**RR/App 25(i)/2023**

(Agenda item: 28(e))

**MINUTES of the Mental Health & Law Committee meeting held on Wednesday 08 March 2023 at 1300 hrs via Microsoft Teams**

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| **Present:** | |
| David Walker (**DW**) (**Chair**) | Trust Chairman |
| Geraldine Cumberbatch (**GC**) | Non-Executive Director |
| 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*) |
| Andrew Molodynski | Consultant, Adult Mental Health Assessment & Treatment Team South |
| Kirsten Prance | Associate Clinical Director, Learning Disabilities |
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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 12 October 2022 (DW)**  The minutes of the meeting held on 12 October 2022 were approved as a true and accurate record. |  |
| **3.**  a  b | **Matters Arising (DW)**  DW confirmed that the issue with mandatory training had been discussed at Board but that was more work to be done.  BK confirmed there was a zero-tolerance policy on assaults on staff and these were being monitored weekly via the Weekly Review Meetings (**WRM**). |  |
| **4.**  a  b  c  d  e  f | **Trends in Mental Health Act (MU)**  MU presented the Trends in Mental Health Act report, highlighting the following:   * the Legislation Group had not met since October 2022, following a survey on availability a programme of meetings for 2023 was being processed; * attendance level at training remained poor; and * there had been a fall in S17 leave;   He referenced CQC visits and highlighted that 3 actions were overdue from last year but that 50 of the 55 actions had been completed. There had been 2 visits so far this year, Marlborough House, and Kennet Ward, with 17 actions arising from these visits. He spoke about significant issues the trust had with delays in the provision of 2nd opinion appointed doctors with some patients waiting months for a T3 to be put in place by a 2nd opinion appointed doctor and a reliance on the S62 where the proper process has not been followed. He confirmed that a meeting with CQC had taken place and we were awaiting their response. Generally, the visits had been positive, and we had received good feedback on the care provided by our staff.  Discussions ensued around ethnicity and the recording of this and whether this could be improved within the new system. MU confirmed this was a nationwide issue.  He highlighted mental health tribunals and confirmed that in October last year face to face hearings had been made available and approximately 50% of our tribunals were now face to face.  GC asked the following questions:   * Did the outage cause a problem because it took away reminders of when a patient’s detention was due to end? MU confirmed this was the case. * Did the trust have a backstop in place in case we suffered another outage? MU confirmed we were not reliant on care notes wholly for mental health act data and highlighted that the processes operated in the mental health act office were driven by simple databases and spreadsheets and had a business continuity plan of business as usual. * Uptake of training still appeared relatively low and with the proposal to bring in a webinar she queried whether there was a pass mark for the training and was this being recorded centrally. MU replied stating there was no assessment phase within the training currently offered but this was something that could be thought about. * 2nd opinion doctors – she asked whether there was anything else within the trust’s control that could be done. MU spoke about the difficulties and highlighted that there was a chronic shortage of 2nd opinion doctors overall.   DW spoke about the low level of training and highlighted the need for himself, KR, KM and GC to take this to board level to think about. BK confirmed that the People, Leadership and Culture Committee were looking at this in detail. | DW/KR KM/GC |
| **5.**  a  b  c  d  e  f  g | **Use of Community Treatment Orders (CTOs) in GA Psychiatry & Forensic Psychiatry (AM)**  AM commented that from his experience and considering the research evidence and the interim report of the select committee scrutinising the proposed new Mental Health Bill he felt that CTOs should not be continued although this was not a view shared by the profession as a whole.  He provided further background explaining that CTOs were introduced in the 2007 amendment to the 1983 Mental Health Act. For the first time they were explicit powers that allowed for the compulsion of individuals with mental health problems to be given treatment outside the hospital environment. However prior to that there were many cases and well established practice of individuals with severe mental health illness having long term treatment outside hospital under the Mental Health Act using things such as S17 leave and S3 of the Mental Health Act for which Oxford was an outlier in terms of the use of the long term S17 leave which is where people are technically still an inpatient but are allowed to leave the ward on licence as long as they cooperate with certain conditions. CTOs were brought in essentially to formalise this practice.  The Mental Health Alliance campaigned against their introduction on civil rights grounds alongside the introduction of the dangerous and severe personality disorder units which were introduced at the same time. The feeling was there would be several hundred people in England & Wales would be made subject to them in the first 12 months and actually 4,500 people were. They were used far more than anticipated. At the time, in Oxford, we were fortunate that we were able to undertake a randomised control trial of CTOs involving 330 people who were randomly assigned to either a CTO or short term S17 leave. The outcomes after 12 months and 3 years were the same. Since then, there has not been any high-level evidence to support them improving outcome in terms of readmission to hospital, suicide, offending behaviour, social functioning etc except there was evidence their use slightly but statistically reduces the risk of individuals being the victim of violence.  