Unconfirmed

MINUTES OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 5TH AUGUST 2021 AT 9.30AM SBUHB HEADQUARTERS/MICROSOFT TEAMS

Present	Stephen Spill	Vice Chair (in the chair)
	Martyn Waygood	Independent Member
	Rab Mcewan	Interim Chief Operating Officer
	Christine Williams	Interim Director of Nursing and Patient Experience
	Dai Roberts	Service Director, Mental Health and Learning Disabilities
In Attendance	Pam Wenger	Director of Corporate Governance
	Claire Mulcahy	Corporate Governance Manager
	Tanya Spriggs	Nurse Director, PCC Service Group (Minute 57/21)
	Nicola Edwards	Head of Safeguarding (Minute 57/21)
	Stephen Jones	Unit Nurse Director, Mental Health and Learning Disabilities (Minute 59/21)

MINUTE		ACTION
50/21	**WELCOME AND INTRODUCTIONS**	
	Stephen Spill welcomed all to the meeting.	
51/21	**APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from Jackie Davies, Independent Member and Rhonwen Parry, Head of Psychological Therapies.	
52/21	**DECLARATIONS OF INTEREST**	
	There were none.	
53/21	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the meeting held on 6th May 2021 were **received** and **approved** as a true and accurate record.	
54/21	**MATTERS ARISING**	
	There were none.	
55/21	**ACTION LOG**	
	The action log was **received** and **noted**	
56/21	**MENTAL HEALTH ACT 1983 MONITORING REPORT**	
	A report providing an update on performance against the Mental Health Act 1983 was **received.**	

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	In introducing the report, Dai Roberts highlighted the following points: - The report presented the data for the period 1st April 2021 to 30th June 2021; - During the reporting period there had been 25 exceptions and 1 invalid detention identified by the Mental Health Act (MHA) Department; - The invalid detention related to unsigned documentation; - There were 7 admissions to Ward F at Neath Port Talbot Hospital of those aged under 18 with length of stay between 1 and 7 days; - Conversations were underway surrounding the this as a health board high risk; - Welsh Government had commissioned two reviews on the provision of inpatient facilities for CAMHs patients and these were now being considered; - Appropriate inpatient facilities for CAMHs patients were essential; - There were 2 deaths of patients during this reporting period and the cause of death appears to be due to physical health conditions; - There were 2 Healthcare Inspectorate Wales (HIW) quality checks in the Mental Health and Learning Disabilities Units during the quarter. No review of MHA documentation was carried out; - HIW would soon recommence onsite unannounced visits; - The Mental Health Act Department will shortly be making arrangements to carry out MHA paperwork audits on the acute wards; - The position within the MHA team was stable and the Interim Team Manager position had been extended until September 2021; In discussing the report, the following points were raised: Martyn Waygood agreed that the appropriate inpatient facilities were essential for these young patients. He queried whether a discussion was needed with Welsh Health Specialised Services Committee (WHSSC) in terms of the commissioning aspect. Dai Roberts informed that he would raise with Welsh Government colleagues at a meeting in August but stated it would also require escalation from the Chief Executive via the appropriate channel at Welsh Government. Martyn Waygood undertook to raise the issue of young people on adult acute wards at the WHSSC Quality and Safety Committee. Christine Williams informed that this was a high risk for the health board. The issue was not unique to SBU HB, all other health boards were expressing concerns with children on adult mental health wards and the lack of provision available, as well the complexity of some of the patients. This issue was continually flagged to Welsh Government	**MW**

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	and the review was underway in which the outcome is awaited. Stephen Spill queried whether Ty Llidiard could accommodate these patients and Dai Roberts informed that Ty Llidiard was a facility for planned admissions only and was itself in special measures. Stephen Spill highlighted that both the issues at Ty Llidiard and the issue of young people on adult wards was being made aware at a ministerial level. Dai Roberts made reference to the recent development of the mother and baby unit at Tonna, reflecting that the CAMHS issue could potentially be dealt with in a similar way. With regards to Section 136's, Martyn Waygood queried whether there was a view on how these had increased in number during the last 4 quarters. Dai Roberts responded that he was not concerned with the figures, the relationship between SBU HB and South Wales Police was very good. The reason for the increase was difficult to pinpoint but added that the use of section 136 would escalate in line with demand, especially within the difficult circumstances of the pandemic. He advised that the health board had commissioned a sanctuary which provided open access and this has been supported by the police. Concerning the unlawful detention of one patient during the quarter due to unsigned documentation by a Doctor, Dai Roberts undertook find out the detail of the outcome and feedback to Martyn Waygood. Dai Roberts advised that it was important to look at the health board processes in terms of professional obligation, highlighting the junior doctor change over and ensuring they are informed of their obligations in relation to mental health legislation. He undertook to liaise with the Medical Director surrounding the professional obligation of Doctors correctly completing MHA documentation. Stephen Spill queried the risk to the health board if HIW encounter a deficiency in the documentation during the unannounced visits. Dai Roberts informed that they would report the findings in regards to quality of paperwork and also any impacts on patient care. He assured that the MHA team had been visiting wards in advance and in preparation of the visits. Dai Roberts advised that he did not expect the outcome to be negative. Pam Wenger informed members that wider discussions around mental health legislation were underway and this related to mental health systems and processes and compliance with legislation. She advised that work was in train and progress would be fed back via a Board briefing in due course. The issue had been alerted to the Chief Executive and the risk had been escalated on the risk register under the Quality and Safety Committee. Pam Wenger undertook to provide an update to Chair outside of committee.	**DR** **DR**
Resolved	Concerning the unlawful detention of one patient during the quarter due to unsigned documentation by a Doctor, Dai Roberts enquire on the outcome of this and feedback to Martyn Waygood; Dai Roberts to liaise with the Medical Director of Mental Health	DR

