Unconfirmed

MINUTES OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 10TH MAY 2018 IN THE BOARD ROOM, HEADQUARTERS

Present	Emma Woollett	Vice-Chair (in the chair)
	Maggie Berry	Non-Officer Member
	Jackie Davies	Non-Officer Member
	Martyn Waygood	Non-Officer Member
	Angela Hopkins	Interim Director of Nursing and Patient Experience (from minute 20/18 until minute 24/18)
	Chris White	Interim Chief Operating Officer (from minute 20/18)
In Attendance	Dai Roberts	Service Director, Mental Health and Learning Disabilities
	Lynda Rogan	Mental Health Act Manager
	Ian Stevenson	Partnership and Development Support Manager
	Liz Stauber	Committee Services Manager

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15/18	**WELCOME AND INTRODUCTIONS**	
	Emma Woollett welcomed everyone to the meeting, in particular Martyn Waygood and Jackie Davies as the committee's new members. She also noted that it was Angela Hopkins's final meeting and offered her thanks for her work, support and contributions to the committee during her time as Interim Director of Nursing and Patient Experience.	
16/18	**APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from Rhonwen Parry, Head of Psychology and Therapies and Pam Wenger, Director of Corporate Governance.	
17/18	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
18/18	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the meeting held on 8th February 2018 were **received** and **confirmed** as a true and accurate record, except to note the following amendments: <u>10/18 (i) Mental Health Act Performance Report (paragraphs one and three)</u> Mental Health Act *1983* and <u>10/18 (ii) Mental Health Measure Performance Report (paragraph two)</u> Dai Roberts advised that there were issues relating to recruitment in Swansea, especially as there was not a specific learning disabilities	

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	nursing qualification at Swansea University *but gave assurance that performance was almost at the level at which it needed to be. He added that a more significant improvement in performance was required within Bridgend*.	
19/18	**MATTERS ARISING**	
	There were no matters arising.	
20/18	**ACTION LOG**	
	The action log was **received** and **noted** with the following updates: i. <u>Action Point One</u> Dai Roberts advised that a briefing note had been shared with Emma Woollett advising of current compliance with care and treatment plans. He added that the issues in Bridgend had since been addressed however concerns had arisen with regard to compliance within Swansea and discussions were ongoing with the Director of Social Services as to how to resolve. Should the issues remain, this would be escalated to Chris White as Interim Chief Operating Officer. ii. <u>Action Point Two</u> Dai Roberts stated that the unit medical director was developing a process to improve the quality and timeliness of medical reports for review tribunals and an update would be provided at the next meeting. iii. <u>Action Point Five</u> Dai Roberts provided assurance that patients detained under the Mental Health Act 1983 requiring end-of-life care were provided with the same treatment as medical or surgical patients. Lynda Rogan added that, where possible, the status was lifted so that the patient did not die under detention.	**DR**
21/18	**MENTAL HEALTH ACT MONITORING REPORT**	
	A report providing an update on performance against the Mental Health Act 1983 was **received.** In introducing the report, Lynda Rogan noted that the time period for the report was 1 December 2017 – 28 February 2018, not February – May 2018. Over this period, she highlighted the following points: - There had been five exceptions and invalid detentions within the reporting period; - The invalid detentions had been as a result of clerical errors which could not be rectified under Section 15 of the act; - Four young people had been admitted to an adult mental health bed, with longest admission at 10 days; - Section 4, which should only be used in cases of urgent necessity and to avoid unacceptable delay, had been used during the time period but was converted to a section two within the 72-hour timeframe;	

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	- A reduction in the number of assessments taking place in police stations had been maintained, with only one assessment taking place during the reporting period; - A meeting of the Hospital Managers Powers of Discharge Committee took place in February 2018, with the only matter to note difficulties in identifying an appropriate venue in Swansea which had since been resolved; - Healthcare Inspectorate Wales had undertaken an unannounced visit to Tonna Hospital however as there were no patients detained under the Mental Health Act 1983, there were no issues of which the committee needed to be aware. In discussing the report, the following points were raised: Emma Woollett complimented Lynda Rogan on her report, advising that it had been useful and informative. Lynda Rogan responded that the report which had been circulated was different to that intended and included graphs not usually provided. She queried as to whether the committee would find it beneficial for these to be included going forward. Emma Woollett stated that it would. Maggie Berry stated that it was pleasing to see the reduction in the number of assessments taking place in police stations. Emma Woollett concurred and queried if there was a plan in place to sustain this. Dai Roberts advised that the service and the police were working together to maintain the performance. Lynda Rogan added that the Policing and Crime Act 2017 had become legislation the previous year and had led to an increase in the number of assessments taking place at a health place of safety. Jackie Davies queried the alternative locations for such assessments. Lynda Rogan stated that the health board had a specific '136 suite' in each locality. She added that Morriston Hospital was occasionally used but only if the patient also had a physical ailment. Martyn Waygood noted that the longest invalid detention was for more than nine hours. Lynda Rogan advised that this was due to the report not being signed and it took that length of time for the nursing staff to confirm that this could not be subsequently re. She added that this type of error was 'fundamental defect' and could not be retracted. Martyn Waygood queried the potential consequences of such errors as patients were informed of them. Lynda Rogan responded that case law stated that only nominal damages would be payable and only in situations where real loss could be established. She added that there was a greater risk of reputational consequences. Martyn Waygood referenced the training available and queried if this would help reduce errors. Lynda Rogan commented that errors were now being identified earlier, adding that the health board had only had one in the previous month compared with higher numbers in other organisations. Jackie Davies queried as to why ward staff were not checking the forms before sending them to the Mental Health Act team for processing. Lynda Rogan advised that the majority of areas were reviewing the forms, as a checklist was provided as part of the receipt and scrutiny policy training. Martyn Waygood noted that in some instances the return to court date	**LR**

