NHS
Oxford Health
NHS Foundation Trust

RR/App BOD 09/2021
(Agenda item: 24(f))

MINUTES of the Mental Health Act Committee meeting held on Tuesday 13 October 2020 at 1230 hrs via Microsoft Teams

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
Mary Buckman (**MB**)	Associate Director of Social Care

In attendance:	
Nicola Larkam minutes	Executive PA

Apologies:	
Marie Crofts (**MC**)	Chief Nurse

Item	Discussion	Action
1.	**Welcome and Apologies for Absence (JA)**	
a.	As above.	
2.	**Minutes of previous meeting held Thursday 23 July 2020 (JA)**	
a.	Minutes of previous meeting accepted as an accurate record	
3.	**Matters arising (JA)**	
a.	Item 5 on TOR; more robust wording needed. Still outstanding. MH would action prior to the next meeting	**MH**
b.	Revised TOR for the Legislation Group –This action was also still outstanding. MU undertook to circulate revised TOR electronically prior to the next meeting.	**MU**
4.	**COVID guidance (MH/MU)**	
a.	MU had provided a paper updating the Committee on COVID Guidance and legal considerations.	
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c.	MH and MB expressed concern about patients' access to IMHAs under Covid conditions with no opportunity for face to face contacts. The Oxfordshire IMHA Service had reported that referrals had dropped. MB questioned whether referrals were going through as they should. MU believed that from the Mental Health Act Office and Ward perspectives the system was working as it should.	
d.	JA expressed concern that, so far as Managers hearings were concerned, the incidence of IMHA involvement was very low indeed. He wondered whether we were taking as many proactive steps as we should to make sure patients were encouraged to use the service. He felt we could be open to criticism from the CQC on this. MH said that IMHAs attended wards regularly and that notices were posted. He could not remember the CQC ever having commented on the IMHA service.	
e.	KR felt that, nevertheless, as a Trust wanting to be outstanding should we not want to see clinicians being more proactive on this? She asked if there was any benchmarking data available to show whether we were an outlier in under-use of the service? She also asked if the offer of support was being recorded on Care Notes.	
f	MH responded that we were not audited against any requirement regarding the use of Care Notes. He did, however, agree that we would want clinicians to be highlighting the IMHA service, although he did not think that we had evidence that they were not.	
g.	MU did not know of any benchmarking data available but, as part of his conversation with the Manager of the IMHA service, he undertook to seek clarification on whether there was any data available.	**MU**
h.	MB felt that those most in need of advocacy were likely to be those who did not raise any concerns. She urged that there was a need to think more creatively about this.	
i.	AM felt that as we try to become an outstanding trust, we really ought to make sure that the IMHA service was offered formerly to every patient who needed it and audit the fact that we were doing so. This ought to be part of a formal discussion, recorded in Care Notes and audited. He could foresee that the CQC would want to see this happening in the next few years.	
j.	SMc confirmed that in the bimonthly Insight Report there is a mention of advocacy, but the bar is set low – we score 100%. We score 100% just because it is available.	

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k.	JA felt that we really needed to do more in this area. We meet the low bar described, but it is about doing the best we can for our patients. When patients come to a hearing or, worse still, do not come, they do not have any help, may not be operating at maximum capability and in many cases do not understand the legal basis of their continued detention; they need professional help and there is no one there to give it to them without a legal advisor. The remedy was to be proactively saying to a patient – “you have your hearing coming up, have you spoken to an IMHA?”	
l.	MB outlined the options for ensuring that managers were encouraging patients to use the IMHA service. She felt that the first call should be on the charity providing the service, POhWER itself, to ascertain exactly what they were commissioned to do by the Local Authority. MB undertook to contact them to seek clarification and, in response to a suggestion from KR, to ask if they would be willing to present to this committee on the service they offer	**MB**
m.	The graph of admissions and discharges between 1 March and 31 May was discussed. MB cautioned about the need to be very mindful of mitigation when we were sending acute Mental Health patients to out of area placements and asked whether the data in the report included patients admitted to other establishments. MU confirmed that this was just Trust data.	
n.	JA’s interest was that, if we had indeed discharged into the community more patients than we might normally have done, how did they fare? MU confirmed that no discernible pattern of readmission could be identified, nor could he see anyone readmitted who had been discharged. JA responded that, if it was the case that additional discharges had been successful, there might be important lessons for the future. Was there something here that was worth studying? MU responded that there was something to learn in terms of the way that services have operated which was different to the last few years and overall bed occupancy was lower. MH confirmed that the Trust would be investigating and that he would report back at a later date. MB asked if we could include a patient experience in this to create a fuller picture. It would be useful to compare data alongside experiences.	**MH**
	AM queried the qualitative statements made in the report and asked whether these were backed by evidence or had been subject to audit. SMc answered that the audits did not delve down into quality. AM responded that he had been a member of the Covid Ethics Panel and that, as the current Chair of the Quality Committee, would probably want some of these qualitative views to be expressed more quantitatively and a bit clearer. JA asked AM to send out a short note on what he would view as helpful.	**AM**