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	and Learning Disabilities Service Group surrounding the professional obligation of Doctors correctly completing MHA documentation. The issue of young people on the adult acute ward to be referred to the Quality and Safety Committee. - Martyn Waygood to raise the issue of young people on adult acute wards at the WHSSC Quality and Safety Committee. The report be **noted.**	DR SS MW
57/21	**MENTAL CAPACITY ACT 2005 AND DEPRIVATION OF LIBERTY SAFEGUARDS MONITORING REPORT**	
	Tanya Spriggs and Nicola Edwards were welcomed to the meeting. A report providing an update on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) position for Quarter 1 was **received.** In introducing the report, Tanya Edwards and Nicola Edwards highlighted the following points; - In quarter 1, there were 257 referrals received, of those 42 were assessed by the 2 dedicated BIAs, the internal (not primary role) BIA's completed 4 assessments and the external BIAs assessed 20 resulting in 3 being granted; - There were significant challenges in terms of breaches with the number increasing in Quarter 1 to 108; - The BIA's have had a virtual presence primarily but risk assessments have taken place to enable access to acute wards; - The Independent Mental Capacity Advocate service (IMCA) reported a consistent level of referrals despite the pandemic; - There was now only one full time internal BIA in post which is a risk. The vacant post was out to advert as a temporary contract due to the imminent changes to the legislation ; - The date for the implementation of legislative changes moving from Deprivation of Liberty Safeguards to Liberty Protection Safeguards (LPS) is planned for April 2022. - The code of practice for this was awaited. A number of Welsh Government level groups were underway with regards to this and the health board had input into these; - A health board level report is being compiled which sets out the requirements as we move into the LPS; - The role of the managing and supervisory bodies would change and would broaden the amount of people that sit under the LPS, as well as the age ranges. - DoLS training continues via virtual platforms; - A webinar had been delivered by Swansea University and was	

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	accessible via the intranet and Safeguarding webpage; - Attendance at the DoLS virtual training had increased during June 2021 and stood at 67 attendances; - MCA Level 1 and 2 training is delivered via e-learning and MCA level 3 training continues by delivered remotely via Microsoft Teams; - There have been concerns across Wales in terms of compliance data and it has been recommended that MCA training is given priority. This is being monitored closely; In discussion, the following points were made; Maggie Berry made reference to the one remaining BIA and raised her concern that this contract would also end. Tanya Spriggs assured that the contract would not change but the job description may once the new legislation was in place. Once there is clarity on the roles required, these would be included in the business case. She also advised that she was working with closely workforce colleagues with regards to the vacant post and that the external BIAs had been blocked booked for the coming months. Maggie Berry queried whether those internally trained staff (not primary role) could 'step in' to cover. Tanya Spriggs advised that this was possible but there had been very little activity undertaken by those staff over the last year. Maggie Berry expressed her concern that the health board would be going into the implementation of the LPS at a disadvantage with one less BIA in place. In reference to the internal BIA's highlighted above, Christine Williams advised that the internal BIA model was the wrong model for the health board. The current pressures and demands on services have meant staff could not be released. There would be also be a skill gap as these practical skills have not been used in the last 12 months. She assured that the health board had been able to secure relevant skills sets via the block bookings and preparation is underway for the implementation of the new legislation to ensure there is more sustainable and robust model in place. Martyn Waygood added that he also had his concerns in relation to the lack of BIA's and queried why investment was not being undertaken immediately. He added that the service had been under resourced and this had been a long standing issue. He queried why the resource could not be used for employing standalone BIA's instead of the block bookings for external assessors. Tanya Spriggs concurred, adding that this was a risk and challenge for the health board. The LPS implementation was expected sooner but due to COVID-19 it was delayed. Within the legislation there were a number of new roles and these would be progressed quickly and it was anticipated that there would be interest in those roles. Stephen Spill queried whether there would be a report on the transition into the LPS and Tanya Spriggs advised this was currently in draft and it would include all elements of the mental health legislation within.	

