**RR/App 14/2023**

(Agenda item: 27(e))

**MINUTES of the Mental Health & Law Committee meeting held on Wednesday 12 October at 0900 hrs via Microsoft Teams**

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| **Present:** | |
| David Walker (**DW**) (**Chair**) | Trust Chairman |
| Geraldine Cumberbatch | Non-Executive Director |
| Britta Klinck | 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*) |
| Peter Allanson (observer) | Good Governance Institute |
| Mike Hobbs (observer) | Lead Governor |
| Andrea Young (observer) | Non-Executive Director |
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| **Apologies:** | |
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| **Item** | **Discussion** | **Action** |
| **1.**  a  b | **Welcome and Apologies for Absence (DW)**  The Chair welcomed members of the Committee present and extended greetings to those observing.  No apologies were received. |  |
| **2.**  a | **Minutes of previous meeting held on 27 July 2022 (DW)**  The minutes of the meeting held on 27 July 2022 were approved as a true and accurate record. |  |
| **3.**  a  b | **Matters Arising (DW)**  DW confirmed that he had spoken to Grant Macdonald and Ben Riley about attendance at these meetings moving forwards.  KM confirmed a meeting had happened on 6 October 2022 which KM attended and would review further these meetings to redesign their functionality. |  |
| **4.**  a  b  c  d  e  f  g  h  i  j | **The Edenfield BBC Panorama Programme (All)**  DW spoke about the recent exposes and explained this was the committee’s opportunity to discuss what actions it may need to take to ensure this did not happen at Oxford Health.  KM confirmed there would be a comprehensive report presented at the Quality Committee in November and this would then be fed into the Board. He commented that because of this, all Heads of Nursing would be completing a series of questions/provocations relating to their services.  BK commented that the restrictive practice data did not tell us much, there had been an increase on certain wards, and she questioned whether this was where the assurance should come from. She confirmed that the data was closely reviewed at both the Weekly Review Meeting (**WRM**) and Positive & Safe Committee. She spoke about her reflections and the fact we needed to be aware that this could, in some form or another, be happening on our wards and indeed probably was happening at some level on our wards. She acknowledged that a standardised assurance framework was being worked on. She felt this was an opportunity to look at the structures we had for encouraging and supporting people to call out behaviour that was dehumanising and to understand the impact of this type of behaviour. These were the things that would provide assurance and she also felt we should take the time to think about what structures would allow a more positive culture to develop within the Trust.  KR asked BK how sophisticated she felt we were at gathering information and feedback from service users? BK felt we could be more proactive and the people who would alert us to anything like this happening would be our services users, their families, and our staff. She questioned whether there was the need to develop another method of proactively reaching out to patients and their families to provide their concerns in a safe environment.  MU commented that despite all the good things we do, patients were in a weak position, and it was difficult for them to speak out which we overlook sometimes. On a tangential note, there had been a few more Freedom of Information requests around restraint, sexualised behaviour, sexual assault of both staff and patients. He confirmed the data was looked at extensively in several forums. He also spoke about the fact that over the last 2 ½ years we had worked in a different way to ever before; we did not have a large acute hospital with everything on one site we had wards in different locations, and he felt it could be quite tempting for those units to become quite isolated and develop their own cultures which differed from the organisation’s. He spoke about the Capacity Act and Mental Health Act training and confirmed he always highlighted the reason why there was a third guiding principal in the middle of the 5, which was about respect and dignity as if we do not get this right then everything else was difficult to achieve. This needed exploring and in the new model of induction they were considering covering culture within the first day which would help guard against institutionalised behaviours developing in siloed areas.  KM commented that we did not have to rely on the CQC only, as an external regulator and that we should also rely on our own checks and balances. He confirmed that CQC did look at detained patients and their rights and restrictive practices. He also highlighted that in the last 2 years PALS and our Complaints procedures had been remotely monitored and there was now the need to reintroduce face to face advocacy and complaints procedures. He spoke about the culture of Induction and confirmed he was involved in inductions for junior doctors during which they were encouraged to raise concerns from the beginning.  Mike Hobbs, Lead Governor reiterated that psychodynamics was an important area and should be explored. He spoke about the potential role governors had in feeding information through which he felt was not being utilised currently. He suggested that how governors channel the information they pick up and to whom should be discussed as we were missing the opportunity to listen to people who were elected to represent patients and their carers.  GC asked about the CCTV considerations from a compliance perspective and whether we had already started to look at DPIAs? BK confirmed there was a planned pilot in one of our forensic wards on body worn cameras although we were not yet near to implementation of this. She confirmed that there was a lot of evidence that this does have a positive impact on the interactions of staff and patients.  DW thanked all for their contributions and confirmed there were several strands of activity pre-existing this and emphasised by this. He confirmed he had spoken to the CEO regarding the Boards responsibility as well as the fact that doctors appeared to be absent in the Manchester case and questioned whether there was an unwanted benefit in having lots of agency staff as their ‘buy in’ to a potential toxic local culture would be less and their capacity to be a whistle-blower might be greater.  DW picked up on the point made by BK about being boundary less and the need to be mindful of the burdens and responsibilities on our staff and cameras may be a useful innovation, but it also puts an extra layer of responsibility on staff who are in short supply. Making an already difficult job more difficult could affect recruitment of staff. |  |
