AGENDA ITEM
3.3

MENTAL HEALTH ACT MONITORING COMMITTEE

MENTAL HEALTH ACT OPERATIONAL REPORT

Date of meeting	05/05/2021
FOI Status	Open/Public
If closed please indicate reason	Choose an item.
Prepared by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Presented by	(Robert Goodwin, Clinical Service Group Manager Bridgend ILG)
Approving Executive Sponsor	Choose an item.
Report purpose	FOR DISCUSSION / REVIEW

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
	MHA – Mental Health Act
	AMHP – Approved Mental Health Practitioner
	EDT – Emergency Team
	SWP – South Wales Police
	CAMHS – Child and Adolescent Mental Health Service
	IMHA – Independent Mental Health Advocacy

1. SITUATION/BACKGROUND

1.1 The Operational Group has met on two occasions since the last meeting of the Mental Health Act Monitoring Committee which took place on 04 November 2020. The meetings on 15 January 2021 and 16 April 2021 were both well attended with representatives from across the Mental Health Service, Social Services and the South Wales Police.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Conveyance of Patients to Hospital Following Assessment

Whilst liaison with the Ambulance Control Room had improved, waiting times for the conveyance of patients to hospital remained long. The group were informed of a new protocol which had been developed with the Welsh Ambulance Services NHS Trust to facilitate access to the St John's Ambulance Service as an alternative in such circumstances. The group considered the Welsh Ambulance Services NHS Trust's Mental Health and Dementia Plan for 2021/2024. The plan aims to improve patient experience and we have indicated the priority which needs to be attached to patient transfers to hospital following Mental Health Act assessment.

2.2 Availability of Medical Staff to Conduct MHA Assessments

The AMHPs from the Merthyr area reported on two instances in Quarter 4 when Health Board Consultant Psychiatrists were not available to undertake a Mental Health Act assessment during normal working hours. In such circumstances the patient will be waiting for an extended period of time and the AMHP may be reliant on the use of an independent Section 12 approved doctor. Where two medical opinions cannot be sought a Section 4 assessment may need to be completed. The group discussed the need for Mental Health Act assessment time to be appropriately job planned. The development of the Nurse Practitioner role may also help to release medical time. It was agreed that this matter would be escalated to the clinical leads for RTE and MC Mental Health Services.

2.3 Consultation Response on the Reform of the Mental Health Act

The Government discussed the route to a new Mental Health Act in its 2021 White Paper. The guiding principles of the proposed reforms are:-

1. Choice and autonomy – ensuring patients' views and choices are respected
2. Least restriction – ensuring MHA powers are used in the least restrictive way
3. Therapeutic benefit – ensuring patients are supported to get better and discharged as quickly as possible, and
4. The person as an individual – ensuring patients are viewed and treated as individuals

New detention criteria are proposed involving the requirement for therapeutic benefit. A higher risk threshold is also proposed in which there is substantial likelihood /risk of self-harm. New treatment provisions include an advance choice document and extended role for the Tribunal. Under the proposals the 'next of kin' would be replaced by a 'Nominated Person' chosen by the patient.

The Operational Group convened a number of extraordinary meetings to develop its consultation response which is attached (Appendix 1). The Hospital Managers Power of Discharge Committee response is also attached (Appendix 2)

2.4 Remote MHA Assessments

The group had previously considered the legal guidance for services supporting people of all ages during the Coronavirus pandemic. This guidance had originally included some provisions set out in the Coronavirus Act which allowed for the delivery of remote Mental Health Act assessments. These temporary arrangements were removed in the Welsh Government letter dated 01 February 2021 which confirmed the need for patients to the 'personally' examined which required the physical attendance of the patient. During the period when these provisions were available for Sections 2, 3 and 4 they were used on one occasion by CAMHs in December 2020 for a Section 3 assessment. The patient was discharged in January 2021. Whilst some remote assessments were undertaken for the extension of Community Treatment Orders, legal advice is being obtained about the need for these to be reviewed.

