CONFIRMED MINUTES OF
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
HELD ON 4 JUNE 2019
NANT FAWR 1, GROUND FLOOR, WOODLANDS HOUSE, HEATH CF14 4TT

Present:

Charles Janczewski	CJ	UHB Vice Chair
Sara Moseley	SM	Independent Member – Third Sector

In attendance:

Julia Barrell	JB	Mental Capacity Act Manager
Rachel Burton	RB	Director of Operations, Children & Women Clinical Board
Steve Curry	SC	Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Dr Peter Durning	PD	Interim Executive Medical Director
Nicola Foreman	NF	Director of Corporate Governance
Dr Jane Hancock	JH	Service User
Amanda Morgan	AM	Service User
Sunni Webb	SW	Mental Health Act Manager
Ian Wile	IW	Head of Operations, Mental Health

Secretariat:

Glynis Mulford	GM	Corporate Governance Officer

Apologies:

Eileen Brandreth	EB	Independent Member - ICT
Kay Jeynes	KJ	Nurse Director – PCIC Clinical Board
Lucy Phelps	LP	Service User

19/06/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting. A special welcome was given to Peter Durning, Interim Executive Medical Director and Rachel Burton, Director of Operations for the Children and Women's Clinical Board.	**ACTION**
19/06/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
19/06/003	**DECLARATIONS OF INTEREST** Charles Janczewski declared his interest as the Chair of the Quality and Patient Safety Committee at WHSCC. Sara Moseley, Independent Member, declared her interest as Director of Mind Cymru and the Chair of the Crisis Care Concordat and Ministerial Assurance Group. The Committee agreed to the declarations of interest.	

19/06/004	**MINUTES OF THE COMMITTEE HELD ON 12 FEBRUARY 2019** The Committee reviewed the Minutes of the meeting held on 12 February 2019, and agreed that the following amendments should be made: • **MH: 19/02/10 - Mental Health Act Monitoring Report:** The second bullet point regarding section 136 should be rephrased "to adhere to the code of practice which was the Statutory Guidance". • The third bullet point should read "Chair of Crisis Care Concordat and Ministerial Assurance Group and the Board was unable to provide assurance in South Wales and the matter has been escalated." • **MH: 19/02/014 – Mental Health Monitoring Report:** First bullet point should read "the delivery unit audit of care and treatment plans". **The Committee resolved that:** a) subject to the agreed amendments being made, the minutes of the meeting held on 12 February 2019 should be agreed as a true and accurate record of the meeting.	
19/06/005	**COMMITTEE ACTION LOG** The Board reviewed the Committee Action Log and in reviewing the log the following comments were made: • **MH: 19/02/016 – Tier 2 CAMHS Update – Benchmarking Information:** The Chair asked when a CAMHS benchmarking report would be received at the Committee. In response, the Director of Operations for Mental Health stated he was not privy to any national benchmarking on CAMHS but noted that information in relation to young people under 18 admitted to a mental health adult ward was provided regularly to Welsh Government (WG). It was noted that the number of such admissions had increased with eight being admitted this year. The Independent Member- Third Sector advised that the admission of under 18s to an adult ward was a concern. Members were assured that Welsh Government transitional guidelines were in place and admissions had occurred due to the needs of the young person. It was noted that a number of beds were allocated for the admission of 16-18 year olds and clear standards had to be complied with. The Committee was informed that clinicians used their discretion and individual assessments to determine what was best for the young person. It was confirmed that there was a good relationship and close working with CAMHS which was responsive when a young person had to be admitted. It was recognised this was an all Wales issue and Welsh Government recognised that there were few alternatives. The Committee noted that the	

