Unconfirmed

MINUTES OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 24TH AUGUST 2018 IN THE BOARD ROOM, HEADQUARTERS

Present	Emma Woollett	Vice-Chair (in the chair)
	Maggie Berry	Non-Officer Member
	Jackie Davies	Non-Officer Member
	Gareth Howells	Director of Nursing and Patient Experience
	Chris White	Interim Chief Operating Officer
In Attendance	Dai Roberts	Service Director, Mental Health and Learning Disabilities
	Lynda Rogan	Mental Health Act Manager
	Liz Stauber	Committee Services Manager

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32/18	**WELCOME AND INTRODUCTIONS**	
	Emma Woollett welcomed everyone to the meeting, particularly Gareth Howells for whom it was his first in his role as Director of Nursing and Patient Experience.	
33/18	**APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from Martyn Waygood, Non-Officer Member; Rhonwen Parry, Head of Psychology and Therapies; Ian Stevenson, Partnership and Development Support Manager and Pam Wenger, Director of Corporate Governance.	
34/18	**DECLARATIONS OF INTEREST**	
	There were no declarations of interest.	
35/18	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the meeting held on 10th May 2018 were **received** and **confirmed** as a true and accurate record, except to note the following amendment: 21/18 Mental Health Act Monitoring Report There had been five exceptions and *one* invalid detention within the reporting period.	
36/18	**MATTERS ARISING**	
	There were no matters arising.	
37/18	**ACTION LOG**	
	The action log was **received** and **noted** with the following updates: (i) Action Point One Emma Woollett noted that discussions were still ongoing with regard to	

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	triangulating the data for child and adolescent mental health services (CAMHS). She queried as to whether sufficient information was being received about the service in relation to the Mental Health Act 1983. Dai Roberts advised that any breaches of the act within CAMHS were reported within Cwm Taf University Health Board as the providers of the service. Emma Woollett asked whether as the commissioners of the service, ABMU Health Board should also receive such details as it would be under the reporting remit of the committee. Gareth Howells concurred, adding that as commissioners, there should be a contract between the two health boards to provide such details. Dai Roberts responded that the same principles could be applied to continuing healthcare patients in nursing or care homes, as the services would also have been commissioned by the health board and would need to conform to the act. Emma Woollett advised that this was a significant point and suggested the requirements be clarified with Pam Wenger. This was agreed. (ii) <u>Action Point Two</u> Dai Roberts advised that a partnership and development support manager from the unit had visited Maesteg Hospital to identify learning in relation to care and treatment plans for a presentation to a unit business meeting the following month in order for it to be shared more widely. (iii) <u>Action Point Three</u> Dai Roberts advised that a nine point checklist had been developed for medical reports to mental health tribunals and an audit was to be undertaken every six months.	**LS**
38/18	**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 highlighted the following points: - During the reporting period, there had been one exception and one detention; - One under 18 had been admitted to an adult ward for a day before transferring to the specialist CAMHS unit under section two of the act; - Section four had been applied five times but converted to section two within 72 hours; - High usage of nursing holding powers had been reported due to the unavailability of doctors to apply a section 5(2); - There had been one death of a detained patient; - A three-year graph for CAMHS usage had been included; - Training for hospital managers was continuing however a recent session had been cancelled; - Healthcare Inspectorate Wales (HIW) had undertaken a visit to Cefn Coed Hospital but no issues with the act had been raised;	