2.5 Service User Feedback

The IMHA representative on the group had agreed in our meeting on 15 January 2021 to seek patient feedback from patients subject to a Community Treatment Order. The group is due to receive a progress report at its next meeting on 16 July 2021.

2.6 Wales Mental Health Care Public Survey

The group considered the Wales Mental Health Care public survey that had been developed by Health Care Inspectorate Wales (HIW) and the National Collaborative Commissioning Unit (NCCU). The Health Board's Mental Health Act team agreed to circulate the questionnaire to relevant Mental Health Services (community and inpatient) within CTMUHB for sharing it with people who are accessing mental health services.

2.7 CAMHS Update

The AMHPs from the Merthyr area informed the group about an out of area referral of a young person to the ED. The AMHP was asked to find a bed by the assessing CAMHs doctor. The group were reminded of the lead doctor's responsibility for locating an appropriate bed and this would be fed back to the CAMHs Service.

The number of patient referrals into the ED Department at Prince Charles Hospital had increased following changes to Nevill Hall Hospital. Whilst the Police were reported as maintaining their attendance with the patient during each 136 assessment, it was suggested that further meetings with Health and Social Service colleagues may help improve the patient pathway. The group were unsure about what agreements had been put in place following the changes to Nevill Hall Hospital.

2.8 MHA Training Programme

The group discussed the scheme of delegation and the role of the Nurse Practitioners within the three general hospitals for scrutinising Mental Health Act paperwork, particularly in connection with the nurses' holding power Section 5(4) and doctors' holding powers Section 5(2). The Mental Health Act team were developing a training plan for these staff and were updating the Sharepoint page on the Health Board's website to ensure it contained access to MHA documentation. The group also discussed the need for better training on the MHA for junior doctors as part of their Induction Programme. Whilst those junior doctors joining the Mental Health Service received such training there was a need to improve access on the general side. It was suggested that a 'step by step' guidance document be generated for junior medical staff to help with their understanding around the MHA.

It was noted that three joint MHA training events between Health and Social Services had been scheduled:-

- Section 117 – July 2021
- CTOs/Guardianship – September 2021
- Interface between MHA/MCA – January 2022

In addition, monthly virtual training events providing a general overview of the Act were planned by the Mental Health Act team during the year. It was agreed that were possible invitations should be extended to the Police and Ambulance Service partners.

2.9 MHA Activity Quarter 3 & 4

In Q4 there were two occasions when **Section 4** emergency applications were made in the Merthyr area. Both had occurred out of hours following prolonged attempts to access assessing doctors during the day. This compared with four occasions when **Section 4** was used in Q3.

In Q3 and Q4 **nurse holding powers Section 5(4)** were used on three occasions in the RGH Mental Health Unit. All were subsequently seen by a doctor within the prescribed 6 hour period.

The use of **Section 136** reduced from 31 in Q3 to 27 in Q4. This may be due in part to the Covid restrictions on population movement and activities. The South Wales Police Section 136 App was undergoing some further development. There was a single **lapse of Section** in Q3 in CAMHS. In Q4 there was also a single lapse of a Section 2 in Older People Services in RGH. The group considered the information on this lapse and the mitigation relating to the Covid isolation of the Responsible Clinician.

There were two **Mental Health Act breaches** in both Q3 and Q4. The two Q4 breaches related to the use of Section 5(2) in the Medical Assessment Unity POWH and in Angelton Clinic. In both cases the receipting and scrutiny process was not followed correctly. Further training is to be provided by the MHA team.

The MHA team currently use manual systems for collecting MHA activity. A local **WCCIS Mental Health Project Board** has been established, which had its first meeting on 19 April 2021. The MHA team continue to work with Aneurin Bevan UHB to understand how they are using WCCIS to pilot the MHA module.