	situation would be reviewed once the CAMHS service was repatriated. • **MHCLC: 18/31 – Hospital Managers Power of Discharge Sub Committee Minutes:** The Chair commented on the status of this action and asked for greater clarity regarding its status. It was confirmed that this item related to issues raised in the Mental Health Legislation Governance Group. It was noted that the concerns raised related to care and treatment planning and a paper on this would be considered later in the meeting. The Committee agreed that the action should be noted as being complete. • **MH: 19/02/008 – Health and Care Standards – Mental Capacity Act Training:** It was confirmed that the Executive Medical Director had written to the Executive Nurse Director requesting that Mental Capacity Act training be embedded in the Health and Care Standards. The Committee agreed that the action should be noted as being complete. **The Committee Resolved that:** (a) The Board reviewed the action log from the meeting held on 31 January 2019 and the updates were noted.	
19/06/006	**CHAIRS ACTION TAKEN SINCE LAST MEETING** It was confirmed that there had been no Chair's action since the previous meeting of the Committee.	
19/06/007	**PATIENT STORY** The Chair introduced Dr Jane Hancock and thanked her for coming to share her story and her experiences of using the UHB's Mental Health services. Dr Hancock provided the Committee with an overview of her struggles with depression that started when she was 15 years of age. As part of her summary, Dr Hancock outlined: • the impact that being caught up in the Moorgate disaster had on her mental health. • the importance of having a trusting relationship with your psychiatrist and those who were caring for you. • how family issues contributed to her deteriorating mental health. • the issues that had impacted on her ability to trust Mental Health Services and hence not wanting to engage with them. When asked by the Committee Chair what should change, Dr Hancock advised that in the first instance doctors should talk to patients and listen before reading their notes. Dr Hancock highlighted her concerns that if an earlier clinician had made an error in diagnosis that error would be	

	perpetuated if there was an overreliance on notes and not enough time spent talking to the patient. As part of the discussions that followed the Chief Operating Officer reminded Members of the presentation that the Mental Health Team gave to the Board that highlighted the way forward was to deliver services from the user's perspective. The need to address the issue on an individual basis was key. The Committee Chair thanked Dr Hancock for her presentation and reminded the Committee that the First Minister was clear that we should be asking the question 'what matters to you' and not 'what's the matter with you'. **The Committee Resolved that:** a) the patient story be noted.	
19/06/008	**MENTAL CAPACITY ACT MONITORING REPORT** The Interim Executive Medical Director introduced the report and confirmed that: • it set out the UHB's position in relation to the Mental Capacity Act. • training uptake was low amongst medical staff. While there were individual clinicians and service areas that had developed an understanding of MCA and complied with it, the position was not uniform across the UHB. It was noted that Advocacy Support Cymru (ASC), the statutory IMCA provider, had highlighted that there was a general lack of understanding and awareness across the UHB of, for example the Independent Mental Capacity Advocate (IMCA) role and the Court of Protection processes. • The Medical Director said that he would discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave. The Committee Chair advised that the approach was welcomed. **The Committee Resolved that:** a) the Mental Health Act monitoring report be noted.	**PD**
19/06/009	**DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) UPDATE REPORT** The Interim Executive Medical Director introduced the report and highlighted that: • the paper set out the position in relation to DoLs assessments. • the Partnership Review Board met on a quarterly basis and the report summarised its progress and provided a set of statistics that were self-explanatory. • the number of DoLs applications had increased significantly	

following the “Cheshire West” Supreme Court ruling in 2014, but appeared to be stabilising.

- the Deputy Executive Nurse Director had become increasingly involved with DoLs and this support was welcome.
- there remained a financial risk in re-negotiation of the DoLS funding equation. It was noted that the Partnership Board was looking at ways to mitigate this.
- Internal Audit’s DoLS Follow-up Audit had been deferred until quarter 4, 2019/20 to allow the process regarding the new DoLS signatories to bed in. It was confirmed that a paper setting out the signatories would be submitted to the Board for ratification.
- the Mental Capacity Amendment Bill had been enacted and DoLS would be replaced by a new system, to be known as Liberty Protection Safeguards (LPS).

The Committee Resolved – that:

a) the continuing arrangements for the provision of a DoLS service be noted and approved.