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	had not been completed correctly which was not the health board's mistake. Lynda Rogan responded that while health board was able to correct some statutory documents under section 15 of the act, this was outside of its remit, and as such, all it could do was request an amended copy from the court. Emma Woollett queried as to whether the training was mandatory and whether performance was monitored, not just for initial completion, but also maintaining compliance. Lynda Rogan advised that it was not included within mandatory training but details were provided to the training department as to who had completed it. Angela Hopkins commented that in general, compliance with mandatory and statutory training was low, and consideration needed to be given to rationalising the requirements, for example through competency training on wards. She added that the approach to mandatory and statutory training needed to be reviewed as it was increasingly becoming more challenging to release ward staff for sessions. Jackie Davies concurred but stated that in relation to Mental Health Act 1983 training, it did not necessarily need to be mandatory, rather awareness needed to be raised with staff as to their responsibilities to check the forms before submission. Emma Woollett commented that the issues in relation to training also applied within other areas of mental health legislation and undertook to raise it as a question to board as part of her update from the meeting to determine what action could or should be taken. Emma Woollett stated that there was insufficient detail in the report relating to child and adolescent mental health services (CAMHS), adding that the Mental Health Act 1983 was relevant to children as well as adults. Dai Roberts stated that CAMHS data was reported to Cwm Taf University Health Board's mental health committee as the service provider. Chris White commented that the committee should have sight of the data. Angela Hopkins concurred, stating that there were some 'low level' CAMHS provided by the health board for which data should be held locally. She added that in-line with good governance, the committee should be receiving an update from Cwm Taf University Health Board as to compliance with the act and suggested that the Director of Strategy be asked to seek such data as the executive lead for CAMHS. Emma Woollett undertook to discuss this further with the Director of Strategy. Jackie Davies queried as to whether there had been feedback from the Mental Health Commissioner with regard to detentions under section 5(4) of the act (which gave nurses authority to detain patients for up to six hours). Lynda Rogan advised that a review of each case had identified that the section had been applied out-of-hours or at weekends when fewer doctors were available but in each case, the section had been appropriately applied. Emma Woollett noted the use of adult mental health beds for young people under the age of 18, adding that this was not ideal. Angela Hopkins concurred but advised that the mental health ward at Neath Port Talbot Hospital had a secure, private accommodation which was used in such instances when the court of protection requested a place	**EW** **EW**

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	of safety for a young person. She added while it was not ideal, it was only used in extreme cases when there was no capacity at the specialist CAMHS unit, and the situation was not unique to ABMU. Dai Roberts stated that that particular bed was allocated as an emergency CAMHS bed and each usage was reported immediately to the health board and Welsh Government. Chris White commented that it was a clinical risk for patients and staff, using an adult bed for young people, and queried if there was a trend which needed to be reported to the board. Angela Hopkins commented that in her six months with the health board, the bed had been used fewer than five times. Chris White advised that this gave some assurance. Dai Roberts undertook to provide a trend analysis of the previous three years in the next iteration of the report.	**DR/LR**
Resolved:	- The report be **noted.** - Graphs to be included within future iterations of the report as well as a three-year trend analysis of the use of an adult mental health bed for young people. - Issues relating to training be raised as a question to the board. - Emma Woollett to discuss the issues relating to CAMHS data with the Director of Strategy.	**LR/DR** **EW** **EW**
22/18	**MENTAL CAPACITY ACT MONITORING REPORT**	
	A report providing an update on performance against the Mental Capacity Act 2005 was **received.** In introducing the report, Angela Hopkins highlighted the following points: - Work was ongoing to develop a single, electronic recording, monitoring and reporting point across the health board for Mental Capacity Act training as it was proving challenging to identify how many staff had and how many were required to complete it; - Compliance with training remained consistent, with the exception of deprivation of liberty safeguards level two which had improved slightly; - During 2017-18, Mental Health Matters Wales, who provided the health board's independent mental capacity advocates (IMCA), service received 72 instructions, the majority of which were to support a long-term move of accommodation; - Best interest decisions had been devolved to the units and consideration was required as to how to centrally collate the number of occasions where such decisions were made; - The health board's corporate safeguarding team was developing a process to log any court of protection cases in which the health board was engaged and any learning identified within judgements and circulate; - A template for best interest decisions and court of protection cases was to be developed to facilitate reporting to the committee.	

