Bundle Mental Health Capacity and Legislation Committee 12 February 2019

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6.3	Review of the Meeting
7	To note the date, time and venue of the next meeting: Tuesday June 4th 2019 at 10am, Corporate Meeting Room

AGENDA
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday 12th February 2019
Corporate Meeting Room, HQ, University Hospital of Wales

1.	**Preliminaries**	
1.1	Welcome & Introductions	Charles Janczewski
1.2	Apologies for Absence	Charles Janczewski
1.3	Declarations of Interest	Charles Janczewski
1.4	Minutes of the Committee Meeting held on 23rd October 2018	Charles Janczewski
1.5	Action Log	Charles Janczewski
1.6	Chairs Action taken since last meeting	Charles Janczewski
1.7	Any Other Urgent Business Agreed with the Chair	Charles Janczewski
2.	**Mental Capacity Act**	
2.1 2.1.1	Deprivation of Liberty Safeguard Monitoring Report • SBAR and Cardiff & Vale DoLS Report	Graham Shortland
2.2 2.2.1 2.2.2	Mental Capacity Act Monitoring Report Supporting Information Advocacy Support Cymru Report	Graham Shortland
3.	**Mental Health Act**	
3.1	Mental Health Act Exception Report • Section 135 Legislation • Section 136 Legislation • Section 136 Changes / Police clock starts	Ian Wile
3.2	Mental Health Benchmarking Report (RCP)	Ian Wile
3.3	RCP Legislative Implications	Ian Wile (verbal)
3.4	National Review of Mental Health Act 1983	Ian Wile (verbal)
3.5	Mental Health Act Hospital Manager's Hearings and Observations.	Sunni Webb (verbal)
4.	**Mental Health Measure**	
4.1	Mental Health Measure Monitoring Report	Ian Wile
4.2	Part 2 MH Measure Care and Treatment Plans	Ian Wile
4.3	Care Treatment Plan (CTP) Update	Ian Wile (verbal)

4.4	Tier 2 CAMHS update	Rachel Burton (verbal)
5.	**Committee Governance**	
5.1	Mental Health Operational Group - Update	Dr Robert Kidd
5.2 5.2.1a 5.2.1b 5.2.2a 5.2.2b 5.2.3a 5.2.3b	Controlled Documents to be Approved • Patient Rights Information to Detained/Community Patients under, Mental Health Act, 1983 Policy • Patient Rights Information to Detained/Community Patients Mental Health Act, 1983 Procedure • Admission to Hospital under Part II of the Mental Health Act, 1983 Policy • Application for admission to hospital under Part II of the Mental Health Act, 1983 Procedure • Review of Detention and Community Treatment Order, Mental Health Act 1983 Policy • Review of Detention and Community Treatment Order, Mental Health Act 1983 Procedure	Ian Wile
5.3.1 5.3.2 5.3.3 5.3.4	• Self-Assessment 2018/19 • Annual Report 2018/19 • Terms of Reference Review • Work-Plan 2019/20	Nicola Foreman
6.	**Items to bring to the attention of the Board/Committee for Information**	
6.1	Inspection / Regulation Compliance H.I.W Report	Ian Wile (verbal)
6.2	Hospital Managers Power of Discharge • sub-Committee Minutes • Terms of Reference	Jeff Champney - Smith
6.3	Review of the Meeting	Charles Janczewski
7.	**To note the date, time and venue of the next meeting: Tuesday June 4th 2019 at 10am, Corporate Meeting Room.**	

UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 10.00AM ON TUESDAY 23 OCTOBER 2018
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Charles Janczewski	**MHCLC Chair and Vice Chair of Cardiff and Vale UHB**
Eileen Brandreth	Independent Member and MHCLC Vice Chair
Sara Moseley	Independent Member

In attendance:

Steve Curry	Chief Operating Officer (Lead Executive for Mental Health)
Nicola Foreman	Director of Corporate Governance
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Julia Barrell	Mental Capacity Act Manager
Dr. Graham Shortland	Medical Director (Lead Executive for Mental Capacity)
Jeff Champney Smith	Chair, Hospital Managers Power of Discharge Sub-Committee
Dr. Jane Hancock	Service User Representative
Dr. Robert Kidd	Consultant Clinical & Forensic Psychologist
Amanda Morgan	Service User Representative
Dr. Jenny Hunt	Clinical Psychologist

Apologies:

Kay Jeynes	Director of Nursing, PCIC
Lucy Phelps	Service User Rep

Secretariat: Helen Bricknell

MHCLC 18/18 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 18/19 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 18/20 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 Quality and Safety Group meetings.
- It was noted that Dr. Robert Kidd is a member of the All Wales AC Approval group.
- It was noted that the Independent Member SM had a relative on Ward East 12
- It was noted that Independent Member SM has an interest in Mind Cymru.

MHCLC 18/21 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 26TH JUNE 2018

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record for 26th June 2018.

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

MHCLC 18/22 ACTION LOG REVIEW

It was noted that the actions assigned to the Medical Director are all complete.

MHCLC 18/07: DoLS Safeguard Monitoring Report. This item is complete.
MHCLC 18/08: MCA Monitoring Report. This item is complete.
MHCLC 18/08: MCA Monitoring Report. This item is complete.

MHCLC 18/23 ANY OTHER URGENT BUSINESS AGREED WITH THE CHAIR.

There was no other urgent business.

MHCLC 18/24 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 Applications for DoLS authorizations seem to have largely stabilized in the April to September

period. There will be a further audit in the final quarter of this year's audit cycle, which will be based on the HIW/CIW All-Wales DoLS Report.

The Medical Director noted that the All-Wales DoLS Report showed marked differences in the application of DoLS by the UHBs. It may be that the UHB was implementing DoLS too enthusiastically, compared to other UHBs. However, where deprivations of liberty are occurring without either a DoLS authorization or a court order, this is unlawful and could lead to the UHB being sued.

The DoLS Tripartite Partnership Board has requested a review of the processes and functions being undertaken by the DoLS team to consider efficiency savings and/or where support or resource is required.

There remains an on-going risk of DoLS authorizations not being processed in a timely manner and hence leading to unauthorized deprivations of liberty, but this is a greater risk for local authority partners as the authorisations for urgent requests – mainly from the UHB - are given priority.

The Medical Director asked for DoLS to remain on the Risk Register because of the possibility of unauthorized DoLS applications and because of the financial risks for the UHB regarding the funding arrangements with the two partner local authorities.

It was mentioned that the Mental Capacity Amendment Bill has been introduced to Parliament and it is going through the House of Lords. If passed, this Act will amend the Mental Capacity Act 2005 by replacing DoLS with a new framework, known as the Liberty Protection Safeguards (LPS).

- The Committee **RECEIVED** and **NOTED** the report.
- The Committee **AGREED** actions to be taken in light of the Internal Audit Limited Assurance
- The Committee **APPROVED** the continuing arrangements for provision of DoLS assessments.

MHCLC 18/25 MENTAL CAPACITY ACT MONITORING REPORT

The Mental Capacity Act Manager gave a brief overview of the submitted report which outlined raising awareness of the Mental Capacity Act. There is poor engagement by some Medical and Dental staff with Mental Capacity Act training. A comparison of the previous quarter's training figures with the most recent quarter revealed that MCA training uptake had generally improved. However, this was not the case for Medical staff.
The following points were discussed:

- How the MCA training compliance figures have been compiled – they are produced by LED and are an aggregation of the numbers of staff

undertaking the ESR MCA e-learning and those receiving face-to-face training from the MCA Manager

- Providing run charts to show the position regarding clinician's compliance with MCA training for the next Committee meeting
- .The MCA Manager explained that she had raised the issue of an All-Wales MCA training data set with Welsh Government's Mental Health Legislation Manager – she will update the Committee on progress with this. Such a data set would allow the UHB to benchmark its position against the other UHBs.
- The MCA Manager drew the Committee's attention to the public interest report from the Ombudsman, regarding a service failure by Newport Council, due to poor implementation of MCA. She explained that awareness of MCA seemed to be increasing amongst regulatory and other statutory bodies.

- A query was raised about who receives the Health Inspectorate Wales (HIW) reports. These are sent to the Clinical Boards' Governance leads initially. Clinical Boards will discuss them at an appropriate meeting such as Quality and Safety and will develop an action plan where necessary. Scrutiny of this process is undertaken by the Nursing Director and the Assistant Director of Patient Safety and Quality.
- Medical Staff have their appraisals through the All-Wales MARS system which is different to the UHB's appraisal process - PADR. The MARS system whilst including checks on professional behaviour and performance, educational and safeguarding checks, does not include mandatory training checks.
- Senior medical staff complete their Mental Capacity Act training in their induction programme. The MCA Manager has enquired about MCA training for junior doctors (F1/F2s) and is awaiting a response.

The Committee **NOTED** the report and in particular the action that the Medical Director and the Mental Capacity Act Manager are taking to improve clinical staff – especially doctors' - compliance with MCA training.

MHCLC 18/26 MENTAL HEALTH ACT EXCEPTION REPORT

The Mental Health Act Manager, Ms. Sunni Webb gave a brief overview of the report and indicated there were no exceptional issues to report. A discussion was held about the different interpretation of the rules around the location and length of time police were required to remain with the detained person following a 136. This is subject to ongoing discussions between the health boards and the police. Further legal advice on Section 136 of the Mental Health Act will be incorporated in Richard Jones' Manual due out shortly.

- Sara Moseley declared an Interest of the Crisis Care Assurance group

The Committee opened up for discussion raising the following points;

- It would be very helpful to clarify the position taken by C&V UHB on the interpretation of 136 compared to other parts of wales, as the South Wales police report that it it an isolated position. This matter will be discussed at the next concordat assurance group on the 13th November.
- The Chair of the Committee was pleased there were no breaches in the last quarter.

The Committee **AGREED** the report
The Committee **NOTED** the report and the **ASSURANCE** provided by the Mental Health Clinical Board Director.

MHCLC 18/27 MENTAL HEALTH MEASURE MONITORING REPORT

The Director of Operations, Mr. Ian Wile presented the report and updated the Committee that there is compliance with Parts 1, 3 & 4 of the Mental Health Measure. With Part 2 of the Measure, which requires Health Boards to ensure all relevant patients in secondary mental health settings have a care and treatment plan there is an ongoing small breach of circa 5% against the 90% target. The issues are complex in relation to this which have received greater attention following a recent DU audit into compliance and quality of CTPs. Critical to this are discussions with medical staff currently having high case-loads with patients in a secondary care settings of patients who may not reach 'relevant' status, about which there are ongoing discussions. Ian Wile then presented the Deep Dive into Part 2 as a fuller response to provide assurance to the committee.

