**RR/App 46/2021**

(Agenda item 23(e))

**MINUTES of the Mental Health Act Committee meeting held on Tuesday 27 April 2020 at 0900 hrs via Microsoft Teams**

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| **Present:** | |
| Sir John Allison (**JA**) (**Chairman**) | 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 |
| Britta Klinck (**BK**) | Deputy Director of Nursing |
| Hannah Wright (**HW**) | Temporary Risk Manager |
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| **In attendance:** | |
| Nicola Larkam minutes | Executive PA |
| Mike Hobbs | Governor |
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| **Apologies:** | |
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| **Item** | **Discussion** | **Action** |
| **1.**  **a.** | **Welcome and Apologies for Absence**  The Chairman welcomed Britta Klinck, deputising for Marie Crofts, and Mike Hobbs, Lead Governor. |  |
| **2.**  **a.** | **Minutes of previous meeting**  The Minutes of the previous meeting were accepted as a true and accurate record, subject to minor textual amendments recorded below. |  |
| **3.**  **a.**  **b.**  **c.**  **d.**  **e.**  **f.** | **Matters arising**  **Item 3d. Admissions and discharges during COVID.** AM confirmed he had discussed the issue of admissions and discharges during COVID with MU, MH and SMc and was satisfied this was well covered in other forums. Action closed.  **Item 3e. T**he extra word ‘training’ had been removed from this paragraph.  **Item 3e. MHA Training.** JA confirmed that he and KR had completed this training. Action closed.    **Item 6h. Signposting for Mental Health Patients.** A question of what we do in our Trust compared to other Trusts for our LD patients in terms of easy read documents, signposting etc was raised. This had yet to be addressed.  **Item 7e. The word** “he” had been added before “reassured”.  **Item 10. MCA & DoLS Update.** The question of resourcing the change from DOLS to LPS was raised. MB advised that there were further delays with LPS, and funding would be provided when the scheme was implemented. We were currently unable to move forward as there was no clarity on timescales. |  |
| **4.**  **a.**  **b.**  **c.**  **d.**  **e.** | **COVID Impact & Recovery (including ‘Devon Ruling’ summary)**  MH confirmed that the recent ‘Devon Ruling’ stated that any detentions that had been undertaken remotely, or indeed any such renewal of a detention, was invalid or likely to be invalid if it were to go to court in the future. This position had been confirmed by legal advice. Based on this, clinicians had been advised that all affected patients should be discharged.  Where clinical risk was involved this was managed. If necessary, patients under section were re-detained, but all patients under CTO were discharged and there had been no reports of adverse consequences.  AM asked whether patients found to have been detained ‘illegally’ under this ruling were persuaded to stay for the benefit of continued treatment or whether some had elected to take the discharge because they could no longer be legally detained. MH confirmed there were a handful of inpatients who were re-detained if deemed necessary. However, the majority were CTO patients and there really was no other option than to discharge them. The bottom line was there was no persuasion. The focus now would be about those patients continuing their medication and staying in touch with Mental Health Services.  JA enquired whether, based on this experience, we could be a littler braver in terms of releasing people from CTO? MH felt this was a good question; he drew attention to quite high numbers on both S17 long term leave and CTO. Possibly the framework of the CTO, despite its limited powers, led some patients simply to accept that they should carry on taking their medication and seeing their team. It did raise a question of whether quite so many patients needed to be on CTOs.  BK felt there could be an opportunity here to utilise the researchers in OHI to track this and see if there is any learning to be taken from this experience. BK offered to make enquiries with OHI and this suggestion was welcomed. | **BK** |
| **5.**  **a.**  **b.**  **c.**  **d.**  **e.**  **f.**  **g.**  **h.** | **Mental Health Benchmarking**  MH presented the Benchmarking Paper circulated with the agenda.  He averred that the paper contained no new information. It was consistent with benchmarking information received a couple of years ago. Most interesting were the areas where we are a considerable outlier. MH offered the following commentary:   * Acute beds per 100,000 – we are very much in the lower quarter of that, which is something we know * The number of admissions per 100,00 was very low, which could be seen as a good thing. Most clinicians would admit a lot earlier if we had beds, but we do not have beds. Therefore we end up admitting patients as an emergency * Mean length of stay – we are at the wrong end with one of the highest lengths of stay in the South East. Arguably this was related to late admissions, with patients very unwell. * Length of stay profiling was interesting. We are one of the highest, with 90+ days. It would be interesting to see what Solent do, with only 2% of patients staying for 90+ days. * In use of the MHA we are a significant outlier – consistent with what clinicians would say. * Bed occupancy levels – slightly lower than average – could be a COVID function as we have kept beds open. * Bank and agency spend - we are 2nd highest Trust. * On caseloads MH suggested the data was unreliable. Taken at face value, it seems that we have very low contacts and this does not reflect the pressure the teams talk about.   