

Agenda attachments

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- 1.2 Apologies for Absence
- 1.3 Declarations of Interest
- 1.4 Minutes of the Mental Health and Capacity Legislation meeting on the 26th June 2018
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- 1.12 COMMITTEE GOVERNANCE
- 1.12.1 Mental Health Operational Group Meeting Minutes
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- 2 PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE
- 2.1 Hospital Managers Power of Discharge sub - Committee Minutes
 - 2.1 Minutes PoD 24 July 2018.doc
- 2.1.1 Hospital Managers Power of Discharge Annual Report

2.2

Review of the Meeting

2.3

To note the date, time and venue of the next meeting - 12th February 2019



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University Health Board

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday October 23rd at 10.00hrs
Corporate Meeting Room, Headquarters, UHW

AGENDA

PATIENT STORY –		
PART 1: ITEMS FOR ACTION		
1.1	Welcome and Introductions	Oral <i>Chair</i>
1.2	Apologies for Absence	Oral <i>Chair</i>
1.3	Declarations of Interest	Oral <i>Chair</i>
1.4	Minutes of the Mental Health and Capacity Legislation meeting held on 26 th June 2018	<i>Chair</i>
1.5	Action Log Review	<i>Chair</i>
1.6	Any Other Urgent Business Agreed with the Chair	<i>Chair</i>
1.7 MENTAL CAPACITY ACT		
1.7.1 (10 min)	Deprivation of Liberty Safeguard Monitoring Report <ul style="list-style-type: none"> Cardiff & Vale DoLS Report & SBAR 	<i>Medical Director</i>
1.7.2	Cardiff and Vale DoLS Safeguard Team Partnership Report	
1.8 (10 min)	Mental Capacity Act Monitoring Report	<i>Medical Director</i>
1.8.1	MCA Supporting Info May 2018	
1.8.2	IMCA Report	
1.8.3	Clinical Board Mental Capacity Act Training Plans	
1.9 MENTAL HEALTH ACT		
1.9.1 (10 min)	Mental Health Act Exception Report <ul style="list-style-type: none"> Section 135 Legislation 	<i>I Wile</i>



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	• Section 136 Legislation	
1.10: MENTAL HEALTH MEASURE		
1.10.1 (20 min)	Mental Health Measure Monitoring Report	<i>Ian Wile</i>
1.10.2 1.10.3	Part 2 MH Measure Care and Treatment Plan's Delivery Unit All Wales Review of the Quality of Care and Treatment Planning.	
1.11 1.11.1	MATRIX Cymru – 26 week waiting time target Appendix 1	<i>Ian Wile</i>
1.12: COMMITTEE GOVERNANCE		
1.12 (5 min)	Mental Health Operational Group - Update	<i>Robert Kidd</i>
1.13 (15min)	Committee Work Plan	<i>Board Secretary</i>
PART 2: ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE Papers are available on the Health Board website		
2.1 2.1.1	a) Hospital Managers Power of Discharge sub-Committee Minutes b) Hospital Managers Power of Discharge Annual Report PoD recommendations	<i>Chair, PoD sub-Committee</i>
2.2	Review of the Meeting	<i>Oral Chair</i>
2.3	To note the date, time and venue of the next meeting:- 12 th February 2019	<i>Chair</i>

**UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 10.00AM ON TUESDAY 26TH JUNE 2018
CORPORATE MEETING ROOM, HEADQUARTERS, UHW**

Present:

Charles Janczewski
Eileen Brandreth

MHCLC Chair and Vice Chair of Cardiff and Vale UHB
Independent Member and MHCLC Vice Chair

In attendance:

Steve Curry
Ian Wile
Sunni Webb

Chief Operating Officer (Lead Executive for Mental Health)
Director of Operations, Mental Health
Mental Health Act Manager

Julia Barrell
Dr. Graham Shortland
Jeff Champney Smith
Dr. Jane Hancock
Dr. Robert Kidd

Mental Capacity Act Manager
Medical Director (Lead Executive for Mental Capacity)
Chair, Hospital Managers Power of Discharge Sub-Committee
Service User Representative
Consultant Clinical & Forensic Psychologist

Apologies:

Jayne Tottle
Peter Welsh
Sara Moseley
Dr. Jenny Hunt
Kay Jeynes
Amanda Morgan
Lucy Phelps

Mental Health Clinical Board Nurse
Director of Corporate Governance
Independent Member
Clinical Psychologist
Director of Nursing, PCIC
Service User Representative
Service User Representative

Secretariat:

Helen Bricknell

MHCLC 18/01 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 18/02 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 18/03 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the Agenda.

- It was noted that the Chair attends WHSSC meetings.
- It was noted that Dr. Robert Kidd is a member of the All Wales AC Approval group.

MHCLC 18/04 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 6TH FEBRUARY 2018

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record for 6th February 2018.

The Chair opened up for any matters arising from the minutes:
No Matters Arising to record.

MHCLC 18/05 ACTION LOG REVIEW

MHCLC 16/129: DoLS Covering Report. This item is complete.

All other items have been completed and will be removed from the Action Log.

MHCLC 18/06 ANY OTHER URGENT BUSINESS AGREED WITH THE CHAIR.

There was no other urgent business.

MHCLC 18/07 DEPRIVATION OF LIBERTY SAFEGUARDS MONITORING REPORT

The Medical Director delivered a brief outline of the report, including the limited assurance given by the recent Internal Audit on DoLS. Regular performance meetings are underway.

There are inadequate numbers of staff trained on the DoLS legislation. The All Wales HIW/CSW DoLS report has been published. This has been discussed by the DoLS Partnership Board and also with Internal Audit department.

All Health Boards across Wales have been struggling to uphold the legal timescales for completing DoLS authorisations.

Internal Audit report stated that that timescales for making the authorizations are delayed and therefore it is logged on the Risk Register. Internal Audit is

working with the Medical Director to agree a set of standards and performance indicators to ensure consistency with the HIW/CSW DoLS report.

The Chair advised the Committee that the Audit Committee has also considered the Internal Audit report and has indicated that the UHB needs to set realistic action plans when trying to complete the recommendations contained within the report. The following points were discussed:

- What percentage of workforce is required to undertake the training?
- What is the cumulative training undertaken per Clinical Board and the percentage of staff within that Board that need the training?
- It was stated that between Cardiff Council and the Vale, individuals are waiting up to a year for their DoLS authorisation and there is a risk of unlawful deprivation of liberty being identified through the Courts.
- A recent court case has established that patients receiving life sustaining care in hospital are not being deprived of their liberty. They therefore do not require a DoLS authorization.

ACTION: Medical Director to work with Internal Audit to determine a suitable timescale for completion of report recommendations and establishing suitable standards and Performance Indicators.

The Committee **RECEIVED** and **NOTED** the report.

The Committee **AGREED** actions to be taken in light of the Internal Audit Limited Assurance

MHCLC 18/08 MENTAL CAPACITY ACT MONITORING REPORT

The Medical Director presented the report. A number of actions have been put in place to improve the Mental Capacity Act training

The Mental Capacity Act Manager stated that more clinical staff have completed the training but there is still limited evidence that the Act is being used appropriately and becoming embedded in clinical practice. However, in some Clinical Boards it seemed that Drs' uptake of MCA training was very low.

It was noted that CD&T, Medicine and Mental Health Clinical Boards have not provided any updates on what they are doing to embed MCA within clinical practice.

ACTION: The Medical Director will write to each Clinical Board to request that they develop an action plan for MCA, with particular emphasis on MCA training for Drs and dentists, to be reported at the next MHCLC meeting. The Chief Operating Officer will lend support.

ACTION: The Chair asked the Medical Director to report back on progress at the next meeting on the actions he will take as set out in the report.

The Chief Operating Officer said that there will come a time where measures will have to be taken if MCA does not become embedded. The chair will consider an escalation process, if considered necessary, with the support of the committee. An effort will be made to obtain bench-marking data from other parts of Wales. .

A question was raised about whether there are consequences with non-compliance with mandatory training – e.g. pay progression and PADRs. In response, it was noted that the Executive Director of Workforce is looking at the issues surrounding this.

The Committee **NOTED** the report and action that the Medical Director is taking to improve doctors' compliance with Mental Capacity Act training with the Mental Capacity Act Manager.

MHCLC 18/09 MENTAL HEALTH ACT EXCEPTION REPORT

The Mental Health Act Manager, Ms. Sunni Webb gave a brief outline indicating within the last quarter there have been three incidents of non-compliance with the Mental Health Act.

- Two issues have been addressed between the Approved Mental Health Professionals and the Emergency Duty Team Service and their approval process.
- The third breach involved a young person in Accident and Emergency department on Section 136, a management plan is now in place and no further issues have arisen.

The above cases have been passed to the Legal team for further advice. Training for officers across the board who will be involved in Mental Health Act assessments was discussed.

The Committee **NOTED** the report for assurance

MHCLC 18/10 MENTAL HEALTH MEASURE MONITORING REPORT

The Director of Operations, Mr. Ian Wile gave a brief overview of the report, including Part 1A of the Mental Health Measure, the 28 day referral process and Part 1b, the follow up within 28 Days following an assessment to receive treatment (56 day period in total).

The Mental Health Clinical board is meeting Part1a of the Measure consistently however it was breached under Part 1b last month. This is largely due to the introduction of Matrics Cymru which requires a broader and deeper

implementation of the range of Psychological Interventions as part of the Part 1 scheme. To enable consistent compliance with the measure Ian Wile contacted Welsh Government for advice on its implementation and Mr. Wile will report back at the next meeting.

ACTION: Ian Wile to provide update at next meeting

Within Part 2, it is a legal right for every service user to have a Care and Treatment Plan. Recently the patient register on PARIS has been cleansed of duplications of care plans and reduced the overall number. This has resulted in the amount of doctors without care plans for patients they are caring for alone has become a bigger proportion of the whole number leading to a breach of 5%. This equated to circa 150 patients.

The long term plan for these patients with very low need on medical caseloads is to be discharged from services. Until that time Mr. Wile will discuss with medical staff the issues being these figures with a view to recovering the target for the September reporting period.

The Chief Operating Officer mentioned best practices need to be followed. A service user mentioned on-going issues with care and treatment plans and having to utilize their own named nurse within the services who may not be readily available due to their substantive hours of working. An issue surrounding an advanced directive which will be brought up with the Medical Director or Nurse Director on an individual basis.

The D.U undertook an All Wales review of the quality of Care and Treatment plans a few months ago to highlight whether the plans are being used as therapeutic tools or not. When the report is disseminated it will be reported to the Committee. The Advocacy Service has been reported on 100%.

The Committee **NOTED** the report.

MHCLC 18/11 PCIC PRESENTATION

The presentation was delivered by Director of Operations, Rachel Burton of Children/Women Clinical Board on Meeting the legal implications of Part 1 Mental Health Measures for CAMHS and repatriation.

The Committee has **RECEIVED** the presentation.

MHCLC 18/12 MENTAL HEALTH OPERATIONAL GROUP

The Director of Operations, Mr. Ian Wile gave a verbal update stating that the group is up and running. Dr. R Kidd mentioned there were high attendance levels, focusing on highly operational matters and discussing what is affecting the quality of the work within the Mental Health Act.

Minutes from the previous Mental Health Legislation and Governance group have been brought back to allow continuous working on some Agenda items which pose a difficulty to the service.

Representation from the AMHP services at the meeting, feedback from both Local Authorities. Approved Mental Health Professionals do meet at their own group and the minutes from their forum have been invited to feed into those minutes of the Operational Group.

There have been discussions around the usage of Section 136 and further information has been given by Prof Richard Jones. The accuracy of Care and Treatment Plans to feed back at the next Mental Health Quality and Safety meeting. The interfaces with other legislation, DoLS and Mental Capacity Act will also be discussed. The Terms of Reference for this meeting was agreed by the Chair.

The Committee **NOTED** the verbal report.

MHCLC 18/13 COMMITTEE WORKPLAN

The Chair introduced the revised Work-plan and offered for any feedback.

The Committee **AGREED** the Work-plan

MHCLC 18/14 DOCUMENTS FOR COMMITTEE APPROVAL

The Committee:

- **APPROVED** the Community Treatment Order Policy
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Community Treatment Order Procedure
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Hospital Manager's Scheme of Delegation Policy
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Hospital Manager's Scheme of Delegation Procedure
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Section 5(2) Doctors' Holding Power Policy
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Section 5(2) Doctors' Holding Power Procedure
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Section 5(4) Nurses' Holding Power Policy
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

The Committee:

- **APPROVED** the Section 5(4) Nurses' Holding Power Procedure
- **APPROVED** the full publication of it in accordance with the UHB Publication Scheme

MHCLC 18/15 HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE MINUTES / HOSPITAL MANAGERS POWER OF DISCHARGE HANDBOOK /

Power of Discharge Recommendations

The Committee **SUPPORTED** the **RECOMMENDATIONS** of the Chair.

MHCLC 18/16 REVIEW OF THE MEETING

The Chair asked for any opinions or views from the committee, it was mentioned that the slight changes of the agenda worked well. It was mentioned that it was good to see the fruition of the Operational Group

MHCLC 18/17 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 23rd October 2018 at 10am, Boardroom, Headquarters, University Hospital of Wales.

ACTION LOG FOLLOWING MHCLC JUNE 2018

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
MHCLC 18/07	26.06.2018	DoLS Safeguards Monitoring Report	Medical Director to work with Internal Audit on completing a set of standards and Performance Indicators.	G Shortland	Agreed with Internal Audit to develop new Terms of Reference for further DOLs audit based on All-Wales National outcomes. Planned for Quarter 4 of 2018/2019 programme
MHCLC 18/08	26.06.2018	MCA Monitoring Report	The Medical Director will write to each Clinical Board, requesting that they develop an action plan to address clinical staff training, particularly Drs and dentists.	G Shortland	Letter sent 8/8/18
MHCLC 18/08	26.06.2018	MCA Monitoring Report	The Chair asked the Medical Director to report back on progress at the next meeting on the actions he will take as set out in the report.	G Shortland	Information included in the MCA Report.
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
MHCLC 16/134	06.02.2018	Mental Health Measure Monitoring Report	Chief Operating Officer to provide a paper on repatriation of CAMHS. Staff from Children and Women Clinical Board to attend the next Committee on this topic. 20	S Curry	COMPLETE (June 2018)

			minute presentation at the next meeting.		
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DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) MENTAL CAPACITY ACT 2005

Name of Meeting: Mental Health and Capacity Legislation Committee
Date of Meeting: 23rd October 2018

Executive Lead : Medical Director

Author : Medical Director

Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together..."

Financial impact: There has been a small increase in funding received by the Partnership Board which will be absorbed in the overall running costs of the service. The other two members of the Partnership Board continue to press for an improved contribution from Cardiff and Vale UHB. This is currently under review/negotiation.

Quality, Safety, Patient Experience impact: Compliance with DoLS means that vulnerable patients will not be deprived of their liberty unlawfully.

Health and Care Standard Number 4.2

CRAF Reference Number 8.1.3

Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

- Regular review of the DoLS service by a tri-partite Partnership Review Board
- Mitigation of risk with priority to Urgent assessments which is predominantly from Cardiff and Vale UHB.
- Further review planned with Internal Audit to develop new Terms of Reference for a further DOLs audit based on All-Wales National outcomes.(Quarter 4 of 2018/2019 audit programme).

The Committee is asked to:

- **APPROVE** the continuing arrangements for provision of DoLS assessments.

SITUATION

The Mental Health and Capacity Legislation Committee had agreed that regular reports, providing information about the UHB's compliance with DoLS should be tabled.

Depriving a patient of their liberty where there is no court order or DoLS authorization in place (and the patient cannot be detained under the Mental Health Act 1983) is unlawful and the UHB could be sued for this.

BACKGROUND

The Deprivation of Liberty Safeguards, an amendment to the Mental Capacity Act 2005, came into force on 1st April 2009. DoLS provide a means by which a mentally disordered, incapacitated, adult can lawfully be deprived of their liberty in hospital, if it is in the best interests of the person and there is no less restrictive way of caring for them.

As of 1st April 2009, the UHB and Cardiff and Vale of Glamorgan Local Authorities formed a partnership to provide a DoLS service across the three organisations delivered by a DoLS team. A Partnership Review Board meets on a three monthly basis with Senior officials from each organisation.

Since the “Cheshire West” Supreme Court ruling in 2014, the number of applications for DoLS authorization has increased very considerably, although now appears to be stabilizing.

The DoLS Team co-ordinates the six assessments that have to be undertaken in order to establish whether a deprivation of liberty is occurring and whether the patient meets the criteria for a DoLS authorization to be granted.

ASSESSMENT AND ASSURANCE

Please see appendix 1 for details of the latest Deprivation of Liberty Safeguard Teams Partnership Report for the first quarter of 2018/2019 (April – September). Broadly activity remains similar to the previous year and remains consistent with the significant increase seen following the “Cheshire West” Supreme Court ruling in 2014, although the number of applications appears to be stabilizing.

Assurance for the UHB is provided by the fact that the Partnership Board continues to give priority to Urgent assessments which is predominantly from Cardiff and Vale UHB. There is a priority tool matrix which continues to be used by the DoLS co-ordinator to determine priority and workflow management.

There remains an on-going risk of outstanding DoLS Authorisation requests and this is a greater risk to Local Council partners as the Authorisations for Urgent requests are given priority. There remains a financial risk in re-negotiation of the DoLS funding equation. Mitigation against this is a joint piece of work by the Partnership Board to look at the processes and functions being undertaken with the DoLS team to consider efficiency savings where support or resource is required. The outcome of this review will be shared with the Partnership Review Board in three months time.

The Medical Director has agreed with Internal Audit to develop new Terms of Reference for further DOLs audit based on All-Wales National outcomes. This is planned for Quarter 4 of 2018/2019 programme.

CARDIFF & VALE DEPREVATION OF LIBERTY SAFEGUARDS TEAM PARTNERSHIP REPORT SEPTEMBER 2018

PURPOSE

- To provide overview of the activity within the team during the first quarter of 2018/19 (April – September)
- To highlight continued resource implications associated with the volume of requests the team receives from Supervisory Bodies
- To identify areas of development and improvement

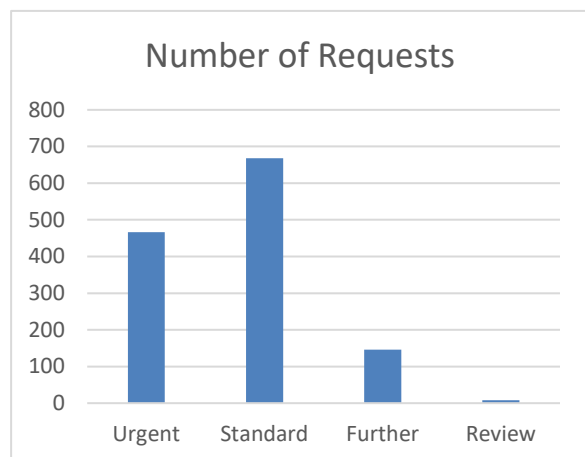
The Cardiff and the Vale DOLS / MCA Team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff and Vale UHB, City of Cardiff Council and Vale of Glamorgan Council, through a partnership management board consisting of senior representatives of each Supervisory Body.

The team acts on behalf of the three Supervisory Bodies in the:

- Coordination of DoLS assessments as requested by Managing Authorities by undertaking the following six assessments, to determine the following:
 - Age - 18 and over
 - Mental Illness- Is medically diagnosed with a mental disorder
 - Mental Capacity - Lacks capacity for the decision to be accommodated in the hospital or care home
 - No refusals - there is no Advanced Decision previously made to refuse treatment or care, or conflict relating to this such as LPA or Deputy
 - Eligibility - This determines whether the person meets the requirements for detention under the Mental Health Act 1983;
 - Best Interests - The person needs to be deprived of liberty for reasons of health, safety and best interests.
- Supervision and workload management of over 20 Best Interest Assessors;
- Advice and support to health and social care teams across the sector in relation to MCA/DoLS issues;
- Training for care homes and all inpatient sites across the hospitals of Cardiff and the Vale of Glamorgan areas.

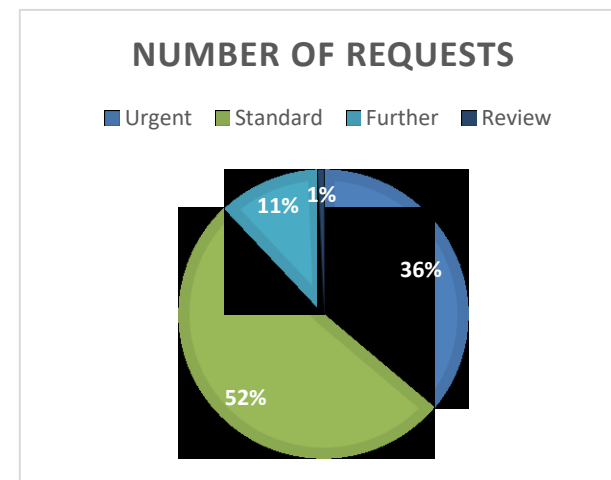
Request/Referrals

The charts below detail the referrals received during the period April 2018 – September 2018

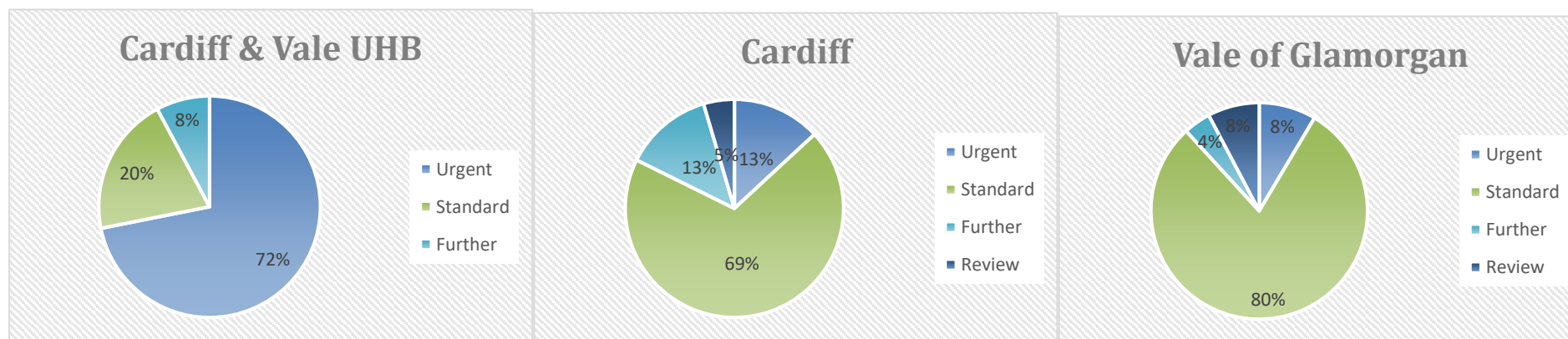


URGENT : 466
 STANDARD: 668
 FURTHER: 147
 REVIEW: 8
 TOTAL REQUESTS: 1289

282 OF THESE REQUESTS WERE LATER WITHDRAWN DUE TO A VARIETY OF REASONS



The charts below detail the requests by type and partner:



UHB

- Urgent 368
- Standard 104
- Further 40
- Review 0

CARDIFF

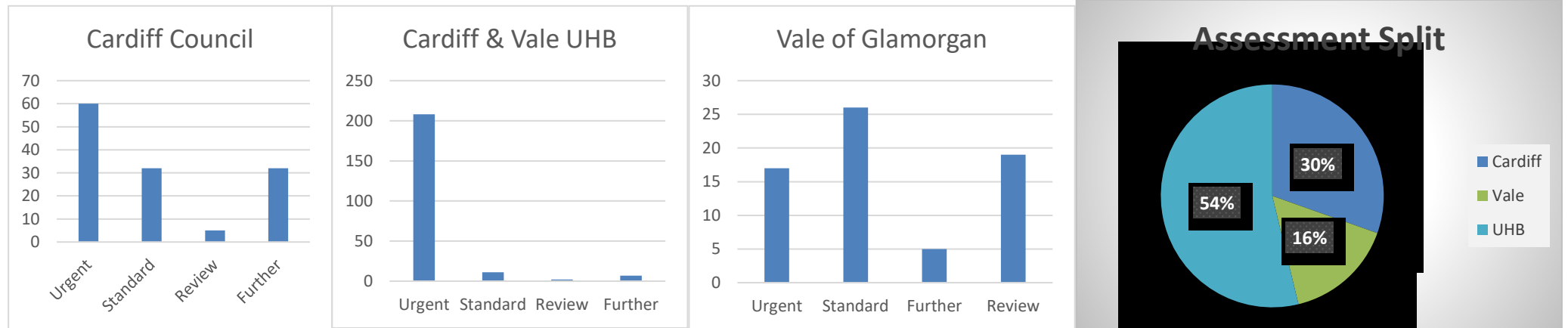
- Urgent 69
- Standard 364
- Further 69
- Review 24

VALE OF GLAMORGAN

- Urgent 21
- Standard 196
- Further 10
- Review 19

Assessments Completed

The charts below detail the number of assessments completed on behalf of each Supervisory Body:



	URGENT	STANDARD	REVIEW	FURTHER	Total Assessments
Cardiff	60	32	5	32	129
Vale Council	17	26	5	19	67
C&V UHB	208	11	2	7	228
Total	285	69	12	58	424

The above highlights that the funding formula split (detailed below) continues to be disproportionate to the number of assessments completed on behalf of each partner:

- Cardiff Council 40.74% plus 1 BIA post @ £45,000
- Vale of Glamorgan Council 14.65% plus 1 BIA post @ £45,000
- Cardiff & Vale UHB 44.61% with additional contribution of £7,000 in 2017/18

As has been identified there continues to be significantly high numbers of urgent requests received from the health board and this reflects the number of

assessments completed on their behalf. The priority tool matrix continues to be used by the DoLS co-ordinator to determine priority and workflow allocation.