2.10 Operational Policies

The MHA team had coordinated the development of the following policies in 2019/20:-

MH04 Community Treatment Order Protocol/Policy

MH09	Hospital Managers Operational Procedure
MH12	Section Leave Policy
MHA117	Joint Section 117 Aftercare Policy
TBA	Section 132 Policy
TBA	Section 135 Policy
TBA	Section 136 Policy
TBA	Procedure for Allocation of Responsible Clinicians and Nominated Deputy

The group were currently developing a full schedule of policies and seeking advice on the process for their ratification once their review had occurred.

2.11 Operational Group Work Programme

The group considered a proposed work plan including the following items:-

Activity	Progress	Timescale
Service user feedback	The IMHA service to obtain feedback from patients subject to a CTO	Progress report 16/07/21
Audit	Patient rights leaflets and crisis plans for Care Coordinated Section 136 patients are to be considered	Audit plan to be discussed 16/07/21
Policy Work	A schedule of MHA policies is being developed together with individual review dates	Scheduled to be reviewed 16/07/21
Training Program	This is to be drawn together into a single document for monitoring and feedback purposes	Plan to be reviewed 16/07/21
Conveyance of patients to hospital	The group will closely review waiting times and access to the St John's Ambulance Service	Ongoing monitoring
Consultation response on reform of the MHA	The group completed their consultation response at their meeting on 16 April 2021	Response to be submitted to Welsh Government before 21/04/21
MHA Activity	Further information to be obtained on CAMHs referrals and admission of adolescents into Adult Services	Review 16/07/21

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 Changes to Patient Flow from Powys in connection with 136 Assessments

This follows changes made to patient pathways into the Nevill Hall Hospital Emergency Department which has resulted in more out of area activity in PCH.

3.2 Availability of Health Board Medical Staff to Conduct MHA Assessments

Local AMHPs expressed concern about the difficulty in accessing Health Board medical staff to complete MHA assessments. This sometimes results in the emergency use of Section 4 which only requires a single medical opinion.

3.3 Waiting Times to Convey Patients to Hospital following Assessment

This is long standing concern with the Welsh Ambulance Service NHS Trust. The frequency of the long waits may reduce with improved access to the St John's Ambulance Service.

3.4 Provision of Training to Junior Medical Staff around the use of Doctors' Holding Powers Section 5(2)

This is a particular issue for junior doctor induction on the general hospital side. Junior doctors joining the Mental Health Service on rotation do receive such training in their induction program.

3.5 Provision of Training for Staff responsible for the Receipt and Scrutiny of Mental Health Act Documentation

The scheme of delegation needs to be amended to identify those staff responsible for the receipt and scrutiny of Mental Health Act documentation. These staff will need specific training to perform this function.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Safe Care
	If more than one Healthcare Standard applies please list below:

Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	The MHA Operational Group meets bi-monthly to review the application of the Act across CTMUHB
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The committee is asked to:

- **NOTE** the work of the MHA Operational Group and mitigation arrangements put in place to manage key risks

Appendix 1

Reforming the Mental Health Act 2021 – Consultation response

Completed by: Robert Goodwin, Service Group Manager for Mental Health, Bridgend Integrated Locality Group

robert.goodwin@wales.nhs.uk Date: 09 April 2021

On behalf of the Mental Health Act Operational Group within the Cwm Taf Morgannwg University Health Board

Consultation Question 1

We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

Our group supports the recommendation of the Independent Review that there needs to be a concerted cross organisational initiative to tackle the culture of risk aversion and to ensure a common understanding of the principles within the Mental Health Act and how it should be applied. This would need to include Stakeholders such as the Coroners' office, Health Boards, Local Authorities, patients, carers and their representatives. The question above needs to be seen within the context of this shared understanding. Within Wales it would be helpful if the relationships of these key principles and other legislative arrangements such as the Mental Health Measure and the Social Services and Wellbeing Act could be described in the new MHA and Code of Practice.

