completeness and these were not possible in the timescales available.

Instead, we have made an assessment that the quality of data for a smaller group of providers supports a like-for-like comparison, based on the following criteria:

- All providers submitted data to the KP90 in 2015/16 and MHSDS in 2016/17 (providers submitting to the Acute collection were excluded from this analysis).
- All providers submitted 12 months' data to the MHSDS
- Our ongoing data quality investigations did not reveal any significant data quality issues reported during 2016/17 relating to measures of detentions.

There were 30 NHS and five independent providers that met these criteria (see Appendix 2).

Our analysis was based on data from these 35 providers. It excluded 'detentions following use of section 136' and 'revocation of community treatment orders'. Although these form part of the total number of detentions (as shown in Table 1a of the Data Tables), they are relatively small components of the total and completeness for these measures are affected by different factors than the two main measures ('detentions on admission' and 'detentions following admission'). Therefore excluding these categories allows for the production of more reliable estimates of trend changes.

Table 6a: Detention and transfer on section figures for 35 selected providers, 2015/16 and 2016/17

	2015/16	2016/17
Detentions on admission	20,944	15,999
Detentions following admission	8,302	9,501
Transfers on section	-	4,326

Sources: KP90 2015/16, MHSDS 2016/17

The data in Table 6a show:

- A decline of 12.8 per cent in detentions from 2015/16 to 2016/17 when 'transfers on section' are not included in the analysis. This is unlikely to be on a comparable basis as our analysis suggests that some 'transfers on section' were included in detention figures in the KP90.
- When we include 'transfers on section' in the comparison, there is an increase of 2.0 per cent in detentions from 2015/16 to 2016/17.

Therefore, we estimate that there was a 2 per cent increase in detentions under the Mental Health Act in 2016/17. Our analysis also indicates that the true level of detentions was lower than that published in previous years, although we do not know the number of 'transfers on section' that occurred in these periods as this information was not collected in the KP90.

Table 6b provides a further breakdown of detentions on admission and transfers on section, by legal status, for these providers.

Table 6b: Detentions on admission and transfers on section for 35 selected providers, by legal status, 2015/16 and 2016/17

	2015/16	2016/17	
	Detentions on admission	Detentions on admission	Transfers on section
Total	20,944	15,999	4,326
Part II	19,886	15,866	3,440
Section 2	16,050	13,579	1,586
Section 3	3,836	2,287	1,854
Part III	1,058	133	755
Previous legislation and other Acts	-	-	131

Sources: KP90 2015/16, MHSDS 2016/17

Geographical comparisons

Using the new MHSDS data source, we have produced geographical analyses and this publication includes the first breakdowns of detentions by Sustainability and Transformation Partnership (STP) areas (Table 1d in the Data Tables).

Comparison between STP areas should be made with caution, as each area is affected by coverage and completeness issues to a different extent. The numbers and rates shown do not allow a true comparison of detentions between different STP areas. However, they can be used to indicate areas where MHSDS coverage is low and require further data quality investigations.

Comparisons using population-based rates

We have presented population-based rates in this publication, which allow comparisons to be made between different groups of people, even though the data are incomplete (see also 'Accuracy and Reliability'). We have presented crude rates for gender and age groups but also standardised rates for ethnicity, which are split into smaller groups of people and are therefore subject to greater variation. These ethnicity rates use direct standardisation to adjust for the different gender and age profile of each ethnic group, allowing us to make comparisons on a like-for-like basis. We have also calculated 95 per cent confidence intervals which are presented alongside the rates.

Population figures do not match across the Data Tables as we have used the latest figures available in each case, at the time of production. For gender and age, we have used ONS mid-year population estimates from 2016. STP breakdowns use ONS mid-year estimates from 2015 as these are the latest available for the underlying geographies. Ethnicity data uses 2011 Census as mid-year estimates are not produced for this breakdown. This Census data will not reflect any changes in the ethnic structure of the population in England which have occurred since 2011. When deriving rates, this creates a mismatch as the numerator is based on 2016/17 data but the denominator uses 2011 data; this mismatch will increase until the next Census data are published.