19/06/010 **MENTAL HEALTH ACT MONITORING EXCEPTION REPORT**

The Director of Operations, Mental Health Clinical Board introduced the report and noted that:

- during the period there had been no incidents of an individual being detained without authority.
- guidance on the implementation of changes to police powers and places of safety provisions in the Mental Health Act 1983 had been issued by Welsh Government since amendments were made to s.136 by the Policing and Crime Act 2017.
- the amendments reduce the detention period from 72 hours to 24 hours which could be extended under certain circumstances to a maximum of 36 hours. The main issue centred around the time that the detention period started. The Committee was advised that the non-statutory guidance issued by Welsh Government suggested a contrary approach is taken to that in the Code of Practice for Wales in relation to patients taken to A&E. It was noted that legal advice had been obtained that confirmed that practitioners should follow the guidance contained in the Code of Practice for Wales. The Committee was advised that the matter had been escalated to the UHB’s Chair for further consideration and action.
- the data provided in the report in relation to people being admitted to crisis care, was sparse. It was confirmed that the intention was to incorporate information on patients being signposted to other services in the next report. It was also noted that this was regarded as a priority as Welsh Government funding had been received to support the management of people in crisis. In addition, it was confirmed that there would be funding for patients known to secondary care services and presenting to crisis out of

hours who required support from the police.

The Committee Resolved that:

a) the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA be supported.

19/06/011 **SECTION 136 PARTNERSHIP ARRANGEMENTS**

The Director of Operations, Mental Health Clinical Board introduced the report and provided a detailed overview of the Mental Health Crisis Care Concordat, its origins and the way in which it was working in the Cardiff and Vale area. As part of the discussions that it was noted that:

- As well as supporting people in crisis, the focus of the Cardiff and Vale approach had been on the preventative agenda, with significant investment used from WG funding as well as local UHB funding support to provide mental health and wellbeing support to primary care practice.
- the Welsh Assembly Health and Social Care Committee had recently explored a number of issues with the UHBs in South Wales related to the crisis care agenda and the questions asked had been used as the framework for the paper.
- a Welsh Assembly Committee was undertaking a deep dive exercise to explore the crisis care issue and the UHB was contributing to the discussions.
- The responsibility to provide assurance to the concordat was shifting from sub regional arrangements and the South East Wales concordat meeting was chaired by Gaynor Jones from ABMU. The Health Board had their own arrangements but this had been delegated out to three health boards in South East Wales to share and support the arrangements. This included the police, third sector and local authority to support the discussions.
- It would be assessed against the completed revised concordat and would wait for an invitation from the National Assurance Group to report back nationally.
- One of the reasons people at a national board level agreed to the concordat was the Task and Finish Group asked to bring this together to encourage joint working, breaking down barriers and to learn from people nationally regarding what was / not working. The challenge in South Wales was the Health Boards who had different boundaries to the police. In shifting the focus towards the local Health Board, the challenge would be for this to be interagency led, focussing on the individual. The crisis of care was broad and covered a number of aspects and integrated with a number of pieces of work ongoing. In providing assurance and reporting upwards there was a need to think of the totality of what the concordat covered.
- There was a need to realise the level of mental illness and distress dealt with by agencies that in comparison the Health Service saw the tip of the iceberg. There was a need to send out

