Unconfirmed

MINUTES OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD 8TH AUGUST 2019 MILLENNIUM ROOM, SBU HEADQUARTERS

Present	Martyn Waygood	Interim Vice Chair (in the chair)
	Jackie Davies	Independent Member
	Maggie Berry	Independent Member
	Chris White	Chief Operating Officer and Director of Therapies and Health Science
	Gareth Howells	Director of Nursing and Patient Experience
	Dai Roberts	Service Director, Mental Health and Learning Disabilities
In Attendance		
	Lynda Rogan	Mental Health Act Manager
	Claire Mulcahy	Corporate Governance Officer
	Leah Joseph	Corporate Governance Officer
	Jacqui Maunder	Interim Head of Compliance
	Ian Stevenson	Partnership and Development Manager

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33/19	**WELCOME AND INTRODUCTIONS**	
	Martyn Waygood welcomed everyone to the meeting and introduced himself as the new Chair of the committee since taking up the post of the Interim Vice Chair of the Health Board.	
34/19	**APOLOGIES FOR ABSENCE**	
	Apologies for absence were received from Pam Wenger, Director of Corporate Governance, Rhonwen Parry, Head of Psychology and Therapies, Jason Crowl Unit Nurse Director and Nicola Edwards, Head of Safeguarding.	
35/19	**DECLARATIONS OF INTEREST**	
	There were none.	
36/19	**MINUTES OF THE PREVIOUS MEETING**	
	The minutes of the meeting held on 9th May 2019 were **received** and **approved** as a true and accurate record.	
37/19	**MATTERS ARISING**	
	(i) <u>Update on Court of Protection Cases</u> Gareth Howells advised there were currently 20 ongoing cases where a review was being undertaken, the outcome of which would come to the next committee meeting. Martyn Waygood commented that the report was not what was expected. The committee was seeking information regarding key themes and trends in the health board court of protection cases. Gareth Howells undertook to ensure	**GH**

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	this detail would be included within the next report. **(ii) <u>CAMHS Bed</u>** Dai Roberts made reference to the ongoing discussions with regards to the CAMHS bed on Ward F at Neath Port Talbot hospital and WHSSC commissioning arrangements at Ty Llidiard. He advised that the Director of Strategy would now be taking the discussions with WHSSC forward. Chris White stated that it was important to ensure our patients were receiving the same access to beds at Ty Lllidiard as patients from Cwm Taf. There needed to be further discussion with WHSSC to ensure we are getting the best for our patients. Gareth Howells also undertook to speak with his counter-part at WHSSC on the matter.	
Resolved	- Court of Protection Case report to be received at the next committee, to include detail of themes and trends.	**GH**
38/19	**ACTION LOG**	
	The action log was **received** and **noted** with the following updates: <u>Action Point 3</u> Gareth Howells advised that a formal audit would be required rather than a 'back to floor' peer review and undertook to arrange this and feedback at the next committee. <u>Action Point 10</u> Dai Roberts advised that a number of presentations were ongoing across the delivery unit to raise the profile of the IMCA service Following completion of these presentations, feedback will be discussed and the committee will receive an update in November.	**GH** **DR**
39/19	**WORK PROGRAMME 2019/20**	
	The work programme for 2019/20 was **received** and **noted** by the committee.	
40/19	**MENTAL HEALTH LEGISLATION COMMITTEE TERMS OF REFERENCE UPDATE**	
	A verbal update on the Mental Health Legislation Committee Terms of Reference was **received.** Jacqui Maunder advised she was in the process of updating the terms of reference following recent advice that a scheme of delegation was required in accordance with the codes of practice. She advised that this would be circulated to members for comment in due course and the draft would be received at the committee in November. Members made reference to the Powers of Discharge Committee and Dai Roberts stated that the it would be an opportune time to undertake an internal audit of the powers of discharge committee to ensure there was an alignment with the rest of Wales, Dai Roberts	