Resources

Section 12 Doctors

Currently each and every DoLS Assessment requires a mental health and eligibility assessment by a Section 12 (MHA83) medical examiner at a cost of £182. The cost per Supervisory Body is indicated in the table. The LPS scheme, although requires a medical assessment, the independent reviewer is able to make use of existing medical assessments rather than commissioning a stand-alone assessment. This represents a significant saving over the resource heavy DoLS process.

Use of Section 12 Doctors	Total number of occasions Sec 12 doctor used (April – September 2018)	Cost to Date(£)
Cardiff Council	137	£24,757.44
Vale Council	55	£10,194.24
C&V UHB	219	£39,866.76

Relevant Persons Representative

The role of the IMCA/Relevant Persons Representative in protecting the rights of people deprived of their liberty cannot be	Total Cost
Cardiff Council	£55,147.40
Vale Council	£49,253.79
C&V UHB	0

Issues to consider

The Cardiff and Vale DoLS Partnership Board is asked to note and consider:

Best Interest Assessors capacity/resource

- Ongoing risk associated with the number of outstanding DoLS Authorisation requests.

DoLS Team Funding

- The UHB might wish to consider increasing funding to the DoLS Team to ensure continued compliance with the safeguards
- Renegotiating the DoLS funding equation or revising funding arrangements

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider – this is being redrafted for approval

Improvement Plan

There is currently a review of the processes and functions being undertaken with the DoLS team to consider efficiency savings and where support or resource is required. The outcome of this review will be shared at the next Board Meeting.

Natasha James
Operational Manager, Safeguarding & Service Outcomes
Vale of Glamorgan Council

MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT	
Name of Meeting:	Mental Health and Capacity Legislation Committee
Date of Meeting:	23rd October 2018
Executive Lead: Medical Director	
Author: Mental Capacity Act Manager – tel: 029 2074 3652	
Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together..."	
Financial impact: No direct impact of this report, but the failure to comply with MCA could lead to costly complaints and litigation	
Quality, Safety, Patient Experience impact: Adherence to MCA will mean that vulnerable patients will receive the treatment and care they need, in line with their best interests.	
Health and Care Standard Number: 4.2	
CRAF Reference Number: 8.1.3	
Equality and Health Impact Assessment Completed: Yes / No / Not Applicable	

ASSURANCE AND RECOMMENDATION

LIMITED ASSURANCE is provided by:

This Report is to raise awareness of this aspect of the legal framework within which treatment and care must be provided. There is poor engagement by some Medical and Dental staff with MCA training.

The Committee is asked to:

Note this report and in particular the action that the Medical Director and the MCA Manager are taking to improve clinical staff – especially doctors' - compliance with MCA training.

SITUATION

The Mental Health and Capacity Legislation Committee has asked for information about the use of MCA, in order to retain awareness of this issue.

This information does not provide direct assurance about compliance with MCA, which can only be done by scrutinising patients' notes. The report of the MCA Manager (appendix one), IMCA report (appendix two) and separate DoLS report provide some evidence of adherence to the MCA but only Limited Assurance.

In view of the particularly poor compliance by doctors in some Clinical Boards

with mandatory MCA training (see Appendix 1), the Medical Director and MCA Manager have developed a programme of work, in order to improve the training of doctors and dentists within the next year. The nature of these plans is of varying quality and needs to be followed up over the next six months to ensure suitable outcomes.

The following have been undertaken –

- The Medical Director wrote to the Clinical Board Directors and Nurses setting out the Committee's concerns and the requirement to produce an action plan for MCA training for clinical staff
- Each Clinical Board has developed an MCA training action plan (please see Appendix 3)
- The Medical Director's September Bulletin included information about the importance of MCA training and how to access it
- The MCA Manager has received numerous queries about accessing training and a number of sessions have been arranged for clinical staff
- The MCA Manager has asked the Medical Education Department about the MCA training that training grade doctors receive
- The MCA Manager has asked other UHB colleagues about their approach to MCA training. 4 UHBs responded, as follows –

Hywel Dda – MCA training is “essential” for clinical staff. All professional staff receive taught training (once only) and updates via MCA e-learning, level two

ABM – MCA training is mandatory, delivered through a combination of e-learning and face-to-face

AB – MCA is mandatory, delivered through a combination of e-learning and face to face

Cwm Taf – MCA mandatory for certain staff, delivered through both e-learning and face to face

- The MCA Manager has suggested to the All-Wales MCA Network that a training data set, shared across NHS Wales, may help to increase compliance. A decision on this is yet to be made

BACKGROUND

The Mental Capacity Act 2005 (MCA) has been in force for over 11 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers people aged 16 years and over with three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for authorizing deprivation of liberty when adult, mentally disordered, incapacitated people are deprived of their liberty in hospitals or care homes (DoLS)

Patients who have impaired decision-making abilities may present in any of the services that the UHB provides. Failure to comply with MCA could lead to the following –

- Patients refusing treatment that they need and their refusal being taken at face value, with no assessment of their capacity to make the decision being made. This could (and does) result in serious harm to vulnerable patients
- Patients not receiving care and treatment tailored to their individual circumstances
- Healthcare professionals and the UHB being sued, prosecuted, complained about and being reported to professional bodies
- Adverse inspection reports and publicity for the UHB

In order to assist UHB staff with using MCA, the following are in place -

Training (mandatory)

- Face-to-face teaching from the MCA Manager including Monthly UHB wide sessions at various locations, "Mandatory May and November" training, Senior Medical Induction and Nurse Foundation Programme
- Bespoke training on request
- The All-Wales MCA e-learning course is available for use on ESR

Information and advice

The MCA Manager provides information and advice to UHB staff on all aspects of MCA. There is also a "Mental Capacity" page on the intranet.

Policies and procedures

A number of policies and procedures are in place to support UHB staff in implementing MCA. The MCA Manager also tries to ensure that other policies adequately and accurately reflect MCA where appropriate.

Additional information

Use of MCA within the UHB

Appendix 1 sets out information that indicates the use of MCA within the UHB.
Independent Mental Capacity Advocacy

See also the report (Appendix 2) provided by Advocacy Support Cymru (ASC)
– the statutory advocacy provider.

Mental Health & Capacity Legislation Committee**MENTAL CAPACITY ACT ISSUES AND INFORMATION****October 2018**

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/7/17 – 30/9/17	36
1/10/17 – 31/12/17	19
1/1/18 - 31/3/18	23
1/4/18 – 30/6/18	24
1/7/18 – 30/9/18	15

There are no obvious themes or trends to the queries. Some are straightforward, whilst others are complex, including obtaining legal advice.

2) Monitoring reports from the Independent Mental Capacity Advocacy (IMCA) service

Referrals from the UHB to IMCA are as follows:

Decision/Issue	July – Sept 17	Oct - Dec 17	Jan – March 18	April – June 18

Accommodation	15	20	14	12
POVA Safeguarding	3	1	2	2
Care Review	2	4	2	1
Serious Med T/ment	6	7	9	3
DoLS s.39A	1	1	0	0
DoLS s.39C	0	0	0	0
DoLS s. 39D	9	11	7	8
DoLS RPR	83	78	59	42
TOTAL	119	122	93	68

For further information, please see the IMCA service report (Appendix 2)

3) Healthcare Inspectorate Wales (HIW) reports

There were 3 inspection reports published by HIW in the period April – September 2018 –

- Beech Ward, UHL (MHA inspection) – no MCA issues raised
- Daffodil Ward, UHL – the inspection mentioned poor mental capacity assessments, the need to update the record of DoLS applications and poor compliance with mandatory training, including MCA
- Pine Ward, UHL – no MCA issues raised

4) Complaints from patients/carers

No complaints concerning or related to MCA issues during this period have been brought to the attention of the MCA Manager. However, it is very likely that there are complaints in this period which include MCA issues.

5) Public Services Ombudsman for Wales reports - <http://www.ombudsman-wales.org.uk/en/publications/The-Ombudsmans-Casebook.aspx>

The Ombudsman's Case Book for the period April to June 2018 includes 4 cases that were upheld or partially upheld against Cardiff and Vale UHB. MCA issues do not appear to be a factor in any of the cases.

However, the Ombudsman has issued (August 2018) a public interest report into the failure of Newport Council to provide an appropriate service to a person, because they did not comply with MCA. This suggests that awareness of MCA is increasing.

6) Staff MCA training as at 31st August 2018

CLINICAL BOARD	Prof Group	No. who have undertaken training	Compliance %
Children & Women			
	Allied Health Profs	109	93.16
	Nursing & Midwif	928	84.06
	Medical & Dental	105	44.49
CD&T			
	Allied Health Profs	577	82.66
	Nursing & Midwif	43	87.76
	Medical & Dental	49	47.12
Dental			
	Allied Health Profs	5	100
	Nursing & Midwif	10	100
	Medical & Dental	93	73.81

Medicine			
	Allied Health Profs	1	33.33
	Nursing & Midwif	697	86.69
	Medical & Dental	37	14.92
Mental Health			
	Allied Health Profs	34	91.89
	Nursing & Midwif	406	74.77
	Medical & Dental	18	23.38
PCIC			
	Allied Health Profs	80	96.39
	Nursing & Midwif	266	70.74
	Medical & Dental	4	8.89
Specialist			
	Allied Health Profs	33	76.74
	Nursing & Midwif	660	77.19
	Medical & Dental	32	13.28
Surgery			
	Allied Health Profs	9	81.82
	Nursing & Midwif	401	77.26
	Medical & Dental	50	13.30

Clinicians must not provide treatment and care to patients outside of the legal framework that covers these issues - in general, patients can only be treated/cared for with valid consent, or through Mental Capacity Act 2005 or Mental Health Act 1983.

INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA)
April to June 2018

General

The IMCA team continues to work with professionals to improve communication and understanding of the IMCA role as well as promoting the MCA 2005 when required. IMCAs try to ensure that correct processes and procedures are followed in line with the MCA 2005 and case judgements. IMCAs are ensuring that the decision maker is pursuing the least restrictive option in relation to the decision that needs to be made, as well as acknowledging the MCA's guiding principles.

IMCAs continue to refer cases to the Court of Protection when necessary, and also highlight to professionals when court involvement may be appropriate in cases relating to Serious Medical Treatment (SMT) decisions, Long Term Move of Accommodation (LTMA) decisions, Adult Safeguarding (POVA) and Care reviews.

Service Issues

- General lack of understanding and acknowledgement from professionals in relation to IMCA role
- General lack of Serious Medical Treatment, Adult Safeguarding and Care Review referrals
- General lack of understanding and acknowledgement from professionals in relation to Court of Protection processes and requirements

Example Case

P was admitted to hospital after being found on their garage floor confused and hallucinating. P was initially placed under s.3 of the Mental Health Act before being made subject to a DoLS authorisation.

P was described as having varying capacity and the MDT was considering discharging P to a care home. P was objecting to being in hospital and objecting to being discharged to a care home.

The MDT had concerns about P going home – e.g. P's alcohol consumption and the people P associated with. P also needed prompting and supervision with personal care and with taking medication. A best interests meeting was held where it was decided that it was in P's best interests to go into a care home. As RPR, the IMCA visited P on 4 occasions and on each occasion P maintained that they were objecting to being in hospital and objecting to a discharge to a care home.

As RPR, the IMCA instructed a solicitor on P's behalf to raise a section 21a appeal in the Court of Protection, enabling P to access their legal rights. The solicitor was going to challenge the DoLS authorisation that was in place, challenge the decision made for P to go into a care home and challenge P's capacity assessment.

A second best interests meeting was held where there were more in-depth discussions held around P going home and more consideration given to this option.

CLINICAL BOARD MENTAL CAPACITY ACT TRAINING ACTION PLANS

CD&T

31st May 2018	Allied Health Profs	685	685	543	79.27
	Nursing & Midwif	47	47	36	76.6
	Medical & Dental	102	102	39	38.24

Data 31st August 2018

Staff Group	Assignment Count	Required	Achieved	Compliance %
Add Prof Scientific and Technic	225	225	182	80.89%
Additional Clinical Services	496	496	406	81.85%
Administrative and Clerical	424	424	342	80.66%
Allied Health Professionals	698	698	577	82.66%
Estates and Ancillary	12	12	11	91.67%
Healthcare Scientists	370	370	349	94.32%
Medical and Dental	104	104	49	47.12%
Nursing and Midwifery Registered	49	49	43	87.76%
CD&T Total	2378	2378	1959	82.38%

Compliance with MCA training in CD+T has improved since May 2018 with overall compliance 82.38%

As expected there is a smaller cohort of medical personnel in CD+T however, compliance is currently below 50%.

Date agreed: 27th September 2018

Monitoring arrangements: Clinical Board and Directorate Quality & Safety Governance Forums

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
1	General awareness of the Mental Capacity Act	MCA information to be shared with staff electronically and via notice boards, newsletters.	MCA lead cascade to Directorate teams via CB secretary.	31.10.2018	
2	All staff to undertake MCA e-learning training	Line managers to inform staff of their responsibility to complete the mandatory MCA e-learning module and to provide evidence of completion. Signposting to ESR with emphasis on medical staff to complete; circulate instructions how to access ESR. Departmental managers and clinicians to discuss completion of the module at PADR meetings. Training and compliance figures will be monitored and discussed monthly at CB QS+PE meetings.	Departmental managers Departmental managers Lead clinicians/department leads MCA lead to obtain and cascade monthly figures for CB.	31.10.2018 31.10.2018 Ongoing Monthly	
3.	Share training compliance figures in QS+PE meetings.	Training + compliance to be discussed in department QS+PE meetings.	Department QS+PE leads/ managers to obtain figures for their departments.	monthly	

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
4.	Face to face training where compliance is low	Contact Julia Barrell to provide training	Department /QS+PE leads to contact Julia Barrell	Depending on compliance	
5.	MCA concerns/ incidents to be shared for learning.	Present patient stories in QS+PE meetings.	MCA lead and departmental QS+PE	ongoing	

Community Child Health

1. LED producing a breakdown of compliance with MCA training specifically for community child health so we can see what is needed to be targeting. Mandatory training session last year in community child health forum was well attended. Report expected early October and can be forwarded at that point.
2. Reminder email regarding training sent to target groups.
3. Upcoming Q and A session with Julia Barell during community forum (Q and S session) in October 2018 to further raise awareness.
4. Mandatory training session face to face to be arranged in community forum for 2019 if compliance remaining low after above interventions.

October 2018

DENTAL

Over the past year, the application of the Mental Capacity Act in relation to the delivery of dental services within the Dental Clinical Board has been presented at the Audit & Clinical Governance meetings of the Restorative Dentistry, Oral Surgery, Medicine & Pathology and Community Dental Service groups. A presentation will be given to the Paediatric Dentistry and Orthodontic groups in the near future.

With regard to the 85% compliance, the data on LED for the Dental Clinical Board is as follows;

Allied Health Professionals	100%
Nursing	91%
Medical & Dental	73%

A list of the names of those staff who have not completed training has been given to the MCA Lead who will be ensuring compliance in the near future.

MEDICINE

- All consultants have been emailed and asked to check whether their training is up to date on ESR
- I have suggested to CDs and Q&S leads that they may wish to ask one of Julia's team to undertake a group training session at a Q&S meeting (I believe at least 1 Directorate has taken up this offer)
- I have also contacted LED, asking them to provide a list of consultants' names and the date they last completed their training. I suspect that the compliance has dropped because we've hit a cut-off point where training has expired (though, as we have discussed, this may be something we wish to look at again).

MENTAL HEALTH

ACTION	TIMESCALE
Medical staff to be reminded, by their CD, to access the online MCA training	3-6 months for 100% compliance
Medical staff MCA training to be linked to annual appraisal	6-12 months
Request Julia Barrell to facilitate small group training sessions for medical staff	3-6 months
Nursing staff compliance to be emphasised over next 3 months to improve upon 71% compliance currently	3 months

It should be noted that Section 12 doctors are required to attend training provided by Cardiff Local Authority. This explains, in part, why the medical compliance appears so low. Mental Capacity is core business for psychiatry/psychiatrists, therefore the mandatory MCA training may not be seen as a priority.

PRIMARY, COMMUNITY AND INTERMEDIATE CARE

MANDATORY MENTAL CAPACITY ACT TRAINING IMPLEMENTATION PLAN

TARGET FOR COMPLIANCE: 100%

Key	Green – target met; action completed	Amber – action scheduled and expected to be completed on time	Red – action not yet taken or scheduled
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ACTION TO COMPLETE	TARGET DATE FOR IMPROVEMENT	RESPONSIBLE PERSON	BUSINESS UNIT UPDATES			
			North and West Locality	South and East Locality	Vale Locality	Palliative Care
Build MCA training into CPET sessions and CD Forum NOTES: <ul style="list-style-type: none"> Community Directors likely to have completed MCA training as part of GP appraisal/MARS; this would not be captured in UHB data GMS is supported by individual Practice input from PCIC Clinical Governance team where need is identified. 	Mental Capacity Act to be covered in December 2018 and January 2019.	Maria Dyban/Anna Kuczynska	All localities will be covered by this action.	All localities will be covered by this action.	All localities will be covered by this action.	All nurses and doctors on the palliative care team are up to date with their training following a recent MCA training session with Julia Barrell
	Covert medication with best interests training completed in 2018.	Maria Dyban	GMS: 27.71% attendance rate		GMS: 24.21% attendance rate	
	DoLS training completed in 2017	Maria Dyban	GMS: 23.61% attendance rate		GMS: 21.87% attendance rate	

Monitor team compliance via Senior Nurse 1:1 meetings with District Nursing sister	Start with immediate effect and maintain as ongoing monitoring	Locality Lead Nurses	Part of regular 1:1 meetings	All Team Leaders have 1:1 meetings – MCA compliance will be discussed	Scheduled for discussion with each Vale nursing lead at individual 1:1 meetings	
Arrange face-to-face training and awareness raising sessions in the Locality from Julia Barrell, Mental Capacity Act Manager	December 2018	Locality Lead Nurses	Two sessions already held; two more planned for September and October	Booked to provide training at Locality Quality and Safety meeting 10th December, 2018		
To raise as a standing item on the Locality QSE meeting agenda	With immediate effect	Locality Lead Nurses	Now incorporated as a standard agenda item	Discussed at Locality QSE meeting August 2018	Agenda item 21 st August 2018	
Team Leads to review their team's compliance and ensure staff who are not up to date to complete MCA training as soon as possible	With immediate effect	Locality Lead Nurses	Part of regular 1:1 discussions	Discussed in Q&S September 2018	Scheduled for discussion with each Vale nursing lead at individual 1:1 meetings	
Email all managers reminding them to ensure all staff undertake training	September 2018	Locality Lead Nurses	Part of regular 1:1 discussions	August 2018	Reminded at August Vale QS&E meeting	
Advise managers to let staff attend "Mandatory October" training sessions	October 2018	Locality Lead Nurses	Part of regular 1:1 discussions	August 2018	Part of regular 1:1 discussions	
Continue to ensure compliance through PADR and mandatory training monitoring	With immediate effect	Locality Lead Nurses	As PADRs become due	As PADRs become due	As PADRs become due	As PADRs become due

SPECIALIST SERVICES

	Recommendation	Action	By Whom	By When	Actual Completed Date*	Progress/Remarks	Monitoring For Compliance	Evidence / Audit
1	Mandatory Training Compliance	Review of current compliance and identification of staff groups not compliant i.e. Medics				Performance information is received on a monthly basis by the Clinical Board. This identifies the nursing and medic compliance rates.		
		To use the Business Intelligence Reporting System to monitor compliance and improvements				Pending accessibility - once able to run these reports, they can be used alongside the Performance information and can be filtered to attend to individual and Directorate level compliance.		
		Review of Mandatory Training E-Learning and Classroom Session availability to maximise engagement				Current confirmed training availability for classroom sessions until November 2018.		
		A report on staff compliance with MCA training should be included by each directorate along with their audit results.						
2	Review of the recent MCA Audit and Tool and	The Audit Tool to be designed to ensure that assessment of capacity is being audited.						

recommendations identified	The audit tool should be re-designed so that the total number of patients screened is recorded and not just the results for those with a suspected disorder of the mind. This should allow a constant sample size between directorates and also comparison of different rates of disorders of the mind between clinical areas.						
	The audit should be conducted prospectively (i.e. not from case notes) so that the audited assessment of Mental Capacity can be compared to the documented assessment.						
	The audit should be repeated annually but at a different time to the documentation audit.						
	It may be worth considering separate audits of capacity assessment as documented in Section 4 consent and DNACPR forms.						
	All SS directorates should take part using the standard audit tool.						
	The UHB's capacity assessment and best interests forms should be used much more widely.						

