Unconfirmed

MINUTES OF THE MENTAL HEALTH CAPACITY LEGISLATION COMMITTEE HELD ON 8TH FEBRUARY 2018 IN THE COMMITTEE ROOM, HEADQUARTERS

Present	Emma Woollett	Vice-Chair (in the chair)
	Maggie Berry	Non-Officer Member
	Chantal Patel	Non-Officer Member
	Angela Hopkins	Interim Director of Nursing and Patient Experience (from minute 10/18 (ii))
	Chris White	Interim Chief Operating Officer
In Attendance	Pamela Wenger	Director of Corporate Governance
	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
	Joanne Abbott-Davies	Assistant Director of Strategy (for minute 12/18)

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01/18	**WELCOME AND INTRODUCTIONS**	
	Emma Woollett welcomed everyone to the meeting and introduced herself as the new chair of the committee.	
02/18	**APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from Rhonwen Parry, Head of Psychology and Therapies.	
03/18	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
04/18	**PATIENT STORY**	
	Ian Stevenson was welcomed to the committee and invited to present the patient story, which highlighted the following points: - The service user's mental health issues began following childhood abuse and he started hearing voices; - When the service user experienced a 'bad week', the voices would return and he would isolate himself in a dark room; - During these episodes, he would contact the crisis team by telephone who would encourage him to write down his feelings, which in turn would help him to talk; - The crisis team were seen as his 'lifeline', giving him the confidence that 'everything was going to be okay' and the voices were not real; - As part of the support provided by the crisis team, the service user developed strategies to manage the condition, which	

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	included activities such as art classes; - Also, the service user was encouraged to listen to CDs at night which helped him relax in order to fall asleep; - The service user noted that thanks to the crisis team, it was possible to have 'decent life' when schizophrenic. In discussing the presentation the following points were raised: Chantal Patel stated that the patient story depicted the complex nature of mental health services as patients admitted for physical conditions were normally discharged when well again, but in mental health, often the conditions were lifelong and small gains not visible to others were significant to the service users. Chris White commented that it was powerful to hear the story told in the service user's voice. He noted the strategies in place and queried if there was equality of support across the localities. Dai Roberts responded that not all services were provided consistently, as such an engagement and consultation was held in relation to the mental health framework to determine what the public wanted. He added this was in the final stages and a clear theme was emerging for simple and consistent services. Ian Stevenson commented that relaxation CDs were available equally across the health board. Chris White queried if there was an evidence of harm in areas were fewer services were available. Dai Roberts confirmed that there was not. Chantal Patel commented that in areas where services were not consistently provided there could be opportunities for the gaps to be filled by voluntary sector services. Ian Stevenson advised that this highlighted the importance of care and treatment plans as strategies which service users found beneficial could be documented. Ian Stevenson advised that the service user had wanted to record the story as a way of 'giving back' to the crisis team for its support.	
05/18	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the meeting held on 3rd August 2017 were **received** and **confirmed** as a true and accurate record.	
06/18	**MATTERS ARISING**	
	There were no matters arising.	
07/18	**ACTION LOG**	
	The action log was **received** and **noted** with the following updates: (i) <u>Action Point One – Mental Health Act Performance Report</u> Lynda Rogan advised that training events had been established at Morriston Hospital for consultants and psychiatry liaison nurses to outline the Mental Health Act 2005 procedure, including how to complete documents and relevant contact details. She added that requests had been received for further sessions and reference guides and leaflets developed for staff to refer to out-of-hours.	

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	Maggie Berry queried the feedback from staff following the training sessions. Lynda Rogan responded that it had been positive and all appreciated having the knowledge. As a result, the training was to be rolled-out to Princess of Wales and Neath Port Talbot hospitals. Maggie Berry asked whether there had been any challenges in getting staff released from the ward for the training. Lynda Rogan advised that the training took place in clinical settings so if there was an issue on the ward, staff were on site to address it. Emma Woollett queried as to whether the training should be mandatory. Pam Wenger responded that this was something that needed to be considered on an organisational-wide basis. Dai Roberts added that if it was mandatory, there would a baseline set as to how many staff needed to be trained as a minimum. Emma Woollett sought clarity as to whether the intended outcome of the training was to reduce the number of breaches in relation to the act. Lynda Rogan advised that this was one of the measures and no breaches had been reported in the previous quarter which was unprecedented. (ii) <u>Action Point Three – Care and Treatment Plans</u> Dai Roberts advised that one of the unit's locality managers had audited the care and treatment plans of the community mental health team and good practice for completion had been identified. He added that internal audit had since revisited the area and the audit assurance rating had improved. Chantal Patel stated that the issue was not necessarily the completion of care and treatment plans rather the quality, which was inconsistent. Dai Roberts concurred, adding that this was kept under review. Ian Stevenson stated that the plans needed to time-limited and patient focussed with a definitive outcome, and linguistics were important.	
08/18	**MATTERS ARISING FROM THE OPERATIONAL GROUP**	
	Dai Roberts advised that there were no matters arising from the operational group for the committee to note.	
09/18	**AGENDA ORDER BE CHANGED**	
	The agenda order be changed and 5.2 (i) and 5.2 (ii) be taken next.	
10/18	**PERFORMANCE REPORTS/INSPECTION REPORTS/ACTION PLANS**	
	(i) <u>Mental Health Act Performance Report</u> A report providing an update on performance against the Mental Health Act 2005 between 1st July and 31st December was 2017 **received.** In introducing the report, Dai Roberts highlighted the following points: - During the period there had been seven invalid detentions, all of which had been administration errors; four young people under the age of 18 had been admitted to an adult ward at Neath Port Talbot (Ward F); section four had been used on seven occasions	