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Resolved:	The report be **noted.**	
23/18	**DEPRIVATION OF LIBERTY SAFEGUARDS UPDATE**	
	A report providing an update regarding deprivation of liberty safeguards (DoLS) standards was **received**. In introducing the report, Angela Hopkins highlighted the following points: - The health board had a clear action to increase compliance with DoLS training, particularly in relation to authorisation; - There were two types of DoLs; a standard authorisation which has to be completed within 28 days and an urgent authorisation which needs completion within seven days; - During 2017-2018, 984 applications were received and 83% breached the timescales; - While there were numerous factors which could result in a breached application, the main two were the scrutiny and signing off a DoLS authorisation and the availability of best interest assessors; - The scrutiny and signing of an authorisation was the responsibility of the Primary Care and Community Service Unit, and a training session had taken place in January 2018 to increase the number of supervisory body signatories from three to seven. There was also a shortage in administrative support which was under review; - The corporate safeguarding team had initiated training for BIAs, increasing the number from 12 to 34 but due to service pressures, there had been difficulties in releasing staff to either shadow current BIAs for training or for trained BIAs to carry out assessments; - A BIA rota had now been established however during 2017-18, 70% of assessments had been undertaken by independent BIAs at a cost of £82k. Discussions were ongoing with the Director of Finance as to whether additional resources could be provided to increase the internal availability of best interest assessors; - DoLS was now included within the units' performance reviews; - 118 cases were still outstanding from 2017-18 but this was not just a process issue as patients were at the heart of it, therefore urgent improvement was required; - The next report would include a trajectory for improvement as well as progress against it and would be a joint paper from the corporate team and Primary Care and Community Services Unit. In discussing the report, the following points were raised: Emma Woollett complimented Angela Hopkins on the report, stating that it was helpful, but an improvement did need to be evident by the next iteration.	

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	Chris White noted that the Primary Care and Community Services Unit was part of his portfolio and queried when the request in relation to administration support would be received as there were significant monies being spent on a process which could be managed internally. Angela Hopkins advised that it had been suggested that this be submitted as a matter of urgency. Martyn Waygood commented that once the rota was fully established it would support an improvement with compliance. He noted that the biggest reason provided for a breach (41%) was 'miscellaneous' and as such, there needed to be a timescale for an analysis of reporting. Jackie Davies noted that a number of managers had expressed concern at not being able to support the rota at all times, adding that it needed to be made clear that DoLS was a legal requirement. Martyn Waygood commented that the health board needed to be mindful that any breaches impacted on services users' human rights. Angela Hopkins concurred, adding that the way in which the process was managed differed across Wales, with some health boards establishing dedicated DoLS teams. Maggie Berry commented that it would be useful to look at the overall cost, including that to release staff for training, as it may prove to be more cost effective to have a dedicated team. Emma Woollett stated that an 83% breach rate was not only unacceptable, but it was a significant risk to the health board. She undertook to raise the issue as part of her report to the board. Emma Woollett thanked Angela Hopkins for her report, summarising that the next iteration would be a joint report from the corporate team and Primary Care and Community Services Unit, would include a trajectory and progress against it, address the resources issue and provide more clarity as to the reason for breaches. This was agreed.	**EW** **AH**
Resolved:	- The report be **noted.** - 83% breach rate to be raised as an issue within the chair's report to the board. - The next iteration to be a joint report from the corporate team and Primary Care and Community Services Unit, would include a trajectory and progress against it, address the resources issue and provide more clarity as to the reason for breaches.	**EW** **AH**
24/18	**MENTAL HEALTH MEASURE MONITORING REPORT**	
	A report providing an update on performance against the Mental Health (Wales) Measure 2010 was **received.** In introducing the report, Dai Roberts highlighted the following points: - While the targets for parts 1, 3 and 4 of the measure had been met by the health board, non-compliance in relation to CAMHS by Cwm Taf University Health Board (as the service provider) against Part 1 measures had significantly impacted on ABMU's performance, bringing it below the trajectory; - The target for Part 2, which focussed on care and treatment	