Other Mental Health Statistics

The summary report contains links to related information, including to:

- Monthly publications of mental health statistics produced by NHS Digital. These cover about secondary mental health, learning disabilities and autism services. The statistics in this Mental Health Act Statistics annual publication are derived from the MHSDS and monthly reports are also published from the MHSDS. The Mental Health Services Monthly Statistics publication includes several measures relating to the number of uses of the Mental Health Act (see Appendix 1). These measures are broken down by age and service type, by provider and CCG of the patient's GP practice. The counts of people in the March 2017 Final publication are the same as those shown in Table 5 of the Data Tables in this publication as they both relate to a snapshot as at 31st March 2017.
- The Mental Health Bulletin, an annual publication produced by NHS Digital about people who used adult secondary mental health and learning disabilities services during the period. A link is provided to the 2015/16 publication; statistics for 2016/17 are due to be published on 30th November 2017 and are also sourced from the MHSDS.
- Statistics on police uses of sections 135 and 136 of The Act. This Mental Health Act Statistics publication only covers uses of section 136 where the place of safety was a hospital. Since the police are involved in all uses of section 136, statistics on police uses also include uses where the place of safety was a police cell. The 2016/17 statistics are due to be published by the Home Office on 26th October 2017. The 2015/16 statistics were published by the National Police Chiefs' Council.
- The use of Guardianship under Sections 7 and 37 of the Mental Health Act; these uses of The Act are reported separately by NHS Digital
- Deprivation of Liberty Safeguards applications under the Mental Capacity Act 2005 (see the Background information to the Mental Health Act section of this document for further information).

Timeliness and Punctuality

Timeliness refers to the time gap between publication and the reference period.

Punctuality refers to the gap between planned and actual publication dates.

This report has been produced within seven months of the end of the reporting period, an improvement of over one month compared to 2015/16. It was produced within six months of the May deadline for providers to submit final data for March 2017, the last month of the annual reporting period.

In this first year using MHSDS as a data source, the time required for producing this publication has included the development of complex analytical methods and data processing. However, now that this work is complete it will be possible to produce more frequent and timely reports covering different reporting periods.

As an example of improved timeliness, since April 2016, NHS Digital has published the measures in Table 5 of the Data Tables accompanying this report in the monthly MHSDS publication. These were chosen as the first measures as they have supported the monitoring of coverage across monthly submissions due to their more timely release.

Accessibility and Clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information. Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

The name of this publication has been changed to improve clarity, in line with recommendations from the UK Statistics Authority. Previous publications in this series were named “Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment”. This publication adopts the more concise title “Mental Health Act Statistics, Annual Figures” but remains part of the same publication series.

The format of the summary report has changed this year to improve the clarity of explanations, present the information in a format suitable for a wider range of users. This background data quality report will be of more interest to the expert user as it provides detailed explanations of the methods and our assurance of the data.

Interactive data visualisations are provided for the first time using Microsoft Power BI reports. This will be of interest to all users and can be used to further explore local data quality issues.

Data are provided in both formatted Microsoft Excel tables and machine-readable (CSV) formats. The Excel Data Tables are provided in the same format as that provided previously, for the expert user, and new breakdowns have been added this year which were not previously possible from the KP90.

Re-use of these data is subject to conditions outlined here:

<https://digital.nhs.uk/article/235/Terms-and-conditions>

Definitions for measures included in this publication are available in the accompanying metadata file. Terminology is defined where appropriate and we provide a summary of the methods used to produce these measures from record-level data.

Full details of the way that MHSDS returns are processed, which will be of use to analysts and other users of these data, are provided in the MHSDS User Guidance, available on the NHS Digital website:

<http://content.digital.nhs.uk/mhsds/spec>

Trade-offs between output quality components

This refers to the extent to which different aspects of quality are balanced against each other

The main trade-off agreed with key stakeholders, was to make information available from the new sources as soon as possible, although this has affected the scope of new analysis. The format of this publication has been determined to summarise key annual measures and adjusting the scope of analysis to be achievable within NHS Digital resources and production time. Nevertheless, we have widened the scope of this annual publication to increase the usefulness and usability of these statistics for different users. This includes new methods of presenting data (including Microsoft Power BI reports) and new reporting on rates of detention by age, gender and ethnicity.

By publishing this information we hope to promote a virtuous cycle of improving data and service quality through more frequent monitoring, data completeness/quality feedback and use.