The evidence was clear that they were not an effective intervention and if this was the evidence relating to a drug then it would not be prescribed. Having said that, practice varied enormously, and they were still commonly used both in the trust and more widely.  BK felt there was a correlation between the teams where we had a higher number of CTOs but much lower use of long-term conditional leave while on section from wards. She felt that our use of longer-term conditional leave could be equally oppressive and wondered whether there was something that could be done to safeguard us against this. AM commented that he felt regret that were so many people on S3 within the trust, he felt that whilst there would always be some, the trust was an outlier, and this was concerning.  DW asked whether the trust should have a policy that states they did not feel these orders were fair, just etc and proceed as a trust collectively on that basis or were the diversity of views amongst his colleagues such that this would not work. AM responded stating that trust did not need to do anything as his understanding was that the legislation should move forwards quickly and if it was accepted that CTOs were dropped then the trust would not need a position. In the interim it would not work due to differing opinions. He did comment that he felt it would be positive if the trust could move towards a position where it became an organisation where clinicians were supported and strongly encouraged in a positive sense to use as little coercion as possible and for people on long term coercive measures in the community to be reviewed and support to be given to teams to think about things differently.  DW thanked AM for his update. |  |
| **6.**  a  b  c  d  e | **Implications for those with LD/ASD not subject to the future Act (KP)**  KP provided an update and commented that she felt the learning disability changes to the Mental Health Act were long overdue. The direction of travel around the Mental Health Act changes was to be welcomed particularly when taken in line with the wider national initiatives and the de-medicalising of learning disability and autism and seeing them as part of our continuum. She felt the changes to the Act were not without risk as we did not necessarily have the infrastructure in place to put the right safeguards around some of our most vulnerable members of society both with autism and learning disabilities.  She commented that the ICB had not got the matrixes in place for monitoring what was happening, CTRs and the methods for prevention of admission or once admitted the correct guidance was followed and had not got enough support around ensuring those results were managed, monitored and met so would agree with everything in the draft committee around ensuring our services are supported in order to provide it but felt it should be used as an opportunity to work with the ICB to strengthen those commissioning arrangements, the policies and protocols which go alongside and we need to be working in a way that thinks about when we re-commission services do this with a prevention eye rather than a treatment eye to ensure we meet the articles of the Act.  She spoke about the Deprivation of Liberty Safeguard and the need for this also to be reviewed but stated that there was quite a lot of safeguards within it as it was a court proceeding overseen by a judge.  She highlighted that Oxfordshire was outperforming other areas in relation to the amount of people with a learning disability and autism that were requiring hospital assessment. We could show that the pro-active community provision implemented in Oxfordshire was helping. One area needing consideration with these changes was the need to enhance our psychiatric offer within L&D as we needed a better psychiatric overview to work with the MDT clinicians around STAMP and STOMP as it was likely we already managed a high level of acuity within the community. When undertaking contract renegotiations, we need to ask for more medic support within the contract to give us the capacity to be much more engaged in the preventative work where we have the psychiatrist working with the MDT to lead dynamic and innovative care packages.  DW thanked KP for her update. |  |
| **7.**  a | **Update on Positive & Safe (BK)**  BK confirmed that Positive & Safe was overseen by the Quality Committee and highlighted the following:   * Overall, a steady decrease across the board had been seen in restrictive practice; * Use of Force Act, a gap analysis had been undertaken and as a result the PEACE training had been amended; * Body Worn Cameras project, this had been reviewed and as a result we were likely to proceed down the route of CCTV instead; and * Ethical data had been looked at in detail. |  |
| **8.**  a | **Practitioners Approved as S12 Doctors and Approved Clinicians under the Mental Health Act 1983 (KM)**  KM confirmed that an audit on S12 doctors had been undertaken and continued to monitor all doctors on the register. |  |
| **9.**  a | **Legal & Regulatory Update (KR)**  KR provided a brief update and summarised with the need to keep a watchful eye on closed cultures developing. She also commented that the committee might benefit from a greater length of time to look at the data provided by MU on CQC allowing for a better understanding of themes and what improvement activity was being taken. |  |
| **OTHER BUSINESS** | | |
| **10.**  a | **Any other business**  BK advised that interviews were taking place the following day for a Head of Safeguarding and that they would also be recruiting for an MCA lead as well as an Associate Director of Social Care. |  |
| **11.**  a | **Meeting Review (ALL)**  DW thanked all for their attendance at the meeting. |  |
| **10.**  a | **Meeting Close**  There being no other business the meeting closed at 14:30 hours. |  |

\*\*The next meeting is scheduled to be held on Tuesday, 16 May 2023 at 0900 hrs via Microsoft Teams\*\*