**MINUTES of the Mental Health Act Committee meeting held on Thursday 23 July 2020 at 1300 hrs via Microsoft Teams**

**RR/App\_BOD 28/2020**

(Agenda item: 31a)

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| **Present:** | |
| Sir John Allison (**JA**) (**Chair**) | Non-Executive Director |
| Mark Hancock (**MH**) | Medical Director |
| Kerry Rogers (**KR**) | Director of Corporate Affairs & Company Secretary |
| Mark Underwood (**MU**) | Head of Information Governance |
| Steven McCourt (**SMc**) | Lead for CQC Standards & Quality |
| Aroop Mozumder (**AM**) | Non-Executive Director |
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| **In attendance:** | |
| Nicola Larkam minutes | Executive PA |
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| **Apologies:** | |
| Marie Crofts (**MC**) | Chief Nurse |
| Mary Buckman (**MB**) | Associate Director of Social Care |

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| **Item** | **Discussion** | **Action** |
| **1.** | **Welcome and Apologies for Absence (JA)**  Noted as above. |  |
| **2.** | **Minutes of previous meeting held 20 May 2020 (JA)**  The Minutes were accepted as a true and accurate record. |  |
| **3.** | **Matters arising (JA)**   * A more robust form of words was required to address the perennial problem of repeat criticisms following CQC inspections. This was still pending. * The date for a December meeting was confirmed – 3 December. | **MH** |
| **4.** | **Report on Essential Standards Audit (SMc)**  SMc said that it had been useful to review the Essential Standards Audit. He gave a PowerPoint presentation (to be circulated after the meeting) related to Point 9 of the TORS, concerning human rights. He picked out 4 main themes:   * Ensuring that patients receive information regarding their rights; * Ensuring that patients have the opportunity to be involved in planning their care; * Checking that the Mental Health Act is applied equitably to all patients; * Ensuring that the principle of application of the least restrictive option is always applied.   Analysis of the present pattern of audits showed some gaps in coverage, notably:   * Equitable application of the MHA was not covered at all; * There was a gap as regards access to advocacy; * There was no audit of ethnicity distribution; * A joined-up approach to oversight of restrictive practices was lacking.   On the other hand, two new audits were in development concerning:   * Segregation * The MCA (this was 50% complete)   SMc also drew attention to the CQC’s new strategy for its approach to improving patient safety, which raised questions as to how the Trust should respond.  In discussion, the following points were made:   * Referring to the Simon Wesley Review, AM observed that a person with LD or autism was normally excluded from the application of the MHA. * MH confirmed that a person should not be detained because the primary consideration was LD or autism. * MU commented that a person can be detained (and assessed under section 2) if he/she exhibited seriously aggressive behaviour. There are some patients who have a learning disability who were detained as they were unfit to be tried or to plead. While very few patients were detained purely on account of LD, the Trust had about a dozen patients with LD that was co-morbid with other conditions. * MH felt we had a grip on this issue and said that the important point was the status of the report and its recommendations. * KR observed that the recommendations within the Wesley Review were unlikely to become part of statute any time soon, but in any event they could not be divorced from the CQC findings. KR went on to highlight that the recommendations would no doubt be recognised as best practice, even if not enshrined in legislation. * MH commented that although these matters were not in the Essential Standards Audit, we should not overlook them. * MU said that while we can include ethnicity in the information, that would only show recorded numbers, not proportionality nor infringements. * SMc said that it was the tie in between ethnicity and the proportion of detentions and other issues suggestive of inequitable treatment that mattered. He added that the task of the Committee would become easier when Directorate information was collated in greater granularity. * KR said we needed to understand how much of this was urgent and how much was longer term improvement activity. * MH advised that nothing was immediately worrying, but there should be a long-term review. MH to confirm the timescales.   JA thanked SMc for an excellent piece of work. | **MH** |
| **5.** | **Views from the front line (MH/MC)**  MH said that one of the biggest early issues had been about the question as to whether isolation amounted to seclusion. Covid positive patients had to be isolated and that affected MH patients some of whom were reluctant to isolate. The CQC position was that isolation amounted to seclusion, whereas legal advice was that it was not seclusion if isolating patients for a medical reason. The CQC had conceded that this was acceptable as a last and temporary resort, so long as there was a plan. The problem had faded as the number of Covid patients dwindled.  Video Tribunal meetings had been instigated and had been largely successful, with only minor problems. This approach was expected to be continued in the event of a second wave.  After initial debate about the legal meaning of being seen “in person”, NHSE had given a ruling in favour of the use of video technology for Managers’ Assessments on the basis of safety for all involved, and these had gone ahead successfully, notwithstanding initial CQC opposition. MH added that it reflected credit on the Trust that we had been able to resource this. It was something that we would look a continuing in any second wave.  In line with OUH, we had excluded visits to Community Hospitals and Mental Health Wards. However, national exceptions were being made for certain groups, for example Autism and Mental Health patients where it would cause them distress, so exceptions were introduced at the Trust. The CQC intervened, declaring that a blanket ban on visitors was not acceptable, so compromises were found involving IT solutions and that had been well received by patients and families.  