Assessment of User Needs and Perceptions

This refers to the processes for finding out about users and uses, and their views on the statistical products.

A key purpose of this annual publication is to provide the Department of Health with information about the number of uses made of Mental Health Act 1983 legislation (except for Guardianship cases under Sections 7 and 37) as amended by the Mental Health Act 2007 and other legislation. It is intended to inform policy development in relation to The Act. Consultation with customers and stakeholders is undertaken through a variety of channels to ensure that developments introduced to the publication meet their requirements. The UK Statistics Authority has supported us and provided guidance as we develop these statistics. This includes working with partners to design statistics that support the changes outlined in the Five Year Forward View for Mental Health Implementation Plan²⁰. NHS Digital last undertook a consultation on Mental Health Act statistics in 2012 and made a series of changes to the publication as a result²¹.

NHS Digital welcomes all feedback and suggestions relating to this publication. Feedback can be provided to NHS Digital via email to enquiries@nhsdigital.nhs.uk (quoting 'Mental Health Act Statistics' in the subject line) or via telephone on 0300 303 5678.

²⁰ <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf>

²¹ http://content.digital.nhs.uk/MentalHealthAct_stats_consultation

Balance between performance, cost and respondent burden

This refers to the effectiveness, efficiency and economy of the statistical output.

The dataset preceding MHSDS (MHLDDS) was identified as the data source to replace others in the Fundamental Review of Returns programme designed to reduce burden on the NHS. However the MHLDDS did not have sufficient scope to replace the KP90 collection. The scope of the administrative data has gradually improved over time and with the inclusion of children and young peoples' services from January 2016, the MHSDS had sufficient scope to replace the KP90 collection.

Therefore the burden of collating Mental Health Act data and submitting KP90 returns has been removed. NHS Digital has estimated that the annual KP90 collection required 1,170 working days of effort from submitting organisations, equivalent to 5.85 person-years. The cost was estimated at approximately £367,000 per year. This publication no longer requires a specific data source as it is produced from the MHSDS which is the source for both the monthly Mental Health Statistics and the annual Mental Health Bulletin.

A small part of this burden saving is offset by the costs of collecting the new Acute collection (at £14,000). This collection was required to ensure that uses of The Act by NHS acute hospitals were covered by this publication (as these organisations are out of scope for MHSDS). However, to minimise the additional burden this creates (as uses of The Act in these settings are a small proportion of all uses), the scope of the new collection was significantly reduced to focus on only those types of use of The Act that actually occur in those settings. It is an aggregate collection and does not include the level of detail provided by the record-level MHSDS data.

Confidentiality, Transparency and Security

This refers to the procedures and policy used to ensure sound confidentiality, security and transparent practices.

Data submissions to the MHSDS have been processed in line with the rules described in the Technical Output Specification for the dataset²² using a fully assured system that pseudonymises individual identifiers. As with all NHS Digital publications, the risk of disclosing an individual's identity in this publication series has been assessed and the data are published in line with the Disclosure Control Method for the MHSDS dataset approved by the NHS Digital Disclosure Control Panel. Figures presented at sub-national geographies are rounded to the nearest five, except for small numbers (those from zero to four) which are suppressed and marked by a "*" symbol. Figures at national level are unrounded and unsuppressed. Table 5 of the Excel Tables also identifies organisations that did not submit data this year with a "-" symbol and these are also identified in Appendix 2.

²² Technical Output Specification is available at: <http://content.digital.nhs.uk/mhsds/spec>

Please see links below to relevant NHS Digital policies:

A Guide to Confidentiality in Health and Social Care

<https://digital.nhs.uk/article/1226/A-Guide-to-Confidentiality-in-Health-and-Social-Care->

How we look after information

<https://digital.nhs.uk/article/364/Looking-after-information>

Freedom of Information Process

<https://digital.nhs.uk/article/253/Freedom-of-Information>

Statistical Governance Policy

[statistical_governance_policy.pdf](#)

Appendix 1: Mental Health Act measures released each month

This appendix lists the Mental Health Act measures which are included in the Mental Health Services Monthly Statistics release.