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	and there had been one recorded death; - Four visits had been undertaken by Healthcare Inspectorate Wales across six services areas and had highlighted only minor issues in relation to the Mental Health Act which was testament to the hard work of Lynda Rogan and the team; - The minutes of the recent meeting of the Hospital Managers Powers of Discharge Committee were appended for information and work was ongoing to establish more appropriate venues for panel meetings; - Details of readmissions had been included within the report at the request of the previous Director of Nursing and Patient Experience. In discussing the report, the following points were raised: Chantal Patel noted the work being undertaken to find alternative venues for panel meetings, adding that the ones to date had not been suitable and as such, some of the reviews had had to be cancelled. Maggie Berry queried what requirements were needed for venues. Dai Roberts advised that they could not be hospital sites and needed to be at community venues on the ground floor with two rooms to enable the family to have privacy during the review. Emma Woollett commented that the report had provided her with assurance that processes were in place to comply with the Mental Health Act 2005 and should breaches occur, it was not due to systemic problems. She added that there were also extra details in the report which provided 'colour' to the position such as the Healthcare Inspectorate Wales visits and it was within the committee's terms of reference to receive these reports and relevant action plans. Chris White noted the request of the previous Director of Nursing and Patient Experience for the report to include details of readmissions and asked what narrative was this information providing as to the way in which care had been delivered. Dai Roberts responded that if a patient was readmitted within 28 days, it raised a number of questions to provide a clinical challenge as to whether discharge had been appropriate, but this would be for the unit nurse and medical directors to consider rather than the committee as it was not aligned with the mental health legislation. Emma Woollett stated that on that basis, inclusion of such information within the report may not be relevant or appropriate. Ian Stevenson advised that it was possible to be readmitted under different sections of the act to that of the original admission and as such, in these instances, readmission figures may still be relevant. Pam Wenger reminded the committee that its papers would be made public via the health board's website and as such, authors needed to be mindful of the level and type of detail included. She added when the patient numbers were small and the narrative included specific details, there was potential for an individual to be identified. Emma Woollett added that while some level of detail could be left out of the report, it could still be provided orally for the committee to seek assurance. (ii) <u>Mental Health Measure Performance Report</u>	

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	A report setting out compliance with the Mental Health (Wales) Measure 2010 was **received.** In introducing the report, Dai Roberts highlighted the following points: - The data was presented in a rolling 12-month period and performance for section one of the measure had been consistently met for the majority of the time; - However, Cwm Taf University Health Board was now reporting performance for child and adolescent mental health services (CAMHS) for which it was commissioned to provide for the health board, and as compliance was low, this was reducing ABMU's compliance to 60% for section 1a. An Assistant Director of Strategy was working with Cwm Taf University Health Board to address this as it was affecting the all-Wales position; - Part two of the measure, which focussed on care and treatment plans, had a compliance of 80% against a 90% target and there were issues within learning disabilities which needed to be addressed; - The target for part three of the measure, which related to access, had been achieved; - Part four had 100% compliance and this required patients to be aware of advocacy support. In discussing the report, the following points were raised: Chris White advised that during a meeting with Welsh Government's quality and delivery team, the health board had requested that correspondence be sent to Cwm Taf University Health Board as the non-compliance was having a noticeable impact on ABMU's previously high performance. Chris White noted a decline in performance within learning disabilities for compliance with care and treatment plans and queried as to whether there was different practice within this area which needed to be addressed. Dai Roberts advised that there were issues relating to recruitment in Swansea, especially as there was not a specific learning disabilities nursing qualification at Swansea University. However there was confidence within the service that performance would improve to the required level in February 2018. Emma Woollett noted that the committee was not due to meet until May 2018 which was a significant period of time to wait to find out whether performance had improved. Dai Roberts undertook to relay the performance data to Emma Woollett outside of the meeting once available. Angela Hopkins advised that she had provided evidence to the national select committee in relation to CAMHS which was looking at the commissioning aspect as whole as well as locally and work needed to be undertaken to support children and teenagers to manage mental health conditions to prevent them requiring specialist services. She added that there were some concerns that providing CAMHS in Swansea was proving a challenge and Chris White had written to Cwm Taf University Health Board to seek assurance. Emma Woollett noted the internal audit undertaken in June 2016 and	**DR**