The incidence of restrictive practices had increased slightly. This was not Covid but was the result of a licensing issue for a medication requiring injection into the gluteal muscle, which was resisted. Alternative approaches were under consideration.  Ethical questions had been raised regarding the use of masks. Certain patient groups were nationally exempt from masks, for example, those with a diagnosis of autism or Asperger’s syndrome. However, the dilemma of how to respond when a patient attending a face to face consultation refused to wear a mask remained. Further consideration was necessary in order to establish whether it was ethical to insist that such patients are seen only remotely. Furthermore, alternative approaches, such as clear masks, were under consideration.  A discussion ensued concerning the hard line being taken by the CQC under its current leadership. It was noted that the CQC did not have enforcement powers but the content of reports was at its discretion.  AM observed, having worked for the CQC, that, although it could not write formal NHS policy, it could create best practice, which in time became standard practice.  Regarding post CQC inspection actions, Covid19 had affected response times. However, 12 actions was a high number and it was acknowledged it was necessary to address them as soon as possible. It was expected these should be completed within the next two months. On that basis an update would be provided to the next meeting.  MU observed that seven wards were involved and that most of the actions came down to presentation of rights and care planning. Regarding the former, part of the problem was that relevant actions were not always included in reports, which themselves might not be up to date.  JA thanked MH for his comprehensive update. | **MH** |
| **6.** | **Update on current Training & Education (MU)**  MU reported that there had been a hold on training for the last three months owing to the challenges to traditional methods owing, inter alia to lack of suitably sized rooms for social distancing. Consequently, there was a considerable backlog. A test session of a hybrid training model was scheduled for the next week. This entailed a mix of purely video based sessions and others with a facilitator and a small audience. There was much work to be done to rectify the back log.  JA asked whether the development of digital delivery would help in the long run. MU opined that it added capacity. He had done some IG sessions which had been purely on Teams and on Friday had one with 109 in attendance. This was proving to be a successful way of training and was achieving higher attendances than face to face had often done. |  |
| **7.** | **Report on work of Mental Health Act Managers (MU)**  MU gave a comprehensive update on detained patients. JA asked whether members of the committee would like a presentation of current detentions to include an ethnicity breakdown and this was welcomed by those present. It was agreed this would be provided in the next report to the Committee.  JA returned to the question of the low completion rate of the 2020 CQC actions and whether COVID had impacted on the work. MU confirmed that COVID had indeed had an impact, also that the nature of some of the actions would merit ongoing work in progress. AM observed that we were vulnerable to criticism and reiterated the urgency of addressing these actions within the next two months.  The change to video hearings had necessitated changes to ways of giving Managers pre-hearing access to patient reports. There had been changes to the interpretation of the Mental Health Act to allow electronic signatures and documentation.  MHA managers were occasionally having to invalidate applications for detention. There have been 3 of these over the last year. There have been none for this year to date.  Lapses (where detention reaches its end without discharge) were not unlawful but were ill-disciplined practice. There had been an improvement in this area.  Managers hearings by video link had initially been done without the RC, but they had now started attending and invitations were now going to patients.  Managers meet on a quarterly basis for training and standardisation purposes. The first such meeting had been held by video link on 14 July and had been well-attended and productive.  JA raised the question of the ambition to recruit more NEDs as Managers, which was most desirable and which he had attempted to foster. However, more and more was being asked of NEDs and time was an issue.  KR suggested that the advent of video hearings could help make the role less demanding of time and therefore more deliverable. It was acknowledged that discussions continued in order to organise training for NEDs and establish minimum requirements. | **MU** |
| **8.** | **Report on work of the MHA/MCA Legislation Group (MU)**  MU reported that this group had met twice over the last two months. They had considered the implications of the inception of the MHA Committee and the Group’s consequently less strategic role. Attention had been given to how they could make a difference operationally. They would submit revised TOR to the MHA Committee for approval at its next meeting. | **MU** |
| **9.** | **Any other business**  JA drew attention to an apparent spike in mental health discharges in February/March, which he presumed was to clear beds for the expected influx of Covid-19 patients. He asked if there would be a study of how those discharged patients had fared as there could be lessons to be applied more widely in the future.  MH responded that although the numbers of detained patients dipped significantly, he was not aware of any conscious decision regarding discharges. He attributed the dip in bed occupancy to a drop in referrals owing to Covid-19.  Attention was drawn to the NHS Legal Guidance set out in Paper MHA 06/20, attached to the meeting papers. MH had undertaken, as Executive Lead, to provide a report to the October meeting of this Committee.  SMc reported that he had attended a CQC Webinar about its plans for a new inspection methodology. Kate Riddle would be leading on this within the Trust. | **MH** |
| **10.** | **Date of Next Meeting**  Dates of next meetings:   * 13 October 2020\*\* * 3 December 2020 * 15 February 2021 |  |
| **10.** | **Meeting Close**  There being no other business the meeting closed at 1433 hours. |  |

\*\*The next meeting is scheduled to be held on Tuesday 13 October 2020 at 1230 hrs via Microsoft Teams\*\*