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Resolved;	- The performance data for Quarter 1 – April to June 2021 was **noted;** - It was **noted** that the further LPS guidance has been delayed due to the COVID-19 pandemic. The new implementation date, has been confirmed as April 2022;	
58/21	**MENTAL HEALTH MEASURE 2010 MONITORING REPORT**	
	A report providing an update on performance against the Mental Health (Wales) Measure 2010 (1st March 2020 to 28th February 2021) was **received.** In introducing the report, Dai Roberts highlighted the following points: - For Part 1a, which related to access to local primary mental health services (LPMHSS) for over 18's, compliance stood above target of 80% of assessments taking place within the 28-day referral period. - For Part 1b (interventions), above 80% of interventions started within the 28 days following an assessment by LPMHSS; - For under 18's (CAMHS), compliance was variable for the period; - Part 2, which relates to care and treatment plans (CTPs), most recent data showed above 90% of patients who were in receipt of secondary mental health services had valid care and treatment plans in place at the end of the month; - Parts 3 and 4 of the measure (relating to self-referral and advocacy) were met throughout the period; - Steps have been taken to mitigate the anticipated increase in demand and restrictions due to social distancing requirements to maintain compliance. - There had been successful bids to supplement GP support in primary care to help with the increase in demand; In discussing the report, the following points were raised; Stephen Spill noted the good performance within adult mental health services and asked what the key factors to this good performance were. Dai Roberts replied that the service was able to recruit and retain good staff and there was good performance management of the waiting lists. In relation to CAMHS, there were a number of vacancies within the service and there were some recruitment and retention issues. He commented that prior to the Bridgend Boundary Change the health board had planned to repatriate primary CAMHS from Cwm Taf Morgannwg Health Board and the health board needed to re-open that discussion. Stephen Spill advised that Cardiff and Vale Health Board had repatriated their patients but were still seeing the same performance issues. Martyn Waygood stressed that this was a fundamental issue that needed to be addressed for the sake of the	

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	children and young people. Maggie Berry agreed that it would beneficial to bring the management of CAMHS back in to the health board under the management of MHLD Service Group. Stephen Spill requested that a conversation is undertaken with Executive colleagues to agree a way forward and Rab McEwan and Christine Williams undertook to raise this at the next Executive Team meeting.	**RM/CW**
Resolved:	- Rab McEwan and Christine Williams to raise the issue of repatriation of the CAMHS Service with Executive colleagues and feedback to committee; - The levels of compliance to Welsh Government access targets with regard to the Mental Health Measure (Wales) 2010 which offer no concerns regarding overall compliance with the legislation were **noted.** - Note that steps have been taken to mitigate the anticipated increase in demand and restrictions due to social distancing requirements to maintain compliance were **noted.** - The report be **noted.**	**RM/CW**
59/21	**CARE AND TREATMENT ACTION PLAN UPDATE**	
	Stephen Jones was welcomed to the meeting. A report updating on the Mental Health and Learning Disabilities Care and Treatment Plans (CTP's) was **received;** In introducing the report, Stephen Jones highlighted the following points; In discussion, the following points were made; - The report updated on the internal audit cycle, and action plans were appended to the report for reference; - Overall performance was high in terms of the main legislation and these action plans focus on both the quality and patients input of the CTPs; - In September 2020 an audit was undertaken using the All Wales too, there had been some delays in responses but in July 2021 they were received at the Mental Health Quality and Safety Committee; - The annual audit cycle had been agreed and the next audit would take place in the Autumn 2021; In discussion, the following points were raised Stephen Spill made reference to single or the consolidated plan for divisions and queried what was the best option. Stephen Jones advised that it was important to have individual, clear actions for the divisions but these could be generated into a single plan that is received at this committee. Pam Wenger agreed that it was important to have individual divisional action plans in terms of accountability and an overarching tracker plan could be received at this committee. It was	

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	agreed that an update on the progress of the CTP action plan be received twice yearly and the report is to focus on those actions that are off track. Members agreed that an update from the Mental Health Quality and Safety Committee on the progress of the CTP action plans is to be included in the Quality Safety Assurance Group Key Issues report to Quality Safety Committee for assurance purposes.	
Resolved;	- It was agreed that an update on the progress of the CTP action plan be received twice yearly and the report is to focus on those actions that are off track; - An update from the Mental Health Quality and Safety Committee on the progress of the CTP Plans is to be included in the Quality Safety Assurance Group Key Issues report to Quality Safety Committee;	**SJ** **SJ**
60/21	**ANY OTHER BUSINESS**	
61/21	**DATE OF THE NEXT MEETING**	
	The next meeting would take place on **Thursday, 4th November 2021**	