Consultation Question 2

We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

We need to move away from the Mental Health Act being used as a risk based Act to a treatment based Act. There needs to be something of a consensus of what therapeutic benefit is defined as together with some guidance on timescales and outcomes. The Mental Health Act can be used to prevent bad things happening where the patient derives little or no long term therapeutic benefit from detention. This is particularly the case for patients with personality disorders where detention maybe 'safe' but have little long term benefit and may actually be against the treatment guidelines. We agree that it is important for the proposals to clarify and strengthen the detention criteria to make more explicit how serious the harm must be to justify detention and/or treatment or how likely it is that the harm will occur. Our group was reminded that it is not the MHA itself but MHA assessors who decide whether a person is to be detained and the Act allows them to exercise significant discretion. With this discretion comes personal risks. Where the Act can provide clearer guidance which is widely accepted this would be helpful. The focus on therapeutic benefit may help to ensure a better interface with the Criminal Justice System. Applying the principle of therapeutic benefit will help ensure that care and treatment provided under the MHA promotes recovery.

Consultation Question 3

We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

There needs to be clear guidance around what constitutes 'significant harm.' Our group felt that this proposal would 'raise the bar' for detention and that any new standard would need to be widely understood and agreed by stakeholders. Our group agrees with the Independent Review

in that 'we cannot act on our own if we are seriously to tackle the problem of risk aversion. Action must proceed across the board – there is little point in professionals deciding to accept more risk if the courts, regulators, media and others do the opposite.' Whilst our group accepts the value of the proposal in Question 3, it must be supported by significant investment in community services which will be better able to help manage patient risks outside the inpatient setting.

Consultation Question 4

Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal?

a) Patients on a section 3
Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

b) Patients on a community treatment order (CTO)
Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

c) Patients subject to part 3
Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

d) Patients on a conditional discharge
Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Automatic referrals are an important safeguard ensuring regular independent review. Our group noted the additional workload required of responsible clinicians and others within the multidisciplinary team should there be an increase in the number of Tribunals.

Consultation Question 5

We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Our group understands the automatic referral for patients subject to a Community Treatment Order would be revoked if they are recalled to hospital under Section 3 which will present alternative access arrangements to the Tribual.

Consultation Question 6

We want to give the Mental Health Tribunal more power to grant leave, transfers and community services.

We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/**Not sure**

Please give reasons for your answer:

Our group considered that whilst in principle this proposal was a good thing if it helped to reduce delays, there were some concerns about potential difficulties in accessing services for complex patients in the community which are not readily available.

Consultation Question 7

Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/**Not sure**

***Please give reasons for your answer**:*

It was noted that the Health Board's Power of Discharge Committee which is made up of 'hospital managers' will be responding separately to this

consultation exercise. Our group were unaware of any previous examples when these powers had been used and noted the proposal to improve accessibility to the Tribunal system.

Consultation Question 8

Do you have any other suggestions for what should be included in a person's advance choice document?

Our group were aware of the need to ensure that the 'advanced choice document' was prepared when the patient was capacitous but were not sure how this would be managed in any proposed changes. Our group were also unsure who would be responsible for challenging an 'advanced choice document.' Our group considered the complexity of some possible scenarios, for example where a patient agreed to formal admission when unwell in an 'advanced choice document' but then wished to leave the ward. It was considered that the clinical team would need to determine if the MHA would need to be applied. Our group considered that these documents would work best for well-known patients who had a history of engaging with local services. It was suggested that within Wales the Care and Treatment Plan could be used to help with advanced directives.

Consultation Question 9

Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

The group agreed that an 'advanced choice document' would require the patient to have been capacitous when it was generated. The group would welcome information on how the issue of capacity would be validated. Our group agreed that it was necessary for the advanced choice made within the document to be clearly related to a particular treatment or intervention.

Consultation Question 10

Do you have any other suggestions for what should be included in a person's care and treatment plans?

In the Welsh context the Mental Health Measure has introduced a strong template for care and treatment planning. These CTPs include crisis and contingency plans which as stated above can help with the delivery of advanced directives.

Consultation Question 11

Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:
Our group reflected on the rights of individuals to make unwise decisions if they have capacity and are able to weigh up the issues. This is related to the personal freedoms which citizens should have.