These reports can be accessed via the landing page:

<http://content.digital.nhs.uk/mhldsreports>

The following information is included in the 'Data Quality Report' Excel file (note that the March 2017 file contains data for the full 12 month reporting period covered by this report):

Coverage worksheet: Number of items submitted by each provider for each MHS table. The following tables collect data which can be used in Mental Health Act analysis (but not all are used in the analysis presented in this report – see the 'Accuracy and Reliability' section of this document):

These tables include:

- MHS001: Master Patient Index
- MHS401: Mental Health Act Legal Status Classification Period
- MHS402: Mental Health Responsible Clinician Assignment
- MHS403: Conditional Discharge
- MHS404: Community Treatment Order
- MHS405: Community Treatment Order Recall
- MHS501: Hospital Provider Spell

Validity (Count and Percentage) worksheets: for the 'MHS-DQM07: Mental Health Act Legal Status Classification Code' measure there are show counts and percentages of data items that are 'valid', 'other', 'default', 'invalid' and 'missing' for each submitting organisation.

Provider Feedback worksheet: contains supplementary information about data quality, including some issues that relate to Mental Health Act data.

The following measures are included in the Data Quality machine-readable CSV file (each monthly report includes data for a single month):

- MHS08 - People in contact with mental health services subject to The Act at the end of the reporting period
 - MHS08a – those aged 0-17
- MHS09 - People in contact with mental health services subject to detention at the end of the reporting period
 - MHS09a – those aged 0-17
 - MHS09b – those aged 18-64
 - MHS09c – those aged 65 and over

- MHS10 - People in contact with mental health services subject to CTO or conditional discharge at the end of the reporting period
 - MHS10a – those aged 0-17
- MHS11 - People in contact with mental health services subject to a short term order at the end of the reporting period

Appendix 2: Mental Health Act data - organisation lists

Provider-level data showing monthly data volumes in key MHSDS tables for organisations listed in Tables 7 and 8 can be interrogated in the Microsoft Power BI reports provided as part of this publication. Users should refer to the 'Provider-level coverage' page of the Power BI reports.

Table 7: Organisations that submitted 12 months' Mental Health Act data to the MHSDS in 2016/17 (table continues on next page)

Org code	Organisation Name	Submitted KP90 in 2015/16?	Organisation Type
RTQ	2GETHER NHS FOUNDATION TRUST	Yes	NHS Trust
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	No	NHS Trust
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	Yes	NHS Trust
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	Yes	NHS Trust
RWX	BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST	Yes	NHS Trust
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	Yes	NHS Trust
TAD	BRADFORD DISTRICT CARE TRUST	Yes	NHS Trust
NTT	CAMBIAN HEALTHCARE LIMITED	Yes	Independent
RT1	CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST	Yes	NHS Trust
TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	Yes	NHS Trust
RV3	CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST	Yes	NHS Trust
NHV	COMMUNITY LINKS (NORTHERN) LTD	No	Independent
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RYG	COVENTRY AND WARWICKSHIRE PARTNERSHIP NHS TRUST	Yes	NHS Trust
NMJ	CYGNET HEALTH CARE LIMITED	Yes	Independent
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	Yes	NHS Trust
RWV	DEVON PARTNERSHIP NHS TRUST	Yes	NHS Trust
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	Yes	NHS Trust
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	Yes	NHS Trust
RWK	EAST LONDON NHS FOUNDATION TRUST	Yes	NHS Trust
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	Yes	NHS Trust
RWR	HERTFORDSHIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Yes	NHS Trust
RV9	HUMBER NHS FOUNDATION TRUST	Yes	NHS Trust
AHL	INMIND HEALTHCARE	Yes	Independent
RW5	LANCASHIRE CARE NHS FOUNDATION TRUST	Yes	NHS Trust
RGD	LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RY6	LEEDS COMMUNITY HEALTHCARE NHS TRUST	Yes	NHS Trust
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
TAE	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	Yes	NHS Trust
RW4	MERSEY CARE NHS TRUST	Yes	NHS Trust
NQL	NAVIGO	Yes	Independent
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	Yes	NHS Trust

