Oxford Health
NHS Foundation Trust

MINUTES of the Mental Health Act Committee meeting held on Thursday 3 December 2020 at 0900 hrs via Microsoft Teams

RR/App 20/2021
(Agenda item: 30(e))

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 (Secretary)	Executive PA
Hannah-Louise Toomey	Governor
Myrddin Roberts	Governor
Benjamin Glass	Governor
Mike Hobbs	Governor

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

Item	**Discussion**	**Action**
1.	**Welcome and Apologies for Absence**	
a.	The Chair welcomed members of the Committee present and the governors observing.	
b.	Apologies for absence were received as above.	
2.	**Minutes of previous meeting of 13 October 2020**	
a.	The Minutes of the previous meeting were approved as a true and accurate record.	
3.	**Matters arising**	
a.	**Item 3a MHAC Terms of Reference**: MH had sent a proposed revision to Item 5 of the ToR. This was approved, as recorded under Item 4 of these minutes.	

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b.	**Item 3b Legislation Group Terms of Reference**: MU confirmed the TOR for the Legislation Group had been updated as agreed.	
c.	Items **4f, 4h and 4K IMHA service:** MU had not managed to find additional information from outside of Oxfordshire and Buckinghamshire. However, MB had made initial contact with the IMHA service and a good start had been made towards better understanding of their responsibilities and towards steps to improve access	
d.	**Item 4n Admissions and discharges during COVID.** AM said he had not sent the requested note as to how information might be provided to the Quality Committee because, on reflection, he thought that the issue went wider than the MHA Committee and would benefit from discussion with MH, MU and SMc before determining any role for the Quality Committee.	
e.	**Item 12 MHA training**. MB had arranged for JA and KR to undertake MHA training. training,	
4.	**Expanded Terms of Reference**	
a.	In the revised ToR before the Committee it had been proposed to change the name of the committee to the Mental Health Legislation Committee to encompass expanded responsibilities, to include the Mental Capacity Act and DoLS. After discussion, it was decided to retain the existing name - the Mental Health Act Committee.	
b.	The revised ToR were approved subject to the following changes: • 2nd line of first paragraph, remove the word 'Legislation' and replace with "Act". • Point 5 – amend wording to: "Oversee the Trust's response to recommendations from CQC Mental Health Act visits, to ensure progress on action plans and to provide strategic thinking around recurrent themes and areas for improvement" • Point 9c – Delete "Obtaining assurance that", substitute "Ensuring that"	
c.	**All agreed the ToR subject to the amendments listed above**	**NL**
5.	**COVID Impact**	
a.	MH said that the impact on the front line was currently not as extreme as in Wave 1. Nevertheless, there were staffing problems owing to shielding	

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	needs, for instance. In terms of the execution of the MHA, no significant changes were contemplated; emergency provisions had not been activated.	
b.	MH confirmed that we had instituted virtual MH Assessments, permitted under the Covid Guidance and accepted by the CQC, where necessary. We did not use it for mere convenience, but in cases such as out of hours occurrences. MH confirmed that virtual assessments were now available, especially out of hours where we cannot do frontline assessments. Most assessments were still carried out face to face.	
c.	MU confirmed that tribunals continue to be provided virtually and without any access issues. No dramatic changes in activity through the MHA Office had been seen.	
6.	**Protection of Patient Rights/Access to IMHA Service**	
a.	MB reported that she had contacted managers of two POhWER organisations, commissioned by local councils to provide IMHA and IMCA services. She had learnt more about the number of referrals and their origins. Historically IMHAs had relied on physical drop ins to MH wards to have face to face discussions with patients and those contacts were the source of most referrals. Notably, there was variability in the quality of support offered across wards in terms of facilitating the IMHAs' work. Post-Covid, IMHAs were obliged to rely on virtual drop ins and, unsurprisingly, that had proved less successful. They had struggled on some wards when logging in to "Teams" to attend ward rounds and were not admitted.	
b.	There was concern about access to advocacy for the large number of individuals detained under the Act while living in the community. More thought needed to be given to the referral pathway for those people. MB had contacted Senior Matrons and proposed an arrangement for them to have regular meetings with advocacy leads, also including AMP and Social Care leads.	
c.	MU commented that it was a consent driven service, while agreeing that there was more that could be done to bring information to patients.	
d.	JA asked if the IMHA service included an expectation to assist patients who were attending hearings. MU advised that the scope of their duties included supporting patients to understand their rights and to prepare for tribunals, also to understand the difference between tribunals and managers' hearings. He explained IMHAs do not see themselves as an	