| **5.**  a  b  c  d | **Trends in Mental Health Act/CQC Activity (MU)**  MU presented the Trends in Mental Health Act report, highlighting the following:   * an increase in the number of Lapses had been seen over the last quarter; * no changes from last year in Nearest Relative Discharges; * detentions had plateaued to the 305-320 level; * CTOs had settled to 105-110; and * gaps in the Mental Health Act office had been filled and they were seeing improved performance as a result.   He highlighted operational issues and the work undertaken to re-energise the Legislation Group. He commented that it would be interesting to note the impact of the reintroduction of face-to-face Mental Health Tribunal hearings. He confirmed that there was currently a review of training. Attendance was at an all-time low and was consistent across all directorates. They were looking to develop e-learning packages which would help with attendance. He spoke about Leave and confirmed that there had been a significant fall in the number of patients on leave over the last 2 years and felt this was down to a significant change in practice.  He confirmed there had not been any CQC visits since May and none had taken place over the systems outage. Almost all actions set by the previous 5 visits had been completed with just a couple needing attention.  GC asked whether the training was undertaken on a portal. MU confirmed that training was currently delivered through set sessions but blended learning including animated access with some video components was being considered.  The Chair proposed discussions with the Executives to ascertain Executive accountability for training. The Chair agreed to speak to the CEO and KM/KR to raise with the Executive Team. | **DW/KM/**  **KR** |
| **6.**  a | **Update on Mental Health Act Managers (MU)**  Covered in agenda item 5. |  |
| **7.**  a | **CQC Activity/Compliance (MU)**  Covered in agenda item 5. |  |
| **8.**  a  b  c  d  e  f | **Highlight Report Positive & Safe (BK)**  BK confirmed that Positive & Safe reported to the Quality Sub Committee and that all projects were progressing well, and they had been invited to present to the Region, the ICB and the National Forum the work undertaken on seclusion by Kestrel Ward.  She spoke about Oxevision, the system being installed on 7 wards. This initially had been paused due to concerns regarding the training provided and governance framework but following considerable work this was due to be restarted. Training had been undertaken by staff and several meetings had taken place along with a Governance Framework provided from Oxehealth. A Benefits Group had been initiated to collate feedback from patients regularly on their experience of this system.  She confirmed that during August and September they had seen the lowest numbers in terms of restraint despite a patient in Kestrel on permanent seclusion which was affecting the data. This patient should be going to a high secure facility, but the only high secure facility Rampton had so far refused to take her. This case was going to a judicial review.  KR asked what our thoughts were about violence and aggression to our staff, in the context of Positive & Safe and the impact this had on them but also the wider impact on recruitment and retention. She asked how good we were at understanding that aspect. KM confirmed that the culture of Oxford Health was that patients assaulting staff were not prosecuted, he went on to state that good practice was that they were always prosecuted irrespective of the diagnosis, irrespective of the capacity of the individual and this was as much to protect the patient as much as the staff. He felt more work was needed on the reporting of such incidents.  The Chair sought assurance regarding the reporting of patients who assault staff. BK confirmed that the Trust had a zero-tolerance policy but concurred that it was a cultural issue and that historically there had been issues with Police not progressing our complaints but felt we were not doing enough to challenge that culture and talk it through with staff and felt it needed to be dealt with more proactively. She confirmed she would raise it with the Chief Nurse and take it to the People Leadership and Culture Committee.  GC suggested that in terms of culture it be interwoven into the training. She queried whether staff were also pointed to criminal injuries compensation if they were badly assaulted. | **BK** |
| **9.**  a  b  c  d | **Mental Health Units (Use of Force) Act 2018 (KM)**  KM spoke about the Mental Health Units (Use of Force) Act 2018 and confirmed that it came into force on 31 March. He explained that The Act, also known as Seni’s Law, was named after Olaseni Lewis, who died because of being forcibly restrained whilst being a voluntary patient in a mental health unit. This Act contained several areas of responsibility for Mental Health Units and was part of the work of Positive & Safe.  BK confirmed that this sat under Positive & Safe, and their incident reporting and a Gap Analysis had been undertaken against the recommendations around the Use of Force Act and it was also a standard agenda item on Positive & Safe agenda.  KM commented that there needed to be an understanding that the Heads of Nursing in each of our Units be the responsible person for the Use of Force in each unit. BK felt the Act spanned both the Positive & Safe and the Mental Health & Law Committee.  It was agreed that this be reported annually to the Committee. |  |
| **10.**  a | **Annual Report 2021-2022 (KM)**  KM confirmed this report had now been completed. |  |
| **11.**  a | **Legal & Regulatory Update (KR)**  KR confirmed there was nothing new to add to the report and highlighted the need to keep a watching brief on rising rates of detention under the Mental Health Act and the need to remain curious about disproportionate numbers of people from black, Asian and minority ethnic groups in the detained population and continue to be concerned as to whether we had modern healthcare systems safeguarding our service users and staff. She spoke about investment in community social care & health services and in the mental health workforce being fundamental to the delivery of this along with focus on human rights. |  |
| **OTHER BUSINESS** | | |
| **12.**  a | **Any other business**  None. |  |
| **13.**  a | **Meeting Review (ALL)**  The Chair felt that the meeting had produced a good discussion but acknowledged some untidiness regarding the remit of the Committee. He felt that although there was a principled reporting line to both the Quality Committee and People Leadership and Culture Committee that having various groups looking at how we treated our detained patients and those on CTOs was vitally important. He felt the committee provided a vital function. |  |
| **14.**  a | **Meeting Close**  There being no other business the meeting closed at 10:27 hours. |  |

\*\*The next meeting is scheduled to be held on Wednesday, 08 March 2023 at 1300 hrs via Microsoft Teams\*\*