SURGERY

Monitoring arrangements: Clinical Board and Directorate Quality & Safety Governance Forums

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
1	Raise staff awareness of the Mental Capacity Act	MCA information to be shared with staff electronically and via notice boards, newsletters and face book pages	Directorate teams	31.10.2018	
2	All staff to undertake MCA e-learning training	<p>Practice educators to provide a report to Sisters/Charge nurses/Directorate teams current compliance for their teams</p> <p>Line managers to inform staff of their responsibility to complete the mandatory MCA e-learning module and to provide evidence of completion to a member of the education team</p> <p>Ward sisters/charge nurses/service managers/ADMs to discuss completion of the module at PADR meetings.</p>	<p>Practice educators</p> <p>Ward sisters/charge nurses/service managers/ADMs</p>	<p>31.10.2018</p> <p>31.10.2018</p>	

	Recommendation	Recommended Action	Person Responsible	Implementation by:	Evidence of Progress and Completion
			Ward sisters/charge nurses/service managers/ADMs	Ongoing	
3	Staff to access face to face MCA training	Practice educators to liaise with Julia Barrell and MCA Team to arrange face to face training on audit sessions/Team meetings	Practice Educators	31.11.18	
4	MCA guidance to be shared with all staff	MCA Guidance to be made available to all staff	Directorate management triumvirate teams	30.10.2018	

MENTAL HEALTH ACT MONITORING	
Name of Meeting :	Mental Health & Capacity Legislation Committee
Date of Meeting :	23 October 2018
Executive Lead :	Chief Operating Officer
Author :	Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well:	This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact :	None
Quality, Safety, Patient Experience impact :	(if applicable)
Health and Care Standard Number:	1 (governance & assurance); 2 (Equality and Diversity); 5 (Patient Experience); 9 (Information and consent); 10 (Dignity and Respect); 11 (Vulnerable adults); 18 (Communicating effectively); 19 (Information); 20 (Records Management); 22 (Managing risk), 23 (Dealing with concerns and managing incidents), 26 (Workforce training organisational development)
CRAF Reference Number This can be found here
Equality and Health Impact Assessment Completed:	Not Applicable

ASSURANCE AND RECOMMENDATION
<p>ASSURANCE is provided by:</p> <ul style="list-style-type: none"> Mental Health Clinical Board Director of Operations <p>The Committee is asked to:</p> <ul style="list-style-type: none"> AGREE

SITUATION

Detention without authority

Any exceptions highlighted in the Mental Health Act Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to a community treatment order is only as the Act allows.

There are no exceptions for this period.

Section 136

Guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983 has been issued by Welsh Government since amendments were made to s.136 by the Policing and Crime Act 2017.

BACKGROUND

Detention without authority

The number of patients detained without authority had been eradicated since January 2017 until last quarter where there were three incidents previously reported.

Section 136

The amendments made to s.136 by the Policing and Crime Act 2017 reduced the detention period from 72 hours to 24 hours which could be extended under certain circumstances to a maximum of 36 hours. The detention period commenced when the person arrived at the designated place of safety which is Hafan Y Coed, University Hospital Llandough for Cardiff and Vale University health Board.

However 4.4 of the guidance for the implementation of changes to police powers and places of safety provisions in the mental health act 1983 states:

"If a person is subject to a section 135 or 136 is taken first to an Emergency Department of a hospital for treatment of an illness or injury (before being removed to another place of safety) the detention period begins at the point when the person arrived at the Emergency Department (because a hospital is a place of safety)."

Legal advice has been obtained and confirmed that the position is fairly clear with regard to practitioners in Wales because of the guidance given in the Welsh Code of Practice. This means that time does not begin to run while the person is in the A and E department **as long as the s.136 interview and examination procedures are not commenced at the department**. If they are, time will begin to run when the person enters the A and E department.

A detailed consideration of this issue is contained in Richard Jones new Mental Health Act Manual:

"There is case law which is supportive of not counting time spent in an A and E department where no mental health assessment has been undertaken. In *Webbley v St George's Hospital NHS Trust*, which is considered in the General Note to s.6 under the heading "Treatment in an A and E department en route to the hospital named in the application", a patient who was subject to an application under s.2 had been detained in an A and E department for physical treatment for two hours prior to his intended admission to the hospital named in the application (the A and E department was located at a different hospital). No point was taken in the case as to the authority for detaining the patient at the department pending his arrival at the hospital named in the application. It is submitted that the authority is to be found in s.137 and that s.137 would also provide authority for detaining a person in an A and E department prior to his arrival at the intended place of safety.

As an element of doubt as to the correct legal position does not constitute a "cogent reason" for departing from the *Code of Practice* (see the General Note to s.118), the approach that should be adopted practitioners in Wales is clear: they should follow the guidance contained in the *Code of Practice for Wales* as long as the interview and examination procedures required by this section are not commenced in the A

and E department. In the absence of guidance on this issue being provided either by the courts or the *Code of Practice* for England, practitioners in England should obtain legal advice as to which approach to adopt. In the author's opinion, the approach advocated by the *Code of Practice for Wales* is to be preferred. Those providing advice should bear in mind that it is clearly unsatisfactory for different approaches to this important issue being followed in the two countries

The Royal College of Emergency Medicine has published a "Brief guide to Section 136 for Emergency Departments" (2017) which can be accessed at:

www.rcem.ac.uk/docs/College%20Guidelines/A%20brief%20guide%20to%20Section%20136%20for%20Emergency%20Departments%20-%20Dec%202017.pdf

ASSESSMENT AND ASSURANCE

Detention without authority

No breaches.

Section 136

No breaches.

**PART 2 MENTAL HEALTH MEASURE – CARE AND TREATMENT PLANS (CTPS)
– DEEP DIVE REPORT**

AUGUST 2018

Name of Meeting : Mental Health Capacity Legislation Committee

Date of Meeting: 23 October 2018

Executive Lead: Clinical Board Director – Mental Health

Author : Mental Health Clinical Board Director of Operations

Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.

Quality, Safety, Patient Experience impact : Applicable to all Health Care Standards

Health and Care Standard Number: 1&6

CRAF Reference Number: 8.1.2

Equality and Health Impact Assessment Completed: N/A

RECOMMENDATION

The Committee is asked to:

- **AGREE** the approach taken by the Mental Health Clinical Board

SITUATION

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee. From June 2018 Part 2 of the Measure has breached by Circa 5%. This paper describes the issues and action plan of the mental health clinical board to reach compliance.

BACKGROUND

The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance. More specifically Part 2 of the measure entitles all service users in receipt of

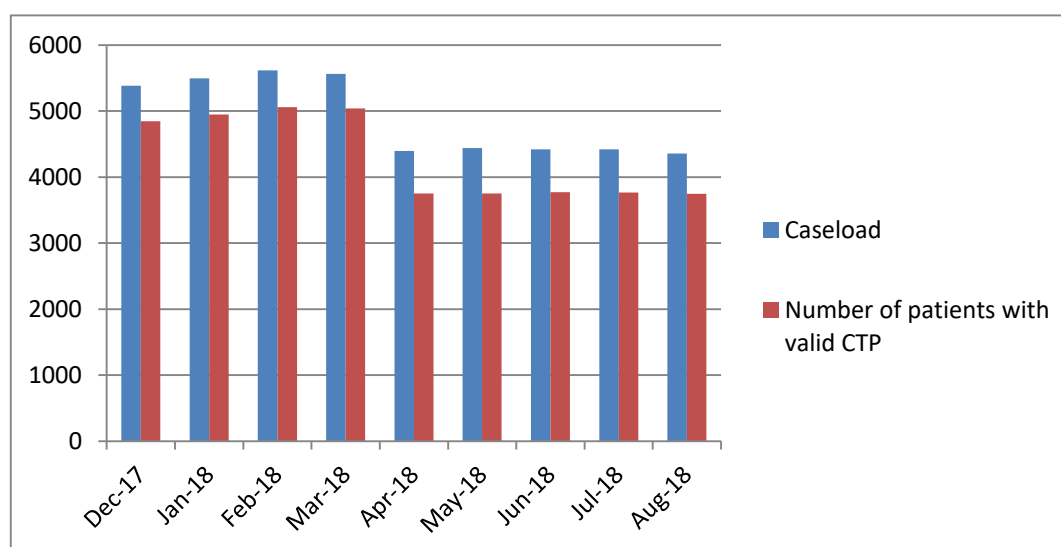
secondary care services to have a care and treatment plan which has been coproduced and signed by the service user. Practitioners are guided in the spirit of this element of the measure to develop CTPs with service users and focus on outcomes desired by those involved in it co-production. The target is for the MHCB to be 90% compliant and the current position is circa 85%. This represents approximately 150 service users care plans out of a community caseload of circa 4,200. Almost half of the people on our caseloads are looked after by a consultant only.

ASSESSMENT AND ASSURANCE

For Parts 1, 2 & 3 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

The performance target set by Welsh Government for Part 2 is 90%. Monthly caseload variance is due to rates of referrals and discharges. The data includes Adult, Older Adult, Forensic, Learning disabilities and CAMHS services:

	Apr - 18	May - 18	June - 18	July - 18	Aug - 18
Total number of patients in receipt of secondary MH services in C&V	4395	4441	4421	4421	4354
90% of Service users have a valid CTP	3762 85.6%	3750 84.4%	3770 85.3%	3764 85.1%	3746 86.1%



Performance Issues

During the past two months the clinical lead for quality, safety and governance in mental Health has been undertaking extensive work relating to C&V's WG returns and cleansing what our computerized system (PARIS) has been reporting – particularly in relation to duplication of patient records and how PARIS counts total caseload numbers. This has reduced somewhat the total caseload numbers in secondary mental health services for April and impacted on compliance.

The impact on compliance is due to low CTP completion compliance for service users that are solely looked after by a psychiatrist - which are now a larger proportion of the total number. The poor CTP compliance amongst the medical staff is due to many of their caseloads being very large, up to 200 in some cases, with many on the caseloads having low health needs not requiring being in secondary care as '**Relevant**' service users.

Often these patients may not have been discharged back to primary care due to 117 eligibility (where legal advice is contrary to both the spirit of 117 after care and the new MH Measure in that discharge is not advised where service users remain on psychiatric medication even if they have been stable for a number of years) or high workloads preventing this. On initial investigation it also appears to be the case that many Patients are reluctant to be discharged due to eligibility for benefits and PIP assessments. In addition the clinical nature of the psychiatrists work is changing with specialist conditions such as ADHD needing to be on a cmht caseload to provide specialist medication but have generally very low levels of need. The CB is asking whether it is reasonable and proportionate to ask medical staff to complete detailed CTPs for these patient groups and is it in the spirit of Part 2 of the Measure or what 117 after-care was originally trying to achieve.

The All Wales Delivery Unit report into CTP completion in Mental Health services confirmed that CTPs were being completed in all UHBs for 'relevant' patients, and this is true for Cardiff and Vale where all complex patients needing MDT support have a care and treatment plan, albeit the CTPs were largely of poor quality – this all-Wales feedback report will be subject of a separate Assurance Report at the Mental Health Legislation Committee and has a far more complex plan for the future which will highlight a range of important issues in Mental Health such as culture, shifting models, the role of professionals and the strengthening SU movement.

The MHCB has current plans and is developing further plans to work closely with the care co-ordinators to improve the uptake of CTP's and reassess its position with medical staff. Urgent actions include the following:

Short Term

- Each directorate within the Mental Health Clinical Board has been directed to undertake their own audit, which they will feed back to the Clinical Board. The audits will relate to the quality of the care and treatment plans as well as the quantity – **September 2018**.
- Where there are medical shortages or vacancies the CB is using the opportunity to support the position by reviewing and reducing medical caseloads in order that the role is manageable for subsequent post holders - **Ongoing**.
- For the adult directorate to meet with the consultant staff through the job planning process to highlight these issues and offer supportive actions to remedy as well as gather intelligence on the issues described in terms of a 'proportionate' response' to 'relevant' patients – **ongoing currently**.
- The Dir of Ops to meet with the consultant body in adult services as a whole to discuss the requirements of the measure Part 2 and the problems that the consultant body have identified in applying it to their practice. On initial discussion, the consultants may have legitimate concerns regarding whether the spirit of the CTP in wrapping complex MDT care around the service user was meant to apply to some of the patient groups on their caseloads as described earlier in this paper. In this meeting also to explore whether the clinical record keeping that the medical staff currently do constitutes the content of a CTP but in a different format – **September/October 18**

Longer term

- Advice from the WG in relation to 117 eligibility and the specific conditions under which service users can be discharged to secondary care – WG Event **in August 2018**.
- Point 1 above will allow the service to take more positive recovery motivated risks with individuals in discharge and support through more general primary care based community services, with the option to re-access mental health specialist services through Part 3 of the measure.
- To pilot a whole locality New Way of Working for the MDT in the Vale from the autumn in terms testing a more sustainable model of CTP development and review. This will be as part of the community mental health services review (change in location, referrals and access pathways) to send a selected group of service users their CTPs prior to their outpatient review meetings to offer they complete the 'needs' and 'outcomes desired' elements of their CPTs prior to the MDT meeting – it is an exploration into whether the shift in dynamic of the responsibility for and expectation of a useful and valued CTP based on a therapeutic relationship between professional and service user will be effective.

Improvement expected

Initially the CB and directorates will request increased focus through August and September 18 to ensure the most complex Service Users requiring strong MDT support all have CTPs. There is a possibility that this will achieve compliance alone by the October/November reporting period.

At the same time if the clinical Board decides that there are certain service user cohorts on caseloads that are not relevant under the MHM then it is very likely that this figure will exceed the 150 required to meet compliance. These adjustments will be made during September/October/ & November.

PART 2 MENTAL HEALTH MEASURE - CARE AND TREATMENT PLANS MENTAL HEALTH SERVICES

Name of Meeting : Mental Health Capacity Legislation Committee Date of Meeting: August 2018
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Executive Lead: Clinical Board Director – Mental Health
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Author : Mental Health Clinical Board Director of Operations

Caring for People, Keeping People Well : This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.

Quality, Safety, Patient Experience impact : Applicable to all Health Care Standards

Health and Care Standard Number:

CRAF Reference Number:

Equality and Health Impact Assessment Completed:

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- | |
|---|
| <ul style="list-style-type: none">• Mental Health Clinical Board Director of Operations |
|---|

RECOMMENDATION

The Committee is asked to:

- | |
|---|
| <ul style="list-style-type: none">• AGREE the approach taken by the Mental Health Clinical Board |
|---|

SITUATION

This is an assurance report following receipt by Cardiff and Vale UHB of the recent National Delivery Unit All Wales report on the quality and use of Care and Treatment plans under Part 2 of the Mental Health Measure (See attached.)

Cardiff and Vale Mental Health services were typical of the All-Wales position in that CTPs were generally completed for all 'relevant' patients (patients who meet the criteria for access into secondary mental health services) but the quality and application of those plans were generally poor. Also completed poorly were the building blocks of good care and treatment planning such as the completion of risk management plans and use of the CTPs as a

therapeutic tool to support the measurement of outcomes that are identified as important to our service users.

This is a long standing issue in mental health services and was the case for the application of the Care Program approach (CPA) prior to the introduction of the Measure despite a number of years of training and support to the care coordinators responsible for the development of care plans.

The report refers to the development of an improvement plan but also recognizes that simply training and cascading responsibility to case managers does not generally improving the quality and use of CTPs.

This report outlines how Mental Health services in Cardiff intend to approach this issue in developing sustainable improvements to CTPs in parallel with the care to service users.

BACKGROUND

The Mental Health (Wales) Measure 2010 was commenced in 2012. Part 2 of the Measure places duties on the 'relevant mental health service provider' to appoint a Care Coordinator for an individual in receipt of secondary mental health services and to ensure that a Care and Treatment Plan (CTP) is developed for them. The Part 2 Regulations prescribe the form and content of the CTP.

The Code of Practice to Parts 2 of the Measure provides additional statutory guidance regarding the preparation, content, consultation and review of CTPs. Part 2 of the Measure is applicable to all individuals **in receipt of secondary mental health services, these people are described within the Measure as 'relevant patient's'**.

'Relevant patient' status also includes 'any individual who has a co-occurring learning disability and mental health problem and receives interventions and treatment from the learning disability service to address their mental health as well as their learning disability.'

Significant improvement has been made in ensuring that CTPs are in place for every individual. However, limited external focus has been given to ensuring that CTPs are developed to an appropriate standard in line with the requirements of the Code of Practice to Part 2 of the Measure and the recommendations of the Welsh Government's (WG) duty to review.

The focus of the Delivery Unit's (DU) review was to evaluate the quality of care and treatment planning processes in adult working age mental health

and learning disability services. The features required of a satisfactory care and treatment plan include the following:

- Care and Treatment Plans should be outcome focussed. Where outcomes are set they need to be routinely specific, measurable, achievable realistic and time bound (SMART).
- Plans need to reflect outcomes across the breadth of the eight life areas as described in the code of practice..
- The recording of assessments and CTPs should reflect service user engagement or co-production, and to evidence this.
- The quality of risk assessment and risk management planning should be of a satisfactory standard with evidence of the application of a risk formulation process such as the Wales Applied Risk Research Network (WARRN) formulation.
- To evidence adherence to the formal duty to review the CTP within 12 months.
- Evidence of integration between mental health and drug and alcohol services and of personalised crisis planning within the CTP, and service users, carers and stakeholders. With clarity of how to access services during a crisis.

ASSESSMENT

Approach and Methodology

The DU's assurance review consisted of four key components; an initial meeting with Health Board and Local Authority (LA) senior management colleagues, site visits including a case note audit undertaken by DU staff and supported by local peer reviewers (PRs), stakeholder focus groups and verbal feedback from the review team.

The meeting with senior managers uses a semi structured interview to address the factors that can effect Measure compliance and the quality of CTPs in Mental Health and Learning Disability Services. Site visits were undertaken at three Community Mental Health Teams (CMHTs) and the Hafan-Y-Coed adult inpatient unit.

During site visits a case note audit was undertaken using a data capture tool created by the DU, based upon the Welsh Government's national CTP audit tool. The case note audit was undertaken by DU staff together with peer reviewers (PRs) drawn from nursing staff across the community and inpatient services. It is important to note that whilst the review methodology enabled the evaluation of performance within the teams and settings visited, the findings in this report relate only to these teams. Findings cannot therefore be generalised to all teams within the Health Board.

Key Messages

‘Care and Treatment Plans are not outcome focussed. Where outcomes are set out they are not routinely specific, measurable, achievable realistic and time bound (SMART). Many plans lack outcomes across the breadth of the eight life areas’

‘The recording of assessments and CTPs does not reflect service user engagement or co-production, even where there are opportunities to evidence this.’

‘The quality of risk assessment and risk management planning is variable with little evidence of the application of a risk formulation process such as the Wales Applied Risk Research Network (WARRN) formulation.’

‘A significant proportion of cases did not evidence adherence to the formal duty to review the CTP within 12 months.’

‘Stakeholders and Carers reported a lack of integration between mental health and drug and alcohol services. There was lack of personalised crisis planning within the CTP, and service users, carers and stakeholders reported difficulty or uncertainty in being able to access services during a crisis.’

Recommendations

1. The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning.
2. The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual’s safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning.
3. The Health Board and partner agencies should ensure that formal reviews of CTPs are undertaken in a timely manner that does not exceed the statutory duty for review.
4. The Health Board and partner agencies should ensure that there is an integrated and joined up approach between mental health and drug and alcohol services for people who experience co-occurring issues.
5. Care Coordinators should ensure the inclusion of third sector agencies that are providing regular and ongoing support to an individual within the assessment, planning and review processes.

In addition to these five recommendations, there are questions to resolve which are being raised in the operational field in terms of 'what is a relevant patient' in current mental health services as there is an acceptance that within current caseloads there are patients who have primary care only needs, in particular:

- People who have ADHD and require medication initiation from secondary care services but then remain on caseloads.
- People who have a moderate or severe mental illness and are in a stable condition but have remained on secondary care caseloads for a long period of time. This could be due to the constraints of 117 after-care or time and capacity to affect discharge, which is often very unpopular amongst service users for various reasons which may include a feeling of security being lost or the fear of impact on benefits received.
- Practitioners report contradicting messages with service users, with practitioners finding that the practical use of a computerized format an inhibiting factor in Collaborative working with the service user in completing the CPT, which they report is similarly not valued by the service user. This reinforces long standing messages that it is felt to be a beaurocratic process that is completed in parallel with the 'real' care and treatment and does not enhance the therapeutic relationship with the service user. Service users continue to report valuing the idea of the CTP process.
- SUs report that crisis plans are their top priority
- Interface between CTP and Social Services & Well-Being Act

Action Plan

This is a challenging agenda that requires a fundamental shift in the value practitioners put on the CTP process in seeing it and it being used as a therapeutic tool at the center of the relationship between mental health professionals and those we care for. It is felt that to develop sustainable improvements, a phased improvement approach is required to test different applications of approaches to adopt more widely if successful

Delivery Unit /UHB Comment	Action / Phases	Who and by when
Phase 1 – Understanding and Commitment		
1. Complex whole system challenge with varying levels of	i. DU to present findings to MDT in Mental Health ii. Clinical Board sponsored multi-agency Implementation team to be established to oversee development and implementation of the action plan with support from LA	Dave Semmens – Complete

understanding and commitment	<p>directors and Third sector leads</p> <p>iii. To consider within the implementation team above broad elements of related issues within the plan such as New Ways of Working, New Mental Health models of care, peer support, Service User empowerment, use of PARIS etc</p>	Ian Wile – Complete
2. Lack of clarity over which service users in secondary care community services meet the 'relevant patient' status to ensure efforts are targeted at those most in need.	<p>i. Clarify with the MDT whether cohorts of service users such as those with ADHD and those who are stable in services require and are receiving a service equivalent to secondary care.</p> <p>ii. If not to discharge safely or develop shared care arrangements with primary care to allow the MDT to focus its CTP efforts on eligible service users.</p>	October 2018 DOO and CDs
Phase 2 – Intervention & Evaluation		
3. The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual's safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning	<p>i. Review the simplicity of documentation related to risk assessment and risk management and refine where necessary (layers of documentation have developed with the various iterations related to the use of CPA, IA,UA and now CTP) and change/reduce where necessary</p> <p>ii. Deliver Risk Assessment & WARRN training in sequence with WARRN training target of 250 staff over 2years and CTP training to 40 % of staff in 2 years based on the new national booklet</p> <p>iii. Audit compliance bi-monthly and feed-back to MHCB Q&S Committee and report into the MHLC Formally annually</p>	<p>DOO DON CCCT LNs October – December 2018</p> <p>SN Community & CMHT Managers - Commenced</p>
4. The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning.	<p>i. Establish an education and training sub group and package which includes a guide to CTP use and development and the following characteristics:</p> <p>a. Its use as a Therapeutic tool</p> <p>b. Link with service user outcome measures</p> <p>c. MDT and Multi-agency delivery</p> <p>d. Focuses on a Pilot site to be determined</p> <p>ii. Ensure a sufficient resource is available from the multi-agencies involved to support the rollout to at least 80% of MH staff in 2 years</p>	Owen Baglow March 2019
5. The Health Board and partner agencies should ensure that formal reviews of CTPs are undertaken in a timely manner that does not exceed the statutory duty for review.	<p>i. See training notes in no. 4 above</p> <p>ii. Continue to circulate lists of clients with 117 after-care responsibility to the integrated managers for use with MDT reviews</p> <p>iii. For Community service leads to develop a process of reminding case managers of review times which could include a PARIS flagging process.</p> <p>iv. Develop a comprehensive caseload supervision process to regularly support practitioners with caseload management and standards of clinical practice records including CTPs.</p>	<p>Ongoing – MHAct Manager DOO</p> <p>Complete on PARIS</p> <p>Senior Nurse Community & Integrated Managers</p>

	v. Undertake CTP audit using the Delivery Unit tool on a sample of at least 50 service users per quarter and report back performance to MHCB Q&S committee and the Mental Health Legislation Committee.	of CMHTs – March 2019 Re-audit January - 2019
6. Care Coordinators should ensure the inclusion of third sector agencies that are providing regular and ongoing support to an individual within the assessment, planning and review processes.	i. Pilot plan to offer to send CTPs to a sample of current SUs to complete and return in preparation for attendance and their next case review. To offer allied advice on sources of support from the third sector and others in completing the CTP – in particular outcomes important to them and timescales. ii. To offer collaborative training for SUs and others in the use of the CTP to improve outcomes as a therapeutic tool. Also to raise expectations in terms of standards expected by service users.	Ongoing – Dan Crossland for 3 months Third sector & SU rep meet planned for November 2019 to plan – DOO
Dual Diagnosis		
7. The Health Board and partner agencies should ensure that there is an integrated and joined up approach between mental health and drug and alcohol services for people who experience co-occurring issues.	i. Establish a discrete resource in general adult and substance misuse services to improve Integrated working – an ANP in general adult with a significant element of the role dedicated to dual diagnosis and sessional time from a senior clinician in Substance misuse services – both roles to work collaboratively and focus on training, joint care planning MDT working and accessing wider support for individuals. ii. For above post-holders to be clear about improvements anticipated to allow for baseline measurement and improvements to be monitored.	Complete Seek funding for COMPASS Model - complete Complete



**The NHS Delivery Unit (DU) all Wales Review
of the Quality of Care and Treatment
Planning in Adult Mental Health Services**

**Cardiff and Vale University Health Board
May 2018**

1 Context

The Mental Health (Wales) Measure 2010 was commenced in 2012. Part 2 of the Measure places duties on the 'relevant mental health service provider' to appoint a Care Coordinator for an individual in receipt of secondary mental health services and to ensure that a Care and Treatment Plan (CTP) is developed for them. The Part 2 Regulations prescribe the form and content of the CTP.

