**MINUTES of the Mental Health Act Committee meeting held on Tuesday 15 February at 1000 hrs via Microsoft Teams**

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| **Present:** | |
| Sir John Allison (**JA**) (**Chair**) | Non-Executive Director |
| Mary Buckman (**MB**) | Associate Director of Social Care |
| Britta Klinck (**BK**) | Deputy Director of Nursing |
| Karl Marlowe (KM) | Chief Medical Officer |
| Kerry Rogers (**KR**) | Director of Corporate Affairs & Company Secretary |
| Mark Underwood (**MU**) | Head of Information Governance |
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| **In attendance:** | |
| Nicola Gill | Executive Project Officer (*minutes*) |
| Deborah Darch | Executive Assistant |
| Philip Rutnam | Non-Executive Director |
| Jonathan Cole | Governor |
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| **Apologies:** | |
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| **Item** | **Discussion** | **Action** |
| **1.**  a  b | **Welcome and Apologies for Absence (JA)**  The Chairman welcomed members of the Committee present and extended greetings to those observing, Philip Rutnam, Non-Executive Director and Jonathan Cole - Governor.  No apologies recorded. |  |
| **2.**  a | **Minutes of previous meeting held on 12 November 2021 (JA)**  The minutes of the meeting held on 12 November 2021 were approved as a true and accurate record, subject to minor textual amendments. |  |
| **3.**  a  b  c | **Matters Arising (JA)**  **Item 7 New Risk entry on TRR**. NMcL to add the new risk ‘Trust implementation of new Mental Health Act to the Trust Risk Register. KR to check and confirm this had been actioned.  **Item 8 Essential Standards Audit**. It was agreed that Emma Lofthouse would contact Angela Ward, Community Governance Lead and request she liaise with MB re the wording of one of the questions asked on Capacity & Consent and Mental Health. MB to follow this up.  **Item 9 Annual Report and Terms of Reference**. The papers are before the committee for discussion. |  |
| **4.**  a  b  c  d  e  f  g  h  i  j  k  l | **Trends in Mental Health Act/CQC Activity (MU)**  MU presented the Trends in Mental Health Act report, highlighting the following:   * 3 invalid detentions to date. Invalid detentions occur when the Trust is unable to accept an application owing to technical faults with the application; * Lapses in detention have gone down; * Nearest relative discharges on par with last year, 5 have gone through and 2 have been barred; * CTOs remained consistent, hovering around the 100 mark; * Very high number of Tribunals, the most we had dealt with year to date; * Mental Health Legislation Group, attendance had been a problem but improving, discussion around CQC, leave and measures to ensure that, with the greater number of tribunals happening, there was compliance with tribunal instructions; and * Training, we were gradually catching up with the 6 months in 2020 when no training was undertaken due to the pandemic. New L&D system had been implemented which had some recording issues. Rate of attendance was too low. Inductions have re-started so we should see an increase in numbers and are able to offer more places virtually.   JA questioned whether the band in red was the percentage completed. MU confirmed this was the case and that it was low and nowhere near the 85% threshold we aimed for. JA commented that this had been discussed previously as to whether it was staff just not completing the training or whether we had taken a pragmatic conscious decision due to COVID. MU felt there was an element of pragmatism in this decision as training had been suspended in 2020 and whilst it was now catching up it was not doing so at the rate needed.  BK acknowledged that we had just managed services through 2 years of a pandemic, where nationally we were instructed to do only what was necessary to look after patients, ourselves, and each other. Every single part of mandatory training was lower than we would like it to be as every single part has been affected and they are all in a position of recovery. On top of this we have services which are heavily under demand, we are struggling with staffing so feels that we must consider ourselves in a period of recovery and this will take time. We must start with the very crucial elements of training like PEACE and Resus. We do need a plan and projection, but we also need to change the mindset about what is attainable right now. Moreover, the Trust had a cyber-attack on our systems thereby having to implement a new L&D system which we are not yet confident about any of the data the system is giving us. She acknowledged it was not where we would like to be, but we needed to consider ourselves in a phase of recovery.  JA concurred with BK and hoped that we do have a recovery plan that over time prioritises the important essential areas. MU confirmed that the training was now available, we had put on more sessions to enable staff to catch up. We were able to deliver many more places through video attendance and he felt confident that we would catch up in time.  KM felt this was an opportunity for us to view what exactly the training was and who required it. He had made it clear via the CEO’s webinar he hosted recently that individuals have a professional duty and responsibility to keep their professional registration up to date. He felt it was an opportunity to transform training and make it as easy and sensible as possible.  MU confirmed that Specialised Services had the highest rate of attendance and we offer specialist sessions when requested. The training is not just Mental Health Act it is Mental Health Act and Mental Capacity Act, and MU delivers this, at least one refresher session and one induction session a month. Following a CQC visit MU had undertaken some specialist sessions with the PEACE team focussed on restraint issues, eating disorders and child and adolescent mental health.  