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o.	JA asked if this was deliverable. MU felt it might be being somewhat beyond his brief but confirmed he would be happy to work with SMc on it. MH asked if we could take a small number of patients and see what results we get. This was agreed.	**MU, SMc**
p.	JA thanked MU for his very interesting and useful report.	
5.	**Report on Essential Standards Audit (SMc)**	
a.	The latest Essential Standards Audit (ESA) had been submitted to the Committee and SMc offered some thoughts, and posed some questions, as to how best to develop the report so as to make optimum use of the capabilities of the expert team who produced it.	
b.	SMc said that he had discussed the purpose of the Audit with his team. It was felt that, as currently configured and used, it did not contribute to our drive towards a rating of outstanding. There was great expertise within the team, but no capacity to address action planning. It was necessary consider further what the role of audit should be in delivery improvements.	
c.	MH said that the ESA helped to identify and make sense of changes quickly, giving an indication if there were areas of concern, if performance dropped off, for example.	
d.	AM felt there was much data that we needed to keep a track of and was very wary of not doing this on a regular basis. There was no question of ending the review. Whether frequency could be adjusted (changing to quarterly reviews, perhaps) in order to liberate capacity to increase scope and depth was worthy of discussion.	
e.	SMc did not feel that the audit should be stopped either. The discussion within his team had been about whether a frequency change from bimonthly to quarterly would help to expand coverage. Another area to explore was whether it would make sense for the audit to live within the individual directorates rather than his team. The Team could then be used to help produce more robust action plans.	
f.	MB felt the audit itself was incredibly useful. It was a main tool for providing timely information as to what was changing, improving or not improving. She would like to see more qualitative information, even if at the expense of reduced frequency. Acknowledging that this was MC's remit, she felt that it was worthy of a conversation.	
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h. i.	KR agreed there was value in the support outlined to develop and progress action plans to deliver improvement and wondered if OHI could help. MU concurred as regards the value of an action focus. JA said that changing the report would require more in-depth discussion and consideration. SMc was happy to take the issue forward with MC. JA thanked SMc for his report and for initiating a most valuable debate.	**SMc**
6. **a.**	**Report on front line activity (MH)** MH reported on a troubling issue affecting the Section 136 Suite in Phoenix Ward. The ward was currently occupied by a patient with severe learning disabilities and causing disruption within the ward and closure of beds. There was nothing for the Committee to do; the issue was being managed at a national level but it was considered helpful to understand the complexity of cases.	
7. **a.** **b.** **c.**	**CQC Update (verbal) (SMc)** SMc gave an update on the CQC with the following headlines: • They were rolling out a new regularity approach with Adult Care and Dental Services, which builds on what they have been doing during the summer months; • They will set out their new strategy in January; • They are going to undertake targeted visits for Mental Health reviews considering any local restrictions – focussed on areas of concern; • They have published a new brief guide for Inspectors on Long Term Segregation; • They have published a draft Strategy that SMc will disseminate to the Committee; JA asked for any advice/recommendations SMc confirmed that the CQC was very much building on the messages they set out in July, which is how they want to regulate services aimed at working more closely with providers and understanding pathways, patient experience and Safety and QI cultures within organisations.	
8. **a.**	**Legal and Regulatory Update (KR)** KR provided an update on her report which had previously been circulated with the agenda. She explained this was an expansion of an item in the	

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b.	Legal and Regulatory update that had gone to the previous Board meeting. Highlighting the third of the CQC's regular COVID-19 insight reports, she advised that the CQC had put the focus on collaboration between providers. Of relevance to the Committee was that the report sets out the concerns that have prompted the CQC to carry out a number of inspections in recent months and the challenges that providers have faced in caring for people detained under the Mental Health Act or subject to a deprivation of liberty. KR said that the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) had not so far been covered in meetings of this committee as they were not part of its remit, but argued in support of conversations that had previously taken place, that they should be included. KR also questioned whether there were areas where we needed to commission a deep dive for this Committee in light of the focus and learning outlined in the CQC's findings/recommendations.	
c.	JA felt that KR had set out very well the case for bringing the MCA and DoLS within the purview of this Committee otherwise there was a risk it would not be appropriately overseen. JA recommended expansion of the ToR to cover these areas. All agreed. MB agreed to provide the relevant wording to appropriately focus the committee to KR, who would update the ToR accordingly.	**MB/KR/**
d.	MB said that, as MCA Lead, she would present a paper at the next (December) meeting setting out where the Trust stood on these matters and proposing an action plan for improvement as necessary.	**MB**
9.	**Report on work of Mental Health Act Managers (MU)**	
a.	The paper provided by MU gave a comprehensive summary of the ongoing work of the MHA Managers and of the MHA/MCA legislation Group and having been circulated with the agenda and read by members previously, was received without need for further discussion.	
10.	**Report on the MHA/MCA Legislation Group (MU)**	
a.	Discussed under item 9.	
11.	**Remit of MHA Committee (JA)**	
a.	Discussed under Item 8.	
12.	**Any other business**	

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a.	SMc referred to the actions log from the last CQC Inspection. There were two issues raised by the Inspection team relevant to the work of this committee: *1.* The Trust should review Board level oversight of the Mental Health Act. JA had agreed to be Non-Executive lead and to take appropriate training. JA responded that he had been learning “on the job” and felt that he would certainly benefit from learning more. MU and MB both offered to discuss/provide any training to JA that he thought would be of benefit. KR said she would also like to be part of any training provided. 2. The Trust should review and monitor trends in the Mental Health Act, especially as regards those with protected characteristics. MH said that he had brought an extra paper to the Board and had investigated those issues. He added that the process was ongoing with monitoring measures in place. KR was concerned that this should be subject to regular review and it was agreed that this topic should be a standing agenda item.	**MU/ MB to provide to JA,KR** **NL**
b.	KR sought views about the idea of receiving service user/patient story presentations at this Committee. MB felt we needed to be careful about inviting service users into these forums; there was a risk of tokenism, and there were better ways of getting service users involved. JA agreed, and additionally drew attention to the limited time available and the volume of work to be done. He felt that meetings should in future be scheduled for 2 hours, even without external presentations.	
13. **a.**	**Meeting Close** There being no other business the meeting closed at 1410 hours.	

The next meeting is scheduled to be held on Thursday 3 December 2020 at 0900 hrs via Microsoft Teams

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