The Code of Practice to Parts 2 and 3 of the Measure provides additional statutory guidance regarding the preparation, content, consultation and review of CTPs.

Part 2 of the Measure is applicable to all individuals in receipt of secondary mental health services, these people are described within the Measure as 'relevant patient's'. 'Relevant patient' status also includes 'any individual who has a co-occurring learning disability and mental health problem and receives interventions and treatment from the learning disability service to address their mental health as well as their learning disability.'

Significant improvement has been made in ensuring that CTPs are in place for every individual. However, little external focus has been given to ensuring that CTPs are developed to an appropriate standard in line with the requirements of the Code of Practice to Parts 2 and 3 of the Measure and the recommendations of the Welsh Government's (WG) duty to review.

The focus of the Delivery Unit's (DU) review is to evaluate the quality of care and treatment planning processes in adult working age mental health and learning disability services.

2 Approach and Methodology

The DU's assurance review consists of four key components; an initial meeting with Health Board and Local Authority (LA) senior management colleagues, site visits including a case note audit undertaken by DU staff and supported by local peer reviewers (PRs), stakeholder focus groups and verbal feedback from the review team.

The meeting with senior managers uses a semi structured interview to address the factors that can effect Measure compliance and the quality of CTPs in Mental Health and Learning Disability Services.

Site visits were undertaken at three Community Mental Health Teams (CMHTs) and the Hafan-Y-Coed adult inpatient unit.

During site visits a case note audit was undertaken using a data capture tool created by the DU, based upon the Welsh Government's national CTP audit tool. The case note audit was undertaken by DU staff together with peer reviewers (PRs) drawn from nursing staff across the community and inpatient services.

It is important to note that whilst the review methodology enabled the evaluation of performance within the teams and settings visited, the findings in this report relate only to these teams. Findings cannot therefore be generalised to all teams within the Health Board.

3 The Data Capture Tool

Welsh Government previously recommended that *'All services in Wales use the comprehensive audit tool and all Health Boards report, from 2016, upon the findings in their annual reports on the local delivery of Together for Mental Health.'*

The data capture tool is based upon the 'All Wales Mental Health (Wales) Measure Part 2' audit tool. This tool has been developed between Health Board CTP leads and Welsh Government with specific reference to the Code of Practice for Parts 2 and 3 of the Measure.

The tool has been amended to include additional categories for care planning in learning disabilities that are not delivered under Part 2 of the Measure. The categories included for learning disability patients without 'relevant patient' status are based upon findings from the 2016 Healthcare Inspectorate Wales thematic review.

The data capture tool requires that reviewers critique the quality of information based upon a four scale rating; *red, amber red, amber green and green*. A familiarisation session was held with local peer reviewers in preparation for the case note audit.

A series of focus groups was also undertaken with members of the multidisciplinary teams, service users, family members, informal carers and stakeholders. At the end of the review feedback was given to the HB senior management team, and senior managers of their Local Authority partners.

A record from these meetings, the outcome of the case note audit, and scrutiny of information provided by local services in advance of the visits, were used to produce this report.

4 Key Messages

- Care and Treatment Plans are not outcome focussed. Where outcomes are set out they are not routinely specific, measurable, achievable realistic and time bound (SMART). Many plans lack outcomes across the breadth of the eight life areas.
- The recording of assessments and CTPs does not reflect service user engagement or co-production, even where there are opportunities to evidence this.
- The quality of risk assessment and risk management planning is variable with little evidence of the application of a risk formulation process such as the Wales Applied Risk Research Network (WARRN) formulation.
- A significant proportion of cases did not evidence adherence to the formal duty to review the CTP within 12 months.

- Stakeholders and Carers reported a lack of integration between mental health and drug and alcohol services.
- There was lack of personalised crisis planning within the CTP, and service users, carers and stakeholders reported difficulty or uncertainty in being able to access services during a crisis.

5 Recommendations

The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning

The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual's safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning.

The Health Board and partner agencies should ensure that formal reviews of CTPs are undertaken in a timely manner that does not exceed the statutory duty for review.

The Health Board and partner agencies should ensure that there is an integrated and joined up approach between mental health and drug and alcohol services for people who experience co-occurring issues.

Care Coordinators should ensure the inclusion of third sector agencies who are providing regular and ongoing support to an individual within the assessment, planning and review processes.

6 Adult Mental Health Services Profile and Operating Arrangements

Cardiff and Vale University Health Board, Cardiff Council and the Vale of Glamorgan Council are responsible for providing care and support to residents of Cardiff and the Vale of Glamorgan. Statutory duties under the Mental Health (Wales) Measure 2010 are fulfilled in partnership with the UHB being agreed as the lead organisation.

Mental health inpatient services for working age adults and more specialist mental health services are delivered and managed by the Adult Mental Health Directorate within the Mental Health Clinical Board as part of Cardiff and Vale UHB.

Community Mental Health Teams (CMHTs) for adults of working age in Cardiff and the Vale of Glamorgan are jointly managed between Cardiff and Vale UHB and the relevant Local Authorities. Each CMHT has an appointed Integrated Manager who operationally reports to the Senior Nurse Manager for Community Mental Health Services and the Local Authority Operational Manager. There are eight adult CMHTs operating across the UHB footprint, five are located within Cardiff and three within the Vale of Glamorgan.

7 Audit and Monitoring

A quarterly audit programme is in place that is based upon the All Wales CTP audit tool, and includes a focus upon people who are in receipt of Section 117 aftercare services. The audit cohort sample is taken from a bespoke Paris report and is undertaken by both Integrated Team Managers and the mental health Quality and Safety Lead.

The audit results are reported to CMHTs through the Integrated Manager's forum and to the UHB legislation committee. The legislation committee is also the executive forum for monitoring the Measure.

8 The Provision of Quality Care Coordination

Part 2 of the Measure requires that a Care Coordinator is appointed as soon as reasonably practicable for each person upon becoming a 'relevant patient', and that in all but exceptional circumstances this should be within 14 days of acceptance.

The Code of Practice to parts 2 and 3 of the Measure states that 'the role of the Care Coordinator is a distinct one within the care and treatment planning process, which may overlap with some areas of professional practice but also has its own distinct responsibilities'.

The Code goes on to state that the role is central to the 'relevant patient's' journey through secondary mental health services and that Care Coordinators should be supported with regular supervision and effective caseload management as well as effective training to undertake their functions.

8.1 Allocation

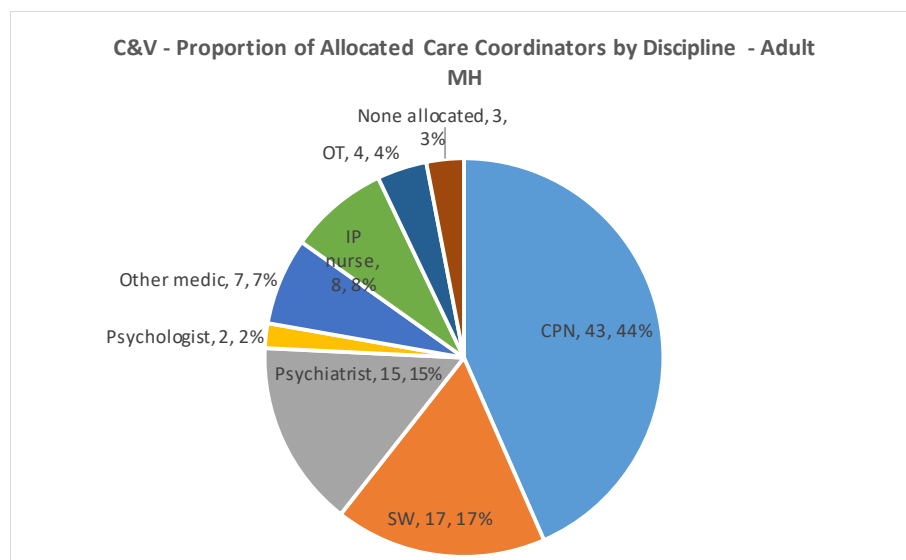
The 'Operational Policy for Integrated Community Mental Health Teams' states that *'following a comprehensive assessment of health and social care needs and a risk assessment, all service users requiring a service will be allocated a named care coordinator.'*

Each CMHT has an Integrated Manager who is responsible for the day to day operation of the CMHT, the role includes chairing referral and allocation meetings, the allocation of new referrals for assessment and the acceptance of service users into the CMHT's caseload.

The operational policy goes on to state that: *'Some service users previously unknown to the CMHT, may be an inpatient or receiving a service from the CRHTT. In these cases the integrated manager at the CMHT will identify a care coordinator within five working days of notification.'*

The Clinical Board reported that all referrals will be discussed in multi- disciplinary team meetings within the CMHT, and stated that currently acceptance criteria is based on a traditional model of secondary mental health services.

Medical staff will Care Coordinate and complete Care and Treatment Plans, however medical staff report that their ability to do so is impacted upon by high caseloads. All the CMHTs visited confirmed that all professions undertook Care Coordination, and agreed that allocations were undertaken as described by the Clinical Board.



Of the relevant patient cases reviewed 44% of cases allocated to a Care Coordinator were to a Community Psychiatric Nurse (CPN), 17% were to a Social Worker and 15% were allocated to a Consultant Psychiatrist.

There was no evidence of a Care Coordinator having been allocated in 3% of cases reviewed.

8.2 Training

Previous training programmes have included content on Measure awareness, outcome focussed care and treatment planning and care coordination. Previously a training programme was developed and delivered by people who use mental health services for people who use services focussing on how to be involved with the CTP. However, there is no training programme currently in place for care coordination or outcome focussed care and treatment planning.

The Clinical Board ensures delivery of a Wales Applied Risk Research Network (WARRN) training programme on 'asking difficult questions and formulating risk' that is delivered to all qualified and registered staff and, where appropriate, support workers working in mental health services, including both health and social care staff. Previously the programme was available to third sector staff.

8.3 Supervision and Support

Members of the Clinical Board stated that caseload management and supervision is undertaken within teams, with professional supervision provided via a manager from the same discipline as the supervisee. CMHTs confirmed this approach. Some professions

stated that there was an issue with accessing regular supervision due to competing demands on staff, or as a result only of part time staff under Professional Lead roles. Supervision and support for inpatient staff is provided by practice development and advance practice nurses. Medical staff are offered 'peer support' rather than supervision.

8.4 IT Support

An electronic system (Paris) is used by the HB to record clinical Information. This includes assessments, Care and Treatment Plans, reviews and case notes entries. The Paris system is integrated and used by both health and social care staff as well as Primary Mental Health Support Services, CMHTs and specialist mental health teams.

Service Managers and individual Care Coordinators can access a range of reports to monitor caseload activity and to support supervision. A dedicated Paris support team provides advice and assistance, reporting and training in the use of the system. Some staff felt that Paris was an inflexible system which did not always meet their needs, with concerns relating to word count limits, visibility on screen and having to "scroll" to see full details.

Some Psychiatrists reported needing to use multiple IT systems as Paris did not have the level of functionality they required. It was also reported that some disciplines, for example Pharmacy, were using paper records, so there were parts of the service not embedded into the Paris system.

FINDINGS

All staff within mental health services have access to the Paris system which contains the electronic patient record. However, it was reported that some disciplines also use other means of recording information increasing the potential for an incomplete central patient record.

Caseload supervision is available via professional leads, however, no caseload management tool was reported as being in use across the Health Board. Staff reported that their caseloads are large and complex.

Training on the Measure or outcome focussed care planning is not currently available to staff but a WARRN training programme is available to staff.

9 The Provision of Quality Care and Treatment Planning

The development and provision of quality care and treatment planning is underpinned by a comprehensive and holistic assessment process, which will include consideration of risk, safety and the contribution of the multi-disciplinary team and wider care and support network.

The quality of the person's experience of receiving care is enhanced through involvement and participation to the fullest extent possible of the person in identifying outcomes and the co-production of the CTP. Ongoing monitoring of the quality and delivery of the person's CTP outcomes is reliant upon good coordination of care and a timely and comprehensive review process that includes the views of those involved.

A case note review was undertaken by the DU review team and peer reviewers between 28th February 2018 and 19th March 2018. A total of 99 records were reviewed across the adult mental health services all of whom were 'relevant patients' under Part 2 of the Measure.

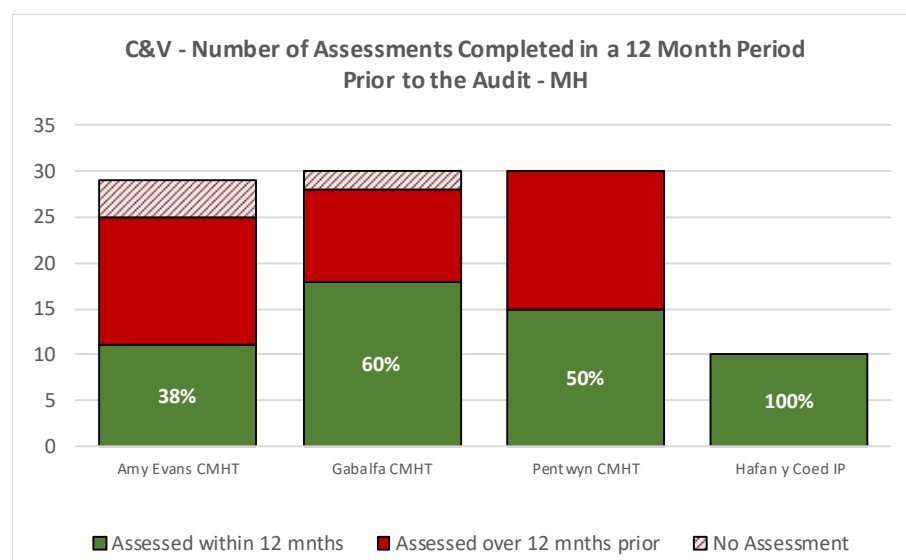
9.1 Assessment

The Measure does not prescribe a particular assessment tool. However, the Code of Practice to Parts 2 and 3 of the Measure requires that all patients in receipt of care and treatment planning should have a holistic assessment identifying their needs and strengths and that the CTP should reflect their involvement in its formulation.

The Operational Policy for Integrated Community Mental Health Teams states that:

'A comprehensive assessment of health and social care needs will be undertaken...the assessment includes consideration of physical health needs and takes into account any family, housing or occupational difficulties.'

The policy requires that the comprehensive assessment is recorded on form 1A which is entered onto the Paris electronic system.

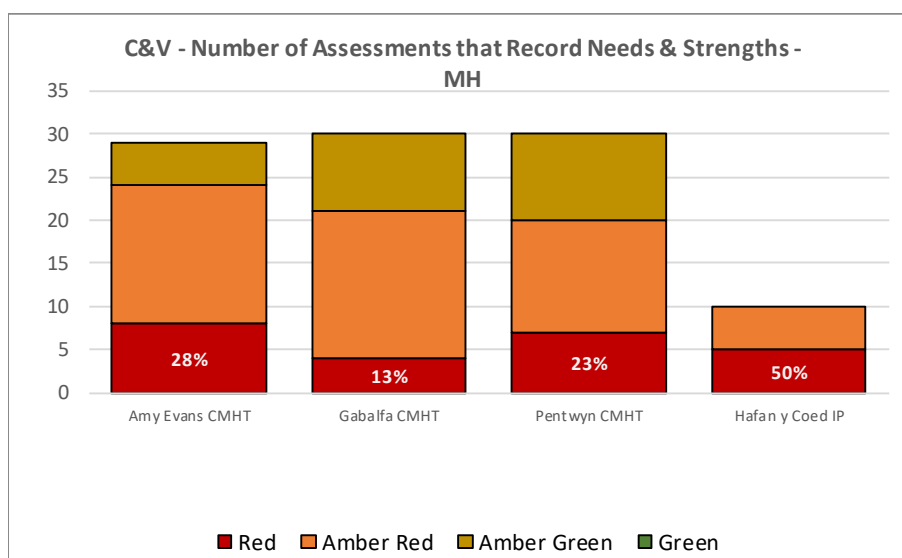


Where there was evidence of an assessment 55% (54) had been completed within the 12 months prior to the case note audit. This ranged from 38% at the Amy Evans CMHT to 60% at the Gabalfa CMHT. In all of the cases reviewed on the inpatient locality wards an assessment was in evidence.

However, there were six cases within the Paris system that did not contain a record of an assessment. Of the cases that did not evidence an assessment, one case had been under the care of the CMHT prior to the commencement of the Measure in 2012.

9.2 Needs and Strengths

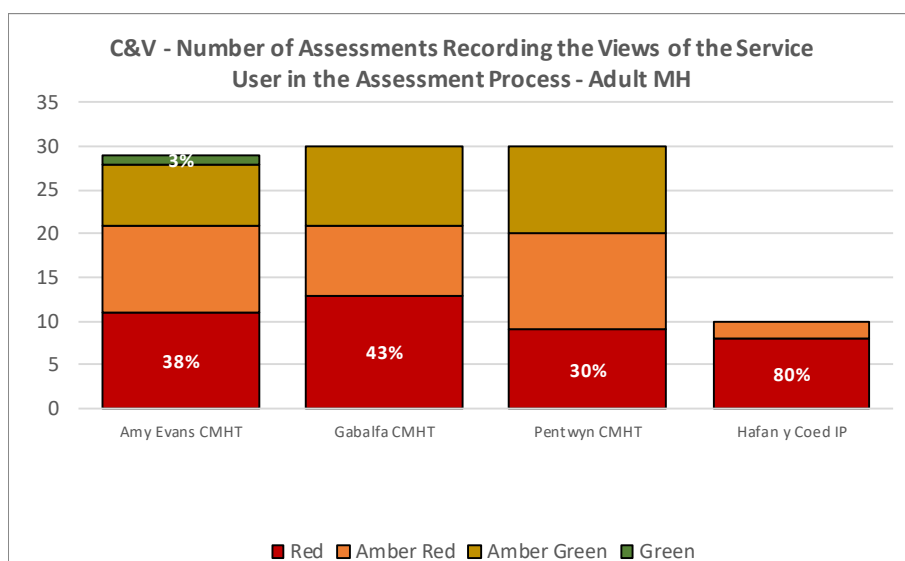
‘Recognising, reinforcing and promoting strengths at an individual, family and social level should be a key aspect of the assessment process.’ (2.10)



The case note review considered the extent to which the assessment evidenced both the needs and strengths of the individual. There were no cases that were rated as green by the reviewers against this standard. However, cases were considered amber green ranging from 33% within the Pentwyn CMHT to 17% within the Amy Evans CMHT.

9.3 Involvement of the Person in the Assessment Process

‘The assessment process should ensure that the ‘relevant patient’ is encouraged and facilitated to make clear their views and ambitions for the future’ (2.16)



The review considered the extent to which the case record evidenced the involvement of the person within the assessment, and whether the assessment recorded the person views.

Overall 73% of records were rated red or amber red for recording the views of the service user within the assessment. Only one case was rated green for this standard. This case was from within the Amy Evans CMHT.

80% of cases reviewed at Hafan-Y-Coed were rated as red against the standard.

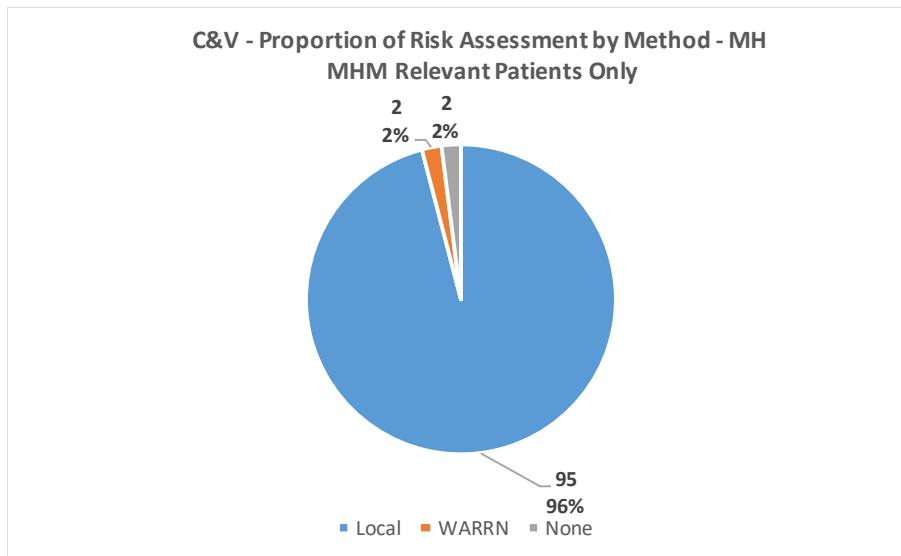
9.4 The Assessment and Management of Risk

‘Assessment of risk forms part of a necessary first step to setting outcomes and formulating the CTP...the CTP should contain steps to mitigate these risks’ (2.18)

The Health Board ‘Mental Health Clinical Risk Assessment and Management Policy’ states that: *‘It is the responsibility of all members of a team delivering care to ensure that service users have a credible risk assessment and a subsequent risk management plan to ensure the effective delivery of safeguarding measures.’*

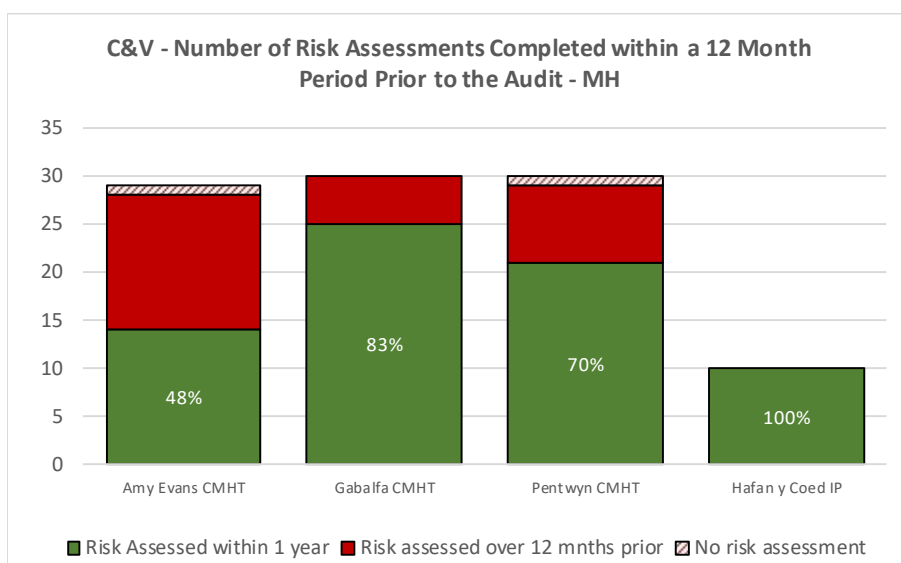
The policy goes on to state that: *‘risk assessments must be completed by all appropriately qualified clinicians who must ensure that any noted risks are communicated to all team members and clearly evidenced within the documentation.’*

The mental health service uses a variety of risk assessment tools including a locally developed form, known as the form 4, and a WARRN (Wales Applied Risk Research Network) assessment tool, both of which are available within the Paris electronic record system.