RAT	NORTH EAST LONDON NHS FOUNDATION TRUST	Yes	NHS Trust
RRD	NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	Yes	NHS Trust
RLY	NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST	Yes	NHS Trust
RX4	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	Yes	NHS Trust
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	Yes	NHS Trust
RNU	OXFORD HEALTH NHS FOUNDATION TRUST	Yes	NHS Trust
RPG	OXLEAS NHS FOUNDATION TRUST	Yes	NHS Trust
NR5	PLYMOUTH COMMUNITY HEALTHCARE (CIC)	Yes	Independent
RXE	ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST	Yes	NHS Trust
TAH	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	Yes	NHS Trust
R1C	SOLENT NHS TRUST	Yes	NHS Trust
RH5	SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RV5	SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST	Yes	NHS Trust
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	Yes	NHS Trust
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	Yes	NHS Trust
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	Yes	NHS Trust
RXX	SURREY AND BORDERS PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	Yes	NHS Trust
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	Yes	NHS Trust
RKL	WEST LONDON MENTAL HEALTH NHS TRUST	Yes	NHS Trust
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	Yes	NHS Trust

Table 8: Organisations that submitted fewer than 12 months' Mental Health Act data to the MHSDS in 2016/17

Org code	Organisation Name	Number of monthly MHSDS submissions	Submitted KP90 in 2015/16?	Organisation Type
RXA	CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	11	Yes	NHS Trust
RXY	KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST	11	Yes	NHS Trust
RP1	NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	11	Yes	NHS Trust
RTF	NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	11	Yes	NHS Trust
RT2	PENNINE CARE NHS FOUNDATION TRUST	11	Yes	NHS Trust
RTV	5 BOROUGH PARTNERSHIP NHS FOUNDATION TRUST	10	Yes	NHS Trust
NMQ	MAKING SPACE	10	Yes	Independent
TAJ	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST	9	Yes	NHS Trust
NR0	RAPHAEL HEALTHCARE LTD	9	Yes	Independent
RCU	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	9	Yes	NHS Trust
NYA	ST ANDREW'S HEALTHCARE	9	Yes	Independent
NQ4	ST GEORGE HEALTHCARE GROUP	9	Yes	Independent
RXV	GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	8	Yes	NHS Trust
NMV	PARTNERSHIPS IN CARE LTD	8	Yes	Independent
NTN	PRIORY GROUP LIMITED	8	Yes	Independent
AHN	EQUILIBRIUM HEALTHCARE	6	Yes	Independent
RNN	CUMBRIA PARTNERSHIP NHS FOUNDATION TRUST	5	Yes	NHS Trust
DE8	ELYSIUM HEALTHCARE	4	No	Independent
RJX	CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST	3	Yes	NHS Trust
RY8	DERBYSHIRE COMMUNITY HEALTH SERVICES NHS FOUNDATION TRUST	1	Yes	NHS Trust

Table 9: Organisations that submitted data to the Acute collection in 2016/17 (applies to NHS Trusts only, table continues on next page)

Org code	Organisation Name	Submitted KP90 in 2015/16?
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	No
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	No
RJN	EAST CHESHIRE NHS TRUST	No
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	No
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	No
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	No
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	No
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	No
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	No
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	No
R1H	BARTS HEALTH NHS TRUST	Yes
RYW	BIRMINGHAM COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	Yes
RQ3	BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	Yes
RAE	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	Yes
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	Yes
RGT	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Yes
RLN	CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	Yes
RXP	COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	Yes
RXC	EAST SUSSEX HEALTHCARE NHS TRUST	Yes
RDU	FRIMLEY HEALTH NHS FOUNDATION TRUST	Yes
RN3	GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	Yes
RJ1	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	Yes
RCD	HARROGATE AND DISTRICT NHS FOUNDATION TRUST	Yes
RYJ	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	Yes
RJZ	KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	Yes
RAX	KINGSTON HOSPITAL NHS FOUNDATION TRUST	Yes
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	Yes
RVJ	NORTH BRISTOL NHS TRUST	Yes
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	Yes
RVW	NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	Yes
RTH	OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Yes
RK9	PLYMOUTH HOSPITALS NHS TRUST	Yes
RHU	PORTSMOUTH HOSPITALS NHS TRUST	Yes
RHW	ROYAL BERKSHIRE NHS FOUNDATION TRUST	Yes
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	Yes
RH8	ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	Yes
RA2	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	Yes
RD1	ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	Yes
RM3	SALFORD ROYAL NHS FOUNDATION TRUST	Yes
RNZ	SALISBURY NHS FOUNDATION TRUST	Yes
RTR	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	Yes
RBA	TAUNTON AND SOMERSET NHS FOUNDATION TRUST	Yes
RNA	THE DUDLEY GROUP NHS FOUNDATION TRUST	Yes
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	Yes
RCX	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	Yes
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	Yes
RRK	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	Yes
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	Yes
RBK	WALSALL HEALTHCARE NHS TRUST	Yes
RWW	WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	Yes
RYR	WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST	Yes
RA3	WESTON AREA HEALTH NHS TRUST	Yes

RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	Yes
RCB	YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	Yes

Table 10: Organisations submitting data to KP90 in 2015/16 but not submitting data about The Act to either MHSDS or the Acute collection in 2016/17 (table continues on next page)

Please note this list excludes 33 small independent hospitals with a combined total of 95 detentions in 2015/16. These were not reported separately in last year's CSV file as they either had no Organisation Data Service (ODS) code and/or represented very small numbers of detentions.

Org code	Organisation Name	All detentions: 2015/16	Organisation Type
A7RH	ALTERNATIVE FUTURES GROUP LTD	35	Independent
RTK	ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	10	NHS Facilities
8JD96	BALDOCK MANOR	5	Independent
KP9097	Barchester Healthcare Homes Limited	5	Independent
8AM50	BILLINGHAM GRANGE	10	Independent
8J554	BREIGHTMET CENTRE	5	Independent
NQ9	BROOKDALE HEALTHCARE LTD (T/A BROOKDALE CARE)	20	Independent
RXQ	BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	*	NHS Facilities
RJF	BURTON HOSPITALS NHS FOUNDATION TRUST	10	NHS Facilities
NT8	CAPIO UK	90	Independent
8AP11	CASTLE LODGE INDEPENDENT HOSPITAL	5	Independent
RW3	CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	NHS Facilities
RQM	CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	15	NHS Facilities
NRN	CHESWOLD PARK HOSPITAL	20	Independent
AHQ	CUROCARE LTD	30	Independent
AG0	DANSHELL GROUP	45	Independent
RTG	DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST	5	NHS Facilities
8JC73	ELLERN MEDE RIDGEWAY	5	Independent
AHY	GLEN CARE	10	Independent
RTE	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	5	NHS Facilities
RN5	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	10	NHS Facilities
NRY	HUNTERS MOOR NEUROREHABILITATION LTD	5	Independent
R1F	ISLE OF WIGHT NHS TRUST	155	NHS Facilities
NLN	JEESSAL AKMAN CARE CORPORATION LTD	25	Independent
NL0	JOHN MUNROE HOSPITAL	25	Independent
RT5	LEICESTERSHIRE PARTNERSHIP NHS TRUST	835	NHS Facilities
NES	LIGHTHOUSE HEALTHCARE LIMITED	30	Independent
AJE	MENTAL HEALTH CARE LTD	10	Independent
RD8	MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	*	NHS Facilities
NXQ	MODUS CARE	*	Independent
RV8	North West London Hospitals NHS Trust	15	NHS Facilities
AEXN	OPTIONS FOR CARE LTD	*	Independent
RD3	POOLE HOSPITAL NHS FOUNDATION TRUST	45	NHS Facilities
RAL	ROYAL FREE HAMPSTEAD NHS TRUST	65	NHS Facilities
8CL59	SHREWSBURY COURT INDEPENDENT HOSPITAL	5	Independent

RA9	SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	10	NHS Facilities
RWN	SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	600	NHS Facilities
RE9	SOUTH TYNESIDE NHS FOUNDATION TRUST	*	NHS Facilities
RAJ	SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	*	NHS Facilities
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	5	NHS Facilities
8CM63	ST MAGNUS HOSPITAL	35	Independent
NFJ	ST MATTHEWS LIMITED	15	Independent
RMP	TAMESIDE HOSPITAL NHS FOUNDATION TRUST	10	NHS Facilities
8J704	THE ATARRAH PROJECT LTD	5	Independent
8DJ77	THE HAMPTONS	5	Independent
NV2	THE HUNTERCOMBE GROUP	440	Independent
8GG74	THE RETREAT (YORK HOUSE)	10	Independent
NPE	THE RETREAT HOSPITAL GROUP	15	Independent
RKE	THE WHITTINGTON HOSPITAL NHS TRUST	200	NHS Facilities
NLH	TRANSITIONAL REHABILITATION UNIT (TRU)	5	Independent
NKI	TURNING POINT	10	Independent
RHM	UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	55	NHS Facilities
8G046	UPLANDS (FAREHAM)	5	Independent
8J339	VISION MENTAL HEALTHCARE	10	Independent
8CJ54	WOODLEIGH COMMUNITY INDEPENDENT HOSPITAL	5	Independent
NR1	WOODSIDE HOSPITAL	5	Independent
RA4	YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	5	NHS Facilities