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

Points presented and discussed as part of assurance report presented to the Committee.

- IW is to sponsor and chair the working group in MH to oversee this long term cultural change plan. There were a number of principles and challenges identified in the report:
- It was discussed that it may be beneficial to try a different approach to completing the Care and Treatment Plans to lift the compliance levels, 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.

- The recording of assessments and CTPs should reflect service user engagement or co-production, and to evidence this.
- 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 that are providing regular and ongoing support to an individual within the assessment, planning and review processes
- The difference between Adult services and Older People with Learning Disability and CAMHS along with the commissioning of Care and Treatment Plans.
- Graphical information showed a drop in performance between March and April because the caseloads were cleansed of any duplicated records or records not shut down which resulted in medical caseload numbers dropping.
- To reference to PIP had an impact also with service users.
- The pilot started between three Mental Health teams in Cardiff and the Vale which are co-located in Barry hospital. The clinical pathway has been redesigned. The referral pathway was frontloaded with more senior staff including psychologist from the third sector to ensure that decisions are made at that junction of the treatment plan and ensure people are correctly processed into the CMHT, also ensure that any further pathways are signposted. The first 6 months of the pilot has been safely transferring people into the unit and the following 6 months will be around the development of the pathways.
- Housing and third sector employment agencies have been offered space within the same premises.

The Committee is asked to:

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

MHCLC 18/28 PSYCHOLOGICAL THERAPIES

REFERRAL TO TREATMENT – 26 WEEKS BRIEFING

The Director of Operations, Mr. Ian Wile gave a brief overview of this new and developmental target, but will reform the paper. A new non Tier 1 RTT which applies to Mental Health of 26 weeks of Referral to Treatment for a Psychological Therapy. The first set of objectives is in line with Welsh Government and Clinical Boards were to ensure the existence of a reporting mechanism and then a reporting methodology. C&V were a little ahead due to the existence of an electronic patient record. Now the MHCB is to align the reporting arrangements with Psychological Therapies Management Committee. The next phase is the performance management to a target of 80% compliance, with C&V currently at between 70 and 80% Comparing all Wales performance there is a stark difference at any one time with 3000 people waiting for psychological intervention in C&V and numbers in double figures elsewhere. Thus indicates the WG have some refining of its understanding of the application of this target to operational services. It is the case that C&V's extremely busy within this area and can be outlined in the new submitted paper.
The Director of Operations, Mr. Ian Wile and Dr. Robert Kidd have mentioned that:

- Psychological Management Therapies Committee is open for other staff to attend the meeting and ask questions along with how we link into other venues and Boards.
- Internal waiting lists in most departments
- CAMHS – 238 cases with waiting time 14 weeks
- Child Psychology services have adopted the 26 RTT.

The Committee will **SUPPORT** the approach taken by the Mental Health Clinical Board**.**

MHCLC 18/29 MENTAL HEALTH LEGISLATION OPERATIONAL GROUP

Dr. Robert Kidd presented the report and mentioned that the attendance to the last meeting was very fruitful. The following was mentioned:

- The Health Board is pursuing an issue on Section 135 where the state can effectively enter someone's home and previously being reliant on the Approved Mental Health Professional going to approach the JP or Magistrate to obtain such warrant. Currently it does not have to be an Approved Mental Health Professional so how can this be pursued to get effective response during the day time service.
- The place of safety that an individual attends and when does the clock start ticking at the Accident and Emergency Unit. The different views after 36 hours the police can leave and what is the legal basis for

someone to still be there, the issue being whether they are still receiving medical treatment or not. This is addressed before the Mental Health Act assessment starts
- Safety issues surrounding the Approved Mental Health Professionals in the entrance to Hafan Y Coed.

Discussion from the Mental Health Act Hospital Managers and the quality of Care and Treatment Plans in addition to the Delivery Unit, the Hospital Managers' are picking up on issues not relating to medication factors. Cross Agencies have participated within this group and it performs extremely well. The Committee was opened up for discussion:

- It was asked about the starting time of the Section 136 from Welsh Government, we are still waiting on clarification
- Currently the AMHP are taking the clients into Accident and Emergency in their own vehicles. Transportation wait can take up to six hours. Mental Health specialist ambulance service is not currently being used for Mental Health Act assessments.
- The Police do use their own vehicles as an option for acute symptoms and transportation of section 136 to place of safety.
- Query relating to the qualities act – whether mental health takes priority from physical health issues and the balance of resources available.

The Committee **NOTED** the report.

MHCLC 18/30 COMMITTEE WORKPLAN

The patient story will be presented at the next Committee meeting in February.
The Committee's annual report will feed onto the work plan for the Board meeting at the end of the reporting year. The Committee reports to the Board every year on the effectiveness and will be providing an update.

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

The Committee **AGREED** the Work-plan

MHCLC 18/31 HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Chair of the Power of Discharge presented the report stating there was no further information to update. The mismatch of recording on the Care and Treatment plans and the delays are making it central to the timely process for the patients.

It was mentioned that information is poorly documented or poor care that is being provided or not being recorded effectively. Good therapeutic interaction with staff and patients and it is being recorded in full.
The Care and Treatment plan is a legally binding document but individuals do not necessarily receive what has been outlined on the Care and Treatment plans and feel that the system has failed them.
Section seven of the report whereby the patient feels they have been physically neglected the Mental Health Act Hospital Managers oversee the information but there is a correct reporting procedure whereby the necessary assessments have been undertaken and correct procedures and feedback is reported on throughout the Clinical Boards.

Mental Health Act Hospital Manager's pick up on responses that are completed in reports by the ward/clinical managers. Upon review it should be been dealt with and brought to review timeframe.
No systemic ongoing issue.
Nurse practitioners will complete this work also.

The Committee **NOTED** the report

MHCLC 18/32 HOSPITAL MANAGERS POWER OF DISCHARGE ANNUAL REPORT/ POD RECOMMENDATIONS

There was no further update to the submitted report.

The Committee **SUPPORTED** the **RECOMMENDATIONS** of the Chair of the Power of Discharge Group.

MHCLC 18/33 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.

MHCLC 18/34 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 12th February 2019 at 10am, Boardroom, Headquarters, University Hospital of Wales.

ACTION LOG FOLLOWING MHCLC OCTOBER 2018

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
MHCLC 18/31	23.10.2018	Hospital Managers Power of Discharge Sub Committee Minutes	Dr R Kidd to report back on the Correct Completion of Care and Treatment Plans from the MHLAG Group.	R Kidd	Raised in Directorate Quality & Safety meetings and link to wider quality of care planning initiative with IW
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
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 programe
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.

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Report Title:	**Deprivation of Liberty Safeguards (DoLS) – Mental Capacity Act 2005**									
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	**12th February 2019**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**		
Lead Executive:	**Medical Director**									
Report Author (Title):	**Medical Director**									

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.

REPORT

Please provide your report in no more than 2 sides of A4 using the headings below. Essential supporting documentation can be provided as an appendix.

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. (The latest report is included in Appendix one following a meeting between all parties on 15th January 2019)

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 but not reducing. Whilst there is recognition of the difficulties that the current legislation causes it is unlikely that there will be any change in the law on this issue within the next 18-24 months.

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

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 on-going 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.

In a related paper (Mental Capacity Act, MCA,Update Report) for this Committee ddifficulties’ in fully embedding MCA awareness and specific issues in the organization is highlighted by Advocacy Support Cymru, the statutory IMCA provider. Referrals from the UHB to the Independent Mental Capacity Advocacy Service (IMCA) continue to rise. The Medical Director, with the MCA Manager, will attend the next routine contract management meeting to assess this trend with the service and look at ways to ensure there is better co-ordinated working. The Medical Director has discussed with the DOLs service the timing of signing the Supervisory Authorisations and that is consistent with legal advice provided to the service. There have been administrative delays releasing reports, including the Christmas period, but at the time of publication of the report all Standard Authorisations were completed.

To ensure there is a more robust system the Medical Director has initiated a specific training programme jointly with Blake Morgan to increase across the Clinical Boards the “signing capacity” of the organization for the DOLs Authorisation (Supervisory role) to be in place by March 31st 2019. This is particularly important for the transition of this statutory function from the current Medical Director (who retires from the post on the 18th April) to a new arrangement.

The Medical Director is agreeing with Internal Audit to develop new Terms of Reference for further DOLs audit based on All-Wales National outcomes in 2019/2020.

ASSURANCE is provided by:

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 for 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 in the New Year 2019/2020
- Improved arrangements for signing of the Supervisory function.

RECOMMENDATION

The Committee is asked to:

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

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration	√	Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.								

Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team Summary Report September 2018 – December 2018

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.

This report is a summary of activity and spend for the period of September 2018 – December 2018.

DoLS Requests

The table below shows the number of DoLS requests by type, per Supervisory Body during this period.

Received	Standard	Further	Urgent	Review	Total
Cardiff	338	52	42	1	433
Cardiff & UHB	148	43	287	5	483
Vale of Glamorgan	219	40	20	4	283
Total	705	135	349	10	1199

Completed	Standard	Further	Urgent	Review	Total
Cardiff	95	30	35	1	161
Cardiff & UHB	106	35	278	5	424
Vale of Glamorgan	103	23	19	4	149
Total					734

Outstanding	Standard	Further	Urgent	Review	Total
Cardiff	243	22	7	0	272
Cardiff & UHB	42	8	9	0	59
Vale of Glamorgan	116	17	1	0	134
Total					465

As these tables demonstrate, the team completed 61% of all the requests that came in during this period. With the primary type of request being authorised being those that are categorised as urgent 332 (45%).

Requests for Cardiff & Vale UHB made up 40% of the total number requested, with Cardiff being 36% and Vale of Glamorgan 24%.

57% of completed DOLS were provided on behalf of Cardiff & Vale UHB, 22% for Cardiff Council and 21% for Vale of Glamorgan Council.

RPR/IMCA Reviews

Responsible Person Representative (RPR) costs for this period are detailed in table below :

Relevant Persons Representative April 18 – Dec 18	Total Cost
Cardiff Council	£29,886.76
Vale Council	£26,692.75
C&V UHB	0

The costs associated with the appointment and ongoing involvement of RPRs continue to be an increasing cost. Discussions are taking place between the LA and the service provider in relation to the current levels of involvement and how this could be rationalised.