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	alternative to legal advocacy, but they will provide support where patients request it.	
e.	JA asked whether IMHAs attended hearings and represent the patient in the same way as a lawyer. MU advised that they were there to help the patient communicate but would not fulfil the role of the solicitor in a tribunal. Indeed, they were not trained for that role.	
f.	JA asked whether a panel should consider adjournment in the event that a patient had not had the opportunity to consult an IMHA. JA suggested that if we are trying to help patients, it was important that they were offered the opportunity. Although, as MU confirmed, whether they chose to take it or not was up to them. Nevertheless, JA felt that ensuring the opportunity was offered was a way of forcing this issue on to the agenda to ensure that we do right by patients.	
g.	A counter view was expressed that a patient might not want an adjournment. MU opined that operationally, in terms of pre meeting communication between the IMHA office and the Ward, patients could be asked if they wanted a pre-hearing consultation; it was a question of getting the wording right. The availability of the IMHA service was part of the information that is given under the statutory pack, under rights information. This was covered in our electronic patient record system, where there is a specific category concerning information given about IMHA service.	
h.	KR raised the applicability of this issue to LD patients – questioning whether there was available to them Easy Read documents about access to help and support. AM felt it would be possible to produce a fact sheet about the availability of the IMHA service and the help that could be given to understand the issues.	
i.	In conclusion, JA asked whether the committee was content with things as they are or whether it was felt some steps should be taken to ensure that patients were at least reminded that advice was available if they wished for it. MH cautioned as to the expectation of “advice”. He was not sure the service had people trained to offer advice. They were there to assist patients with communication. He thought that holding out the promise of advice about managers hearings was pushing the remit.	
j.	JR requested that AM draft an appropriate form of words about IMHA’s for the Trust, based on the Department of Health Factsheet for KR to review.	**AM**

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7.	**Essential Standards Audit [ESA] Report**	
a.	Presentation of Paper 17, Clinical Audit Report, previously circulated with the meeting agenda.	
b.	Since the previous meeting SMc had spoken with MC, and had consulted his team, regarding optimisation of the effectiveness of the ESA. The ESA was acknowledged by all to be a valuable tool. Its frequency was thought appropriate, but a lot of time was spent chasing data and deadlines were often missed in consequence. They were trying to promote timely data submission by clinical teams. MC was now chairing a new QI working group and potentially she sees a role for the clinical audit being more integral into that process. An idea from within SMc's team was to hold an annual meeting around effective action planning as they can see potential dividends with increasing the audit ratings.	
c.	MH pointed out that data submission was optional under Covid conditions.	
d.	KR felt the QI link was a good move forward.	
e.	AM said was reassured by it. He added that the breadth of the information was seen as very large, with areas well beyond the MHA Committee. He advocated wider reporting, to include the Quality Sub-Committee	
f.	SMc said that a baseline audit of Mental Capacity Act work had just been started as a pilot based on a small sample of teams. The deadline for submission of initial data was next week and the results would be available by the next meeting. **SMc would send this data to MB as soon as available.**	**SMc**
8.	**CQC Update**	
a.	SMc briefed on the following developments: • He had received very positive feedback from the remote Mental Health Act Review on Opal Ward • He had received notification of a review of Wenrick Forensic Ward, to take place w/c 11 December • CQC were adopting a transitional approach to inspections until May 2021 when they would announce their new methodology. • The CQC would only conduct inspections where concerns exist. • The CQC would carry out occasional site visits for Mental Health Act Review in accordance with COVID guidance	

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9.	**Legal Regulatory Update**	
a.	Presentation of Paper 18, Legal Regulatory Update, previously circulated with the meeting agenda.	
b.	KR recommended that certain matters covered in the report were a useful checklist and potential stimulant for improvements if applying a "true for us" test to the issues within the report.	
c.	She drew particular attention to the CQC paper "Out of Sight Who Cares?" which gave a sense of progress and addressed working with Social Care and addressing the needs of those with LD. This paper had wide application within mental health.	
d.	On the matter of preparedness for the use of electronic forms, MU confirmed that we had the necessary forms ready and were prepared.	
e.	On the important topic of restraint, which had been a significant issue nationally, MH said that this had been a major area of attention for the Trust over the last few months. We had relevant policies in place, and much work had been done on reducing prone restraint, with a target of zero. The practical issue was the need for access to the gluteal muscle for injections. He described work with the Pharmacy department regarding medications that would be suitable for use without prone restraint.	
10.	**MCA & DoLS Update**	
a.	Presentation of the Mental Capacity Act, tabled by MB.	
b.	In discussion of the presentation, the following points were raised:	
c.	The application of DoLS was queried should a hospital inpatient lacking the capacity to decide for themselves about detention be detained. MB advised that the acid test in such a case was whether the person so detained was free to leave. If yes, they were subject to DoLS.	
d.	The aim was to replace DoLS through the introduction of Liberty Protection Safeguards (LPS) by April 2022, which could be delayed as late as June because the target date was loosely defined as "Spring".	
e.	Under DoLS the supervisory bodies were local councils. The transfer of this responsibility under LPS to treating organisations (such as OHFT) would entail extra costs to the latter.	

