

Mental Health and Capacity Compliance Committee (MHCCC)

Minutes of the Mental Health and Capacity Compliance Committee meeting held on

10 February 2023

Via Teams

Present:

Lucy Reid	Health Board Vice Chair (Chair)
Cheryl Carlisle	Independent Member
John Gallanders	Independent Member

In Attendance:

Louise Bell	Assistant Director Mental Health
Michelle Denwood	Director of Safeguarding and Public Protection
Matt Joyce	The Deputy Director of Quality
Wendy Lapin	The Mental Health Act Manager
Paul Lumsdon	Interim Director of Nursing
Chris Lynes	Deputy Executive Director of Nursing
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (Minutes)
Pravitha Rajendraprasadh	Head of Risk Management
Peter Roots	Clinical Director/CAMHS Consultant Psychiatrist
Alberto Saimoiraghi	Consultant Psychiatrist/Medical Director
Iain Wilkie	Interim Director of Mental Health
Huw Williams	Interim Head of Risk Management

Agenda item	Action
<p>MH23.01 Welcome, introductions and apologies for absence</p> <p>MH23.01.1 The Chair welcomed everyone to the meeting thanking attendees and report authors for the improved quality of papers. Interim Director of Mental Health specifically thanked the Mental Health Act Manager.</p> <p>MH23.01.2 Apologies were received from Chris Stockport, Executive Director of Transformation and Planning, Angela Wood, Executive Director of Nursing and Midwifery, Phil Meakin, Associate Director of Governance, Helena Thomas, Louise Cunliffe and Ruth Joyce.</p>	
<p>MH23.02 Declarations of interest on current agenda</p> <p>MH23.02.1 No declarations of interest were received.</p>	
<p>MH23.03 Minutes of last meeting – 4 November 2022</p>	

<p>MH23.03.1 The minutes were approved as an accurate record of the meeting held on</p>	
<p>MH23.04 Action log</p> <p>MH23.04.1 The action log was reviewed and updated accordingly.</p>	
<p>MH23.05 Patient Story</p> <p>MH23.05.1 The item was withdrawn a discussion took place around patient stories and the possibility of extending the terms of reference.</p>	
<p>MH23.06 Terms of Reference</p> <p>MH23.06.1 The item was withdrawn</p>	
<p>MH23.07 Approval of All Wales Approved Clinicians and Section12 (2) Doctors</p> <p>MH23.07.1 The Committee noted for assurance purposes that appropriate governance arrangements, processes and activities were in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.</p>	
<p>MH23.08 Update on reforming the Mental Health Act</p> <p>MH23.08.1 The Committee were advised that the joint committee had published a report in relation to the draft legislation and that government would be responding within two months. It was noted that there were contentious issues identified which would have financial implications. The Committee noted that a link would be shared.</p>	WL
<p>MH23.09 Deprivation of Liberty Safeguards Quarterly Report</p> <p>MH23.09.1 The Director of Safeguarding and Public Protection presented the quarterly report noting that the delay in the Mental Health Code of Practice was having an impact but that the Welsh Government interim money was being utilised. It was noted that there was a need to educate with regards to workforce capacity to ensure proportion and flexibility and shared the need to understand how the implementation of the legislation through consultation from a regional to national platform is clear.</p> <p>MH23.09.2 The Director of Safeguarding and Public Protection clarified the detail around how the Welsh Government Money had been utilised accurately by addressing the backlog and that this had improved 144 patient cases. The Committee noted that the additional resource was required substantively.</p> <p>MH23.09.3 The Committee were updated on the Safeguarding Business Case linking DOL and Mental Capacity noting that it was supported but not finalised. Risk reduction was discussed noting that a lot of work had been undertaken but</p>	

<p>that it still sat as a corporate risk but the trajectory of the risk was to be reduced by August 2023 but there were challenges to overcome to achieve this.</p> <p>MH23.09.4 The Director of Safeguarding and Public Protection Improvement updated on audit activity, consent, training on case law and evidence of learning.</p> <p>MH23.09.5 The Chair thanked the Director of Safeguarding and Public Protection and an Independent Member queried what would happen if the business case funding was unsuccessful, it was noted that the biggest challenge was that reoccurring funding was necessary in order to take the safeguarding agenda forward.</p> <p>MH23.09.6 A discussion took place around the Risk Management Group and the Executive Director Public Health advised that she would update Independent Members on the status of the meeting once she had gained clarity.</p> <p>MH23.09.7 A further discussion took place around the incoming legislation and how it would impact on care homes.</p>	TO
<p>MH23.10 Associate Hospital Managers' Update Report</p> <p>MH23.10.1 The Mental Health Act Manager presented the report noting that it is prepared from the Power of Discharge Group and is fully discussed in detail at the group. The Committee noted that 19 hearing had taken place, one patient had been discharged, and two appeals hearings didn't go ahead due to one discharge and one had gone to an informal. The committee heard about challenges when patients move units and the responsible clinicians having to change. It was noted that at the next meeting a focus would be on a deep dive review on what the patients think.</p> <p>MH23.10.2 It was highlighted that a Mental Health Group was being formed and that some of its focus would be on KPI's, patient choice and any delays in resulting from this. The attached Audit Report showed that only the larger units were being scrutinised but that the administrators go into all the units which was having a positive impact. Training of Managers was highlighted.</p> <p>MH23.10.3 The Mental Health Act Manager advised that there were still issues with iPads and some laptops are still outstanding some of this was due to hospital managers changing their IT requirements.</p> <p>MH23.10.4 Independent Members raised concern around lack of report, care and treatment plans. The Consultant Psychiatrist/Medical Director advised that a care and treatment plans needed to be completed within six weeks. The Interim Director of Nursing and that there is further work to do on plans and would look at this with Clinical Directors and Heads of Nursing. Further discussion took place around why patient information may not have been filed and that just because the information is not in the file does not mean it doesn't exist.</p> <p>MH23.10.4 The Deputy Director of Quality advised that this was an area that needed look at from a quality of care perspective and that it linked in with Mental Health Improvement Plan that is being scrutinised at QSE.</p>	PL