S.12 Doctors

S.12 doctors costs for this period are detailed in table below :

S.12 Doctors April 18 – Dec 18	Total Cost
Cardiff Council	£24,757.44
Vale Council	£10,194.24
C&V UHB	£39,866.76

These costs remain reflective of the numbers of requests submitted and subsequent authorisations that are made.

Partnership Funding

The funding contributions from the three partners are as follows:

- 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

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

Liberty Protection Safeguards (LPS)

- Future proofing
- How teams may function once Bill has been passed

Natasha James
Operational Manager, Safeguarding & Service Outcomes
Vale of Glamorgan Council
January 2019

Report Title:	**MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	**12/2/19**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√	
Lead Executive:	**Medical Director**								
Report Author (Title):	**Mental Capacity Act Manager**								

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.

REPORT

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

Specialist Services CB has recently conducted an audit of mental capacity assessments within its departments. Preliminary results suggest that understanding of – and compliance with – MCA is patchy.

Mental Health CB – in process of organizing a MCA training session for doctors.

Medical Education Dept – considering how best to ensure that all training grade doctors have undertaken MCA training.

Welsh Government - to convene the All Wales MCA Forum to consider training requirements for clinicians and all-Wales data on training, etc.

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.

ASSESSMENT

Whilst there are individual clinicians and service areas that have developed an understanding of MCA and comply with it, the position is not uniform across the UHB: there is still a way to go until MCA is embedded in clinical practice. The need to highlight the training of doctors has previously been raised by this Committee and there has previously been a plan brought to the Committee to improve training in this Professional group. Some of that improved approach is highlighted above in the additional information section with targeted training by departments. Unfortunately it has not been possible to provide training figures for this report, as LED is in the process of reviewing and revising each individual member of staff's MCA training requirement on ESR. It is not possible to report on compliance whilst this work is in progress. LED has advised that MCA training compliance will be available for the next Committee meeting. This will be an important measure of whether there has been improvement in uptake in training and whether this provides greater assurance to the Committee.

Difficulties in fully embedding MCA awareness in the organization is highlighted by Advocacy Support Cymru, the statutory IMCA provider in their report (appendix two). Issues relating to Deprivation of Liberty
Safeguards (DOLs) in that report are dealt with in a separate report to the Committee.

It is noted in the more detailed report (appendix one) that:

1. Queries to the MCA Manager do not identify any specific trends

2. Referrals from the UHB to the Independent Mental Capacity Advocacy Service (IMCA) continue to rise.
   The Medical Director, with the MCA Manager, will attend the next routine contract management meeting to assess this trend with the service.
3. No complaints concerning or related to MCA issues during the period of her report have been brought to the attention of the MCA manger.
4. The Ombudsman's case book for the period July to September 2018 includes three cases that were upheld or partially upheld against the UHB, MCA does not appear to be a factor in any of the cases.

ASSURANCE is provided by:

This information only provides indirect assurance about compliance with MCA, direct assurance would require more detailed assessment including scrutiny of patients' notes.

The report of the MCA Manager (appendix one), IMCA report (appendix two) and separate DoLS report provide evidence of adherence to the MCA but only Limited Assurance.

RECOMMENDATION

The Committee is asked to:

- Note this report

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	√	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*			

Prevention		Long term		Integration	√	Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.								

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION
February 2019

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
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
1/10/18 – 31/12/18	31

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	Jan – March 18	April – June 18	July – Sept 2018	Oct – Dec 2018

Accommodation	14	12	22	15
POVA Safeguarding	2	2	1	1
Care Review	2	1	2	4
Serious Med T/ment	9	3	9	8
DoLS s.39A	0	0	0	1
DoLS s.39C	0	0	0	0
DoLS s. 39D	7	8	3	11
DoLS RPR	59	42	28	60
TOTAL	**93**	**68**	**65**	**100**

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

3) Healthcare Inspectorate Wales (HIW) reports

There were no inspection reports about UHB services published by HIW in the period October – December 2018.

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 July to September 2018 includes 3 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.

6) Staff MCA training as at 31st December 2018

Unfortunately, it has not been possible to provide training figures for this report, as LED is in the process of reviewing and revising each individual member of staff's MCA training requirement on ESR. It is not possible to report on compliance whilst this work is in progress. LED has advised that MCA training compliance will be available for the next Committee meeting.

APPENDIX 2

Mental Health and Capacity Legislation Committee

Provision of South East Wales Independent Mental Capacity Advocacy (IMCA)

Service issues/Areas of concern - Cardiff and Vale University Health Board

- General lack of understanding and acknowledgement from professionals across the health board in relation to IMCA role.

- General lack of understanding and acknowledgement from professionals across the health board in relation to Court of Protection processes and requirements.

- General lack of SMT, POVA and Care Review referrals.

- Issues around DoLS –
  - The IMCA team are experiencing an increasing number of DoLS referrals that are being sent either as the authorisation is about to expire or when P has already been discharged from hospital.
  - DoLS authorisations backdated to time of assessment rather than dated when Supervisory Body signs authorisation.
  - IMCA team receiving DoLS authorisations/RPR referrals when they have been active for weeks (leaves little time to act)
  - DoLS coordinator insisting RPRs attend Best Interest Meetings relating to LTM when there are no issues and family are appropriately involved.

- IMCAs are repeatedly explaining to professionals the purpose of the Best Interest process, explaining in detail about the "least restrictive" principle and why the patient should be central to the process. IMCAs also question staff about the legal authority (or lack of it) they are using in order to impose a decision on a client who is objecting and protesting to the Best Interests outcome.

- The IMCA team have recently received a number of referrals that are very short notice or where a decision has already been made, Serious Medical Treatment has already taken place, or a Best Interests Meeting is due to take place the following day.

- Barry Hospital: LTMA IMCA closed case after best interests meeting for P had taken place and decision was made to move P into a residential placement. A few weeks later, the ward manager rang the IMCA to ask what was happening with P's placement. The IMCA explained that this was to be looked at by the social worker and explained that the IMCA's involvement had ended. The IMCA explained, as stated in their report, that P was objecting to discharge to a residential placement and so it would need to be considered in the Court of Protection. The staff member asked, 'even though they lack capacity?' IMCA explained that the Court of Protection would need to be considered.

- IMCA previously involved with P as RPR and safeguarding IMCA. However, safeguarding case had closed and DoLS had expired. Therefore, there was no remit for the IMCA to be involved. Despite this, on the day of a discharge-planning meeting for P, the IMCA received a phone call from the Head of Integrated Discharge who told the IMCA that it was not in the client's best interests for IMCA not to be involved and that it was essential that the IMCA attended the meeting. The IMCA expressed their concern that they did not have a remit to be involved and the issue was referred to the IMCA manager.

REPORT TITLE:	**MENTAL HEALTH ACT MONITORING**								
MEETING:	**Mental Health & Capacity Legislation Committee**						**MEETING DATE:**	**12 February 2019**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**		**x**
LEAD EXECUTIVE:	**Chief Operating Officer**								
REPORT AUTHOR (TITLE):	**Mental Health Clinical Board Director of Operations**								

PURPOSE OF REPORT:

SITUATION:

This report provides the Committee with further information relating to wider issues of the Mental Health Act. 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 have been no exceptions during this period. The full report can be accessed below:

MHA Monitoring Report.docx

REPORT:

BACKGROUND, ASSESSMENT AND ASSURANCE

Detention without authority
During the period there have been no breaches. The number of patients detained without authority has been eradicated since quarter 2. There have been no incidents to report since the period July – September 2018.

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.

The amendments made 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.

This non statutory guidance suggests a contrary approach is taken to that in the Code of Practice for Wales in relation to patients taken to A&E.[1]

A detailed consideration of this issue is contained in the Mental Health Act Manual, Richard Jones, twenty - first edition, 1-1366, 606/607.

Legal advice has been obtained and is clear that practitioners should follow the guidance contained in the Code of Practice for Wales, 16.46[2]. Furthermore *"an element of uncertainty about the correct legal position does not constitute a "cogent reason" for departing from the Code of Practice (see the Munjaz case), the approach that should be adopted practitioners in Wales while awaiting clarification by the courts is clear.*

It is worthy of note that some NHS Trust in England follow the guidance in the Code of Practice for Wales."

Cardiff and Vale UHB's designated PoS is Hafan Y Coed, UHL. There is no dispute that A&E could of course be a place of safety but only in exceptional circumstances, when it is deemed suitable. This will be dictated by health staffs that are in a position to agree on behalf of the management not by the police.

The Mental Health Act Manager has requested clarification on the position of Welsh Government from the Mental Health Legislation Manager on behalf of this Committee. The Mental Health Legislation Manager has confirmed that the request has been logged and a response will be issued in due course.

Hospital Managers
Section 23 of the Mental Health Act 1983 (the Act) gives hospital managers the power to discharge most detained patients and all patients subject to a community treatment order (CTO).

This power is delegated to a hospital managers' discharge panel which comprises of independent persons not employed by Cardiff and Vale University health Board. Hospital managers are drawn from members of the Power of Discharge Group.

Members appointed to consider exercising the power of discharge should fully comprehend the role they are to perform and receive adequate and appropriate training to ensure they:

- understand the Act and other relevant legislation
- understand the associated Codes of Practice
- understand risk assessment and risk management reports
- are able to reach sound judgments and properly record their decisions

An all Wales hospital managers training event funded by Welsh Government took place on 28 November 2018. The event was well received and feedback indicated that those present were grateful for the opportunity to attend and would welcome future events like this. There was a 74% attendance rate with many making a significant journey from north/west Wales to attend the event in Cardiff. 80% of those that left feedback rated the event good/excellent and 73% reported that they would use the skills/knowledge

[1] *"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)."*

[2] *"If in exceptional circumstances, a police officer needs to take a person to an emergency department after detaining that person under section 136, for the emergency medical assessment or treatment of their physical health this should not be treated as admission to a place of safety. Detention under section 136 will begin when the person is taken to the appropriate place of safety for the assessment of their mental health."*

gained from the day weekly/monthly.