Please note that the following NHS organisations in this list have closed or merged:

- **RV8** North West London Hospitals NHS Trust
- **RWN** South Essex Partnership University NHS Foundation Trust

Independent sector hospitals must register with the CQC on an annual basis. As the registration status and ownership of ISPs is subject to frequent change, where organisations are not registered with ODS, local knowledge may be required to determine their eligibility to submit data to MHSDS.

Table 11: Organisations submitting data about The Act in 2016/17 that did not submit data to KP90 in 2015/16

Org code	Organisation Name	All detentions : 2016/17	Organisation Type	Collection submitted to
REM	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	*	NHS Facilities	Acute
RBS	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	*	NHS Facilities	MHSDS
NHV	COMMUNITY LINKS (NORTHERN) LTD	5	Independent	MHSDS
RJR	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	*	NHS Facilities	Acute
RJN	EAST CHESHIRE NHS TRUST	*	NHS Facilities	Acute
DE8	ELYSIUM HEALTHCARE	460	Independent	MHSDS
RXN	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	*	NHS Facilities	Acute
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	*	NHS Facilities	Acute
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	5	NHS Facilities	Acute
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	*	NHS Facilities	Acute
RAN	ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	*	NHS Facilities	Acute
RA7	UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	*	NHS Facilities	Acute
RBL	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	*	NHS Facilities	Acute

Table 12: Selected providers used in comparison of 2015/16 and 2016/17 detentions
(table continues on next page)

We have provided counts of people detained at year-end for 2015/16 and 2016/17, as these helped to inform the process for selecting providers whose data was judged to be reliable. We recognise that the number of detained patients is also limited by capacity and organisational changes (e.g. mergers and ward closures) will result in changes in numbers that do not result from data quality issues.

Org Code	Organisation Name	Organisation Type	Number of people detained 31/03/2016	Number of people detained 31/03/2017
RTQ	2GETHER NHS FOUNDATION TRUST	NHS Facilities	180	220
RVN	AVON AND WILTSHIRE MENTAL HEALTH PARTNERSHIP NHS TRUST	NHS Facilities	510	480
RRP	BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST	NHS Facilities	440	525
RXT	BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	NHS Facilities	705	770
TAD	BRADFORD DISTRICT CARE TRUST	NHS Facilities	200	205
NTT	CAMBIAN HEALTHCARE LIMITED	Independent	505	415
TAF	CAMDEN AND ISLINGTON NHS FOUNDATION TRUST	NHS Facilities	285	415
RJ8	CORNWALL PARTNERSHIP NHS FOUNDATION TRUST	NHS Facilities	105	125
NMJ	CYGNET HEALTH CARE LIMITED	Independent	835	715
RXM	DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	NHS Facilities	225	235
RWV	DEVON PARTNERSHIP NHS TRUST	NHS Facilities	285	150
RDY	DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	NHS Facilities	230	245
RYK	DUDLEY AND WALSALL MENTAL HEALTH PARTNERSHIP NHS TRUST	NHS Facilities	90	40
RWK	EAST LONDON NHS FOUNDATION TRUST	NHS Facilities	790	755
RR7	GATESHEAD HEALTH NHS FOUNDATION TRUST	NHS Facilities	15	*
RV9	HUMBER NHS FOUNDATION TRUST	NHS Facilities	195	215
AHL	INMIND HEALTHCARE	Independent	75	60
RP7	LINCOLNSHIRE PARTNERSHIP NHS FOUNDATION TRUST	NHS Facilities	130	130
TAE	MANCHESTER MENTAL HEALTH AND SOCIAL CARE TRUST	NHS Facilities	300	260
NQL	NAVIGO	Independent	35	50
RMY	NORFOLK AND SUFFOLK NHS FOUNDATION TRUST	NHS Facilities	335	380
RRD	NORTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST	NHS Facilities	180	115
RX4	NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST	NHS Facilities	750	695
RHA	NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	NHS Facilities	855	805
NR5	PLYMOUTH COMMUNITY HEALTHCARE (CIC)	Independent	80	80
TAH	SHEFFIELD HEALTH AND SOCIAL CARE NHS FOUNDATION TRUST	NHS Facilities	200	205
R1C	SOLENT NHS TRUST	NHS Facilities	30	60
RRE	SOUTH STAFFORDSHIRE AND SHROPSHIRE HEALTHCARE NHS FOUNDATION TRUST	NHS Facilities	310	255
RQY	SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	NHS Facilities	420	410
RXG	SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST	NHS Facilities	350	360