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	undertook to arrange this with the Internal Audit department	
Resolved	- Dai Roberts to arrange an internal audit review of the Powers of Discharge Committee.	**DR**
41/19	**MENTAL HEALTH ACT 1983 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 four exceptions and one invalid detention identified by the Mental Health Act (MHA) Department; - There were no breaches of the Mental Health Act for in-patients admitted to Swansea Bay UHB who are under the age of 18; - Two under 18 year olds were admitted to Ward F, Neath Port Talbot Hospital, one informally, the other under section 2 of the Mental Health Act. No breaches were recorded for the reporting period; - Section 4 which should only take place in cases of urgent necessity and to avoid an unacceptable delay was used on three occasions, all patients had their section 4 converted to section 2 within the 72 hour period allowed. - There was one death recorded of a patient detained under the Act. The death was reported to Healthcare Inspectorate Wales(HIW) in accordance with protocol; - During the reporting period there were no visits by HIW in the Mental Health and Learning Disabilities Unit. - There were three postponed Hospital Managers hearings during the period; In discussing the report, the following points were raised: Lynda Rogan advised the committee that she had created 3 bespoke Mental Health Act guidance documents for use on the general wards aimed at nurses and doctors. She stated that the guidance had been circulated to matrons across the board and the feedback had been very positive. She sought advice on the best process to ensure doctors had sight on this guidance. Chris White advised that this should go via the Medical Director's office. He would follow this up to ensure circulation and a reminder of the requirements under Section 5 (2) of the Act. Martyn Waygood gave his thanks to Lynda Rogan for her hard work in the creation of these bespoke documents. Maggie Berry raised her concern with regards to the sending of letters to patients advising of their inappropriate detention. She was also concerned with the lack of understanding these patients may	**CW**

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	have of the information within the letter. Lynda Rogan assured that the patients are advised of their detention as thoroughly as possible and the content is explained verbally by ward staff. Letters were sent out as a formality. With regards to the Health Inspectorate Wales (HIW) visits, Lynda Rogan advised there had been none during the period. Lynda Rogan stated that regular visits were undertaken to wards across the health board to carry out pre-HIW audits, to ensure continued compliance with the Act and Code of Practice. Chris White commented that this was great news and he requested some detail on their ward visits within the next iteration of the report. Chris White stated that he felt the senior team should be more visible within Learning Disability sites across the health board. Martyn Waygood concurred and stated it would be helpful to have a programme of visits arranged for this. Dai Roberts added that this autumn the service unit senior team would be undertaking the 15-Step Challenge across all 11 learning disability units and he would support members' attendance. Claire Mulcahy to link in with the service delivery unit to arrange. An issue was raised with regards to some senior staff not accepting the advice of the Mental Health Act designated team and requesting further legal advice on Mental Health Act issues. Chris White stated that this should not be happening and these instances need to be escalated to the service director and/or the clinical directors. Members referred to the appended minutes of the Powers of Discharge Committee. Jackie Davies highlighted minute HM/19/06, which referred to the use of paper copies of patient reviews. She advised that work was in progress to establish a better way of working via electronic means. There were currently information governance issues of which she was working through with Pam Wenger. Martyn Waygood highlighted minute HM/19/11 concerning the standards of medical reports for hearings. He requested to have sight of the outcome of that action at the next committee. Concerning minute HM/19/13 of issues relating to specific hospital managers' hearings, Jackie Davies advised there was currently a review of the Hospital Managers' Powers of Discharge Committee being undertaken at a Corporate Governance level and an overview of the work being undertaken would be shared with this committee in November. Maggie Berry advised that as Independent Members are also hospital managers, it was important the governance structure surrounding this was clarified and there was a scheme of delegation in place for this committee. Jacqui Maunder offered support in terms of strengthening the terms of reference. With regards to the information on fundamentally defective applications and rectifiable errors, Martyn Waygood requested that narrative be added to ensure clarity around what the figures show. Lynda Rogan undertook to do this for the next report. With regards to the appended CAMHS Governance Report,	**LR** **JD** **LR**