	the right message regarding the concordat's remit. A co-chair would be in place to provide balance and perspective to the group as this could not be achieved by looking at health alone. • In summary, the Chair stated the driver was around the assurance mechanism for the minister which needed to be monitored to ensure it was considered safe for everyone. This was a sensitive area and looked at South East Wales with Health Boards cutting across police boundaries. **The Committee Resolved that:** a) A Section 136 report would continue to be received and monitored by the MHCLC. b) an update be provided by the Director of Operations in six months' time	IW
19/06/012	**FEEDBACK ON MENTAL HEALTH LEGISLATION GROUP (MHLG)** As Mr Robert Kidd, Consultant Clinical Psychologist was unavailable to attend the meeting, Sunni Webb made the following comments: • Attendance was good and everyone found the Group valuable. The main aim was to continue to improve the patient experience. • It was recognised that a number of issues on the Groups agenda were also relevant to the Concordat and should be prioritised in the Concordat plan. It was confirmed that the Welsh Ambulance Service was part of Concordat group, and was invited to the MHLG. • The Committee Chair raised a concern regarding a section 136 patient who had been suicidal and not seen by the service for two months. It was confirmed that this matter had been reported to the senior nurse for the Crisis and Liaison Service but no feedback had been received. The Committee was advised that this case had been reported to the police and it was confirmed that an update would be brought back to next committee meeting. The Committee Chair asked for confirmation as to whether this constituted a Serious Incident that should be reported to the Welsh Government. **The Committee Resolved that:** a) the report be noted b) An update on the matter of concern be scheduled for the next Committee meeting. c) The Committee Chair receive confirmation of the status of the matter of concern be checked i.e. whether it was a serious incident that need to be reported to the Welsh Government.	SW SW
19/06/013	**MENTAL HEALTH MEASURE MONITORING REPORT** The Director of Operations, Mental Health Clinical Board presented the report and informed the Committee that:	

- the UHB was compliant with all aspects of the Mental Health Act measure for this reporting period including part 1a and 1b part 3 and part 4.
- Part 2 centred on the requirement to have a treatment care plan for every relevant patient in the mental health service and the UHB was not compliant in this area. It was noted that a Delivery Unit (DU) inspection of care and treatment plans had taken place across Wales and the UHB had been criticised alongside other health boards.
- the action plan discussed at the last meeting had been revised with the support of the local MDT. Objectives and timescales had been included in the action plan which was submitted for the consideration of the Committee.
- Care and treatment planning was about the therapeutic relationship with the patient; supporting service users, helping them address their needs and asking what outcomes they expected. It was noted that this work encompassed a range of actions which would span across 18 months. It was confirmed that the action plan would be brought to the Committee regularly.
- Within the action plan there was a need to develop a planned trajectory for improving performance against care and treatment plans. Members were advised of the two elements required from Welsh Government relating to compliance and the quality of the Care and Treatment plans being measured separately.
- The performance reports were being lifted from PARIS and the DU was reassured that there was a treatment plan available for every relevant patient.
- The Interim Medical Director asked if there was an analysis to what the barriers were to complete the outstanding 14-15%. It was explained that the figures related to:
    - service users and outpatients waiting for a long length of time,
    - those who had been discharged from the service or subject to 117 aftercare,
    - low primary care needs or
    - patients in secondary care for medication needs but did not require an MDT care plan.
- The Delivery Unit's work in relation to care and treatment plans had highlighted a need for cultural change and the importance of having information for patients and relatives and advising them of what treatment and care planning involved was valuable. It was confirmed that the UHB's audit process would continue to involve service users doing a dip test on how care and treatment plans were being actively used and how valuable they were to the individual.
- The Chair of the Powers of Discharge sub Committee commented that although the onus was on the nurse to populate the plan, responsibility lay on both sides for the contract of care.

- Due to staff shortages for the following quarter, part 1a would be breached for around 50%. This was a temporary situation and would not be complied with for a couple of months. The service would be back to full capacity and in compliance by July. The risks were low but the targets were taken seriously.

The Committee Resolved that:

a) the report together with the updated action plan be noted.

19/06/014 **DELIVERY UNIT ACTION PLAN IN RESPONSE TO CARE AND TREATMENT PLAN**

The Chair confirmed that as the Delivery Unit Action Plan had been discussed in relation to the Mental Health Measure Monitoring Report, the item should be noted.

The Committee Resolved that:

(a) the report be noted.

