



AGENDA ITEM

4.3

MENTAL HEALTH ACT MONITORING COMMITTEE

RISKS RELATED TO THE MONITORING OF THE MENTAL HEALTH ACT

Date of meeting	08/03/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Robert Goodwin Service Group Manager for Mental Health, Bridgend
Presented by	Ana Llewellyn Nurse Director Primary Care, Community & Mental Health
Approving Executive Sponsor	Chief Operating Officer (COO, DPCMH)

Report purpose	FOR DISCUSSION / REVIEW
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
Mental Health Act Team	(DD/MM/YYYY)	SUPPORTED

ACRONYMS

MHA	Mental Health Act
UHB	University Health Board
RC	Responsible Clinician
ILG	Integrated Locality Group
AMHP	Advanced Mental Health Practitioner



GDPR	General Data Protection Regulation
HIW	Healthcare Inspectorate Wales
DGH	District General Hospital

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to present risks related to the monitoring of the Mental Health Act (MHA) evident in Quarter 3 2022/23 and for discussion and scrutiny related to actions and key milestones related to mitigating these risks.

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

- 2.1 The number of minor errors in Q3 reduced to 18 which compared favourably with 36 in Q2. There were 2 fundamental errors in Q3 the same as the previous quarter. The Operational Group regularly reviews the training plans and scrutiny check lists developed by the Mental Health Act Team. These aim to help reduce the number of errors each quarter. The All Wales Benchmarking Report for Q3 has shown our Health Board to compare favourably in this area.
- 2.2 The number of Section 136 Detentions reduced from 73 in Q2 down to 36 in Q3. The All Wales Benchmarking Report for Q3 has again shown our region to compare favourably in this area.
- 2.3 The Operational Group has discussed some delays in the provision of Approved Mental Health Practitioners from the Emergency Duty Team which operates out of hours. The Regional AMHP Group has agreed to capture the detail of these delays so that they can be closely monitored.
- 2.4 The Operational Group has also discussed some delays in the provision of Section 12 Approved Doctors during normal working hours when medical staff are involved in scheduled activities. The Monthly Police Liaison Group has agreed to closely monitor these delays as they relate to Mental Health Act Assessments for Section 135 and 136.
- 2.5 The work to clearly identify waiting times for Section 12 Approved Doctors and AMHPs will help to develop the discussion around the future configuration of individual hospital Places of Safety. Currently these are provided within the Princess of Wales Hospital, the Royal



Glamorgan Hospital and Prince Charles Hospital. None of the 3 units has been purposefully designed as a Place of Safety.

- 2.6 Concerns have been expressed about the suitability of the Place of Safety within the Prince Charles Hospital Emergency Department. Delays in the work to create an improved area within the department have been escalated and the scheme is now a priority within the hospital.
- 2.7 Paragraph 14.70 of the Mental Health Act 1983; Code of Practice for Wales requires Health Boards to commission mental health services to meet the inpatient needs of patients in cases of special urgency or for those under the age of 18. It is understood that no Health Board in Wales has a current Section 140 Policy and the All Wales Mental Health Act Team Managers group is reviewing progress. Health Boards across Wales support each other in providing emergency short term access to beds and within our Health Board we have options for transferring patients between Localities when there are particular bed pressures.
- 2.8 There have been 3 recent HIW Inspections of Adult and Older Peoples Mental Health Services within our Health Board:
- 1) Review of Discharge Arrangements from Adult Inpatient Mental Health Units within CTMUHB**
The Health Board is awaiting publication of the final report on 07 March 2023.
 - 2) Unannounced visit to Angelton Clinic, 14 – 16 November 2022**
The Health Board is awaiting publication of the final report on 15 March 2023.
 - 3) Announced visit to North Bridgend CMHT, 13 – 14 December 2022**
The Health Board is awaiting publication of the final report on 16 March 2023.
- 2.9 Although this paper focuses on risks for balance, a few key positive highlights in other papers are noted below:
- Progress on the policy review is very evident.
 - The St John's Ambulance Mental Health Conveyance Pilot Scheme is progressing well.
 - The Operational Group closely monitors developments with the draft Mental Health Bill as it progresses through Parliament.
 - Progress is being made on the development of a joint training plan with Local Authority partners.



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

- 3.1 Whilst there is improvement in the number of Mental Health Act errors being made during detention the Operational Group will further review such breaches over a 5 year period to inform action planning to improve compliance.
- 3.2 The Operational Group has considered anecdotal evidence of some extended waiting times for AMHPs within the out of hours Emergency Duty Team hosted by Rhondda Cynon Taff County Borough Council and for Section 12 Approved Doctors during normal hours. The Operational Group has introduced proposals for the collection of detailed information during these Mental Health Act Assessments in order that these delays can be mapped going forward.
- 3.3 Partners including the South Wales Police and Merthyr Tydfil County Borough Council have expressed concern about the suitability of the Place of Safety within Prince Charles Hospital. Plans have been agreed in relation to the upgrading of a room within the department but no timescales have yet been given. The Board is asked to escalate this issue.
- 3.4 Informal feedback from Health Inspectorate Wales in relation to the application of the Mental Health Act following 3 recent visits to Adult and Older Peoples Services has been largely positive. The Service Group is awaiting publication of the reports in March.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The issue of a lack of a single clinical record system stems from patient safety concerns and learning from events.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	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.



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 Goals	Improving Care

5. RECOMMENDATION

5.1 The Mental Health Act Monitoring Committee is asked to:

DISCUSS and **NOTE** the report and the areas for reporting through to Board.