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	plans, had been met in March 2018 for adult mental health services and older people's services but not for learning disabilities or CAMHS; - The NHS Wales Delivery Unit had recently reviewed the quality of care and treatment plans and identified a number of recommendations as part of the informal feedback. The full report was now awaited and would be shared with the committee in due course; - As part of its review, the NHS Wales Delivery Unit had identified Bridgend as the highest performer in Wales for care and treatment plans, particularly in Maesteg, highlighting its process as a model to follow; - The unit had asked the NHS Wales Delivery Unit to present its findings to each of the localities as this was an opportunity to start a two-way dialogue as to the actions needed. In discussing the report, the following points were raised: Chris White noted that the final report from the NHS Wales Delivery Unit was yet to be received but queried if there was any learning which could be taken from the Maesteg care and treatment plan process in the meantime which other areas could start to implement. He added that this would demonstrate learning and direction of travel for when the NHS Wales Delivery Unit came to deliver its report to the localities. Dai Roberts undertook to consider this with the unit. Martyn Waygood referenced a report provided to the Quality and Safety Committee earlier in the year which noted that Cardiff and Vale University Hospital had repatriated some of its CAMHS from Cwm Taf University Health Board. Dai Roberts responded that consideration had been given by ABMU to repatriating 'tier one' of the service several months previously, however given the current Welsh Government consultation to change the health boundaries for Bridgend, discussions as to whether to repatriate CAMHS services had been postponed. Chris White stated that CAMHS performance was of significant concern, especially as it was impacting on ABMU's compliance with the Mental Health (Wales) Measure 2010. He added that he had already written to Cwm Taf University Health Board and queried as to what the next step should be. Emma Woollett advised that she had met the director and assistant director of strategy to discuss CAMHS and had agreed that a report providing performance trajectories was to be submitted to the Quality and Safety Committee, while a more strategic report was to be received by the Strategy, Planning and Commissioning Group. She added that the position was unacceptable, particularly as the health board had a unit with mental health expertise but no remit for CAMHS.	**DR**
Resolved:	- The report be **noted.** - Consideration be given as to how to take forward the care and treatment plans learning from Maesteg in other areas.	**DR**
25/18	**2018/19 COMMITTEE WORK PROGRAMME**	

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	The committee's work programme for 2018/19 was **received.** In discussing the work programme, Emma Woollett stated that, following the conversation at the previous meeting, the remit of the committee was now focussed solely on compliance with mental health legislation, and as such, the work programme reflected this.	
Resolved:	The work programme be **noted.**	
26/18	**MENTAL HEALTH LEGISLATION COMMITTEE TERMS OF REFERENCE**	
	Revised terms of reference for the committee were **received.** In introducing the report, Liz Stauber advised that the only significant change to the terms of reference had been to rename the committee the 'Mental Health Legislation Committee' to provide clarity as to its remit. In discussing the report, the following points were raised: Lynda Rogan advised that there had been changes to the legislation which needed to be reflected in the appendix. Chris White suggested that the membership cite the Director of Primary, Community and Mental Health Services rather than the Chief Operating Officer as this was the more relevant portfolio. This was agreed.	**PW** **PW**
Resolved:	The terms of reference be **approved** subject to the changes discussed.	**PW**
27/18	**MENTAL HEALTH AND CAPACITY ACT LEGISLATIVE COMMITTEE ANNUAL REPORT 2017-18**	
	The Mental Health and Capacity Act Legislative Committee annual report for 2017-18 was **received.** In discussing the report, the following points were raised: Martyn Waygood identified typographical errors for correction. Emma Woollett advised that next year, consideration would be given to including outcomes within the annual report.	**PW**
Resolved:	The Mental Health and Capacity Act Legislative Committee annual report for 2017-18 be **approved** subject to the discussed corrections.	**PW**
28/18	**HOSPITAL MANAGERS' POWERS OF DISCHARGE COMMITTEE TERMS OF REFERENCE**	
	Revised terms of the reference for the Hospital Managers' Powers of Discharge Committee was **received.** In discussing the report, Martyn Waygood identified typographical errors for correction.	**PW**
Resolved:	The terms of reference be **approved** subject to the discussed corrections**.**	**PW**
29/18	**HOSPITAL MANAGERS' POWERS OF DISCHARGE COMMITTEE**	

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	ANNUAL REPORT 2017-18	
	The Hospital Managers' Powers of Discharge Committee annual report for 2017-18 was **received** and **approved.**	
30/18	**ANY OTHER BUSINESS**	
	(i) Tribunal Case Ian Stevenson advised that a legal case regarding the Mental Capacity Act 2010 had raised a number of learning opportunities for the health board, particularly relating to capacity. The final report was awaited and would be shared with the committee in due course.	
	There was no further business and the meeting was closed.	
31/18	**DATE OF THE NEXT MEETING**	
	The next meeting would take place on **Friday, 24th August at 2pm.**	