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	members felt the report did not provide any assurance and Martyn Waygood undertook to clarify with Emma Woollett as previous Chair, as to what her requirement was with regards to seeking governance information from CAMHS.	
Resolved	- The Medical Director's Office to be contacted to advise on the guidance available to doctors for the completion of MHA documentation. - Lynda Rogan to provide detail on ward audits within the next iteration of the report. - Jackie Davies to provide an update on the action arising from Minute HM/19/11 of the Powers of Discharge Committee. - Narrative to be added to the report on the fundamentally defective and rectifiable errors. - Martyn Waygood undertook to clarify with Emma Woollett as previous Chair, as to what her requirement was with regards to seeking governance information from CAMHS.	**CW** **LR** **JD/LR** **LR** **MW**
42/19	**MENTAL CAPACITY ACT (MCA) MONITORING REPORT**	
	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: - During the period 1st April to 30th June 2019, the IMCA provider service, Mental Health Matters, received 17 instructions for an Independent Mental Capacity Advocate (IMCA) from the health board; - For the period the majority of the instructions of IMCA's were for support in making decisions regarding Long term move of accommodation; - Work was underway to establish an effective way of recording the number of best interest assessments taking place across the organisation; - There were currently 20 ongoing Court of Protection DoLS cases that the legal team were engaged in, involving the health board; - A health board wide training needs analysis was in progress and would identify a more accurate figure for staff who require MCA training; - The implementation of the changes to the Mental Health Act Legislation was due in Autumn 2020; In discussing the report, the following points were raised: Martyn Waygood made reference to item 2.1 of the report (Legislative Update) which stated that the role of the supervisory body in Wales would change and be replaced by that of a 'Responsible Body and for NHS hospitals that was deemed to be	

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	'hospital managers'. Martyn Waygood stated that clarification needed to be sought on this and what this would mean for the health board. With regards to item 2.4 and the issue of best interest decisions not being recorded within the service delivery units, Gareth Howells stated that the corporate safeguarding team were linking with the Mental Health Act team to look at current processes and best practice in order to scope out the way forward for recording of best interest assessments. A draft would be shared at the November meeting. Chris White commented that it was too early to communicate the upcoming legislation changes across the organisation but this would need to be looked at soon. Gareth Howells concurred and stated that there were fundamental changes and the transition needed to be as smooth as possible.	**GH**
Resolved:	- Clarification be sought on the changes to the legislation which states that the role of the supervisory body in Wales would change and be replaced by that of a 'Responsible Body and for NHS hospitals that was deemed to be 'hospital managers'. Clarification sought on what this would mean for the health board. - The report be **noted**	**GH**
43/19	**SAFEGUARDING TRAINING UPDATE**	
	A report providing an update on the Health Board position in relation to Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards training was **received**: In introducing the report, Gareth Howells highlighted the following points: - As at the 18th July the health board compliance figures for MCA Level 1 was 11.81% and for MCA Level 2 it was 5.47%. - Mental Capacity Act training was not included in the mandatory training framework, this results in priority being given to other mandatory training requirements. - There continued to be issues with data recording via the Electronic Staff Record (ESR) which has impacted on verifying the health board wide training compliance; - The Safeguarding Team are undergoing a Safeguarding training needs analysis to identify which staff require which level of training; In discussing the report the following points were raised; Martyn Waygood commented that the issue of MCA training not being mandatory across the health board was a concern. He undertook to refer this issue into the Workforce and OD Committee for further discussion .He stated that all staff should undergo Mental Health Act training at varying levels depending on their role but all	