Where a risk assessment was completed it was evident that in 96% of cases the local form 4 risk assessment tool had been used.

2% of cases audited evidenced completion of the WARRN assessment and 2% of cases did not evidence any risk assessment.



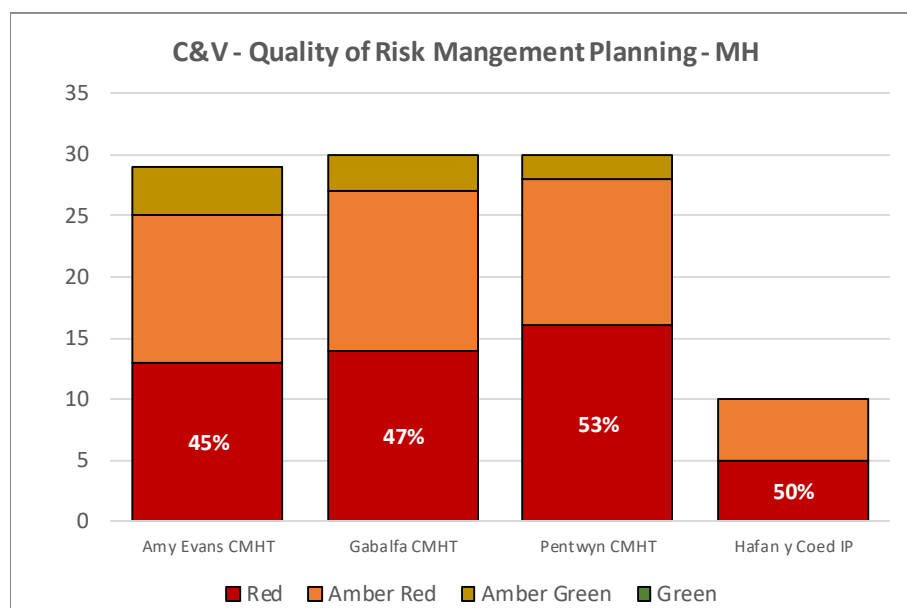
The Mental Health Clinical Risk Assessment and Management policy states that *'all service users within secondary mental health care will receive a risk assessment as a minimum on an annual basis.'*

Where risk assessments had been undertaken their timeliness varied between teams.

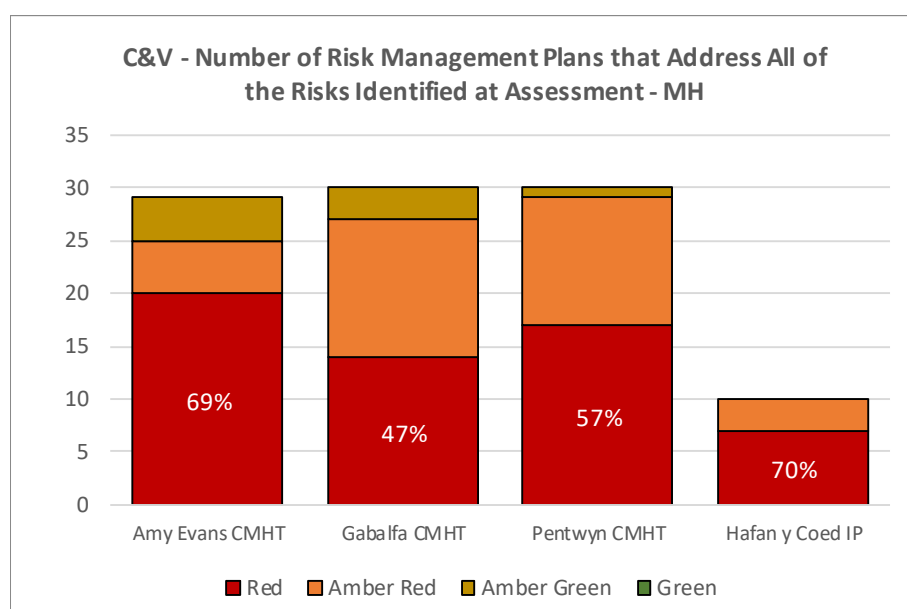
83% of risk assessments reviewed within the Gabalfa CMHT had been completed within the twelve months prior to the audit, whereas within the Amy Evans CMHT 48% of cases reviewed had been reviewed within the 12 months prior to audit.

Of the 2 cases audited that did not contain a risk assessment, neither was a newly allocated case to the CMHT.

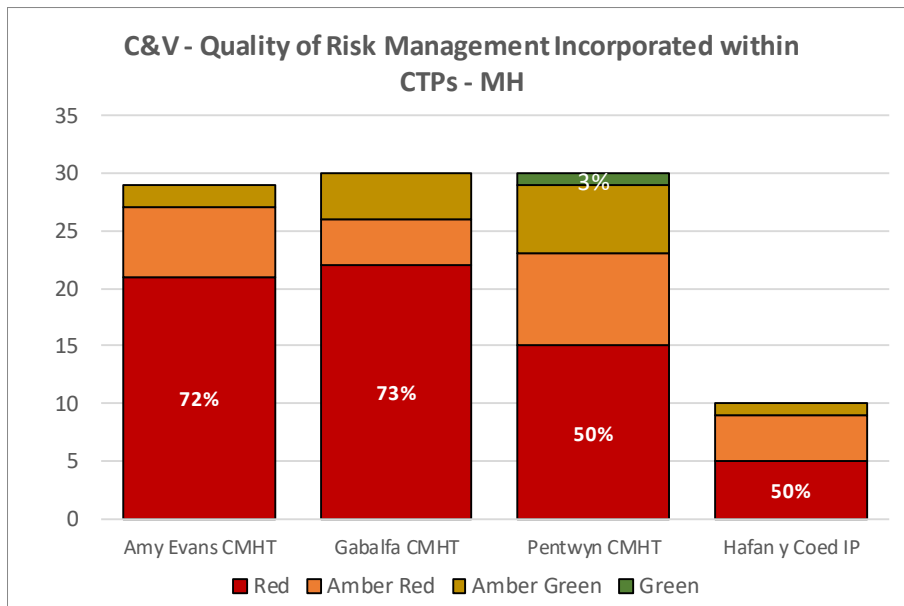
9.5 Risk management Arrangements



The case note review considered the quality of risk management planning. Across the service 9% of risk management plans were rated as amber green and 48% were rated as red. No risk management plans were rated green.



Risk management plans did not demonstrate that all of the risks identified within the assessment had been incorporated within the plan. Across the service 92% of cases were considered to be red or amber red against this standard with 69% (20) of cases reviewed at the Amy Evans CMHT rated as red.



Risk management was not routinely incorporated within the CTP. 14% of cases across the service were rated as green or amber green against this standard. 72% of cases at the Amy Evans CMHT and 73% of cases at the Gabalfa CMHT were rated red

FINDINGS

Whilst the HB has an established assessment process, 6 (6%) of the cases with 'relevant patient' status reviewed provided no evidence of an assessment having been completed. In those cases where an assessment had been completed 39 assessments (39%) had been completed in excess of 12 months prior to the date of the audit.

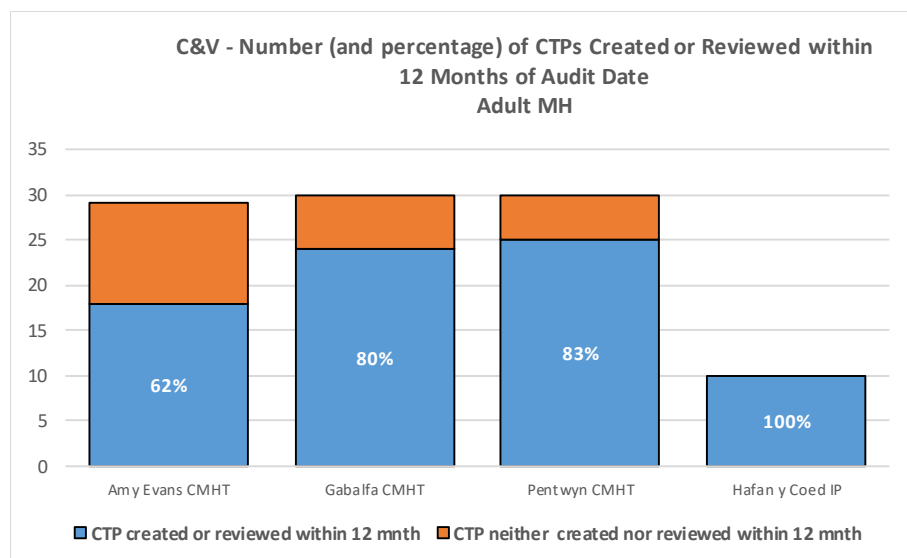
The DU review focused upon the quality of the assessment process including the degree to which assessments identify the needs and the strengths of the individual and where practicable and to the fullest extent possible, the views of the individual are addressed. In the majority of assessments the strengths of the individual were not well identified nor were their views addressed, with cases being rated as red or amber red in 76% and 73% of cases respectively against these standards.

A risk assessment process was evident in 98% of the case note sample. However, only 2% of cases recorded the assessment using the Wales Applied Risk Research Network (WARRN) assessment and formulation approach, this is despite investment by the Mental Health Clinical Board in the WARRN training programme. In 27 (27%) of cases the risk assessment was more than 12 months old.

The quality of risk management plans varied, and in a high proportion (90%) they were rated as red or amber red. In a significant number of cases (92%) the risk management arrangements were considered by the review team to be brief, lacking detail, and did not reflect all of the risks identified within the assessment on file. Furthermore, risk was not routinely incorporated into CTPs.

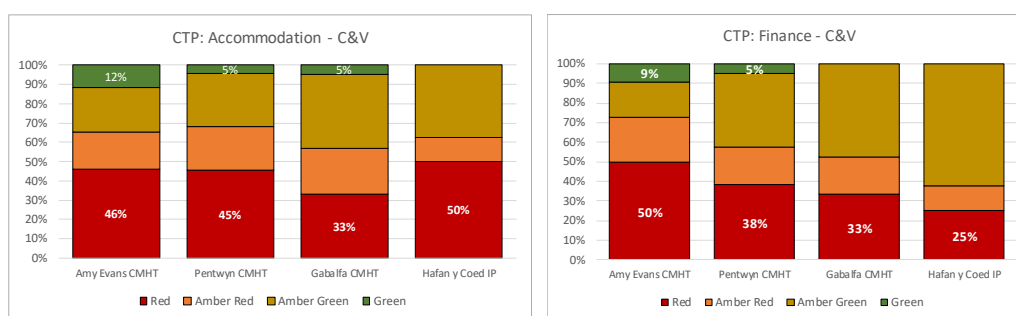
10 Care and Treatment Plan Outcomes

The Care Coordinator must work with the ‘relevant patient’ and providers of services to agree the outcomes that the provision of mental health services are designed to achieve. (4.33)

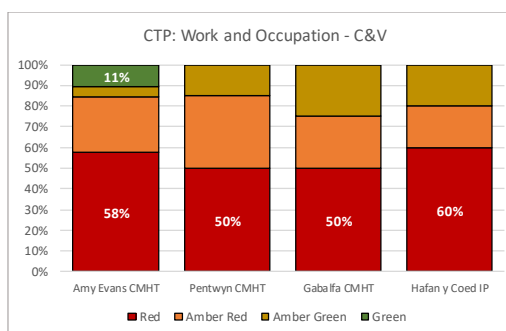
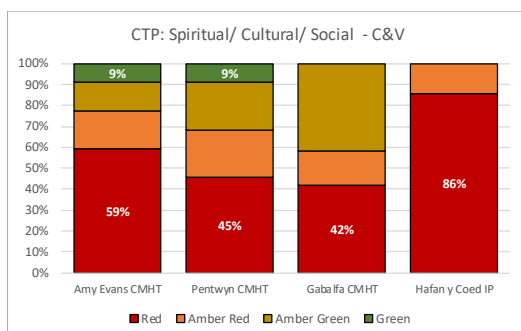


Across the service 77 (78%) of cases reviewed contained a CTP that had been created or reviewed within the previous 12 months. This ranged from 25 (83%) within the Pentwyn CMHT to 18 (62%) at the Amy Evans CMHT.

Whilst there is no requirement for a CTP to record outcomes against each of the potential areas for intervention, it is likely that outcomes would arise in more than one of these areas. (4.37)

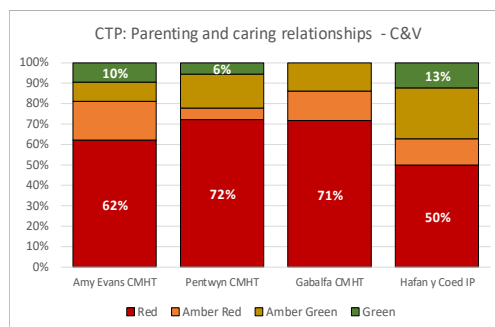
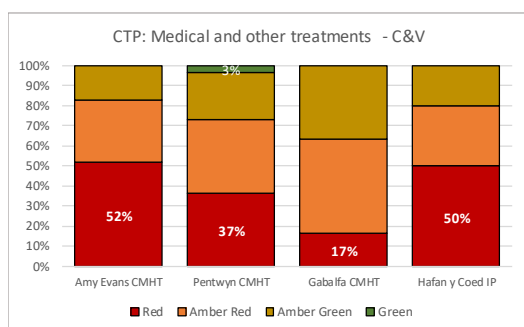


The outcome statement and actions for accommodation and finance were the two areas most frequently rated green or amber green. However, across all teams over 64% of outcomes relating to accommodation were rated as red or amber red.



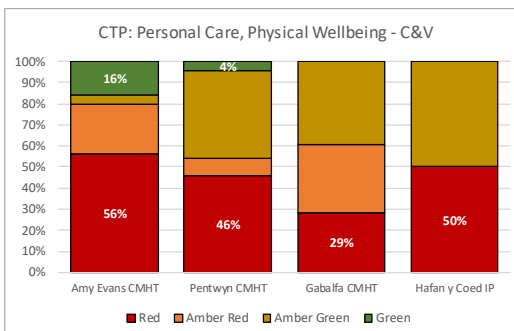
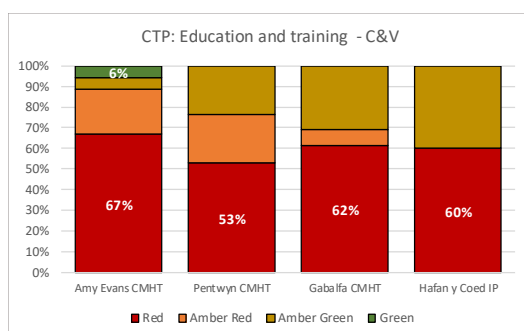
The majority of CTPs (71%) were rated red or amber red for the quality of outcomes recorded against social, cultural and spiritual, and work and occupation outcomes. Within the inpatient service 86% of CTPs reviewed were considered as red for outcomes relating to social, cultural and spiritual aspects.

In 82% of CTPs reviewed in all areas the quality of outcome relating to work and occupation was considered red or amber red.



Outcomes recorded against medical and other forms of treatment, within all teams, was rated red or amber red in over 74% of CTPs. At the Amy Evans CMHT and the inpatient unit over 80% of CTPs were rated red or amber red against this standard.

Where parenting and caring relationships were considered applicable as outcomes, the quality of recording was rated red or amber red in over 70% of cases within the CMHTs, and in more than 60% of cases within the inpatient unit.

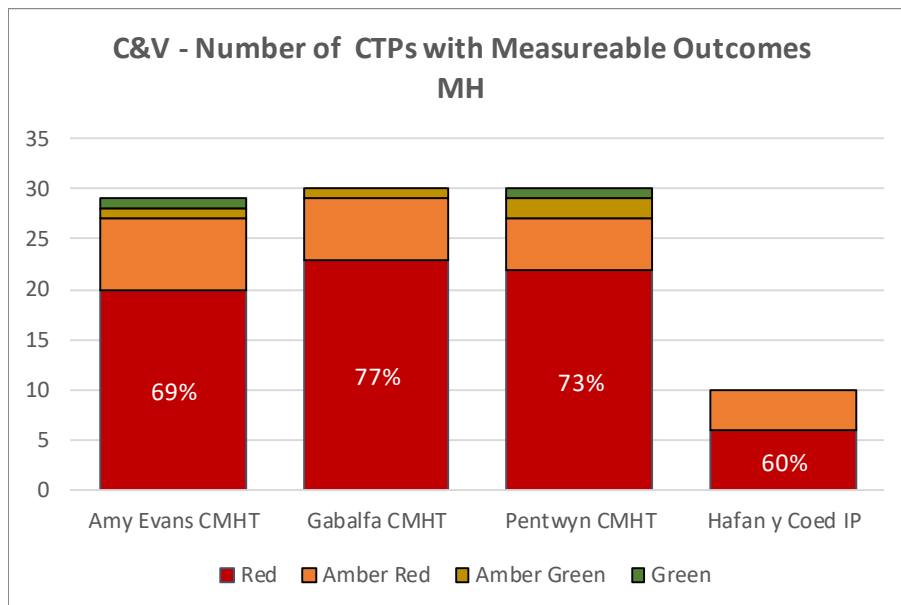


Outcomes relating to education and training within CTPs were not well recorded. Overall 77% were rated as red or amber red. However, within Hafan-Y- Coed and Gabalfa CMHT 40% and 31% were rated amber green respectively.

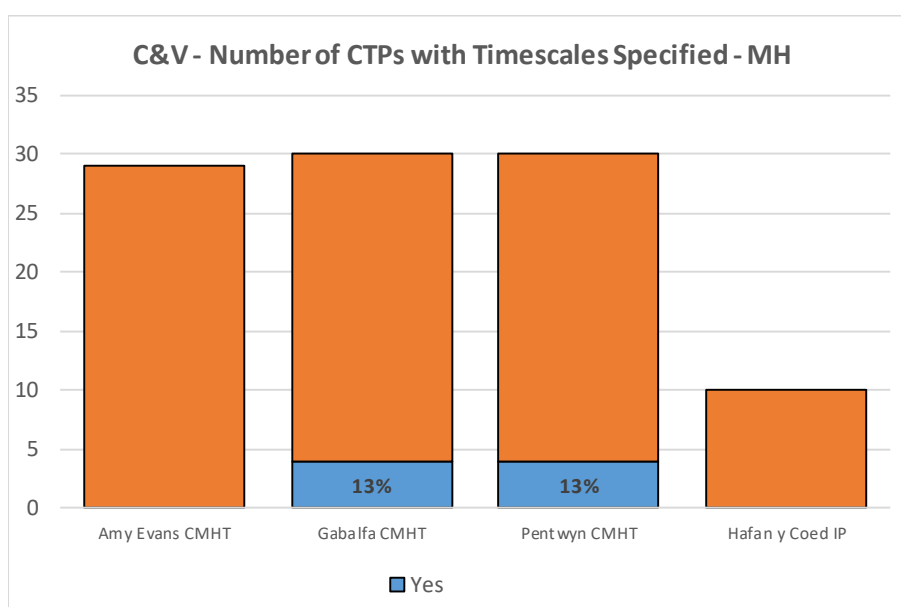
Similarly, outcomes relating to personal care and physical wellbeing were not well recorded. A small number of CTPs were rated as green at the Amy Evans (16%) and Pentwyn (4%) CMHTs but in total 64% of CTPs were rated as red or amber red against this standard.

10.1 Outcomes that are Specific, Measurable, Achievable, Realistic and Timely (SMART)

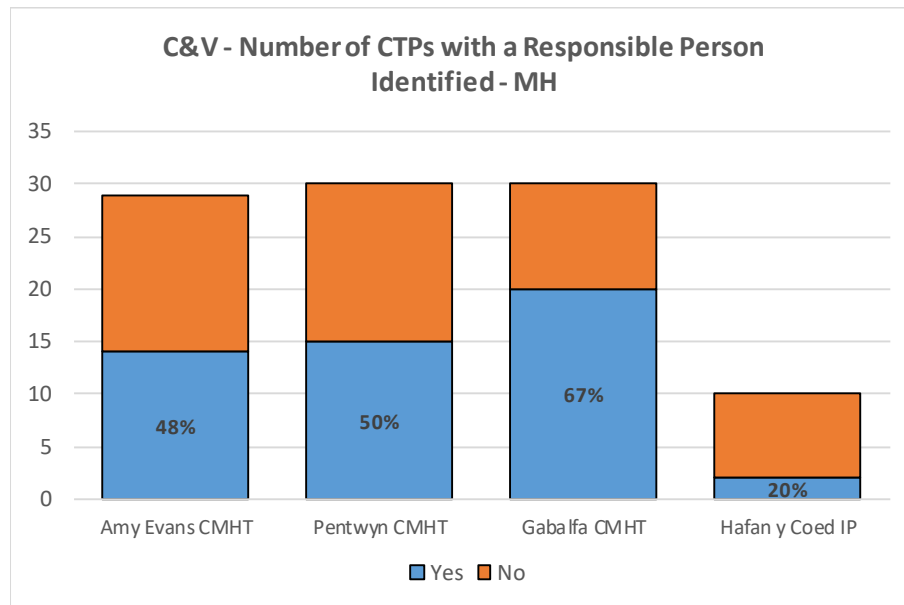
'To achieve a full and meaningful outcomes-based CTP the Care Coordinator, care team and 'relevant patient' will need to work together to identify and agree realistic, observable and achievable milestones' (4.40).



There was little evidence that CTPs were recording outcomes using SMART principles. Overall 94% of CTPs were rated as red or amber red for including outcomes that are measurable.



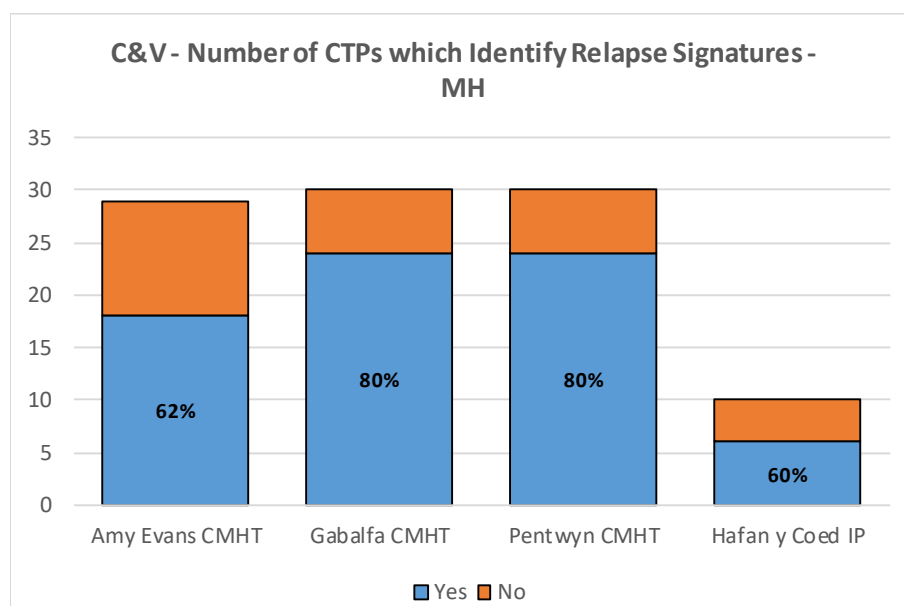
Within the audit sample, specific timescales were recorded in 8% of CTPs. The majority of cases recorded timescales as 'ongoing'.