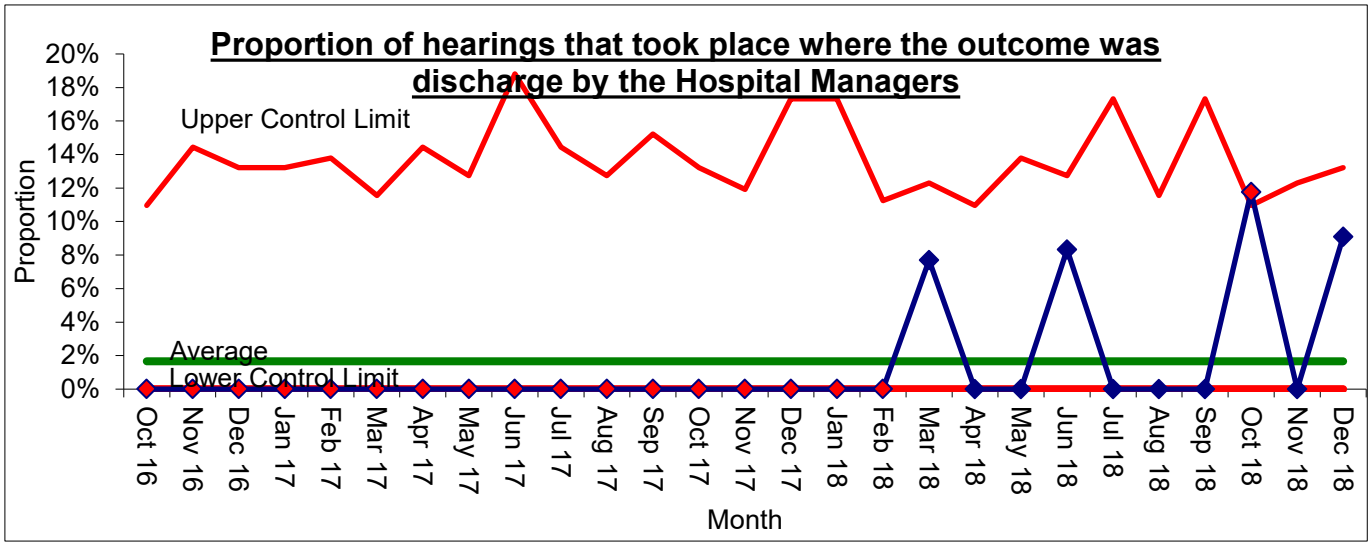
For the full report providing feedback to Welsh Government see below:

WG report All Wales Hospital Managers Cc

The Mental Health Act Manager continues to ensure that the Power of Discharge Group are provided with sufficient training. A decision making/writing workshop is to be arranged, incorporating the skills acquired at the all Wales event in Cardiff.

The Director of Operations, Mental Health and Mental Health Act Manager have observed seven hearings during the period to provide assurance that panel members are communicating effectively with patients under often particularly challenging circumstances . All members observed have displayed appropriate skills and behavior as a panel member, good knowledge of law and procedure and sound judgment and decision making.

There has been a noticeable increase in hospital managers exercising their power of discharge since



February 2018. Prior to this there was one discharge during 2015. Three patients have been discharged from detention during this period.

Policies and Procedures

It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 is monitored.

The Mental Health Act 1983 Code of Practice for Wales, Revised 2016 sets out a non exhaustive list of recommended policies organised into categories and referenced to the relevant chapters.

All policies should be developed to ensure that the care and treatment patients receive is in line with the guiding principles.

The All Wales Mental Health Act Policy Group was established in 2017 to ensure that policies, procedures and guidance were developed in line with the Mental Health Act 1983, Code of Practice for Wales, Revised 2016. Nine policies were identified to be specifically written by Mental Health Act Teams. This task is now complete pending approval by the MHLCC of the following:

- Application for admission under Part II of the Mental Health Act 1983 Policy
- Application for admission under Part II of the Mental Health Act Procedure
- Patient Rights Information to Detained/ Community Patients Mental Health Act, 1983 Policy
- Patient Rights Information to Detained/ Community Patients Mental Health Act, 1983 Procedure
- Review of Detention and Community Treatment Order, Mental Health Act 1983 Policy
- Review of Detention and Community Treatment Order, Mental Health Act 1983 Procedure

The documents will differ slightly in each Health Board depending on local arrangements.

The Group will meet annually to review the Mental Health Act polices/procedures.

A list of the remaining documents required has been provided to the UHB's Mental Health Policy Group for further consideration.

Independent Review of the Mental Health Act 1983
The Department of Health and Social Care published the final Independent Review of the Mental Health Act 1983 and has set out recommendations for government on how the Act and associated practice needs to change.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf

154 recommendations were made, 2 of these recommendations have been accepted by the Secretary of State and a further response will be provided in due course:

- The establishment of new statutory advance choice documents (ACDs), so that people's wishes and preferences can carry far more legal weight. These would enable people to express preferences on their care and treatment, to help ensure that these preferences are considered by clinicians, even when the person may be too ill to express themselves.
- Ensuring that people have a say in which relative has power to act for them, through the creation of a new role of Nominated Person, to be chosen by the patient, rather than allocated to them from a list of relatives. This person would have enhanced powers in their role; both to be informed about the person's detention in hospital and to be involved in decisions made about their care.

The Head of Operations and Delivery, Mental Health Clinical Board and the Mental Health Act Manager continue to work with Mental Health Act Leads from other Health Boards to agree and collate core data so that reliable and valid information can be routinely compared from each Health Board.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

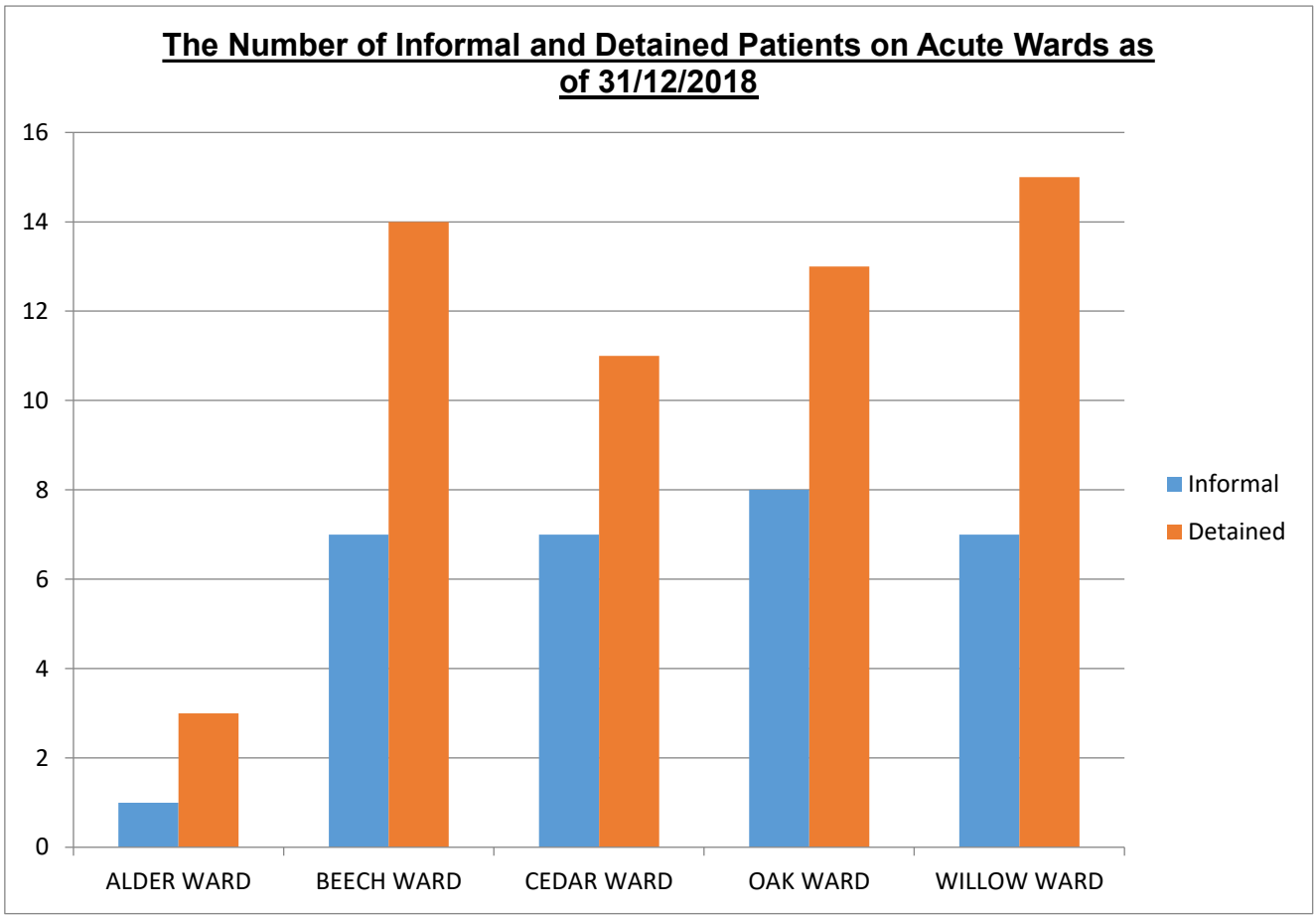
Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