RW1	SOUTHERN HEALTH NHS FOUNDATION TRUST	NHS Facilities	355	450
RX2	SUSSEX PARTNERSHIP NHS FOUNDATION TRUST	NHS Facilities	515	255
RX3	TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST	NHS Facilities	895	715
RKL	WEST LONDON MENTAL HEALTH NHS TRUST	NHS Facilities	775	760
R1A	WORCESTERSHIRE HEALTH AND CARE NHS TRUST	NHS Facilities	90	95

Appendix 3: Enhanced Assurance Activities

Practice area	Suggested activities (UK Statistics Authority)	MHSDS assurance processes relating to this publication
Operational context & administrative data collection	<p>Producer has provided users with a fuller description of the operational context and administrative data collection arrangements, e.g.:</p> <ul style="list-style-type: none"> - a process map detailing the data collection processes, - explanations for classifications, • Identified and summarised potential sources of bias and error in administrative system, • Identified and described safeguards taken to minimise risks to data quality, • Provided a detailed description of the implications for accuracy and quality of data, including the impact of any changes in the context or collection arrangements 	<ul style="list-style-type: none"> • Detailed description and assessment of changes to the way we source and produce these statistics comprise the main content of this report. • Metadata file describes methods and constructions. • Accuracy and reliability section (pp 15-19) assesses bias and error. • Table 7 and 8 demonstrated monthly monitoring of submissions.
Communication with data supply partners	<ul style="list-style-type: none"> • Producer has agreed and documented: <ul style="list-style-type: none"> - data requirements for statistical purposes, - legal basis for data supply, - data transfer process, - arrangements for data protection, - sign-off arrangements by data suppliers, • Established an effective mode of communication with contacts (e.g. with data collector and supplier bodies, IT systems, operational/policy officials) to discuss the ongoing statistical needs in the data collection system and quality of supplied data, • Sought the views/experiences of statistics users and resolved any quality issues reported 	<ul style="list-style-type: none"> • Information Standards Notice for Mandatory Collection of Mental Health Services Data Set Version 1.0 published July 2014 • Announcement of changes to way we source and produce these statistics published November 2016 • Methodological Change paper explaining changes to the way the statistics will be produced published August 2017 • Completeness section (pp13-14) describes routine feedback on provider submissions.
QA principles, standards and checks applied by data suppliers	<ul style="list-style-type: none"> • Producer has provided a fuller description of the main QA principles, quality indicators and checks used by the data suppliers, • Described the role of relevant information management or governance groups in data quality management, • Described the role of audit of the admin data within the collection and operational settings, • Described the implications for the statistics for the quality issues identified by data supply bodies and regulators 	<ul style="list-style-type: none"> • MHSDS version 1.1 Submission Guidance and Technical Output Specification provide full details of validation checks and how data are processed. • Legal obligation to complete statutory forms relating to uses of The Act. • This report provides details of the implications of quality issues.
Producer's QA investigations & documentation	<ul style="list-style-type: none"> • Producer has provided a fuller description of its own QA checks on the admin data, • Detailed the general approach and findings for specific quality indicators, • Identified the strengths and limitations of the admin data, • Explained the likely degree of risk to the quality of the admin data 	<ul style="list-style-type: none"> • The Data Quality Assessment presented in this report.

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