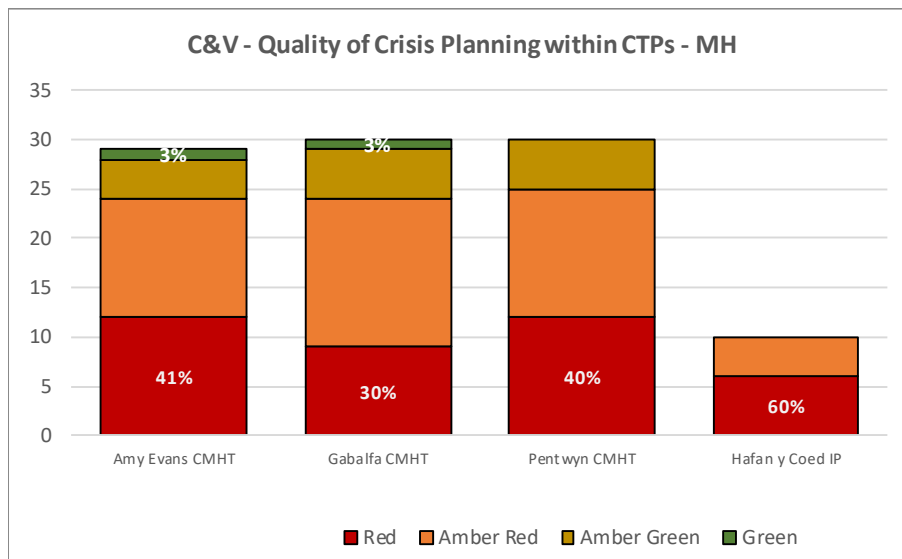
In 52% of cases a person had been identified within the CTP as responsible to carry out the actions recorded. This ranged from 68% within the Gabalfa CMHT to 20% within the Inpatient unit. However, it was not uncommon for the description of the responsible person to be recorded within the CTP as 'all staff'.

10.2 Relapse Signatures and Crisis Planning

The Part 2 Regulations set out a standard format for care and treatment planning which includes sections to record the thoughts, feelings and behaviours that may indicate when a patient is becoming unwell and may require extra help or support (sometimes referred to as relapse signatures) and also the actions that ought to be taken should this happen (sometimes referred to as a crisis plan) (4.81).



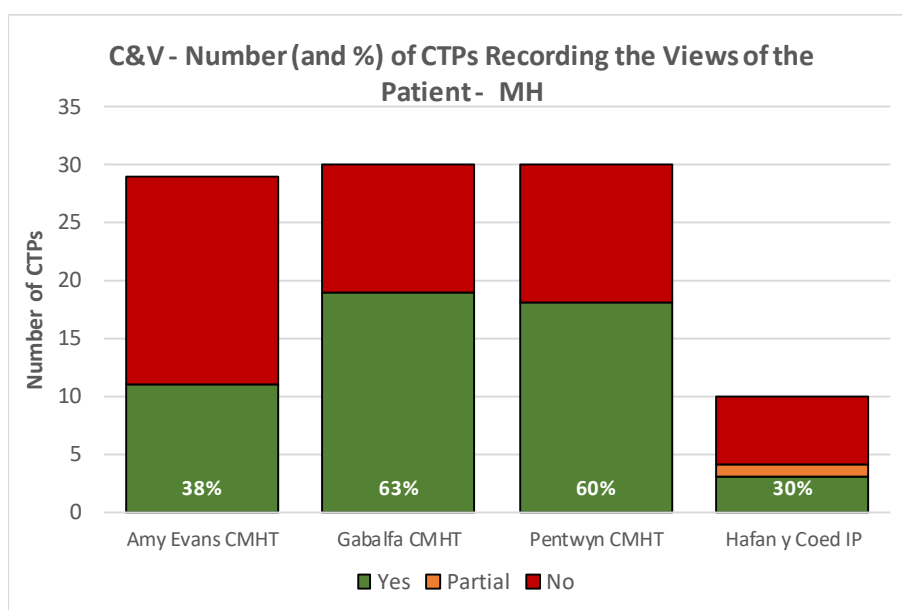
Relapse indicators were frequently recorded within CTPs, overall these were evident in 73% of the cases reviewed. This varied from 80% of CTPs in the Gabalfa and Pentwyn CMHTs to 62% within the Amy Evans CMHT.



The quality of the recording of crisis plans within the CTP was rated as red or amber red in 84% of the cases reviewed. Frequently the crisis plan consisted of a list of telephone numbers for services such as the CMHT duty worker or the Crisis Resolution Home Treatment Team and did not contain any further detail or explanation about what support these services should provide with specific actions to take during a crisis.

10.3 Recording the Views of the Person

The views of the 'relevant patient' on the content of the care and treatment plan can be recorded on the plan itself...if no views are expressed, or no views can be ascertained, then this should be recorded. (4.15).



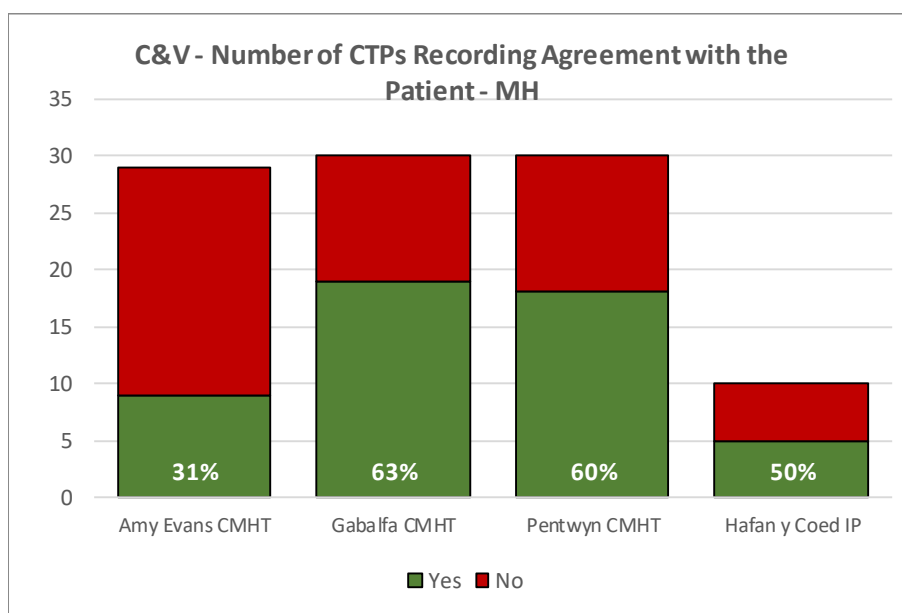
There was some evidence that the views of the person were included within the CTP, however this was variable.

Overall 51 (51.5%) of CTPs incorporated the views of the service user. This ranged from 63% within the Gabalfa CMHT, 60% within the Pentwyn CMHT, 38% at the Amy Evans CMHT and 30% at the inpatient unit.

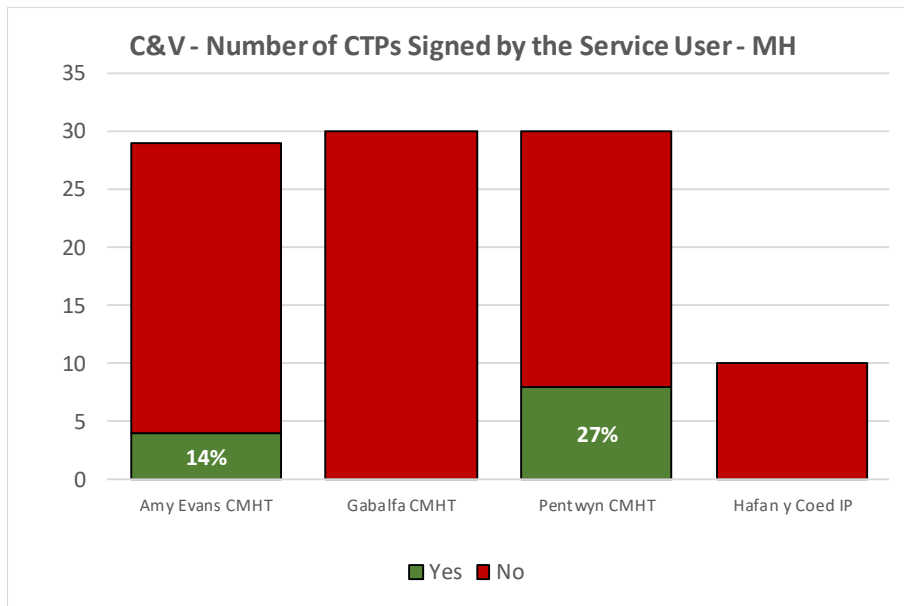
Many of the CTPs that included the patient's views were simply recorded as 'agreed'.

10.4 Agreement and Signatures

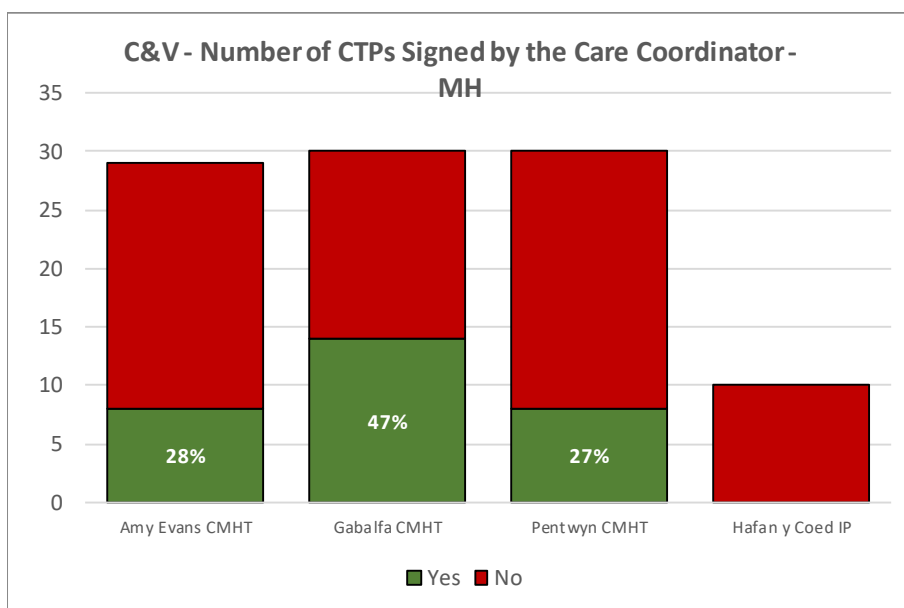
The Part 2 Regulations require that a record is made on the CTP as to whether the plan has been agreed with the 'relevant patient' (4.16)



In 51 (52%) of the CTPs reviewed the service user's agreement or disagreement with the plan was recorded, ranging from 63% within the Gabalfa CMHT to 31% at the Amy Evans CMHT.



Among the CTPs that recorded the service user's agreement or disagreement with the plan 24% included were either signed by the service user or had recorded that they had refused to sign the plan. In 76% of cases reviewed the plan was not signed and no record had been made of a refusal to sign.



The review team found it difficult to ascertain whether the CTP had been signed by the Care Coordinator. In some instances the CTP had been completed by a person who was not allocated as the Care Coordinator and in other instances, the section within the Paris system which identifies that the Care Coordinator had agreed and 'signed off' the CTP was not always completed.

Evidence that the CTP had been agreed and signed by the Care Coordinator ranged from 47% within the Gabalfa CMHT to 28% at the Amy Evans CMHT and 27% at the Pentwyn CMHT. There was no evidence that CTPs were signed by the Care Coordinator within the inpatient unit.

FINDINGS

There was evidence of the use of the CTP in all teams including the recording of a range of outcomes to be achieved. However, the quality of the outcome statements recorded was variable and frequently rated as red against this standard.

CTPs did not routinely include SMART outcomes and timescales were frequently not specified. A person responsible to carry out actions recorded within the CTP was identified in 52% of cases.

The recording of personalised relapse indicators within CTPs was identified as occurring regularly. However, the approach to recording crisis plans was standardised and frequently did not record detail beyond a list of telephone numbers to be used in a time of crisis.

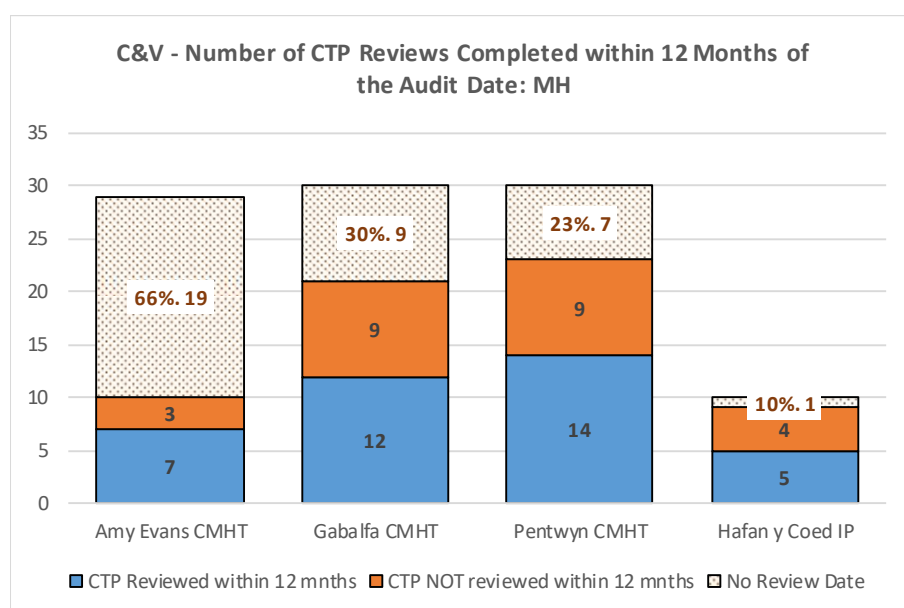
The recording of patients' views of their CTP varied, as did the inclusion of their agreement or disagreement with the plan. Where a person may not wish to agree with or sign their CTP their rationale for doing so was frequently not recorded.

There were cases on Paris where someone other than the Care Coordinator had completed the CTP. It was unclear on Paris whether the Care Coordinator had signed off the CTP.

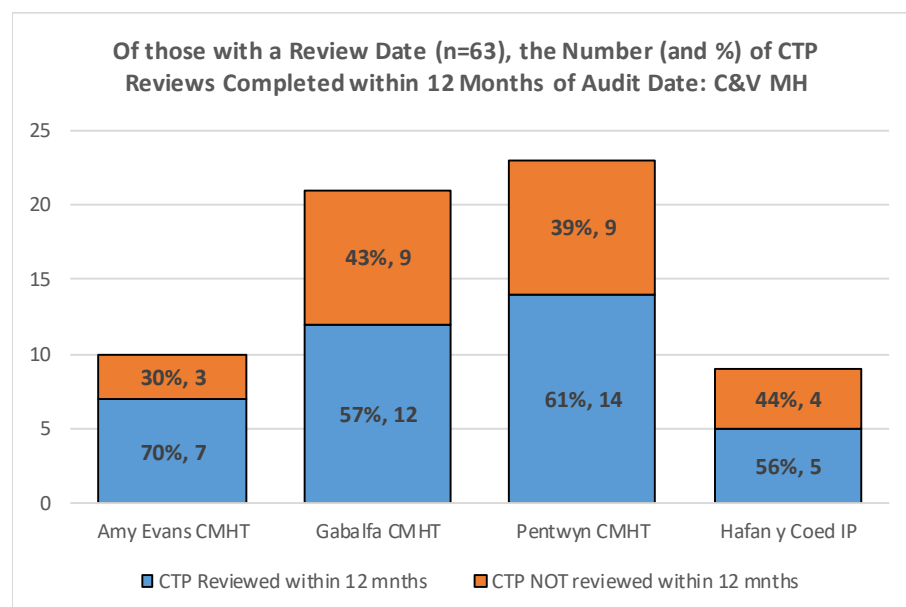
11 Review of CTPs

'In order to ensure that the care and treatment plan provision remains optimal to the 'relevant patient's recovery, regular monitoring of the plan and the delivery of services is required.' (6.3)

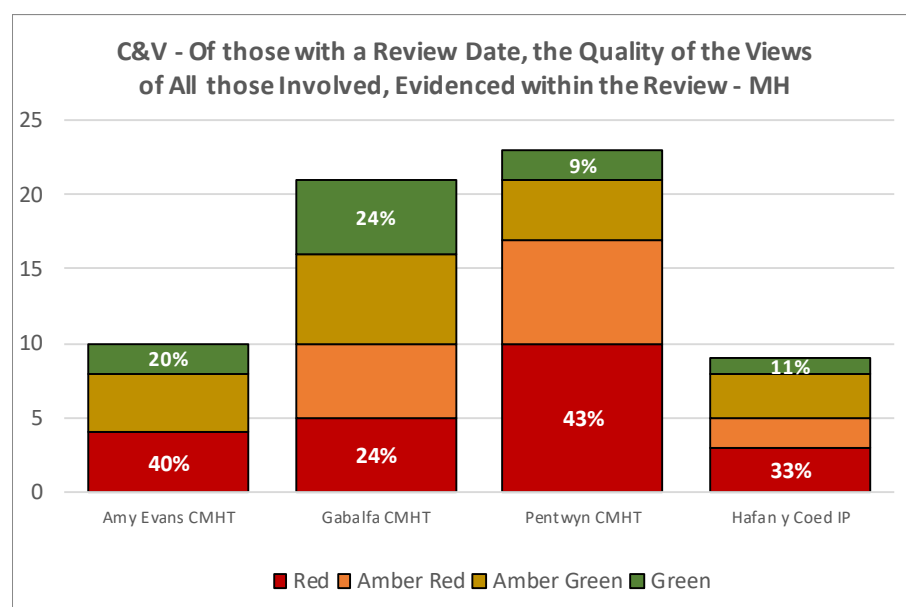
The documentation used to evidence a formal review of the Care and Treatment Plan is held within the clinical information module of the Paris electronic record system.



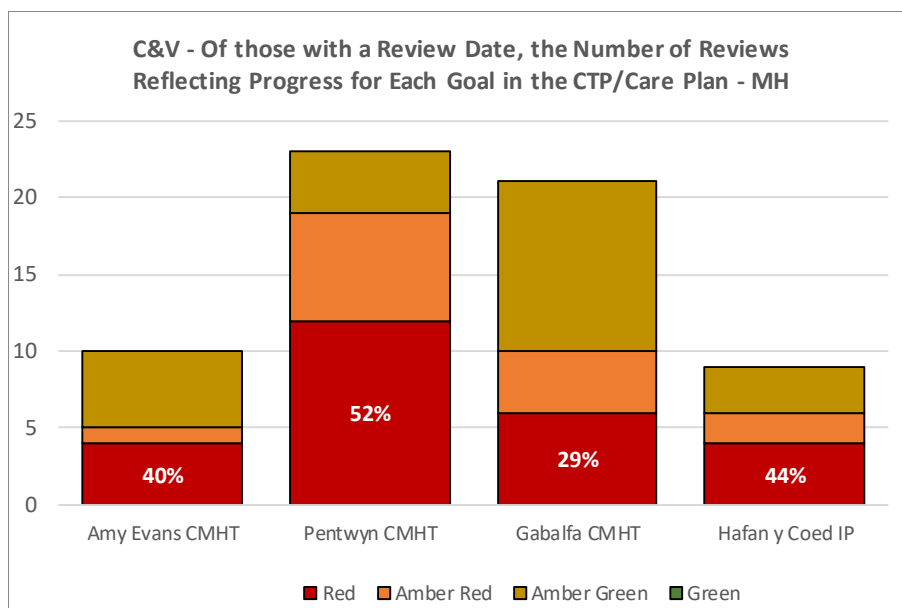
Overall 36 (36%) cases did not demonstrate that a formal review of the CTP had been undertaken. Three of these cases had been accepted onto the CMHT caseload within the last 12 months and therefore may not have required review within that time.



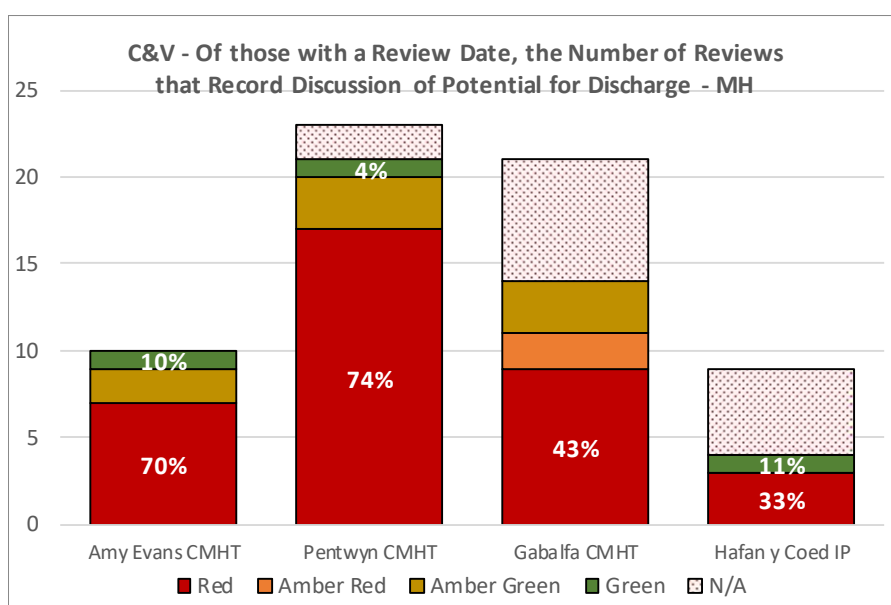
Where there was evidence of a formal review of the CTP, 25 (39.6%) demonstrated that the review had not been held within the 12 months prior to the audit date.



Of the CTPs that had been the subject of a formal review, 27 (42.8%) of these were rated as green or amber green for the quality of the review. Among the total cases that had been subject to review there was variation in the recording of the views of all those involved in the case.



Furthermore where a formal CTP review had been recorded, there was a lack of evidence that the review reflected the progress against each outcome identified within the CTP. This ranged from 52% of cases being rated as red against this standard within the Pentwyn CMHT, to 29% being rated red at the Gabalfa CMHT.



There was a lack of evidence that the formal CTP review discussed discharge or potential discharge of the person from secondary mental health services. Whilst there were some cases where this was deemed to be an inappropriate discussion at this time, the majority of cases where a review had been recorded were considered as red.

FINDINGS

In approximately 30% of cases there was no evidence that the CTP had been subject to a formal review.

Where reviews had been recorded they did not routinely provide evidence that the views of all those involved in providing care and treatment or support for the person were included in the review process.

A significant proportion of reviews did not evidence that progress towards all of the outcomes identified within the person's CTP were discussed nor did they record discharge planning or progress toward discharge.

12 Views of Service Users, Carers and Stakeholders

As part of the assurance review process the DU seeks to elicit the views of service users, family members, other informal carers and stakeholders through specific engagement events. The review team attended both pre- arranged consultation events and existing user and carer forums in Cardiff and the Vale. These events focused upon the views and experiences of participants in the level of involvement by the Health Board in care and treatment planning processes.

Views and Experience of Service Users

Service users reported a mixed experience of awareness and involvement of care and treatment planning. Not everyone had heard of CTPs. Of those that had, about half said they had one but not all had received a copy of it. Others stated that they were not sure whether they had a CTP and if they did, they had not been involved in its development. Some said that whilst they had a CTP, it had not been reviewed.

Some people stated that they had previously attended training on CTP with Sefyll (the local Service User representation forum) but they were unsure if they had a CTP currently.