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	- As a result of the work to provide Mental Health Act 1983 training to clinical staff across the units, a reduction in the number of errors and invalid detentions had been evident. In discussing the report, the following points were raised: Chris White noted the admission of the under 18 to an adult mental health bed and queried whether there was any criteria as to how long these patients should be within that placement before transfer to the specialist CAMHS unit. Dai Roberts advised that it was an emergency placement and there was no defined period, but it was a serious issue, as this would not occur within other specialities. Chris White concurred, adding that within other specialities, if there was no available bed, a less acute patient would be transferred to a lower dependency area to accommodate the new patient. Jackie Davies concurred, adding that the medium secure at Glanrhyd Hospital admitted all patients who needed treatment regardless of whether a bed was available. Gareth Howells commented that there appeared to be a reactionary approach to emergency CAMHS and as such, the environment and care needed to be checked to ensure it was appropriate for anyone admitted within these circumstances. He added that care could be provided anywhere so long as the environment was right. Chris White responded that it was unclear as to whether the skill mix of the staff within the adult ward was the right one for caring for younger people. He suggested that a piece of work be undertaken to identify how often the bed within the adult ward was used against the capacity in the specialist CAMHS unit. Dai Roberts concurred, adding that the unit nurse director had raised some concerns as to the current approach when she took up post and he had also raised it with a former chief executive. Gareth Howells advised that he would speak with the unit nurse director to determine if it was possible to collate patient stories from adolescents as to their experience of admissions to adult mental health wards. Maggie Berry referenced the cancellation of the training at Morriston Hospital and queried whether it had been rescheduled. Lynda Rogan advised that the aim was to have a full training day and so work was undergoing to determine the right time of year to do this to enable as many staff to attend as possible. She added that bed managers and the psychiatry liaison team at the hospital had already completed the course. Emma Woollett commented that it was useful for the committee to receive training compliance at each meeting to see hotspot areas.	**DR** **GH** **LR**
Resolved:	- The report be **noted.** - A piece of work be undertaken to identify how often the bed within the adult ward was used against the capacity in the specialist CAMHS unit. - Gareth Howells to speak with the unit nurse director to determine if it was possible to collate patient stories from adolescents as to their experience of admissions to adult mental health wards. - Report to include training compliance on an ongoing basis	**DR** **GH** **LR**
39/18	**MENTAL CAPACITY ACT MONITORING REPORT**	

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	A report providing an update on performance against the Mental Capacity Act 2005 was **received.** In introducing the report, Gareth Howells highlighted the following points: - The report needed to be developed further in order to provide the right assurance; - Reporting training compliance via the electronic staff record (ESR) was challenging as the percentage requiring training by unit needed to be identified to determine the number outstanding, but this was yet to be established; - There were no particular concerns within the data being reported. In discussing the report, the following points were raised: Jackie Davies noted that the health board currently did not have a dedicated lead for deprivation of liberty safeguards (DoLS), adding that the 70% of breaches demonstrated the significance of the role. Emma Woollett stated that the main concern within the report was training as the current it was unclear and while work was being undertaken, the timescales were not specified and there was also an issue of staff not being released to complete the sessions. She added that the issue had been raised at a board meeting but was yet to be addressed, and this would be from where the committee gained assurance.	
Resolved:	The report be **noted.**	
40/18	**DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) UPDATE**	
	A report providing an update regarding (DoLS) standards was **received**. In introducing the report, Gareth Howells highlighted the following points: - The number of applications and breaches was a concern; - There were some challenges as to who undertook assessments and funding; - Internal audit had completed a review of DoLS and from this he would like to see a clear action plan as to how improvements would be made. In discussing the report, the following points were raised: Emma Woollett stated that she was also looking for an action plan for improvements and this was yet to be provided. Jackie Davies concurred and reiterated the importance of a designated lead. Emma Woollett noted a review by a supervisory body for which an action plan had been developed and identified key actions to be undertaken in a way which reduced the number of breaches. She suggested that a more substantive report be received at the next meeting. This was agreed.	**GH**

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Resolved:	- The report be **noted.** - A more substantive report be received at the next meeting.	 **GH**
41/18	**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: - Parts three and four of the measure (relating to self referral and advocacy) were meeting the performance targets; - As a health board, part one performance met the performance targets for both access to primary mental health and interventions including and excluding CAMHS data. CAMHS performance alone however did not meet the target for part 1a (access to primary mental health services), with only 30% access within 28 days; - Part two, which related to care and treatment plans, was met in two out of three months. Consideration needed to be given as to how best to achieve this target sustainably. Hotspot areas had been identified; - Performance was not as it should be within Swansea for learning disabilities care and treatment plans, with a number of breaches reported, therefore meetings were to be undertaken with the local authorities; - Overall, performance against the measure was satisfactory and close to green in most areas as such, Welsh Government had stood the organisation down from quality and delivery meetings. In discussing the report, Maggie Berry commented that the 30% for CAMHS performance was a concern. Emma Woollett advised that until the entire list reduced so that the longest person waiting was within one month, performance would not increase, however significant improvements had already been made.	
Resolved:	The report be **noted.**	
42/18	**ANY OTHER BUSINESS**	
	There was no further business and the meeting was closed.	
43/18	**DATE OF THE NEXT MEETING**	
	The next meeting would take place on 8th November 2018 at 2pm.	