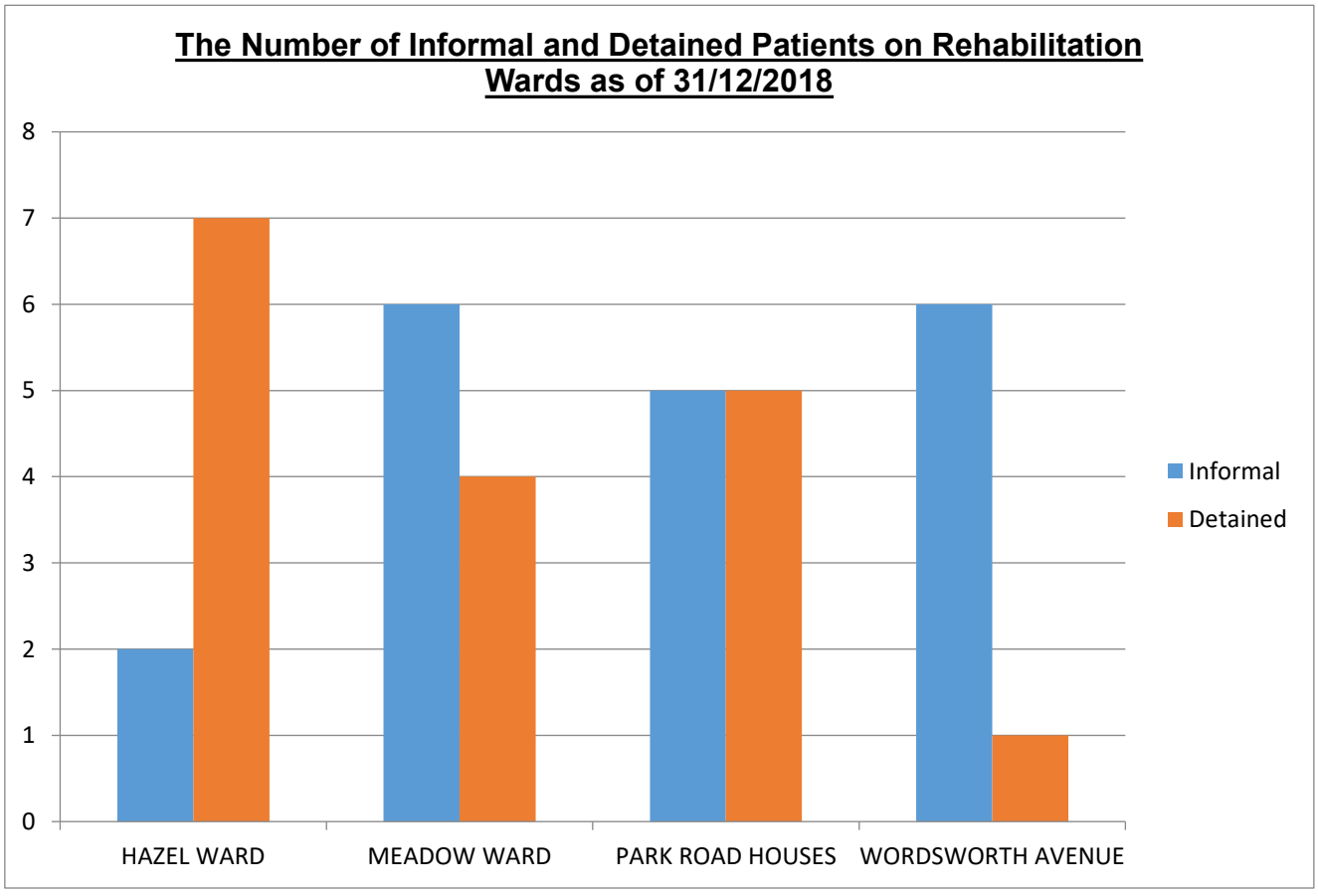
Report to the

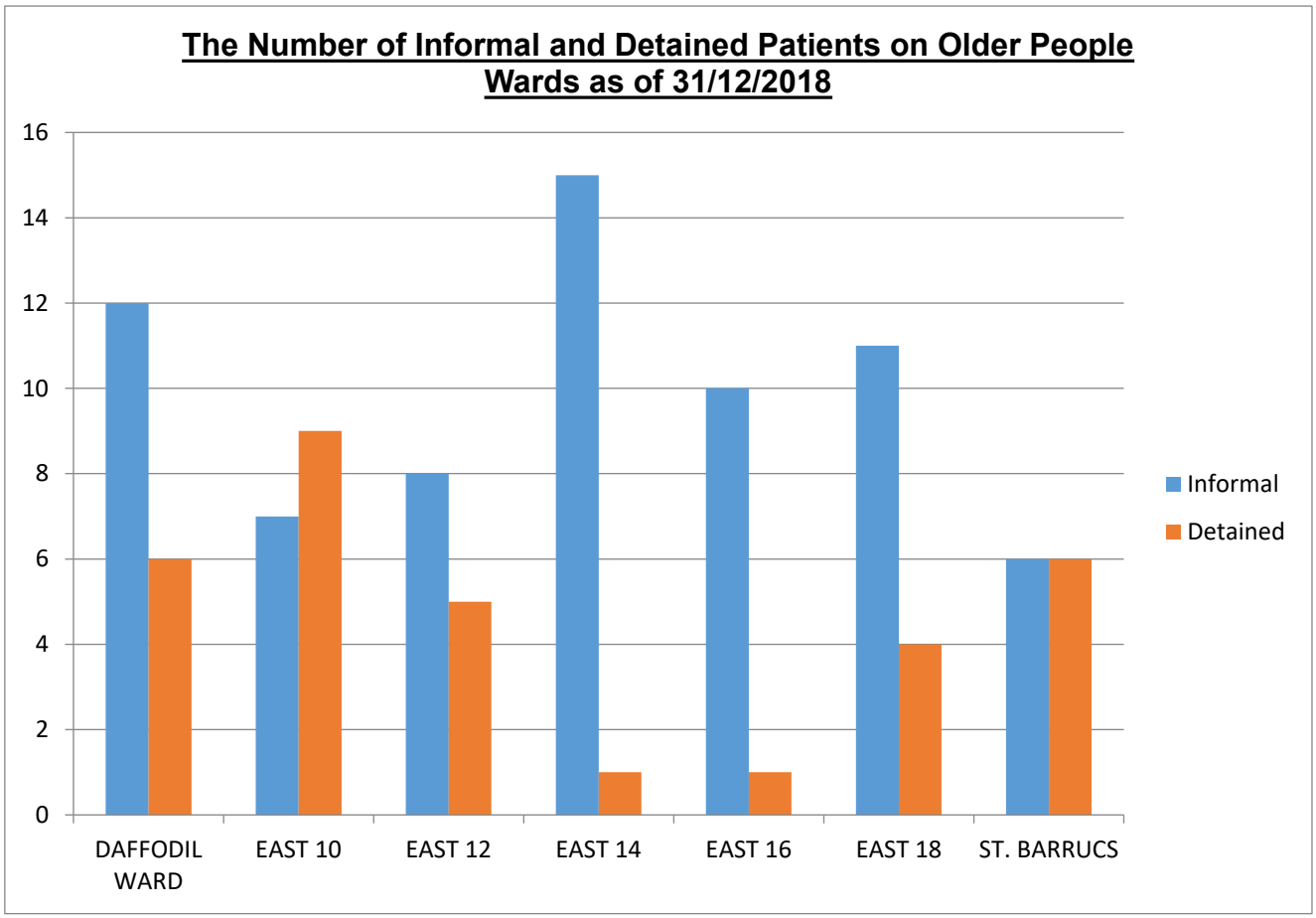
Mental Health and Capacity Legislation Committee

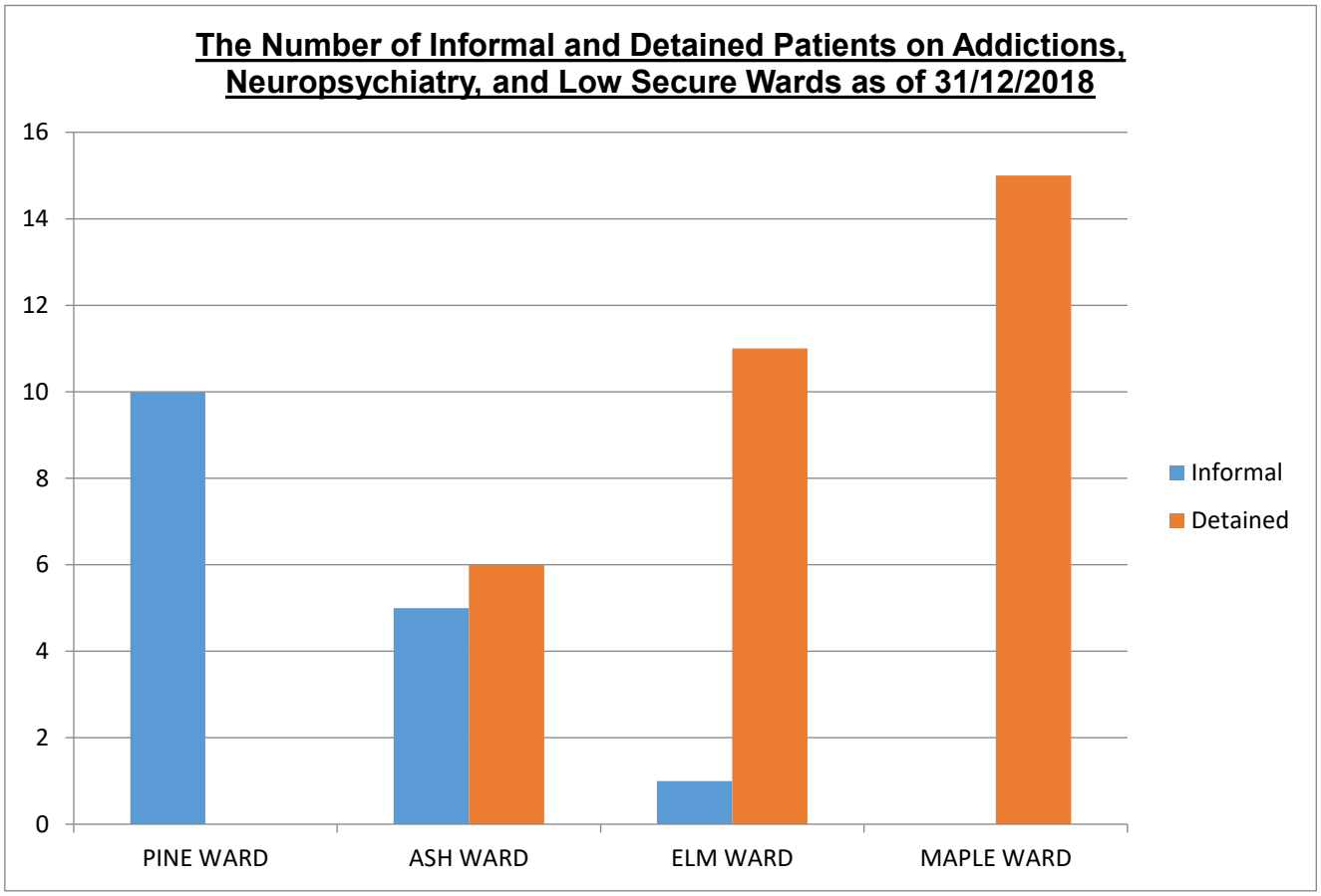
on the use of The Mental Health Act, 1983

October - December 2018


The Number of Informal and Detained Patients on Acute Wards as of 31/12/2018
16
14
12
10
8
6
4
2
0
ALDER WARD
BEECH WARD
CEDAR WARD
OAK WARD
WILLOW WARD
Informal
Detained