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	should have knowledge of MCA and DoLs.	
Resolved:	- Martyn Waygood to refer the issue of MCA training not being mandatory across the health board to the Workforce and OD Committee for further discussion. - The report be **noted.**	**MW**
44/19	**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: - In the period 1st April – 30th June 2019 there had been 203 referrals, of which a total of 171 best interest assessments were allocated; - Of the 68 assessments completed by Internal assessors, only 9 were provided by assessors from the delivery units which confirms that the internal delivery unit model was ineffective; - The highest referring site was Morriston Hospital; - A repeat DOLs audit was due to commence on the 29th July with the report due in September 2019; In discussing the report, the following points were raised: Discussion ensued surrounding the benchmarking exercise carried out with Hywel Dda. Martyn Waygood commented on how well resourced they appeared in terms of staff. He queried whether there was an opportunity to collaborate. Gareth Howells advised this could be a possibility and would make enquiries via the network. Jackie Davies queried whether it would be helpful to carry out broader benchmarking with other health boards across Wales in order to get a global overview on this. Jackie Davies made reference to the recommendations at the end of the report in which it refers to ending the internal BIA rota and proceeding to recruit further BIA roles. She queried whether those internal staff previously trained had stepped back from carrying out assessments. Maggie Berry commented that the staff had never been released and had never been used as BIAs. Gareth Howells, added in terms of the budget for recruitment of BIA'S, he was looking for opportunities to fund another post via the Investment and Benefits group.	**GH**
Resolved:	- Gareth Howells to make enquiries on whether there was an opportunity to collaborate with Hywel Dda DoLs teams. - The report be **noted.**	**GH**
45/19	**MENTAL HEALTH MEASURE 2010 MONITORING REPORT**	
	A report providing an update on performance against the Mental Health (Wales) Measure 2010 (1st June 2018 to 31st May 2019) was	

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	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) , 80% of assessments took place within the 28 day referral period; - For Part 1b (interventions), 80% of intervention started within the 28 days following an assessment by LPMHSS - Part 2, which relates to care and treatment plans (CTPs), 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; - There was a slight dip in Part 2 compliance in April and May - In response to the review of care and treatment plans each locality continued to monitor and report against the actions identified in the improvement plans; - Parts 3 and 4 of the measure (relating to self-referral and advocacy) were met throughout the period; In discussing the report the following points were made; Dai Roberts made reference to the part 2 figures and advised he had met with the senior team and made them aware of his disappointment with the May and June figures, he assured the committee that actions with the delivery unit were being taken to address.	
Resolved:	The report be **noted.**	
46/19	**CARE AND TREATMENT PLANNING – UPDATE ON ACTIONS**	
	A verbal update on the actions following the review on Care and Treatment Planning was **received.** Dai Roberts advised that a report on the progress of the care and treatment planning actions would be prepared and shared with the committee in due course.	**DR**
Resolved	- Dai Roberts to share the report on the progress of the care and treatment planning action plan with the committee.	**DR**
47/19	**ANY OTHER BUSINESS**	
	(i) Easy Read Information Leaflets Lynda Rogan advised that there was a need across NHS Wales for easy read leaflets for detained patients who had learning disabilities or were intellectually impaired. She stated that these were already provided in NHS England and it was a requirement under the Act. Chris White requested that Lynda Rogan gathered some information together on volumes and costs of this requirement for further consideration.	**LR**

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	(ii) Delivery Units Review of Primary Care Child and Adolescent Mental Health Services (CAMHS) and Health Inspectorate Wales' Annual Report 2017/18 Martyn Waygood advised the committee of the above reports which were currently in circulation. He advised that the key recommendations within the HIW Annual Report for Mental Health and Learning Disabilities were; maintenance and estates issues, staff vacancies, medicines management, dignity and respect and health and safety. Within the Delivery Unit's report on CAMHS, key issues raised related to referral mechanisms, difficult relationships between primary and secondary care CAMHS services, GP referrals, staffing vacancies and access to CAMHS services. He added there was ministerial focus on these areas, and these need to be a priority for the health board. Gareth Howells concurred and added issues arising in CAMHS service needed to be more visible to the Board. Martyn advised he would refer both reports into Quality and Safety Committee and Workforce and OD Committee for discussion and focus.	**MW**
Resolved	- Lynda Rogan to seek further information on volumes and costs for the Easy Read Leaflets. - Martyn Waygood to refer reports into Quality and Safety Committee and Workforce and OD Committee for discussion and focus.	**LR** **MW**
47/19	**DATE OF THE NEXT MEETING**	
	The next meeting would take place on **the 25th November 2019, Millennium Room, HQ**	