JA commented that this illustrated one of the dilemmas for Trust committees generally, that they were non-executive. If it were an executive committee, he would be asking members to agree there should be a training review and that should be clinically led and it should lead to a hierarchy of needs in terms of priority during the recovery to make sure those areas of primary importance reach the 85% threshold and others, whilst still important, could be at a lower rate. He would like to see this work undertaken and the committee to note that it supported this and recommended it. BK gave assurance that training was being reviewed in various other committees.  ***The Committee agreed that it supported and recommended a training review.***  MU continued his report, highlighting the following:   * CQC Visits – a summary breakdown of visits, actions and how many had been completed was given in the report; * Ethnicity – MU acknowledged there was a data quality issue where the rate of ‘not stated’ or ‘not known’ was quite high and did impair the meaning of the numbers. Ethnicity was an area in the Trust where the recording rate was not as good as it should be; and * Leave – previously we were commonly looking at 70 detained patients who were on long term leave, this was now down to under 20 which was a significant change in practice over time. There had been a commendable change in practice over the last 2 years to achieve this.   ***Mental Health Act Statistics report***  MU highlighted that the use of the Mental Health Act had not slowed down and continued to increase year on year. He also spoke about detention rates per 100,000 and confirmed that across Bucks, Oxford, and Berkshire it was quite low, being 72 people per 100,000 which fell below the national 100,000 figure of 92. Across the CCGs our rate was lower than the national rate. Short term orders, use of Section 136 continues to increase year on year, now 21,000 Section 135s and 136s recorded as opposed to 15,000 five years ago which was quite a significant rise. In hospital the number of Section 52s and 54s had fallen by comparison.  He highlighted the Trust comparative figures and confirmed that Oxford Health had returned 410 detained and CTO patients in 20/21, we were not in the top ten users of the Mental Health Act but sat towards the middle of the table. This was reflected in the actual number of detentions separately presented and the number of CTOs, which were quite low on the table. He commended the committee to look at the report but gave a cautionary note that the change from Mental Health Act Administrators returning it five years ago to taking it from the National Return for Mental Health Services Data Set has impaired the coverage. It was not as accurate as it used to be partly due to the private sector not consistently returning data.  BK questioned what detailed data we extracted regarding CTOs. MU confirmed that comparisons could be done but quite a lot of work would be required to do this. BK wondered whether, as our usage of CTOs slowly creeps up were we sufficiently examining that data to assure ourselves about practice? MU confirmed that it formed part of the Weekly Review Meeting (**WRM**) every week and BK acknowledged that that was more the number of CTOs rather than any detailed analysis. MU acknowledged this needed more discussion outside of committee.  ***MU/BK to discuss further.***  MB spoke about social determinants of health and that this should help us focus the mind when looking at whole population health that we do not address mental health needs purely by providing a mental health service. What are the opportunities particularly across BOB, but also in terms of partnerships with public health, local authorities, housing etc around more preventive methods? Thinking about the disparity highlighted between the NHS and Independent Sector providers was a good example of what we have experienced locally. We have an independent provider within Buckinghamshire who are a CAMHS and eating disorder inpatient service and what we find are that young people from all over the country are admitted informally and placed on a Section 5(2) very quickly so they are detained subsequent to admission and MB was picking up from the data that you are much more likely to be detained subsequent to your admission whereas with our beds you are more likely to have had a local community input and if you are admitted you are detained and then admitted. The AMP service in Bucks every so often has to raise issues with the CQC around their concerns of young people who either never had capacity, could not consent or were not being admitted informally but they were arriving in Buckinghamshire and it then becomes Buckinghamshire AMP services who have to pick this up.  JA acknowledged the following substantive issues raised:   * CTOs and where was their place in the firmament? Was this a subject that this committee should return to specifically? * Social deprivation scale and the way people are treated, was that a point that should be subject to further discussion?   ***CTOs to be put on a future agenda.*** | **MU/BK**  **NG** |