Consultation Question 12

Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/**Not sure**

Please give reasons for your answer:

Our group would welcome some further clarification on the types of treatments which were likely to be covered by this proposal. There were some concerns about non clinical members of the Tribunal challenging the clinical judgment of individuals within local services. It was presumed

that this proposal related to those treatments which may contravene some aspect of the law.

Consultation Question 13

Do you agree or disagree with the proposed additional powers of the nominated person?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Our group thought this was a good proposal which required strong safeguards to ensure the nominated person acts in the patient's best interest. Our group thought there would however be increased pressures on the AMHP in making decisions regarding their suitability. The position of the existing Nearest Relative is quite clear and understood. The group also questioned the arrangements in the event that the patient lacked the capacity to nominate an appropriate person. Generally, however it was agreed to be good practice for a patient to have the choice about who advocates for them.

Consultation Question 14

Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Our group thought that this proposal was consistent with existing legislation concerning the responsibility of people under the age of 16 and would need to be subject to the normal safeguards. A competent child should have the same rights as an adult in this regard.

Consultation Question 15

Do you agree with the proposed additional powers of independent mental health advocates?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

The provision of independent advocacy is an important safeguard. Our group considered the need for this proposal to be adequately resourced with perhaps some accredited training for those performing this advocacy role.

Consultation Question 16

Do you agree or disagree that advocacy services could be improved by:

1) enhanced standards
Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

2) regulation
Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

3) enhanced accreditation
Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

4) none of the above, but by other means
Highlight as appropriate:
Strongly agree/Agree/**Disagree**/Strongly disagree/Not sure

Please give reasons for your answer:

Whilst our group considered there may be some benefit in preserving the informality of the role, the above proposals 1, 2 & 3 would help in the delivery of a high quality independent advocacy service and reduce the potential for variability. The issues relating to the application of the MHA are very complex and a structured learning package for advocates would be helpful.

Consultation Question 17

How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?

The development of clear guidance setting out the preferred Act when dealing with people who lack capacity due to mental health would be helpful. At present individual professional judgements and discretion can be the main determinants in deciding whether an individual should go down the MCA or MHA route. Whilst the principle of delivering care in the least restrictive way should guide decisions, it is acknowledged that the MHA has additional safeguards which are not available within the MCA.

Consultation Question 18

Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Our group considered this to be a helpful option for patients, particularly those who are well known to services and have good working relationships with inpatient care teams. Within Wales such decisions can be recorded within the formal Care and Treatment Plan.

Consultation Question 18a

If you agree:

Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Advocacy services would be a helpful resource for patients when considering such decisions and in consultation with their care team. In

making such decisions about the possibility of future informal admission, the patient should be fully aware of alternative options which would be available to care teams, for example use of the MHA should a patient decide to leave the ward.

Consultation Question 19

We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E.

Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?

a) rely on section 4B of the Mental Capacity Act only
b) extend section 5 of the MHA so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate

Please give reasons for your answer:

Option b would be our preference extending section 5 powers into A&E. Training would need to be provided for staff and it would be helpful to identify particular areas within the department where such patients can be safely detained.

Consultation Question 20

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit. Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

Highlight as appropriate:

Yes No Not sure

Assessments are often complex and require good interagency working. Delays can sometimes occur in facilitating a safe transfer because of the availability of a suitable placement.

Consultation Question 21

We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health. Which of the following options do you think is the most effective approach to achieving this?

- expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers
- creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process
- an alternative approach (please specify)
- creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process
- an alternative approach (please specify)

Please give reasons for your answer:

Where local community Forensic Mental Health Services are in place, they could be empowered to coordinate prison transfers. In the absence of such a service a specialist mental health practitioner with forensic experience would be helpful in coordinating arrangements.

Consultation Question 22

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. How do you think that the role of social supervisor could be strengthened?