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	queried the progress made in relation to the recommendations. Dai Roberts advised that the action plan had been completed and a re-audit undertaken, which had resulted in an improved rating. He added that the original review had included the quality of the information structure but this could not be addressed until the Welsh Community Care Information System had been implemented and as such, actions had been put in place to mitigate the issues. Emma Woollett queried whether the follow-up audit would be received by the Audit Committee. Pam Wenger advised that it would.	
Resolved:	- The Mental Health Act 2005 performance report be **noted.** - The Mental Health Measure (Wales) 2010 performance report be **noted.** - Dai Roberts to inform Emma Woollett of the learning disabilities service's compliance with care and treatment plans once the February 2018 data was available.	**DR**
11/18	**DEPRIVATION OF LIBERTY SAFEGUARDS / MENTAL CAPACITY ACT PERFORMANCE REPORT**	
	A report providing an update regarding deprivation of liberty safeguards (DoLS) standards was **received**. In introducing the report, Angela Hopkins highlighted the following points: - In the period 1st April 2017 until 30th January 2018, 852 DoLS applications were received, of which, 691 breached timescales; - As at 31st January 2018, 166 DoLS cases were outstanding; - The safeguarding team was working to develop a bespoke safeguarding risk register; - A training session had taken place for additional supervisory body signatories and the health board had increased its number from three to seven; - DoLS was not just a corporate responsibility but one for all staff; - Additional best interest assessor (BIA) training had taken place in 2017 to increase the number of staff able to undertaken the process but they had not yet had the opportunity to shadow an established BIA. As such, independent BIAs, local authorities and neighbouring health boards had agreed to support health board to provide shadowing opportunities; - Work was ongoing to establish a BIA rota which would be presented to the Safeguarding Committee in March 2018; - There was currently no accreditation for BIA training and as such, consideration needed to be given as to how to assess competence; - DoLS was included on the corporate risk register and the score was to be reviewed in summer 2018 with a view to reducing the risk, but the overall aim was to remove it entirely.	

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	In discussing the report, the following points were raised: Chantal Patel advised that she had delivered a recent BIA training session during which a basic refresher had to be given of DoLS and the Mental Health Act 2005 as often patients were on the ward for a significant period of time before an assessment was requested. She added that the health board only had two trained BIAs able to provide shadowing opportunities and consideration was required as to how many it needed. Emma Woollett stated that given the number of breaches, it was a troubling report but there was assurance that mitigating action was being taken. She added that a reducing risk score would only be credible if the number of DoLS decreased and asked for an update at the next meeting. Angela Hopkins undertook to provide this, adding that the executive team monitored the position closely.	**AH**
Resolved:	- The report be **noted**. - A further update be provided at the next meeting.	**AH**
12/18	**CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) UPDATE**	
	Joanne Abbott-Davies was welcomed to the meeting. A report providing an update in relation to children and adolescent mental health services (CAMHS) was **received.** In introducing the report, Joanne Abbott-Davies advised that a comprehensive update had been given to the Quality and Safety Committee but this report outlined the mechanisms in place to gain assurance in relation to CAMHS following a request to the last meeting. In discussing the report, the following points were raised: Chris White noted that some of the narrative within the delivery plan required updating. Joanne Abbott-Davies advised that this was an action from the Quality and Safety Committee which was to receive an update at its next meeting. Pam Wenger commented that it was important that work was not duplicated by committees and responsibility for monitoring CAMHS was with the Quality and Safety Committee. Chantal Patel queried if there was a register of items referred between committees. Pam Wenger responded that this was being considered as part of a governance review that she was currently undertaking.	
Resolved:	The report be **noted**.	
13/18	**ISSUES TO BE REPORTED TO THE BOARD**	
	In discussing the issues to report to the board, the following points were raised: Emma Woollett stated that it was important that the committee focused purely on compliance with the mental health legislation and any aspects relating to quality and safety were to be received by that particular	

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	committee. Pam Wenger advised that a board development session was taking place later that month at which the board committee structure would be discussed. She added that the Mental Health and Capacity Act Legislative Committee's remit needed to focus on the Mental Health Act 1983, Mental Capacity Act 2005 and the Mental Health Measure (Wales) 2010 as per its terms of reference. Maggie Berry commented if areas of concern relating to quality or performance arose, these could be referred to the relevant board committee. Emma Woollett concurred, adding that it would be for these fora to scrutinise the issues in more detail. It was agreed the following issues would be reported to the board: - The impact of CAMHS performance on the health board's compliance with the Mental Health Act; - DoLS performance noting that assurance had been taken that a plan was in place to address this; - The remit of the committee should focus on compliance with the mental health legislation.	**LS/EW**
14/18	**ANY OTHER BUSINESS**	
	There was no further business and the meeting was closed.	
15/18	**DATE OF THE NEXT MEETING**	
	The next meeting would take place on **Thursday 10th May 2018** at 2pm in the board room, Headquarters. (Corporate admin deadline for papers 30th April).	