19/06/015 **COMMITTEE'S SELF ASSESSMENT OF EFFECTIVENESS**

The Director of Corporate Governance introduced the report and provided an overview of the findings arising from the self-assessment. It was noted that:

- going forward the assessment process would involve attendees and not only members.
- the action plan had been developed to help strengthen and improve the effectiveness of committee.
- consideration should be given to how the committee interacted with other Board committees.

The Committee Resolved that:

a) the results of the Committee's Effectiveness Review for 2019 be noted.
b) The action plan for improvement to be completed by March 2020 in preparation for the next Effectiveness Review be approved.

19/06/016 **ANNUAL ALL WALES BENCHMARKING REPORT**

The Director of Operations, Mental Health informed members that the data collection for the annual benchmarking exercise had commenced.

The Committee Resolved that:

(a) The Committee noted the report.
(b)

19/06/017	**HIW MENTAL HEALTH INSPECTION REPORTS** The Director of Mental Health Operations advised the Committee that as yet no report had been received therefore no immediate assurance could be provided.	
19/06/018	**INHERITANCE REPORT FOR CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)** The Chief Operating Officer introduced the report and highlighted the following: • the report had been prepared following a 12 month project to repatriate CAMHS back to the UHB and highlighted the key issues that had been inherited from Cwm Taf UHB. • the Directorate Management Team had identified a wide range of concerns about the service in relation not only to performance against required targets, but to the management of capacity and demand, clinical practice and HR and workforce. Three areas of action to address these issues were proposed. • an independent review of the service had been commissioned that will provide an overview of how it compared to similar services across UK. It was confirmed that this report would be brought to the October meeting of the Committee. • it was emphasised that the key challenge the service faced related to a shortage of relevant skills and so consideration needed to be given to how to manage the service differently, for example by the provision of digital platforms. It was confirmed that Transformation monies had been made available and would be used to invest in young people and children services. • the Health and Social Care Minister had a keen interest in the service and the UHB was required to report to WG on its performance regularly. It was confirmed that the Minister had made it clear that the UHB needed to improve its performance as it had an impact on the performance of Wales overall. The Committee Chair confirmed that he was delighted that the service had been repatriated back to the UHB and acknowledged the hard work of all those involved. The Committee Chair also confirmed that the Board had asked for a deep dive review of CAMHS performance to be undertaken and confirmed that he would be happy to provide feedback to the Committee. The Committee noted that the Strategy and Delivery Committee had been asked to take on the responsibility of monitoring CAMHS performance and in particular intervention rates. It was noted that discussions were taking place in relation to the integration of CAMHS primary and secondary care at the Strategy and Delivery Committee. The Independent Member – Third Sector confirmed that she fully supported the integration of primary and secondary care CAMHS services and suggested that the Regional Partnership Board should be linked in to this work.	SC

	The Committee Resolved that: a) the status of the Specialist CAMHS service inherited by the UHB and the implications for performance be noted. b) it be noted that a definitive trajectory for improvement would be developed over the coming months as the work on service redesign, productivity and recruitment is progressed further c) the plans to review the service models and recruit to the existing vacancies be noted.	
19/06/019	**HOSPITAL MANAGERS POWER OF DISCHARGE** The Chair of the Powers of Discharge sub-Committee presented the report. The following comments were made: • Concerns with the lack of activity in Hafan y Coed had repeatedly been raised. A mechanism was now in place which would be monitored. • From the governance point of view the Group was happy with how well the observations proceeded and was pleased with the feedback. • The Chair thanked Jeff Champney-Smith for his participation in the work undertaken and his reinstatement as Chair. **The Committee resolved that:** a) The reported be noted.	
19/06/020	**REVIEW OF THE MEETING** The Committee Chair facilitated a review of the meeting and Members agreed that it had been a very good meeting and the patient story had helped in setting the scene for the discussions that followed.	
19/06/021	**ANY OTHER URGENT BUSINESS** There was no other urgent business raised.	
19/06/022	**DATE OF THE NEXT COMMITTEE MEETING:** Tuesday, 22 October 2019, 10.00am Woodlands House, Heath, Cardiff CF14 4TT	