| **5.**  a  b  c  d  e  f  g  h | **Highlight Report Positive & Safe (BK)**  BK provided an update on the work that was overseen by the Positive & Safe Committee. They oversee the Quality Improvement (**QI**) project around the reduction in restrictive practice which is focused on reduction in seclusions. We have 6 teams across the Trust who are part of a national collaborative on this project and 11 teams in all who are at varying places in terms of their project. They have all been trained in QI. There are a variety of projects that teams have locally decided to work on which have been determined by local data and incidents that have occurred.  For the last quarter our numbers looked skewed as we have a forensic patient, for whom there have been a high number of incidents. This patient is in long term segregation and has a care plan that includes the use of prone. If you were to take that unique patient out of the data, it looks steady. It has been high and rising over the last 5 years and the main causes for that have been aggression and violence, self-harm or health related in the case of patients who need restraining while being given intravenous feeding in eating disorder units.  We are overseeing the recovery of PEACE training; this was affected by COVID because of the numbers having to be taught face to face. We are currently training all new starters and nationally the follow up course had been extended to accommodate the recovery from COVID. We are also overseeing the Use of Force Act through the Positive & Safe Committee, also relevant to this committee.  We are continuing our implementation of alternative injection sites; it is expected that this will reduce our use of prone restraint by at least 50%. It involves every ward now having safety pods, facilitating injection in the arm or thigh rather than the buttock, thus avoiding the prone position. We have trained our trainers and further training is being rolled out.  There are insufficient places of safety in the Trust. Last week there were several days where we had none and we have also had a lot of people coming from other areas into our place of safety. For example, we currently have a 16-year-old girl in the place of safety on Vaughan Thomas Ward; she requires a CAMHS PICU bed and there are none nationally and a waiting list for the few that do come up.  Much work has been undertaken to improve ward level performance on presentation of rights. We look at this weekly and it is something that the CQC are concerned about. We do have issues with adequate staff recording their efforts to read rights and are monitoring this. Historically in Oxford we have had quite high use of S17 leave, this week we were down to 15 patients on long term leave which is the lowest for some time.  KM spoke about the Use of Force Act and the fact it had been delayed. It states that the recording of utilisation of force should be clearly documented. The suggestion is that staff should be wearing body worn cameras in the same way that the police would when restraining someone. Potentially, NHS organisations might be considering using body worn cameras as well. There was a position in some NHS organisations that we should not be recording people who are detained. As a committee we have a responsibility to make sure we have a clear statement as an organisation on why we would record this action.  JA asked whether there was any follow up action that this committee could usefully do? BK confirmed she was updating the committee on the work being undertaken, most of the actions were taking place by the Positive & Safe Committee. There would be a case going to Exec and Board for a pilot for Forensics to wear body worn cameras. She did not feel there was anything at present she required the committee to do. |  |
| **6.**  a  b  c  d | **Local Authority/AMPs Reports Update (MB)**  MB confirmed she had spoken with the Approved Mental Health Professional Managers (registered social workers, nurses, OTs who have undertaken special training and are approved under the Mental Health Act) in Buckinghamshire and Oxfordshire regarding the AMP service. They undertake assessments under the Mental Health Act on behalf of the respective Local Authorities. In terms of arrangements in Oxfordshire and Buckinghamshire, in Buckinghamshire the AMP service sits within our Partnership Arrangement with Bucks Council so it is provided under our S75. It is managed within the Buckinghamshire directorate. In Oxfordshire it sits back within the Council, not managed within our services although clearly delivered in very close partnership and many of the AMPs have substantive contracts with us and we release them to go on that rota. In terms of the picture that the AMPs services have found, unsurprisingly, it very similar across the two counties. She spoke about S136 and explained that it was a power that police have if they think someone needs immediate care or control and needs to be taken to a place of safety where they can have an assessment of their mental health needs. Over the last year we have seen a significant increase. In 2021 in Bucks there were 374 uses of S136, the previous year there were 306, but what is really striking is the increase in the use of the power for Under 18s. In Bucks the use nearly doubled so it was used 18 times in 2020 and 34 in 2021. These will be young people who were seen by Police to be outside of their homes and in need of immediate care or control, often involving suicidality and immediate risk to themselves and are brought to a place of safety. Although the numbers are still low that is a doubling, and something we need to be mindful of in terms of what young people are presenting with in terms of their mental health needs, their crises, particularly around self-harm, and suicidality.  There are some issues around the use of Elysium beds and reference has already been made to the fact that we have been placing people outside of our own inpatient beds, largely with Elysium who are the provider we have the main contract with. This takes time because part of the process of detaining someone is that it is first necessary to have a bed. Assessments can be protracted, could be handed over from one person to the next, could go from one day to another, for example. It is a huge piece of work and has an impact on capacity. If we detain someone under S2 for assessment, they go out of area, if they then stay in that bed and need to be detained for treatment under the Mental Health Act, they need a S3 to be considered. The AMP service who did the S2 who are responsible under the Mental Health Act for the S3, so would then have to travel to out of area to do the assessment.  