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f.	KR sought clarity as to whether MB was sure she would have capacity in relation to structure and resource with the proposed increase in workload. MB felt we would need a specific post and for someone to be AMCP qualified.	
g.	MU agreed. He felt the new process would be a very admin heavy. The MHA office do not currently process or monitor DoLS.	
h.	JA thanked MB for a clear comprehensive and encouraging presentation.	
11.	**Trends in Mental Health Act**	
a.	Presentation of Paper 19, Headline Report, previously circulated with the meeting agenda.	
b.	• The CQC visit to Opel Ward on 16 October was positive and complimentary on staff and the care of patients. No trust issues were raised. • People were attending training but records were not being updated; he was working with L&D to rectify this. • A lot of online work had been done to prepare electronic forms and to plan for assessments under COVID conditions that did not allow face to face assessments. • There were 3 invalid detentions this year to date. They were all owing to technical issues under Section 15 of MHA, such as missing signatures on forms. • Managers had caught up on the backlog of hearings; only 11 remained. The MHA office had done a sterling job of catching up.	
c.	MB asked about patients on long term Section 17 leave. It would be useful if information could be provided. **MU undertook to do so in future reports.**	**MU**
d.	KR asked for a breakdown of detention details by patient category and length of detention. **Again, MU undertook to include this in future reports.**	**MU**
12.	**Topics for Next Meeting (ALL)**	
a.	KR felt it would be appropriate for Hannah Wright, Temporary Risk Manager to attend to discuss risk as a small number of items on the Risk Register relate to this Committee. She would not need to attend every meeting and the agenda item would not need to be long, but such an item	

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	would contribute to Board assurance that the relevant risks were being mitigated and monitored.	
b.	Information was still sought on what looked like a spike in discharges during COVID first wave and outcomes. **MH and SMc would discuss offline and bring back to the next meeting.**	**MC/SMc**
c.	JA was interested in establishing whether the standards for initial detention under the Act were compatible with standards for discharge.	
OTHER BUSINESS		
13.	**Any other business**	
a.	JA invited questions or comments from Governors: • Myrddin Roberts felt it had been an excellent meeting; he particularly commended MB's presentation. He drew attention to the availability of legal aid at tribunals • Mike Hobbs also felt it was a very valuable meeting and he had appreciated the engagement and clarity. He found the explanation of zero prone restraint especially interesting. He would also be interested in an ethnicity breakdown and felt that Governors would benefit from training concerning the MHA. • Hannah-Louise Toomey thanked the committee and expressed appreciation for the presentations and the answering of questions. She felt the Trust had flourished during COVID and it made her feel proud. Benjamin Glass raised 2 questions: i. The availability of information on use of restraint over the last 12 months, and if it had changed during COVID? MH confirmed that we do have this information, and that it was presented to a weekly meeting. There is information regarding this on the Freedom of Information Section on the intranet. MH confirmed we had seen a small increase during COVID. ii. If information was held on MHA applications for people with autism and/or LD over the last 12 months? MH confirmed we have a limited number of beds for people with Learning Disabilities. We do not provide general beds but will potentially have	

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	patients in general adult services who have LD, but this would be a secondary diagnosis. JA thanked everyone for their contributions and time.	
14. **a.** **b.** **c.**	**Meeting Review (ALL)** JA sought feedback as to whether the meeting had been useful, had looked at the right topics, had been conducted with an appropriate atmosphere and tone and whether there were areas that could be improved. KR felt it important to ensure that areas of the meeting get the right amount of time for discussion. To this end, it might be productive to rotate the sequencing of items on the agenda. MH felt it was a very good meeting looking at the right areas; one notable omission was nursing input as a good number of issues related to frontline nursing care. He would support Britta Klink attending the meeting regularly to deputise the Chief Nurse. That was agreed.	
15. **a.**	**Meeting Close** The meeting closed at 1110 hours. The next meeting is scheduled to be held on Monday 15 February 2021 at 0900 hrs via Microsoft Teams	

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