<p>MH23.11 Mental Health Act Performance Report</p> <p>MH23.11.1 The Mental Health Act Manager highlighted that during the reporting period there were four sections that had lapsed, the detail was highlighted on page three of the report. One of the instances was still under investigation but extra checks had been introduced in conjunction with the wards and ward staff to ensure that lapses do not happen again. It was noted that the Health Board is not an outlier with regards to rectifiable errors. In comparison to other Health Boards there are a lot more detentions and that given there is a lot of paperwork required and a lot of avenues for errors, to still be on a downward trajectory is positive.</p> <p>MH23.11.2 An update was given with regards to two children being admitted to an adult ward where they were in a 136 suite and cared for separately to the adults. Discussion took place with regards to the number of section 136's being higher, with the committee noting that this had been looked into and the numbers were around transfers in December.</p> <p>MH23.11.3 An Independent Member thanked the division for their huge effort that had been undertaken and the significant improvement. The Interim Director of Mental Health acknowledged that there had been significant improvement but more to do.</p>	
<p>MH23.12 Mental Health Legislation Risk Register</p> <p>MH23.12.1 The Chair thanked report writers for the paper but noted that a shorter paper should be produced given there was only one risk to manage. It was noted that the Committee had previously asked if the risk around the New Mental Health Act had been shared with RMG. The Head of Risk Management confirmed that this had not been added to the risk register. The Executive Director of Public Health advised that discussions had taken place but it had yet to be moved onto a written document and would move this forward outside the meeting.</p>	TO
<p>MH23.13 Criminal Justice Liaison Report</p> <p>MH23.13.1 The Committee received the report, noting what had happened since July was a step to move away from utilising 136's, with further work on engagement with the police.</p> <p>MH23.13.2 A discussion took place around the out of hours service provision noting that presentations are often out of hours but preventative work needed to be undertaken. It was noted that further consideration was required around out of hours services, not just criminal justice. The Executive Director of Public Health advised that she would ask for an holistic update around crisis response and advice between out of hours and during the day.</p>	
<p>MH23.14 Restraints Report (Mental Health Act)</p> <p>MH23.14.1 The Interim Director of Nursing presented the report noting two meetings of the restraints group had taken place, work of the group focussed down on the areas as to where there had been incidents, a high number of</p>	

<p>restraints in the PICU services, generally around self-harm. There had been a focus on positions of restraint, noting that further work was required around recording timing and position. Six restraints were in relation to one young person. It was noted that although onsite training had improved there is more to do with roll out to past the 85% complete marker by April. A discussion took place around the HIW figures verses the figures being reported on, noting that there was further work to do around ESR.</p> <p>MH23.14.2 The Executive Director of Public Health thanked the team noting that there would be a link on this work to the QSE Committee and that further work on non-physical restraint was to come.</p>	
<p>MH23.15 Court of Protection Report</p> <p>MH23.15.1 The Deputy Director of Quality presented the report noting that the Health Board was in a better position, he detailed the cases and highlighted the strengthened work with Legal and Risk. It was noted that a training programme with Legal and Risk was being developed and a revised policy which should return to the next meeting and that with regards to the risk on the risk register, steps were being undertaken to revise it. The Chair Requested the high-level detail around the Court of Protection cases at the next meeting.</p>	MJ
<p>MH23.16 Section 17 Leave Policy</p> <p>MH23.16.1 The Committee approved the Section 17 Leave Policy.</p>	
<p>MH23.17 Quarterly Mental Health Act rolling Audit Report</p> <p>MH23.17.1 The Committee received with thanks the Quarterly Mental Health Act rolling Audit Report highlighting that the care and treatment plans are inconsistent with some doing better than others.</p>	
<p>MH23.18 Consideration of any HIW/Inspection Reports/Audit Reports</p> <p>MH23.18.1 The Committee received the HIW Monitoring Report, an Independent Member queried if the Health Board received HIW reports for private health care providers with the Deputy Director of Quality advising it did not unless it was a primary care provider. It was noted that immediate concerns highlighted in the report were around restraints training which was being addressed.</p> <p>MH23.18.1 The Interim Director of Mental Health advised that there had been a positive report regarding Bryn Hesketh which would come to the next meeting.</p>	
<p>MH23.19 Date of Next Meeting – 16 May 2023</p>	