Service users stated that often the detail recorded within the CTP can be too short adding that a person centred approach would mean that people would be more likely to feel they matter and are an equal partner. People were often unaware that their family could be involved in the CTP process. One person felt that the CTP had been used against them and felt it was a contract.

There was some confusion expressed as to who the CTP could be shared with, and whether they had permission to share it with people. Some expressed concern that the community advocacy service no longer existed and they would value this service becoming available again. Concern was expressed about the proposals to transform local mental health services and whether this would mean more travel to access support.

Of those that reported being involved in the production of their CTP, one person reported that it included activities and helped promote wellbeing. Another person said they had filled

in a questionnaire to assist with the review process about whether their situation had changed.

Concern was expressed by several people about access to appointments with Psychiatrists, due to vacancies or the use of short term locums. This had led people to have long delays between appointments, repeated cancellations or having to re-tell their story to new staff each time. One person expressed it as, "When they want to see me, they're available tomorrow, but when I want to see them, its months".

There was a common concern expressed with regards to accessing crisis services out of hours, and that the crisis plan on the CTP was neither sufficient nor appropriate. People did not know who to contact in a crisis, and were often reliant on family or the emergency services to respond. One person reported that they had a detailed crisis and relapse prevention plan which was really helpful in a crisis, and was used by her and her husband when needed.

Some reported difficulties with speaking to the Care Coordinator in hours when in need of additional support although others had very positive experiences in accessing their Care Coordinator when required.

Views and Experience of Carers

The review team were invited to an existing carer's forum during which many members stated they were aware of the Measure and some had seen CTPs. However, members felt that they had not been involved in the process, that there were delays in getting a copy of the CTP and when they did receive a copy it was brief, inaccurate or out of date.

Carers were very complimentary of the support received from the group (facilitated by Hafal) and felt there was more support here than offered by CMHTs. However, they felt that generally, "there is not enough inclusion of carers, and there are challenges in trying to get information as a carer". One person suggested that it would be a good idea for the carer to also sign and agree the CTP.

Some people described negative experiences when being involved in a service user's care. One person said that they felt ignored and that their opinions did not matter to the CMHT. Another person stated that they had attended a meeting and felt humiliated. In a further case where the 3rd sector were providing support, they were told that they were not allowed to be involved as mediators by the CMHT.

There were some concerns about accessing services in a crisis or out of hours. One person stated that they had contacted the CRHT but had been put through to an answer machine, during a lunch time. Carers reinforced that care does not stop after 5pm and that there is a need to provide 24/7 support in line with other services (e.g. police, ambulance). Some members expressed anxieties that they were not able to leave their relatives as they felt there would be a lack of respite support. Many people said they want to be shown compassion and for people to recognise what they go through on a daily basis.

One person stated that the current CPN is 'amazing' however they were off work for a number of weeks and were not replaced even though the CTP said weekly visits. Another carer said that they had a good CPN and felt that this was because the CPN took time to understand the individual, and included carers in the conversation.

Concerns were raised by carers about the availability to access some services stating that there is a long waiting list for psychological therapies of up to 18 months. The impact of drug and alcohol use on a person's mental health was raised as a significant issue and carers felt that support is not joined up and is inadequate.

Views and Experience of Stakeholders

The review team attended the local Mental Health Forum which included a range of third sector agencies.

All participants were aware of the Measure and many had direct involvement of supporting people who had CTPs, however experience varied. One member stated that they had experience of seeing CTPs work well for people which could be attributed to better ownership of the plan from the CMHT.

Some members of the forum stated that CMHTs have found the 'intelligence' gained from other agencies helpful and that they are invited to CTP reviews. However, not all agencies stated they were regularly invited to the CTP reviews of people they support nor are they included in the CTP arrangements.

Members described some clients as having a range of complex support needs. They stated that many have housing and drug and alcohol support needs in addition to their primary mental health needs. Despite this agencies identified that people do not always receive a holistic CTP stating that mental health is still viewed through the lens of a "medical model" and that services are not joined up.

Stakeholders also stated that services were not always accessible in times of crisis, even when people are well known to the team.

Good Practice

Engagement from third sector organisations in supporting people who are relevant patients under the CMHT in both engaging with CTPs and preparation for discharge.

A drive by the team Psychologist within the Pentwyn CMHT to embed recovery focussed practice into a whole team approach and encourage a culture of positive risk taking.

Acknowledgements

The Delivery Unit would like to extend thanks to the service users and stakeholders, the staff of Cardiff & Vale University Health Board and its partner Local Authorities for their co-operation and contributions during the review.

We would like to thank CAVAMH, the Four Winds Centre and Mind in the Vale for providing and supporting opportunities to meet with service users, carers and stakeholders.

We would like to give particular thanks to the peer reviewers for their diligence and enthusiasm shown throughout the review process.

<p style="text-align: center;">PSYCHOLOGICAL THERAPIES</p> <p style="text-align: center;">REFERRAL TO TREATMENT – 26 WEEKS BRIEFING</p>
<p>Name of Meeting : Mental Health Capacity Legislation Committee</p> <p>Date of Meeting: 23 October 2018</p>

Executive Lead: Clinical Board Director – Mental Health
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Quality, Safety, Patient Experience impact : Applicable to all Health Care Standards
Health and Care Standard Number: 1&6
CRAF Reference Number: 8.1.2
Equality and Health Impact Assessment Completed: N/A

RECOMMENDATION

The Committee is asked to:

SUPPORT the approach taken by the clinical board

SITUATION

The Welsh Government published a ten year mental health strategy, Together for Mental Health, in 2012. This was the first Welsh Government mental health plan that encompassed people of all ages. A key outcome of the strategy was that the 'access to, and the quality of preventative measures, early intervention and treatment services are improved and more people recover as a result'. A key action was included in the strategy is to improve access to and provision of Psychological Therapies. The strategy is delivered through local mental health delivery plans which contain the measures against which progress towards the strategic objectives are met.

The Referral To Treatment (RTT) introduced was 26 weeks. During the first submissions through 2018, Cardiff and Vale showed that it was busy and offering a broad range of psychological interventions frequently but have struggled to achieve the 80% compliance. The paper details the way C&V is to spend its WG investment into PTs to improve this position and achieve compliance.

BACKGROUND

Launched in October 2016, contains a key action for local health boards to improve access to evidence based psychological therapies for adults in line with the National Psychological Therapies Management Committee Action Plan, by March 2017. It requires LHBs to report on a 26 week referral to treatment target in specialist mental health services. It will be undertaken in June 2017 to assess whether waiting lists have reduced over the period. Part 2 of the Measure promotes psychological therapies in secondary care by strengthening the care planning process for patients. The Welsh Government released Policy Implementation Guidance for bodies responsible for improving access to psychological therapies in 2012. The guidance contains four implementation steps which should be taken by the relevant authorities, in order to develop psychological therapies:

1. Each LHB Psychological Therapy Management Committee (PTMC), to have responsibility for ensuring the guidance is implemented.
2. Each LHB should, as part of their Health and Wellbeing Strategy, measure local demand for and capacity to deliver a locally appropriate range of psychological therapies and ensure they train and deliver a workforce capable of delivering a range of interventions.
3. Each LHB should establish a clinical outcome data collection system compatible with other LHBs across all tiers of service.
4. Arrangements should be in place at a LHB and national level, to performance manage the delivery of improvements in the availability of psychological services.

In 2015, the National Psychological Therapies Management Committee, published the Wales Psychological Therapies Plan for Adult Mental Health. The plan addresses psychological therapies' access and treatment improvements for adults of all ages and should inform the targeting of resources to improve access to psychological therapies and bring down waiting times.

ASSESSMENT

The C&V Mental Health Clinical Board have positioned the responsibility for the points 1-4 above with the recently constituted Psychology and Psychological Therapies Directorate. All points have now been completed.

The compliance through the first half of 2018 is shown in Fig 1 with the cumulative compliance in Figs 2 and 3

Fig 1

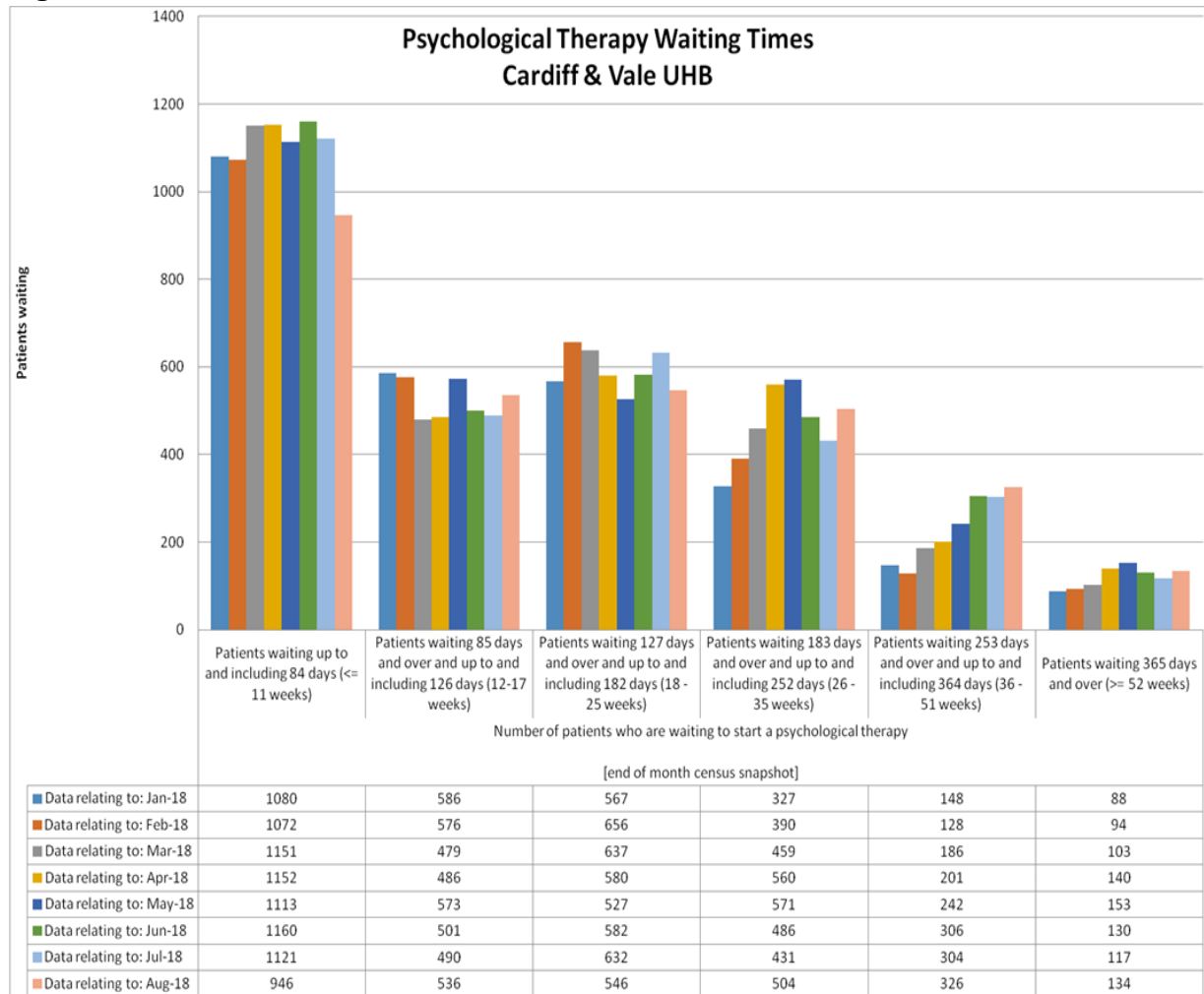


Fig 2

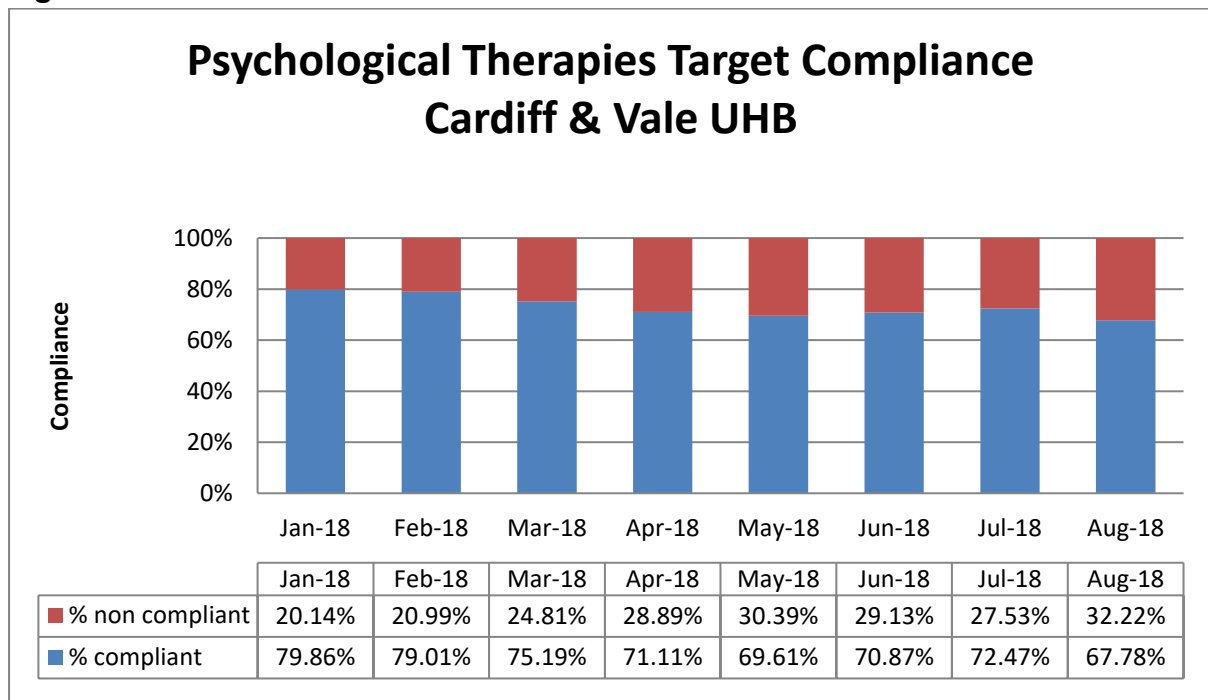
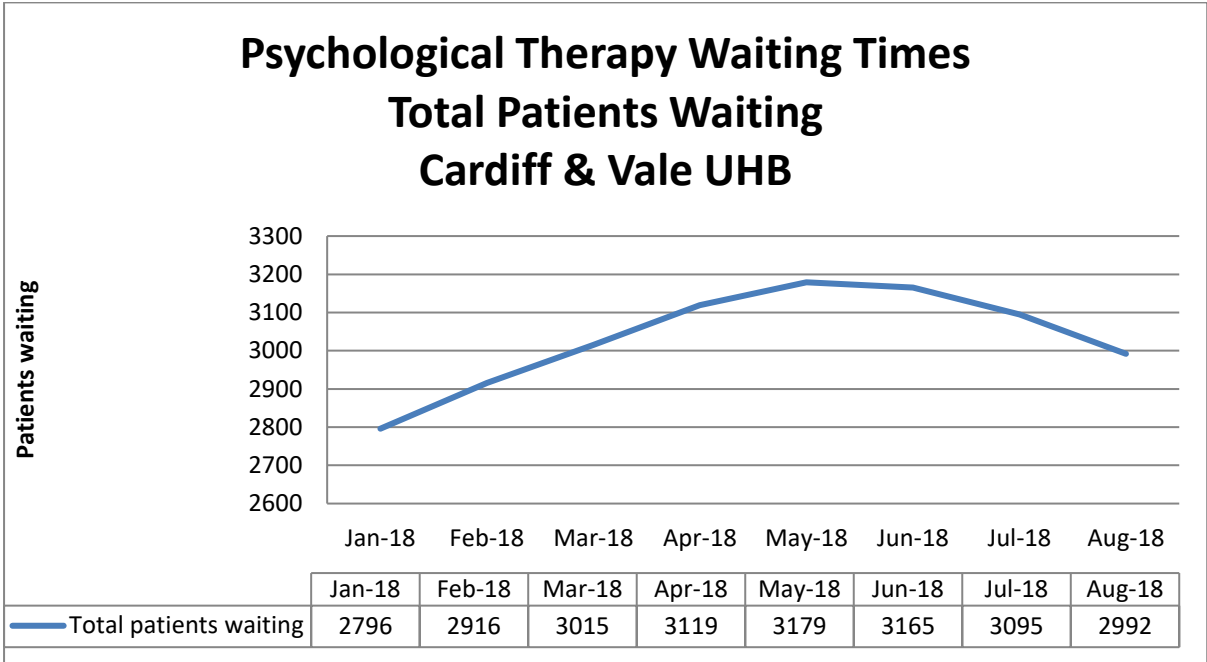


Fig 3

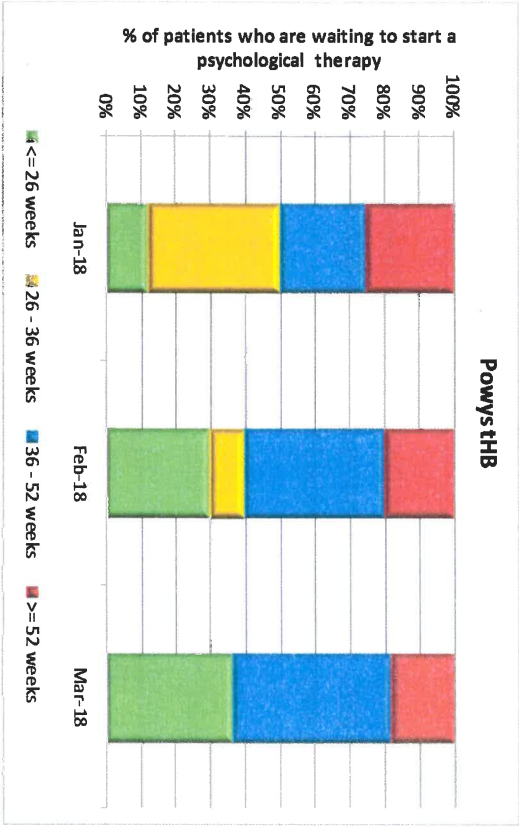
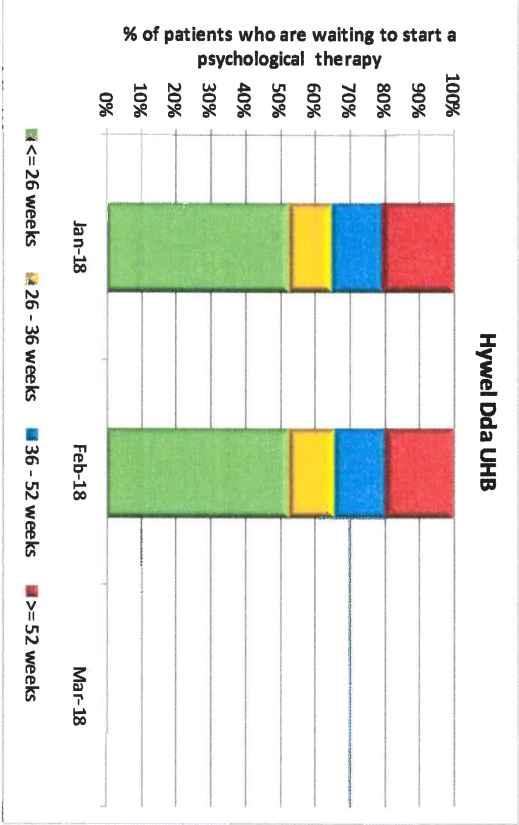
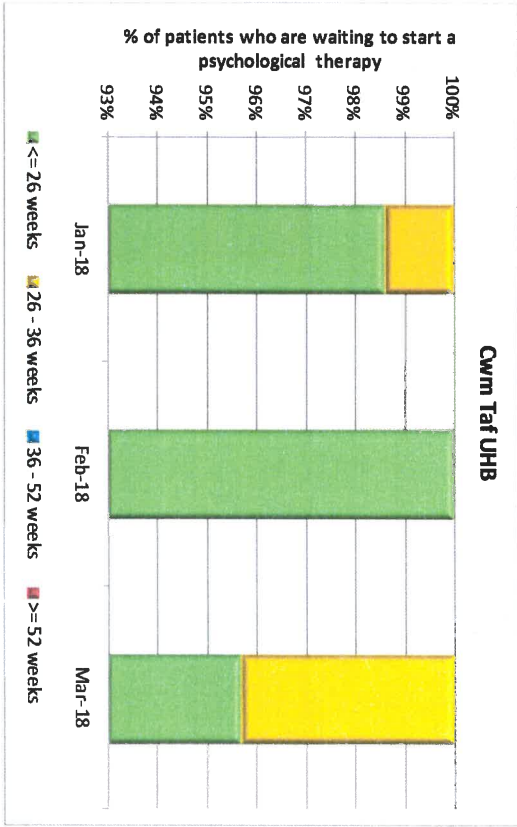
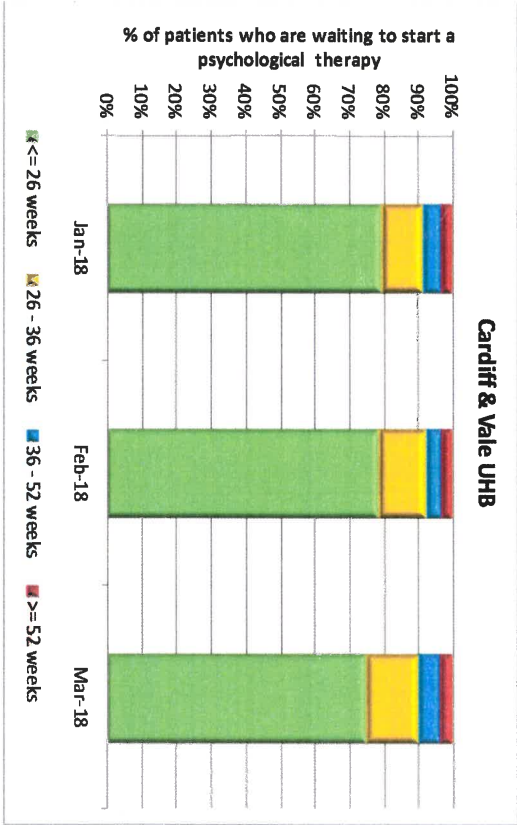
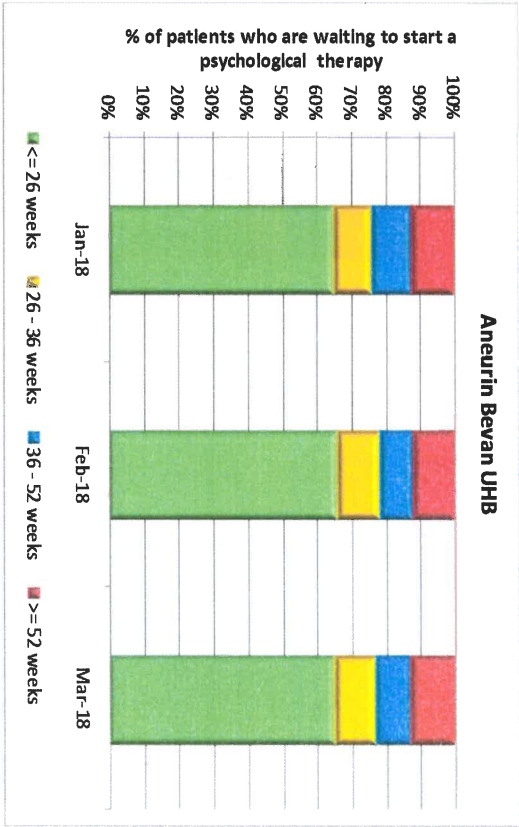
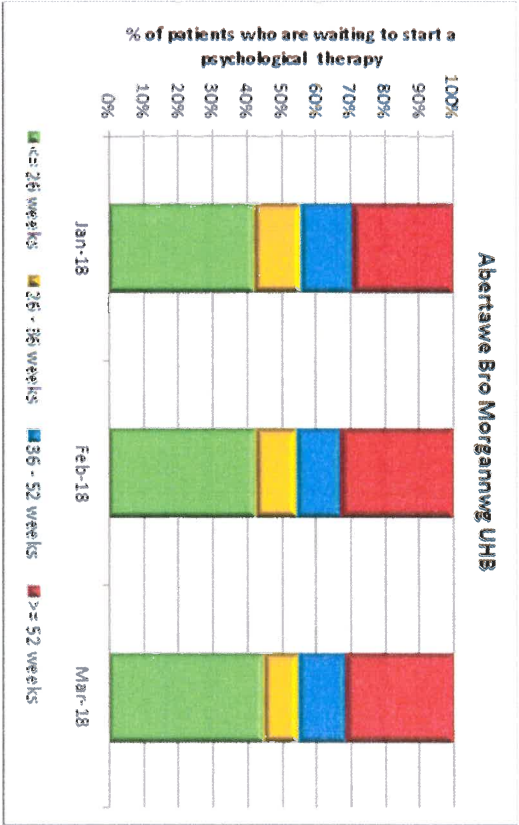


The figures reveal a high activity rate in Cardiff and Vale with circa 3,000 service users in the process of receiving a formal psychological intervention (compared to the All Wales position – attachment 1), with the majority being delivered up to 26 weeks. Cardiff and Vale also offers a broad range of interventions as per Matrics guidelines.