Our group recognised the significant responsibility attached to the role of social supervisor. Such practitioners can sometimes feel isolated without a dedicated Forensic Mental Health team to link with. Further professional support and training together with recognition around the responsibilities of the role by all stakeholders would be helpful

Consultation Question 23

For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.

Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:
Such community discharges need to be supported by appropriate safeguards. Promoting care in the least restrictive environment must be a priority but with effective risk management and patient safeguards in place.

Consultation Question 24

We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

This proposal would help to deliver additional safeguards for patients subject to supervised discharge.

Consultation Question 25

Beyond this, what further safeguards do you think are required?

Provision of patient advocacy services would be helpful together with proposals to strengthen the role of the social supervisor.

Consultation Question 26

Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Whilst some patients with a learning disability or autism can present with challenging behaviour, it is the mental disorder which should determine the course of the Mental Health Act assessment. For those patients who are appropriately detained under the Mental Health Act our group identified the need to ensure that staff were appropriately trained and aware of the range of reasonable adjustments which should be considered for a mental health patient with a learning disability and perhaps challenging behaviour. Further development of joint working between mental health and specialist learning disability staff would be helpful

Consultation Question 27

Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?

Highlight as appropriate:
Strongly agree/Agree/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

The absence of locally accessible service provision for this group of patients with challenging behaviour was the significant concern of our group. Whilst the proposals offer protection around the inappropriate detention of some patients with a learning disability they do not describe the alternative arrangements which need to be put in place to ensure the individual's needs are safely met in the least restrictive way.

Consultation Question 28

Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?

Highlight as appropriate:
Yes No Not sure

Please give reasons for your answer:

Where a person is considered to lack capacity there is a potential risk the person could still be admitted to hospital under the Deprivation of Liberty Safeguards and not under the Mental Health Act. Our group identified the need for alternative crisis accommodation to become available when a person with a learning disability is presenting as extremely distressed and with risk behaviours but does not have a co-occurring mental health condition.

Consultation Question 29

We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Whilst patients in the criminal justice system need to have their rights protected in the same way, effective diversion schemes need to be in place for all groups.

Consultation Question 30

Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and to autistic people?

Yes unless there are effective diversion from custody schemes in place for people with a learning disability who have challenging behaviours but not a mental health concern. The availability of appropriately trained staff within the criminal justice system and alternative crisis accommodation

options was thought to be important.

Consultation Question 31

Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

Within the Welsh context this responsibility would need to relate to eligible secondary care patients under Part 2 of the Mental Health (Wales) Measure concerning Care and Treatment Planning.

Consultation Question 32

We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

There is a lack of specialist learning disability resources which are locally available and this proposal would be welcome if supported by additional funding to help deliver this well needed provision.

Consultation Question 33

We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people

in the local population through the creation of a local 'at risk' or 'support' register. Do you agree or disagree with this?

Highlight as appropriate:
Strongly agree/**Agree**/Disagree/Strongly disagree/Not sure

Please give reasons for your answer:

The development of a 'support register' would be welcome if it is associated with adequate resourcing. Our group identified the need to be clear on which organisation would lead on this. It was thought that it would be particularly helpful in transition planning for individuals from children's to adult services.

Consultation Question 34

What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?

The Welsh Government has recently strengthened the joint planning arrangements which promote integration between health and social services. In Bridgend there are some good examples of pooled budgets using Section 33 agreements. Our experience is that these do help to deliver joined up services which meet the needs of the community. In Bridgend we also have a cost sharing agreement for social care and healthcare costs which are shared equally for all Section 117 after care patients. This helps us to work in partnership and avoid time consuming discussions when trying to agree cost sharing arrangements for individual patient placements.

Consultation Question 35

How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?

Within Wales HIW have a monitoring role in relation to the application of the Mental Health Act. It is understood that these regulation arrangements are currently being reviewed by the Welsh Government.

Consultation Question 36

In the impact assessment we have estimated likely costs and benefits of implementing the proposed changes to the act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates.