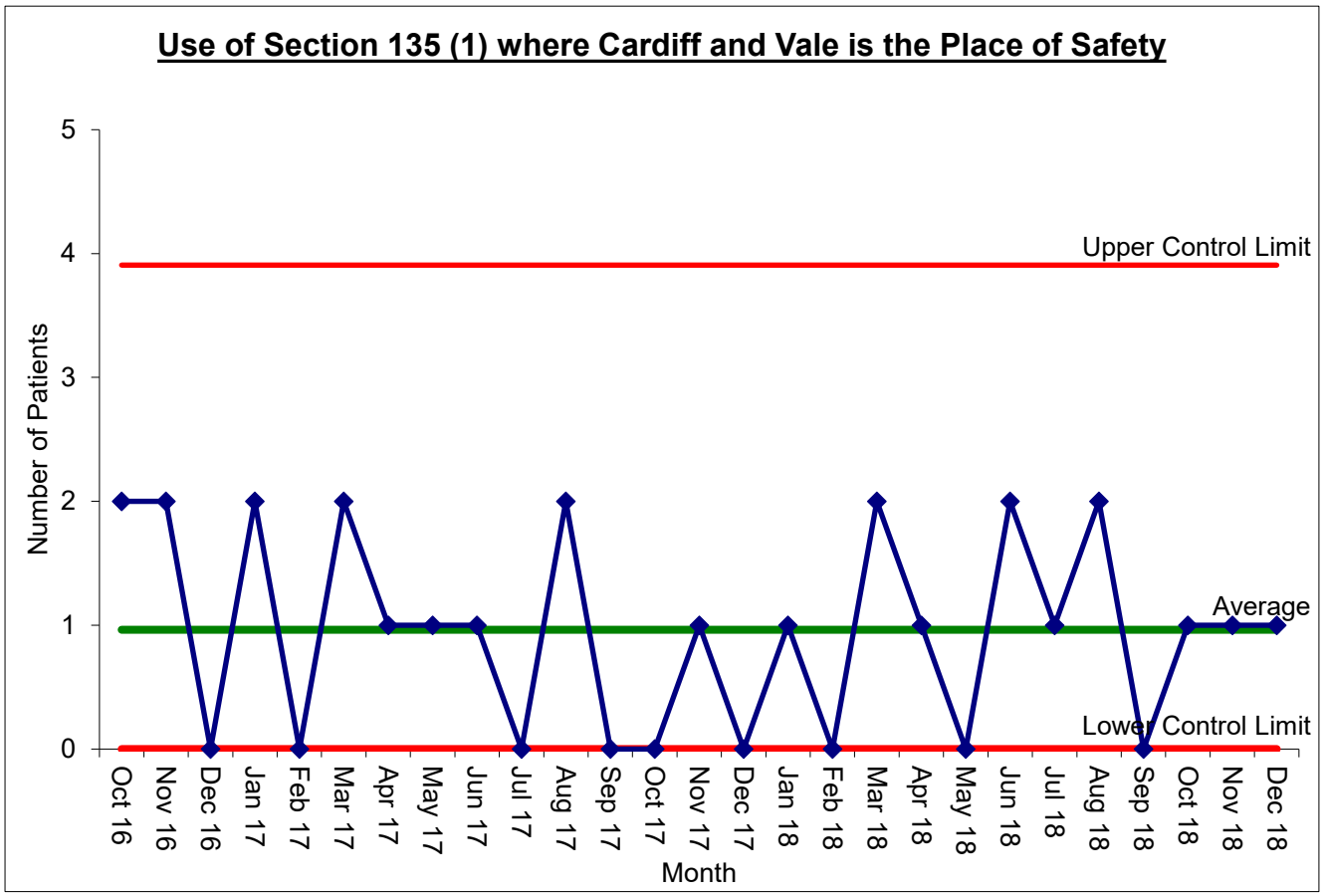

The Number of Informal and Detained Patients on Rehabilitation Wards as of 31/12/2018
8
7
6
5
4
3
2
1
0
HAZEL WARD
MEADOW WARD
PARK ROAD HOUSES
WORDSWORTH AVENUE
Informal
Detained


The Number of Informal and Detained Patients on Older People Wards as of 31/12/2018
16
14
12
10
8
6
4
2
0
DAFFODIL WARD
EAST 10
EAST 12
EAST 14
EAST 16
EAST 18
ST. BARRUCS
Informal
Detained

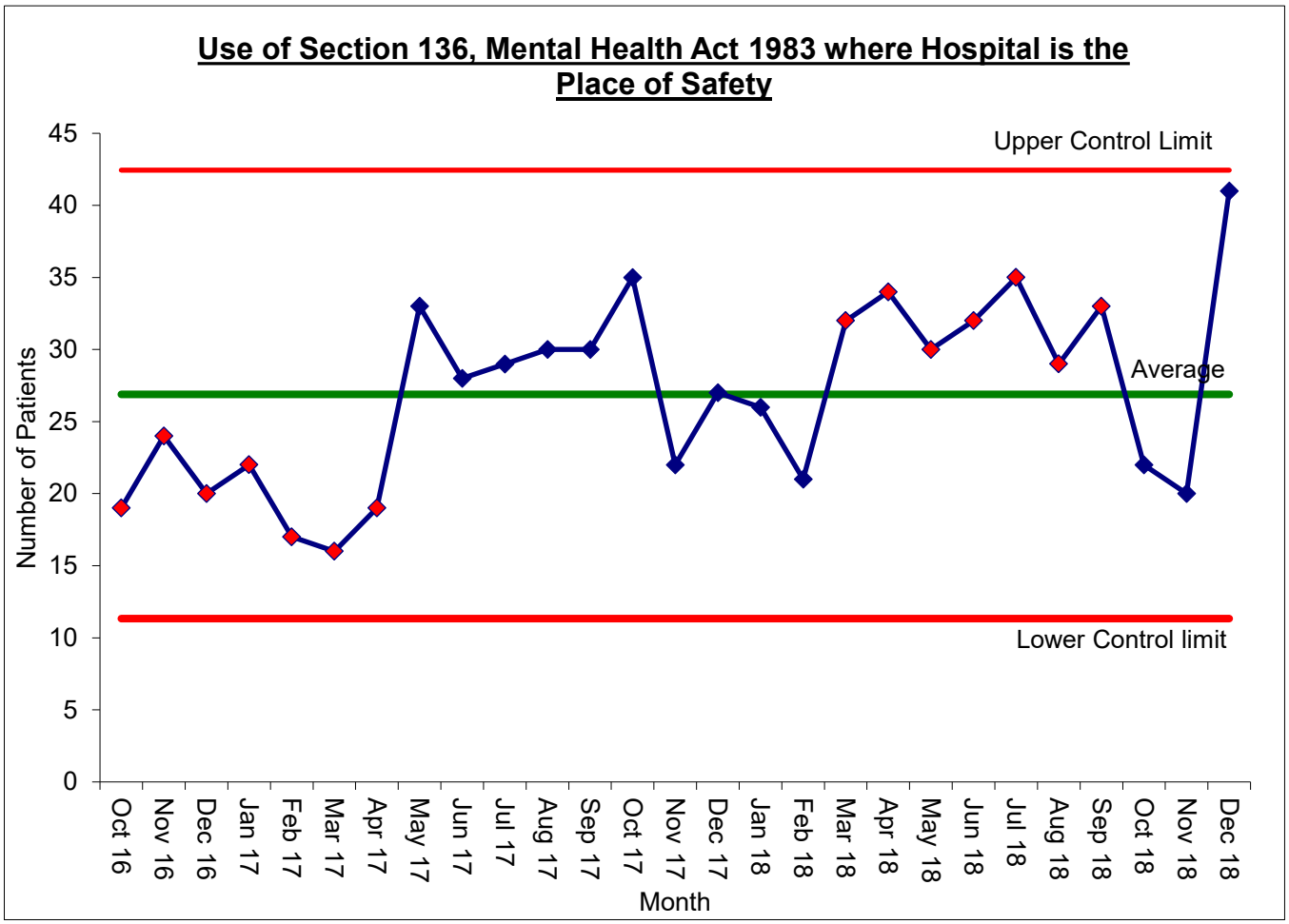

The Number of Informal and Detained Patients on Addictions, Neuropsychiatry, and Low Secure Wards as of 31/12/2018
16
14
12
10
8
6
4
2
0
PINE WARD
ASH WARD
ELM WARD
MAPLE WARD
Informal
Detained

Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on three occasions. Two of these patients were subsequently detained under Section 2 whilst the third was subsequently detained under Section 3.



Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

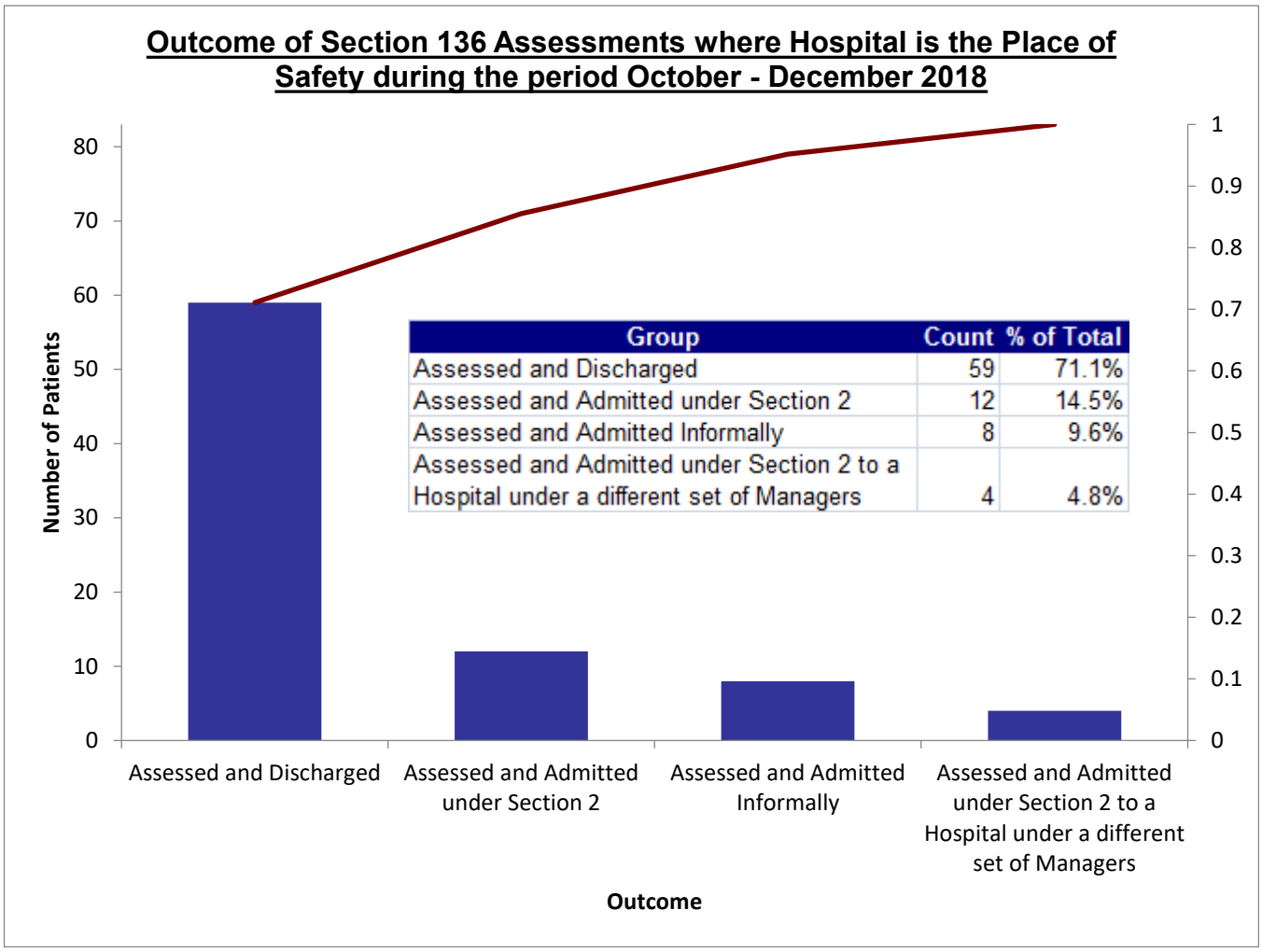


During the period a total of 83 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

CAMHS

Two of these assessments were carried out on patients under the age of 18. The outcomes were as follows:

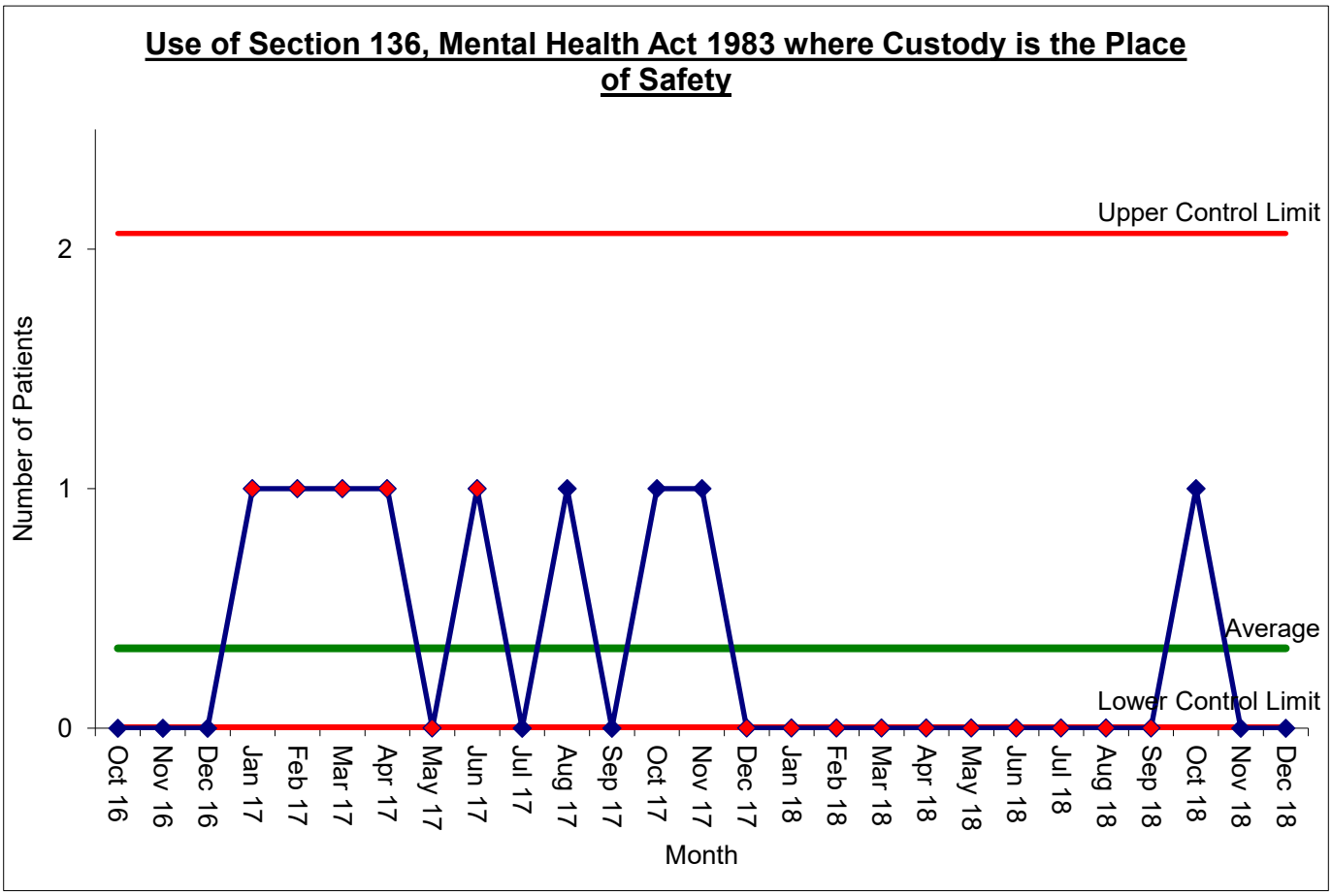
- One discharged to CAMHS community services
- One admitted under Section 2 to a CAMHS specialist hospital under a different set of managers



The pareto chart highlights that 71.1% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.

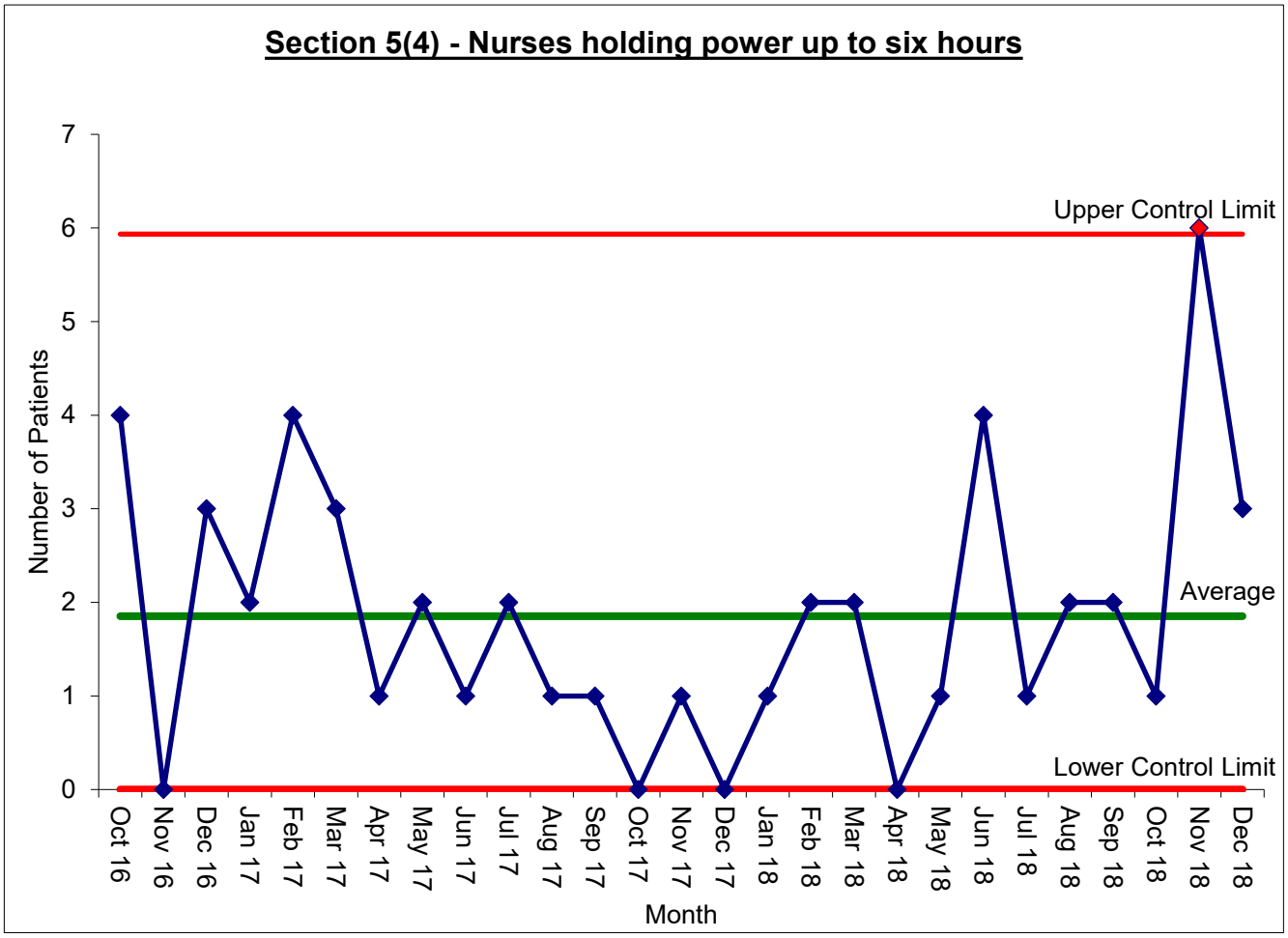
- Four of the patients were transferred back to their local area for further assessment and treatment