The MHCB has supported the Psychology and Psychological Therapies Directorate to submit costed plans to the Welsh Government as part of the 2018/9 investment to improve compliance through increasing the capacity of the service to do this and to focus on the long and high risk waits such as Trauma/PTSD. The clinical board is current looking for resource to assess demand and capacity in order to predict when the investment will translate into compliance.

% of patients who are waiting to start a psychological therapy

	Abertawe Bro Morgannwg UHB				Aneurin Bevan UHB				Betsi Cadwaladr UHB				Cardiff & Vale UHB				Cwm Taf UHB				Hywel Dda UHB				Powys tHB							
	<= 26 weeks	26 - 36 weeks	36 - 52 weeks	>= 52 weeks	<= 26 weeks	26 - 36 weeks	36 - 52 weeks	>= 52 weeks	Total	<= 26 weeks	26 - 36 weeks	36 - 52 weeks	>= 52 weeks	Total	<= 26 weeks	26 - 36 weeks	36 - 52 weeks	>= 52 weeks	Total	<= 26 weeks	26 - 36 weeks	36 - 52 weeks	>= 52 weeks	Total								
Jan-18	42.3%	13.8%	14.7%	29.2%	100.0%	65.4%	10.8%	11.5%	12.3%	100.0%			79.9%	11.7%	5.3%	3.1%	100.0%	98.6%	1.4%	0.0%	0.0%	100.0%	52.9%	12.1%	14.5%	20.4%	100.0%	12.5%	37.5%	25.0%	25.0%	100.0%
Feb-18	42.6%	12.0%	12.8%	32.6%	100.0%	66.0%	12.3%	9.7%	12.1%	100.0%			79.0%	13.4%	4.4%	3.2%	100.0%	100.0%	0.0%	0.0%	0.0%	100.0%	53.1%	12.8%	14.9%	19.3%	100.0%	30.0%	10.0%	40.0%	20.0%	100.0%
Mar-18	44.9%	10.0%	14.0%	31.1%	100.0%	65.3%	11.8%	10.3%	12.6%	100.0%			75.2%	15.2%	6.2%	3.4%	100.0%	95.7%	4.3%	0.0%	0.0%	100.0%					36.4%	0.0%	45.5%	18.2%	100.0%	





**Minutes of the Mental Health Legislation and Governance Group held at
14:00 on 13 September 2018 in Seminar Room 1, Hafan Y Coed, Llandough
Hospital**

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Sunni Webb	Mental Health Act Manager
Morgan Bellamy	Mental Health Act Administrator
Dr Emily Harrington	Approved Clinician Representative
Will Adams	Team Leader – North Cardiff Crisis Team
Dr Munawar Al-Mudhaffar	Consultant in Emergency Medicine
Dr Arpita Chakrabarti	MHSOP Consultant and Interim Deputy Clinical Director
Jeff Champney-Smith	Chair Power of Discharge Group
Stephen Johnson	Patient Safety/Clinical Risk Manager – Welsh Ambulance Services Trust
Alex Allegretto	Independent Mental Health Advocacy Manager
Mark Warren	Interim Nurse Lead – Adult Mental Health
Charles Janczewski	Vice Chair, Cardiff and Vale UHB
Gareth John	Consultant Social Worker – DoLS/AMHP
Nicola Hockridge	Best Interests Assessor DoLS Team
Gerry Wilson	WAST Clinical Team Leader
Justin Williams	Team Lead – South Cardiff Crisis Team

Apologies

Dr Mary Lawrence	Approved Clinician Representative
Owen Baglow	Clinical Lead for Quality, Safety and Governance
Sarah Thomas	Advocacy Manager - IMCA
Julia Barrell	Mental Capacity Act Manager
Simon Amphlett	Senior Nurse – Crisis and Liaison Services
Ceri Lovell	Team Leader – CAMHS Crisis Liaison Team
Peter Thomas	South Wales Police
Myfanwy Moran	Operational Manager Cardiff
Linda Woodley	Operational Manager Vale of Glamorgan
Rebekah Vincent-Newson	Social Work Lead for Vale of Glamorgan
Jayne Bell	Lead Nurse Adult Mental Health
Dr Tayyeb Tahir	Consultant Liaison Psychiatrist - Liaison Psychiatry
Keithley Wilkinson	Equality Manager
Adele Watkins	Paediatrics Representative
Wendy Davies	Pharmacist
Lorinda Walters	Complex Care and Commissioning Team

1 **Welcome and Introductions**

The chair welcomed members and those in attendance

2 **Apologies for Absence**

Apologies were accepted and noted.

4 **Previous minutes**

The minutes were accepted as a true and accurate record of the previous meeting.

5 **Matters Arising**

Obtaining Section 135(2) Warrant

The MHA Manager gave a brief explanation of Section 135(1) and 135(2) and raised an issue about who can apply for a Section 135(2) warrant.

Currently AMHPs tend to be the only people who apply for these warrants. This uses unnecessary resource in terms of paying for the warrant and the AMHP's time obtaining it. There is no reason that another person involved in the patients care couldn't apply for the Section 135 (2) warrant, including NHS staff or even Police.

It was decided that this point could not be clarified at this meeting and it would be best to have IM engagement and Senior Nurse Manager's involvement. This will be taken to the ITM Meeting.

Agreed that there will be some learning needs once this decision is made and a process is required specifying a process for both in-hours and out-of-hours.

ACTION – For discussion by ITM's and Senior Nurse Managers

6 **Interagency feedback on operation issues**

Conveyance

There are issues getting an ambulance to convey patients to hospital either before or post MHA assessment.

The hardest part of an assessment is the transport. AMHPs are using their own cars, asking for staff from wards and various other improvised methods to arrange patient transport.

Section 136

There have been a small number of Section 136 lapse's prior to mental health assessment's being carried out in A&E. It was noted that this has been since the change in the law that came into effect towards the end of last year. There is some confusion about when the new 24 hour limit commences – MHA Manager has escalated the legal advice as per S136 in A&E to all.

The Chair clarified that the UHB position is to operate to the guidance set out in the Mental Health Act Code of Practice for Wales, Revised 2016, which ensures we are following statutory requirements and suggested that this was put in writing to the Police by the Board.

Action – Chair, MHLGG to forward advice to Vice Chair, UHB following discussion with Peter Thomas, SWP

A clear need for information to be provided to A&E in relation to s136. It was agreed that the MHA Manager would devise a poster.

Action – MHA Manager to liaise with Team Leader, North Crisis Team

Social Worker attendance at Managers Hearings

MHA Manager explained various issues that have arisen at Managers Hearing due to Social Worker non-attendance.

A trial solution is being looked at whereby dates are offered a week prior to I.Ms so this can be discussed in MDTs so both RC and SW can agree dates whereby both are available to attend. This should help improve attendance.

This is currently a trial for MHAM only.

Safety of AMHPs

An issue was raised in relation to an incident which occurred in one of the CMHT's, where a MHA assessment was carried out but there was no bed available. The patient stayed at the CMHT all day, agitated and hostile, agreeing to go to Hafan Y Coed, but no other hospital.

Considerations were being given for the patient to wait at Hafan Y Coed. However staff could not be guaranteed to wait with the patient upon arrival.

Clarification was sought as to whether the Crisis Team have a duty to provide staff to sit with a patient, who is potentially dangerous, agitated, going to become aggressive.

The Team Lead, South Crisis Team Manager explained that CRHTT do not have a duty to sit with this client group in EAS, the capacity to help in these situations changes on too frequent a basis. EAS is an unstaffed area. The MHA assessing team need to liaise with the shift co-ordinator on a case by case basis to ascertain if transfer to EAS is the most appropriate course of action who will be able to make a decision based on clinical presentation, risk and staff resource.

Disclosure of Information to Nearest Relative

MHA manager discussed a situation whereby a patient complained that reports were shared with nearest relative that they didn't want them to have access to.

Rights procedures were followed correctly.

It was agreed that wards would ask nursing staff to clarify that yes to sharing information to Nearest Relative does include reports for Tribunal and Managers Hearings – it was raised this could be an issue with mental state at the time of discussion and rights should be visited more regular to clarify understanding.

7 Feedback from other meetings

AMHP Forum

Consultant Social Worker informed the group of the current AMHP situation and raised concerns in relation to conveyance. There have been a number of incidents where AMHPs have been waiting for up to 19 hours for an ambulance to convey a patient to hospital.

The group were informed that this seems to be less problematic out of hours because a private ambulance service has been used.

It was suggested that this practice could be a resolution in hours.

Some members of the group expressed concerns as to the financial impact this could have and were not aware that this was general practice.

It was agreed that a protocol would be required and the Interim Nurse Lead, Adult Mental Health agreed to discuss this with the Senior Team and feedback to the group.

Action – Discussion with Senior Team for clarification/resolution

Consultants Meeting

No feedback

AC Approval Process

Meeting Chair informed the group of the new process for approval for AC's online.

MHLCC - SBAR

The Mental Health Act Manager explained that the SBAR is a report that is submitted to the Mental Health Legislation Committee and focuses on compliance and any areas of concern.

The Mental Health Act Monitoring report identifies these areas for this group to look at any operational issues where improvement is required.

8 Power of Discharge Group

Comments/Compliments and Feedback April – June 2018

The Chair of the PoD Group stated that Care and Treatment Plans are a constant concern. They tend to be not up to date, not accurate and issues with them being cut and pasted badly from previous reports.

Action – For discussion at the Consultants meeting

9 External Reviews

HIW Inspection Report

There has been a recent local HIW review, Beech on the 16 January 2018 and Pine on the 14 March 2018. No others at present.

10 Interface MHA/MCA/DoLS

DoLS representative expressed concerns in relation to appropriate use of legislation and explained that staff are being encouraged to apply for a DoLS when it is clear that the MHA is required. This is resulting in delayed detentions and having an impact on medical wards as it can take up to 2 weeks for a DoLS assessment to take place.

11 Quality Indicators and Audit Activities

The Chair of the group will discuss with the Acting Clinical Director.

Action – Chair to agree quality indicators and audit objectives with the Acting Clinical Director

12 MHA Activity April – June 2018

MHA Managers briefed there are no exceptions to raise during this period.

It was noted that the use of community treatment is reducing and a discussion took place as to whether long-term S17 leave is potentially being used instead.

If a person is on long term s17 leave needs to be recalled to hospital they would be admitted to their locality ward whereas a person revoked from a CTO would be admitted to the Crisis Assessment Unit. Discussion took place around whether this could have anything to do with the current situation.

The Approved Clinician Representative agreed to take this to the next consultant meeting for further discussion and provide feedback at the next meeting.

Action – Approved Clinician Representative to provide feedback

13 Any other business

It was raised that HR need to be made aware of the functions of AC approval requirements as there has been issues whereby a new RC has been unable to complete the full capacity of their role due to this not being checked at recruitment stage and this can be a long process.

Ambulance service raised concerns with transfers between HYC and Llanfair Unit. Ambulance Service and MHSOP are taking this forward.

Action – Ambulance and MHSOP

14 Next Meeting

The next meetings to be held in Seminar Room 1, HYC from 14:00hrs:

17 January 2019

18 April 2019

18 July 2019

17 October 2019



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Mental Health and Capacity Legislation committee Draft Work Plan 2018-19				
	Feb-18	Jun-18	Oct-18	Feb-19
Patient Story	Mental Capacity Act	Mental Health Act S117	Mental Health Act	Mental Health Measure
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) <i>Standing item</i>	x	x	x	x
Section 117 Compliance	x	x	x	x
Section 136 Partnership arrangements	x	x	x	x
HIW MHA Annual Report	x			
HIW MHA Inspection Reports (as received)	x			
Hospital Managers Power of Discharge sub-Committee Annual Report			x	
Hospital Managers Power of Discharge sub-Committee minutes	x	x	x	x
Mental Health Measure Act Monitoring Report				
Mental Health Measure Monitoring Report	x	x	x	x
Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) <i>Risk rating 16</i>	x	x	x	x
DoLS Monitoring Report	x	x	x	x
DoLS Audits			x	
Committee Governance				
Committee Work planner / Review of Effectiveness to include self assessment			x	
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference	x			
Review of Terms of Reference				x



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Attachment 1

**MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL
MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 24
JULY 2018 IN SEMINAR ROOM ONE AT HAFAN Y COED.**

Present:

Mr Jeff Champney-Smith	Chair, PoD Group
Mrs Elizabeth Singer	Vice Chair, Pod Group
Mrs Sarah Vetter	PoD member
Mrs Teresa Goss	PoD member
Mrs Mair Rawle	PoD member
Mrs Elaine Gorvett	PoD member
Mr John Owen	PoD member
Mr Huw Roberts	PoD member
Mr Simon Williams	PoD member
Mrs Patricia Hallett	PoD member
Mrs Wendy Hewitt-Sayer	PoD member
Mr Mike Lewis	PoD member

In attendance:

Mr Martin Harper	Integrated Team Manager, Links CMHT
Miss Sunni Webb	Mental Health Act Manager
Mr Simon McDonald	Mental Health Act Coordinator

Apologies:

Mr Alan Parker	PoD member
Mrs Sharon Dixon	PoD member
Dr John Copley	PoD member
Mr Peter Kelly	PoD member
Mr Rashpal Singh	PoD member
Mr Tony Summers	PoD member
Mrs Mary Williams	PoD member

1 Welcome and Introductions

The Chair of the group introduced everyone to the meeting and welcomed Martin Harper, the Integrated Team Manager, Links CMHT.

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

Risk Assessment

Martin Harper has a high level of expertise in risk assessments having worked in Caswell clinic. He reminded the meeting that roughly 95% of Mental Health patients are treated in the community. Since Martin has become the Integrated Manager for the Links CMHT, he has overseen a reduction in the number of active patients being seen by the Links CMHT from circa 1400 to 506. This is due to culture/practices change amongst professionals and better understanding of the self referral process introduced in the Mental Health Measure.

Martin explained how difficult it is to manage risk with a community patient with little or no past history of incidents. CMHT's are held responsible for managing risk whilst they have no ability to control the risk, due to the nature of community treatment.

There was a brief discussion about the understanding of the Hospital Managers role amongst CMHT staff.

It was decided that whilst Martin Harper had been very informative, there was not enough time to discuss things in enough depth. Therefore Martin Harper will attend a future Power of Discharge Group training session so matters could be discussed in more detail.

CTP (Care and Treatment Plan), MHSOP

One of the members questioned the validity of the CTP's provided by the MHSOP service as they are not on the statutory form. The Mental Health Act Manager had investigated and confirmed that although they may look different they do conform to the statutory requirement.

It was noted that as the MHSOP community service don't use the Paris system to record CTP's, then as soon as a patient is discharged from hospital the records make it appear as though no further work was being completed on them. This is not the case, just that a different system is being used to record the CTP's.

Unanimous decisions

There was a brief clarification given by the Chair, PoD Group about unanimous decisions, as per the Hospital Managers Power of Discharge Handbook. If there is no unanimous decision about discharge, then the Hearing should be adjourned. The following Hearing must have a different panel. If the decision is about anything else, then the MHA Manager should be consulted for guidance.

Social Worker Attendance

Several of the members stated that they have experienced issues around Social Worker attendance. There have been several occasions where the Social Worker has not attended, and several occasions where the Social Worker does not know the patient. In one recent Hearing the Social Worker introduced themselves to the patient in the Hearing.

ACTION: - MHA Manager to discuss with the Operation Manager, LSSA

Section 17 Leave

It was clarified that extended Section 17 leave **must** have an element of hospital treatment. This can include assessment and monitoring in a CMHT. A home visit for the same reason does not count. If there is no element of Hospital Treatment then the patient must be discharged.

ACTION:- MHA Manager to clarify the point at which s17 leave becomes extended s17 leave

4 Minutes of Meeting held on 09 January 2018

The minutes were accepted as a true and accurate record of the previous meeting.

4 Matters Arising

Break Away Training

The chair of the group is to check the online break away training to see if it is suitable for the PoD groups requirements.

Contentious case

It was felt that the responses from the clinicians involved were of a satisfactory response to this case and that it need not be discussed further.

DBS Checks

The Mental Health Manager had checked with Corporate Governance and they had confirmed that it was UHB policy to run a DBS check every three years. One of the members stated that it is illegal to carry out a DBS check when it is not required.

ACTION:- MHA Manager to discuss with Recruitment

List of Ward Specialities

The group would like a list of all of the Mental Health Wards listing their specialities.

ACTION:- Mental Health Administration Manager to compile and distribute this list

6 MHA Activity Monitoring report April – June 2018

PoD and MHRT Activity

The group read and accepted both reports

7 Recommendations from Power of Discharge Group hearings April - June 2018

One of the Recommendations triggered a discussion about patients who have physical issues on Mental Health wards. There was a general feeling that physical issues were increasingly being left untreated. Several different cases were mentioned, including:-

- lack of physiotherapy for injured leg

- being given eye drops for several years (continuing) with no follow up from an optician
- one patient who had lost a significant amount of weight who had no teeth or dentures for several months

ACTION:- MHA Manager to discuss the issue with PoD chair at a later date

8 Training

A workshop has been arranged to look at decision making/writing. Managers hearing and MHRT outcomes will be compared to see how and whether manager's hearings reasons can be improved. This is due to take place on 25/09/2018.

The all Wales training day was also discussed. This will take place in the Angel Hotel in Cardiff on 28/11/2018

9 Any other business

The MHA Manager informed the group that the period of staff difficulties is soon to be over. One Mental Health Act Administrator has now left the team and two new staff members have been appointed in an overlapping job share role. Their primary roles will be organising Hearings, both PoD and Tribunals.

The group were informed that the MHA Administration Manager has had her second child and that they are both doing well.

Mrs Elizabeth Singer, the Vice Chair of the Pod Group agreed to compile the analysis of the concerns/compliments of the Power of Discharge Group to cover the period July 2017 and June 2018.

10 Date of future meeting

To be held at 10.00hrs in the Seminar Room, First Floor, HYC, and UHL on 30 October 2018

Power of Discharge Group – Hospital Manager’s Annual Report

1st April 2017 - 31st March 2018



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1. Membership:-

There are twenty Hospital Managers at present:-

Teresa Goss	Peter Kelly	John Owen
Mike Lewis	Rashpal Singh	Tony Summers
Elaine Gorvett	Mair Rawle	Alan Parker
Jeff Champney-Smith	Sarah Vetter	Mary Williams
Dr John Copley	Wendy Hewitt- Sayer	
Huw Roberts	Elizabeth Singer	Sharon Dixon
Patricia Hallett	Simon Williams	Carol Thomas

The work of the Power of Discharge group would be impossible without the support of the Mental Health Act Manager and her team. The logistics of bringing panel members and professionals together for both Manager's Hearings and Tribunals are daunting but this is achieved with efficiency and good humour.

Unfortunately we have lost one member of the group during the last year for personal reasons.

2. Activity – Outcome of Hospital Manager’s Power of Discharge Group hearings during the period 1st April 2016 - 31st March 2017.

Section upheld	112
Discharged from Section prior to hearing	49
Hearing adjourned by PoD Panel	10
Hearing postponed in period	16
Cancelled by patient prior to hearing	3
CTO applied before hearing	0

Advocates have represented patients at 49 Panel Hearings (38%) an increase of 12% compared to 2015/2016 and 8% compared to 2016/2017, a total of 20%.

3. Training Activity

The group continue to have regular training sessions which are well attended and the members have given a positive response to. Members are invited to attend training covering a variety of topics. Since April 2017 the group have covered:

Power of Discharge Group – Hospital Manager’s Annual Report

1st April 2017 - 31st March 2018

- Roles and remit of the hospital manager – Prof Richard Jones
- Mental Health (Wales) Measure 2010
- Fire Safety
- Mental Capacity Act
- Power of Attorney
- Court of Protection
- Advance Directives
- CJSM secure email

4. Quarterly Power of Discharge Group and Peer Support Meeting

We have a formal business meeting on a quaterly basis. The agenda includes such items as training needs, activity reports, items of interest gleaned from hearings and legal advice. Minutes are made available to the Mental Health Capacity and Legislation Committee for noting and approval. After a suggestion from a member of the group this meeting is now followed by a less formal session, with notes taken for information only, in which members are able to debate items in more depth. Issues may then be referred to the main meeting for ratification.

5. Recruitment

We have been very fortunate in recruiting two new members to the group who come with excellent credentials. Both have under gone their initial induction, delivered by the Mental Health Act Manager, and will now begin to gain knowledge and experience by observing hearings with experienced group members.

6. Appraisals

Appraisals were held during March 2018 using a Self-Assessment Questionnaire and one-to-one interviews with Marcus Longley, Vice-Chair.

It has been agreed that the following information will be used to inform the review process, identifying any performance issues or developmental needs:

Observation of hearings

It has now been agreed that the MHCB Head of Operations, Clinical Lead for Quality, Safety and Governance and MHA Manager will observe hearings and provide annual feedback to the group.

Reports from participants

All present at hearings are provided with a leaflet reminding them of the procedure for notifying the UHB of matters of concern or praise, and by making notification as easy as possible.

Power of Discharge Group – Hospital Manager’s Annual Report 1st April 2017 - 31st March 2018

7. Comments

An Annual Review and Content Analysis of the comments we make as part of Panel Hearings was undertaken and discussed. The objective was to lead discussions around the Recommendations made and look for any trends that may need consideration.

The period covered July 2016 - June 2017. The Vice Chair, PoD Group compiled the Analysis and led the debate in October 2017.

Main highlights for discussion were as follows:

The number of recommendations had almost doubled compared to the previous year. Despite the mentioned improvements the report highlighted that care and treatment plans are still of the greatest concern to the PoD group. The report also highlighted that recommendations on the subject of the hospital environment and ward activity had also increased. It was suggested that this is possibly due to the move to Hafan Y Coed in 2016.

The Vice Chair noted that the number of compliments given to professionals had also increased.

In the main the group are happy with the responses they receive from their recommendations.

Jeff Champney-Smith
Chair, Power of Discharge Group

June 2018