We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following:

different professional groups, in particular:

- how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc
- whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered

service users, their families and friends, in particular:

- how the proposal may affect health outcomes
- ability to return to work or effects on any other daily activity
- whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- any other impacts on the health and social care system and the justice system more broadly

The Mental Health Act Operational Group has no particular information to add other than a general comment about the need to ensure that any future changes are adequately resourced and their effect on health outcomes is closely monitored. To help facilitate this it would be helpful to have a range of indicators for which information is currently available in order that a before and after assessment can be made.

Appendix 2

CTMUHB HOSPITAL MANAGERS RESPONSE TO WHITE PAPER ON MENTAL HEALTH PROVISION REFORM

CTMUHB Hospital Managers

The CTMUHB Panel of Hospital Managers sitting on mental health hearings comprises a dozen well qualified, experienced professional people, who whilst now retired, in their working lives held senior positions of responsibility and authority in areas such as the health service, social services, local government, third sector, engineering, business and education. Some of the panel members have previously served as non-executive directors of local health boards and on MHRTs. They possess a range of academic and other qualifications, independence of thought and strong powers of evaluation and analysis.

Most of the panel members have at least 10 years experience of sitting as mental health hospital managers and some significantly more. Most have experience of being hospital managers with a number of different NHS and private providers of mental health services.

The CTMUHB Panel Hospital Managers are therefore very well experienced both for and in the role they perform. They engage in regular training and development sessions and panel discussions to update and further their knowledge, analyse, evaluate and further the role they perform. They have a commitment to quality mental health provision and its importance to our society, valuing patients and staff and wanting to fulfil, what they see as a very important role, to the very best of their ability.

Whilst it is accepted the hospital managers receive a fee for their duties, the level of that remuneration given the time, skills and commitment needed in the role, cannot be regarded as no more than a nominal payment when considering the inputs needed. When considered in total on an hourly basis, considering the preparation time and actual hearing duration, it often falls below the level of the minimum wage.

Reform Proposals

The CTMUHB Panel of Hospital Managers unanimously and very strongly oppose the proposal in Sir Simon Wessley's Report on Mental Health provision to abolish their role and function. They would see such action as a retrograde step and one that would undermine the scrutiny of mental health provision as it applies to patients under Section or a CTO.

If they did not feel that they perform an important and necessary role, in the most effective and economical way possible, the managers would not feel so strongly on this matter. They therefore, urge the Government not to adopt this feature of the reform report proposals.

The CTMUHB Panel of Hospital Managers view their role as important in:

1. Providing an independent, impartial and critical scrutiny and assessment of mental health patients' care and treatment through reviewing Sections and CTOs in relation to the MHA and MCA. This independent voice focussed on service accountability is of crucial importance.

Because of the variations in professional backgrounds, experience and skills amongst the members of a hospital managers panel a range of different, contrasting and complementary perspectives can be brought to bear when considering complex issues, patient histories and care and treatment plans. This enhances the scrutiny that is necessary when considering the ongoing detention of a patient.

A managers panel hearing can offer a more relaxed and informal forum than a MHRT for this scrutiny to take place. Both the managers' hearing and MHRT have a potentially very important and complementary role to play in providing the patient a range of forums and safeguards necessary to reviewing their detention and treatment.

It is the experience of the CTMUHB Managers Panel members that this role is taken very seriously both in the preparation required and the hearing itself. In no way should managers' hearings be taken as mere rubber stamping of the decisions of professional teams. The intense scrutiny and questioning often seen and sometimes discharge against the views of the professional team members, offers clear evidence of this.

2. Hospital Managers Panel hearings can offer a more speedy, responsive and flexible approach than MHRTs. They can be held at shorter notice and so take account of changing circumstances better, respond better should a need to adjourn arise and be reconvened more speedily. Experience shows such flexibility to be very important in preserving a patient's right to effective scrutiny of their continuing detention. Speed in responding for example to a Barring Order being issued is very important in preserving patients and nearest relatives' rights. Quick responsiveness is crucial to the effectiveness of the system.