Another issue that both Counties are struggling with is how we can effectively and quickly support people who are presenting with emotionally unstable personality disorder. We often end up in a vicious circle with these patients who sometimes are very well known. They present on a regular basis in crises expressing significant thoughts of harming themselves, or having harmed themselves, in particular ways. There is often a consensus that an inpatient admission to our acute wards is not helpful for them but the challenge for our AMP service is what else is on offer. We need to think about how we are supporting people with emotional dysregulation, with high risks of self-harm and suicide for whom we are not meeting their needs in the community. What are the other options?  MB spoke about the availability of S12 doctors in Oxfordshire, which had been brought to her attention recently. This has apparently become a particular issue and they are struggling to get S12 doctors to attend Mental Health Act assessments, because of concerns about indemnity. KM would expect doctors to have indemnity so would investigate this further to see if this really was the issue and will be monitored.  ***KM to investigate doctor’s indemnity further*** | **KM** |
| **7.**  a  b | **Annual Report inc Draft Terms of Reference for review (KM)**  JA referred to the Annual Report, confirming that it had been discussed at length at the November meeting and changes proposed had now been implemented.  ***It was agreed that the Mental Health Act Statistics and MU’s data paper would be added to the Annual Report as Appendices, KR to add appropriate wording to the cover report to introduce the appendices.***  JA drew attention to the draft revised Terms of Reference which were discussed previously. JA thanked KM for his work leading on these. KM confirmed these were not set in stone and could be reviewed and amended. He acknowledged the major change in the Terms of Reference was to have a slightly wider view of legislation which was related to the way that we work as an organisation, in particular with mental health legislation. At times, it would be appropriate to invite experts to join the meetings where appropriate. KR expanded on KM’s point about using experts by experience. She drew attention to Jonathan Cole, who was in attendance at this meeting, and is a representative of our Council of Governors and has access to a number who are service user governors, some of whom have lived experience of this so working with Jonathan and others on how the governors might support us get that experience into this meeting might be useful.  ***All agreed that the Terms of Reference along with the Annual Report to be put before the Board for approval.*** | **KR/NG** |
| **8.**  a | **Legal & Regulatory Update (KR)**  Nothing new to report on at this stage. |  |
| **OTHER BUSINESS** | | |
| **09.**  a  b  c  d  e  f | **Any other business**  None.  JA invited Jonathan Cole to ask any questions or provide input. Jonathan Cole commented that it had been a very interesting meeting, very interesting to listen to the issues being discussed. He spoke about the issues around the use of S136 and some of the ways that patients with diagnosis that are often contested by them of Emotionally Unstable Personality Disorder (EUPD) are treated by services and the observation he made was that prevention is usually better than cure. He felt the real issue around this was that people were coming to services when they had already reached crisis point and made the point that treating someone before they reach crisis point would use up less resources.  He commented upon the increase from 18 to 34 people reporting suicidal feelings aged under 18 and felt this was not capturing the entire problem; this is a very common problem. MB confirmed that this figure related only to young people detained under S136, the vast majority of young people experiencing that level of distress and trauma would not end up being detained. JA thanked Jonathan Cole for his comments and acknowledged he himself came to this topic as a complete amateur as his professional area was completely different. He had reached a very similar conclusion to his on this topic. It was quite hard to get treated early enough and if we did it would be better for those involved and more efficient. He felt he had made a very valuable point and hoped the Committee would pursue it.  BK noted our thanks to MB as this was her last meeting. JA acknowledged that MB had been a great member of the committee who had made a terrific contribution and congratulated her on her advancement in her career. MB thanked him and commented she had enjoyed the discussions.  KR thanked JA on behalf of the Board and particularly on behalf of the membership of the committee. She thanked him for his passion, interest, and dedication in making this a useful and purposeful meeting and improving things for service users and patients. It had been magnificent to see this committee, first set up under his watch and where we have got to in time and how relentlessly he had looked to improve the committee and Non-Executive Director involvement in it and in the application of the Mental Health Act.  JA thanked everyone and acknowledged it had been a great privilege. |  |
| **10.**  a | **Meeting Review (ALL)**  JA thanked the committee for a useful and worthwhile meeting. |  |
| **11.**  a | **Meeting Close**  There being no other business the meeting closed at 11:30 hours. |  |

\*\*The next meeting is scheduled to be held on Thursday 28 April at 0900 hrs via Microsoft Teams\*\*