In discussion, the following points were made:  BK observed that “Get it Right First Time” philosophy would favour early admission leading to early discharge with social support, which was the opposite of our current approach. She added that, since this data was collected, we had done a great deal of work to change the balance in favour of earlier intervention and now our length of stay was more down to the average, for example it was now to 32 days in Oxford. We needed to continue this work to enable us to stay at this figure.  AM, observing that we and Solent seem to be at opposite ends of the spectrum in a lot of areas, wondered whether it would be worth talking to them and finding out why our approaches were so different. There could be a happy balance in the middle. He also noted that we seemed to be using the Mental Health Act a lot more than other trusts. Why was this? Was it just that we leave things to crisis due to bed limitations etc, or is there more to it than that? MH responded that the reality was that when we admit people it is likely to be under the Mental Health Act and that is just the consequence of leaving it until such time as they are more unwell.  MB supported the idea of contacting Solent. It would be interesting to look at their community data and she was wondering what was their readmission rate? We seemed to be stuck in a cycle. Speaking to Solent would be interesting.  BK felt that we needed to be a bit clearer if we were to talk to Solent as to what it is that we really wanted to know – for example, did we want an overview or specific detail of their admissions process/length of stay. To understand the inpatient dimension, we needed to understand how their community services work. Have they done something specific to get to where they are? MB would welcome being part of that wider conversation with them and would be happy to approach Solent.  It was agreed that MB would approach Solent along the lines discussed | MB |
| **6.**  **a.** | **Trends in the Mental Health Act**  MU presented his paper, drawing attention to the following points:   * Proportion detained in the 80%-mark, slight fall * Reflecting the effect of the Devon judgement, the number of CTOs had dropped over the last 3 months. * Detentions had also reduced from from circa 390 to around 340. * We had not had a virtual CQC visit for a while and all 36 actions from previous visits since December 2019 had been completed * A small recovery in the training backlog had been achieved. Induction and refresher sessions and sessions for medical staff had been reinstated. * In terms of Trust legal responsibilities we have had 5 invalid detentions across the year * We had 2 successful nearest relative discharges over the course of the year * A fall in Mental Health Act Managers hearings was COVID related * A benefit of virtual hearings has been increased attendance by patients   JA thanked MU and asked if the position on training was reflective of training deficits across the trust generally. MU confirmed this was the case, believing that Equality and Diversity was the only aspect that was green at year end.  Acknowledging that all actions from CQC visits were complete, KR wondered whether there was sufficient emphasis on recurring themes – did we do enough to identify and rectify recurring shortcomings? MU said that they were covered in weekly review meetings, and were pursued through the Legislation Group; in audit terms those items were picked up within within the essential standards audit. He acknowledged that more might be done and would be guided by the committee. KR mentioned work being led by the Chief Nurse on drawing thematic lessons from SIs and BK confirmed that this was under way, reporting to the new Quality Improvement and Clinical Standards Group, which had met twice and now replaced the old CQC oversight group IC5. SMc sits on this group. We track all CQC actions with the intention of identifying themes and have oversight on project work with these recurrent themes from a QI perspective. This was where all the thematic work gets picks up. |  |
| **7.**  **a.**  **b.**  **c.**  **d**  **e.** | **Mental Health Act White Paper**  MH gave a brief summary of our responses to the consultation. He subsequently provided the following summary embedded in these minutes    MH drew attention to the very heavy emphasis (25% of the consultation) on learning disability and autism and how the changes might affect that group. Another 25% was around forensic arrangements; the remaining 50% was on changes in tribunals. There was general support for, and strong agreement with, the proposals, with the caveat that substantial additional resources would be required to support the revised arrangements or significant harm could ensue. Tribunals are not cheap and it was not clear how the increased provision would be funded.  MU reported that the proposed demise of the MHA Managers had generated a wide-ranging debate.  MH added that, more widely, there had been consultation with a significant number of staff. His main concern was the resourcing of Mental Health Act work; this would impact inpatient wards more than any other area and it was already difficult to get get consultant psychiatrists to work on inpatient wards as that was generally perceived as less attractive. If, as presaged, inpatient work becomes increasingly bureaucratic, we just will not get the people to do it.  KR observed that this was quite worrying. Given that HW was in attendance to present on risk, it would be useful to consider what aspects of the consultation proposals might incur additional risks if the proposals became law. |  |