3. The system of Managers Hearings is clearly far less costly than that of MHRTs. The disparity in payment for those attending, between managers' hearings and MHRTs, is clearly evident

both in terms of level of fees paid and associated costs. Considering the importance of the work done and function provided managers hearings are vastly more cost effective to operate than are MHRTs. Whilst making no disparaging assertion whatsoever on the quality of MHRTs operation and decision making, the CTMUHB Hospital Managers would claim their operation and decision making could be considered of a comparable quality and level.

4. The CTMUHB Hospital Managers would strongly reject the claim, that is made by some, that managers hearings do not result in effective scrutiny and good decision making because they are not equipped to carry out their role, not qualified to fulfil such a function or do not put in the required thought and effort.

The CTMUHB Panel of Hospital Managers are committed to their role and fully accept it can only be carried out effectively and to the required standard if the requisite amount of thought, effort and commitment is given. They seek to give to the role the same commitment they gave to their previous professional careers where, as already said, most achieved notable success. They would not seek to continue in their role if they could not do it to the best of their ability.

5. The CTMUHB Hospital Managers also strongly reject the claim, that is made by some, that holding managers hearings is an intrusion in and waste of professional team members' valuable time.

It should be a crucial tenant of mental health service provision and especially of the factors underlying a patient's detention that it should be open to periodic independent review and scrutiny and accountability according to criteria set down in legislation.

Whilst accepting there clearly is a resource factor in professional team members providing written and verbal reports to a managers hearing, that very process requiring them to review a patient's case history, consider the nature and effectiveness of their care and treatment and evaluate future potential courses of action such matters should be a natural feature of how they operate as professionals.

Justifying such matters and subjecting them to the scrutiny and questioning of a panel of independent lay members, surely adds another extremely valuable and required dimension to such a professional approach.

The CTMUHB Hospital Managers would therefore claim that their participation in hearings adds great value to mental health provision and is therefore a very effective use of professional team members' time and resources.

6. In fulfilling their designated role the CTMUHB Hospital Managers always seek to do so by showing the greatest respect to all involved including patients, family members, professional team members and providing institutions. Whilst commenting and questioning where and if felt necessary on shortcomings and concerning issues, they also can offer support, complement and congratulate and be appreciative of difficulties faced and work being done often under difficult circumstances. Hospital Managers in working for a particular provider can both get to know and build up valuable relationships with professional team members' that adds to the benefit of the whole system.

7. If managers hearings were to be abolished it would be proposed that MHRTs would be given a greater and more frequent role in the scrutiny of patients Sections and CTOs. In addition, as already mentioned to the far greater financial cost implications, the issue of member recruitment also needs to be considered. Under present regulations a maximum age of 70 for lay members to MHRTs clearly puts limits on potential recruitment. This is not the case with managers' panels where there is no maximum age limit.

When the later age for receipt of state pensions is taken into account requiring people to stay in full time work longer questions could arise over sufficient and suitable recruitment to any proposed enhanced tribunal system.

It is certainly the case with the CTMUHB Panel of Hospital Managers that most members are over the age of 70 and retired from full-time employment. Managers Panels would appear to offer greater flexibility in recruitment than MHRTs.

8. As mentioned previously the managers hearing offers a more 'informal' forum than a MHRT, though the members of the CTMUHB Panel certainly accept a degree of formality and adhering to required procedures is required.

It is often quoted by professional teams that patients can grow anxious when a managers hearing is approaching and even more so when a MHRT is imminent. Clearly having more of the latter by abolishing the former could increase levels of patient anxiety that could potentially undermine their care and treatment plans.

The CTMUHB Panel of Hospital Managers would therefore respectfully put forward that the abolition of managers hearings would prove to be a very costly exercise, one that jettisons an extremely experienced, skilled and committed set of people and be of overall detriment to the review and scrutiny of mental health care provision.

This report was written on behalf of, following consultation with and with the agreement of all the members of the CTMUHB Panel of Hospital Managers.

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Chairman