Bradford District Care
NHS Foundation Trust

Escalation and Assurance Report

Report from the: Mental Health Legislation Committee
Date the meeting took place: 19 November 2020
Report to the: Board of Directors

Agenda item

11.0

Key discussion points and matters to be escalated from the discussion at the meeting:
Alert:
• The Committee discussed the increase in physical intervention and the number of service users that had been subject to a form of intervention or rapid tranquilisation. The Committee sought to understand if this related to a small number of individuals and had requested a further analysis of the data from the positive and proactive group. The Committee had asked to receive performance data on restrictive practices and physical intervention on a monthly basis in order to be sighted on the trend more clearly.
Advise:
• The Committee heard that the number of patients detained under Section 136 of the Mental Health Act had continued to increase rapidly. It was noted that the Trust continued to engage with the police. • It was also noted that the Committee would continue to review the Street Triage which had commenced in April 2020, as the initiative was intended to result in the reduction of the number of patients under Section 136. The Committee heard that a comprehensive audit was underway.
Assure:
• The Committee noted that service users and legal representatives were able to attend virtual Mental Health hearings, which had been done by three service users and five legal representatives. It was recognised that Bradford District Care NHS Foundation Trust were one of only a few Mental Health NHS Trusts that have developed creative ways of working to increase engagement and emphasise inclusivity. • The Committee reviewed an external independent report that investigated a Mental Health Act Administration error that was recognised as a Serious Incident. The investigation concluded that human error, exacerbated by a high workload, was a factor that resulted in the error. The Committee noted the SystmOne limitations that did not facilitate the process of recording review dates, which had been flagged to the supplier, TPP. The Committee agreed that the report was of good quality and provided significant assurance that the correct actions had been taken and the systems were now robust. It was also agreed that an independent review from another Mental Health Act team would be good practice and would provide robust assurance

Risks discussed:
• Risk 1 – To provide Seamless access to care
  ○ Risk 1.1 – If demand exceeds capacity, then service quality, safety and performance could deteriorate.
• Risk 2 – To provide excellent quality services
  ○ Risk 2.1 – If regulatory standards are not met, then we will experience intervention from regulators and/or damage our reputation.

New risks identified: • None identified

Report completed by: Carole Panteli
20 November 2020