| **8.**  **a.**  **b.**  **c.**  **d.** | **Discharges during first wave of COVID**  SMc said that this was an interesting piece of work. It had been raised as a potential concern that COVID might have been a factor in rushed discharges, in order to create additional bed spaces. Evidence had been sought in the care notes, either in the discharge or any future readmissions.  SMc reported that, to provide focus, the month of April 2020 had been studied, yielding the following results:   * Total 93 discharges in April * A thorough search of the records for 30 (32%) of these revealed that none of them had COVID mentioned as a factor in terms of timing of discharge and certainly not that the discharge had been brought forward due to COVID. It was not possible to say whether COVID was or was not a factor or simply was not recorded as such. * Of these 30 patients, four were subsequently readmitted to a ward. Again, nothing was recorded in care notes to suggest that a COVID- influenced discharge was a precipitating factor in the patient needing to be readmitted.   BK observed that readmissions would be telling, also that the discharges did free up a lot of beds and there was no evidence of negative outcome, so this perhaps indicated something that we should be doing anyway. The evidence suggested that we might be too risk averse. MH agreed.  JA expressed thanks for the work done. He, too, agreed with BK and MH, but was not unduly surprised by the outcome of the study as he would not have expected COVID to be mentioned, even if it was a factor in any discharge decision.  Given that, he did not feel that this work could reasonably be taken any further. It had, however, been useful in focussing our attention on whether we could consider a bolder discharge policy |  |
| **9.**  **a.**  **b.**  **c.**  **d.**  **e.**  **f.**  **g.**  **h.**  **i.**  **j.** | **Trust Risks arising from Mental Health work**  HW explained that the Trust’s top-level risks were being assigned to whatever was the most appropriate monitoring committee and those that relate to our legal duties under the Mental Health Act and Mental Capacity Act would now be brought to this committee, to ensure that they were being managed appropriately within the Trust.  HW had provided a paper that set out the three risks assigned to this committee.  HW proposed that at each session the committee would focus on one of the risks, to allow in-depth consideration. Today’s focus would be on Risk 1066.  The other 2 risks related to DOLS and the new liberty protection safeguards which would be looked at in more detail at subsequent sessions.  Risk1066 captures issues around non-compliance with the Mental Health Act. Some of the key risks in this area that had been identified were:   * Section 136 and potential breaches * Failure to properly complete Mental Health Act paperwork * Failing to present patients with their rights * Inadequate scrutiny of medical recommendations and reasons for detention * Issues around COVID-19 – some of the changes in the way we have done things with and for our patients and what risks might arise   KR asked how we seek assurances. She referred to the BAF, which has an assurance column that presents a list of controls that manage the risk. To get some sense of whether those controls are effective we have got things like the Mental Health Act and CQC Inspections. How can we triangulate this to see the effectiveness of those controls? HW responded that this could partly be a question of the reporting rather than the content of the risk itself. Sitting behind this report, on Ulysses there was quite a lot more details. She and Neil Mc Laughlin had worked to try and capture the right amount of information that can be presented in a usable format. HW undertook toconsider how the report could be tweaked so that more information was captured.  JA asked about scrutiny of reasons for admission. He observed that we spend a lot of time (rightly) on the question of wrongful detention. But it was also important to ensure that we do not fail to detain people we should detain. He had sat on a number of SI panels in recent months where somebody had obviously needed to be detained, and in a couple of cases wanted to be detained, but we declined to detain them and they ended up committing suicide. The risk to human life was obvious; there was also an entailed risk to the Trust’s reputation and its competence if it did not admit for treatment where treatment was needed. JA wondered if such situations arose from the sheer pressure on resources and the demand and capacity gap, leading to a reluctance to detain, which in his view was as bad as wrongly detaining. HW said that she could pick this up outside of this meeting; this risk might end up changing committees and moving to the Quality Committee.  MH observed that the reality was not that clinicians did not consider admission; they just assume that there are not going to be any beds - that is just the way it is. You have to choose which patients get beds otherwise out of area placements take place. When looking at cases that had gone wrong it is very easy to say they should have been admitted, but the reality is we are dealing with very high risk patients in the community all the time and can’t accommodate them all due to lack of beds.  KR said that learning was a key control mechanism and we should have something included in the controls that show how we learn from incidents, HW agreed.  JA asked if the committee was content with the proposals for the presentation of risks and there was unanimous agreement.  KR proposed that we have an item at the end of the meeting where we agree any items we should escalate to the Board. JA felt this was a good idea. | **HW**  **HW**  **HW**  **JA** |
| **10.**  **a.**  **b.**  **c.** | **IMHA’s role & availability**  MB provided a verbal update. She has had conversations with the leads for our advocacy service for Oxfordshire and Buckinghamshire, POhWER. They report that historically they have got most referrals from physically going onto the wards and talking to patients, which has not been possible during COVID. MB will be single point of contact for them and now has regular meetings in her diary.  She asked POhWER how we compared to other Trusts in terms of referrals. Compared with two other trusts we were significantly lower, so there was work to do. MB will be maintaining oversight. JA thanked MB for her work.  KR observed that it was great that by digging the committee had identified something that could be done better. It was progress. | MB |
| **11.**  **a.**  **b.**  **c.** | **Essential Standards Audit**  SMc said that the Essential Standards Audit focussed on mental health and forensic inpatient wards on a bimonthly basis. The audit had been cancelled in February due to COVID; in April 3 questions were added to capture the recording of safety planning taking total number of questions to 36.  SMc shared a breakdown of the results.  A new Trust Clinical Audit Plan 21/22 had been agreed at the Audit Committee in March and contained within it was a proposal for a biennial documentation audit. This new audit will be a qualitative audit of patient care records. |  |
| **12.**  **a.**  **b.**  **c.** | **CQC Update**  SMc reported that unannounced mental health act reviews would resume in July. The proposed approach was for continued use of virtual technology combined with a physical visit. On site activities would primarily consist of a review of the care records, environmental checks, and interviews with patients. Following the site visit, staff interviews would take place via Microsoft Teams.    Continuing, he said that the CQC were going to conduct a provider collaborative review across the BOB ICS during May, focussing on the provision of mental health services for children and young people in response to COVID. This would be conducted via a series of remote interviews via Teams. Potentially, the review could be widened to cover the application of the MHA generally.  KR asked what could be done to prepare for CQC visits. SMc replied that as unannounced MHA visits were to resume it was difficult to advise on specific actions. |  |
| **13.** | **Legal & Regulatory Update (if required)**  There was nothing to update |  |
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| **14.**  **a.**  **b.**  **c.**  **d.**  **e.** | **Any other business**  It was agreed that the following items should be brought to the attention of the Main Board:   * Resource implication as a result of changes in white paper * Benchmarking results where we are an outlier   MU had circulated a paper on length of detention as requested at the previous meeting. It had entailed considerable work and he sought feedback on its utility.  Comments/observations from Mike Hobbs:   * Very interesting and informative meeting * Critically, we have all been afforded a high degree of assurance * Governors will be interested in continued monitoring of benchmarking * In relation to MHA work in particular, provision of information, and perhaps training, to Governors is crucial as this work is at the sharp end of the Trust’s performance   Particular areas where Governors will be concerned were:   * Length of detention * Ethnic category breakdown   Governors would like to have a dialogue and wondered if MU could come and join a meeting of Governors, and JA as well. | **JA**  **All** |
|  | **Meeting review**  The following feedback was offered:   * Really good meeting * Good papers * SMc considered it one of most interesting meetings he goes to – we have the room to have good discussions * MB agreed: we do have worthwhile conversations |  |
| **15.**  **a.** | **Meeting Close**  The meeting closed at 1115 hours. |  |

\*\*The next meeting is scheduled to be held on Tuesday 20 July at 1400 hrs via Microsoft Teams\*\*