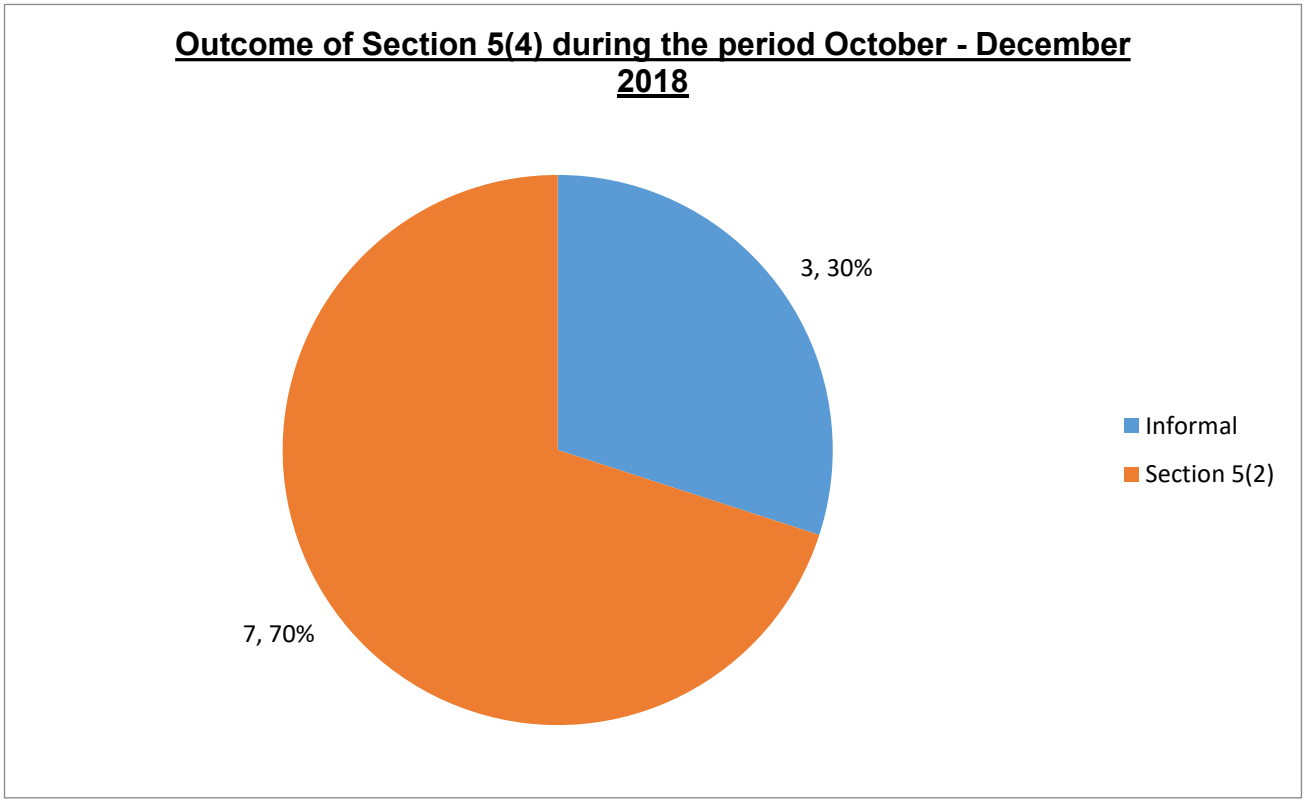
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station



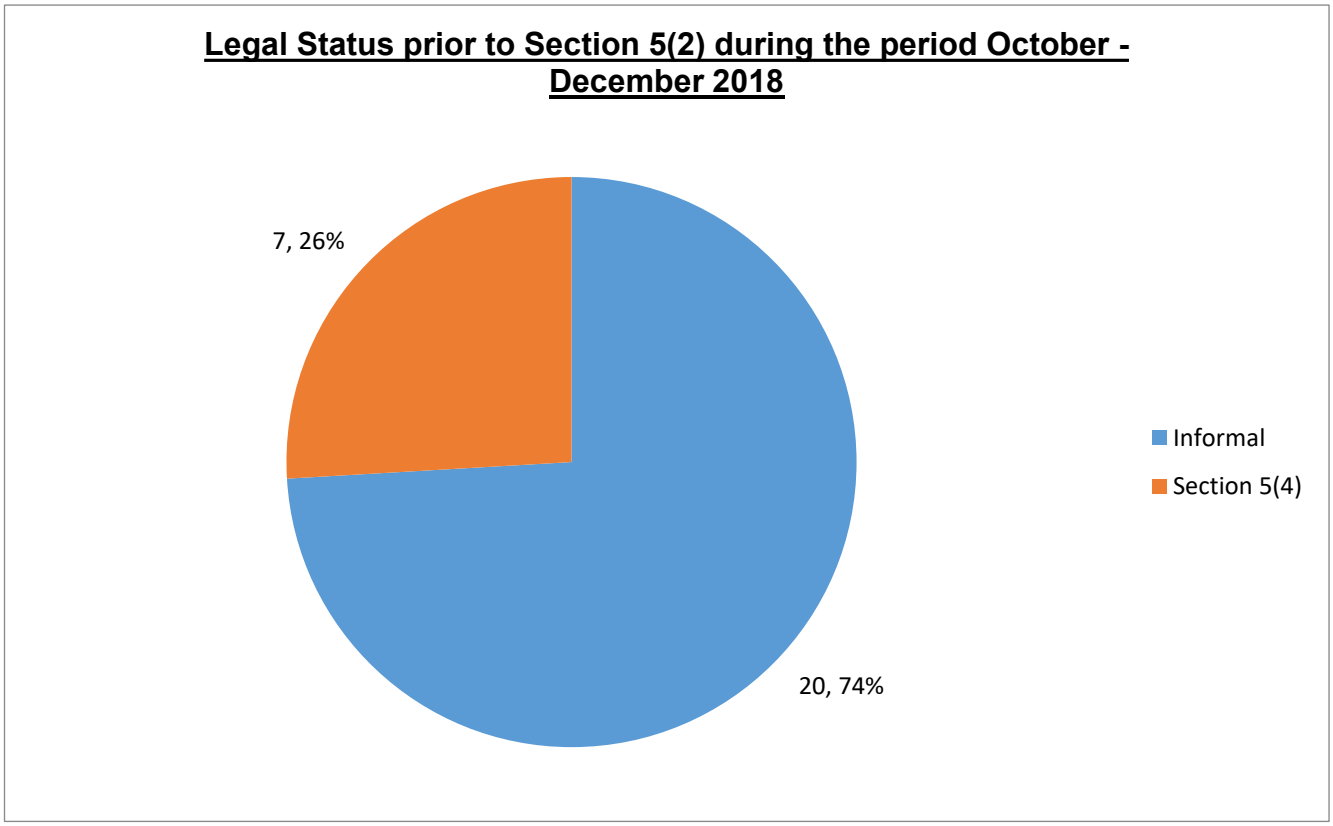
During the period one assessment that was initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite. The patient was subsequently discharged with no mental disorder.

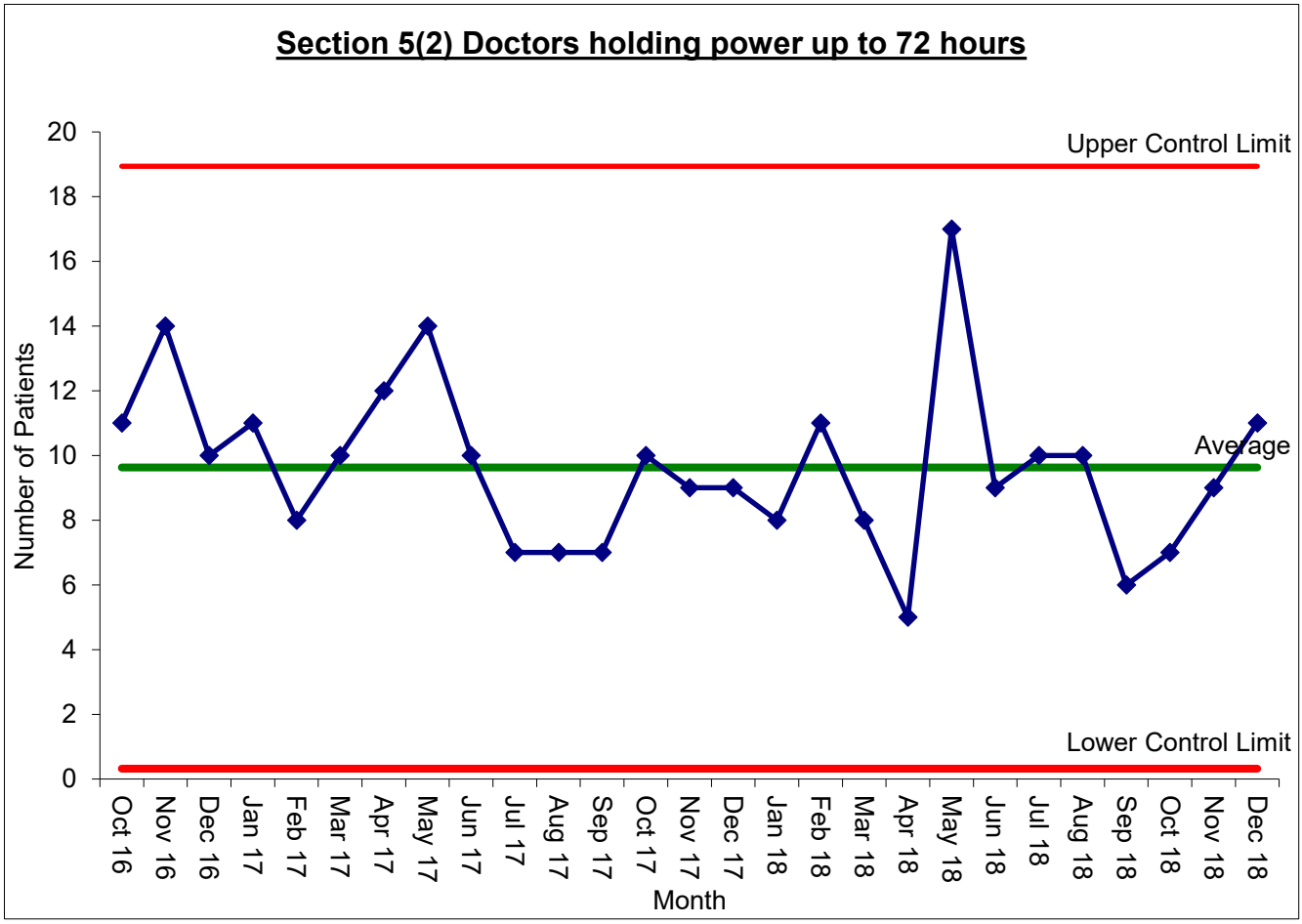
Section 5(4) - Nurses Holding Power

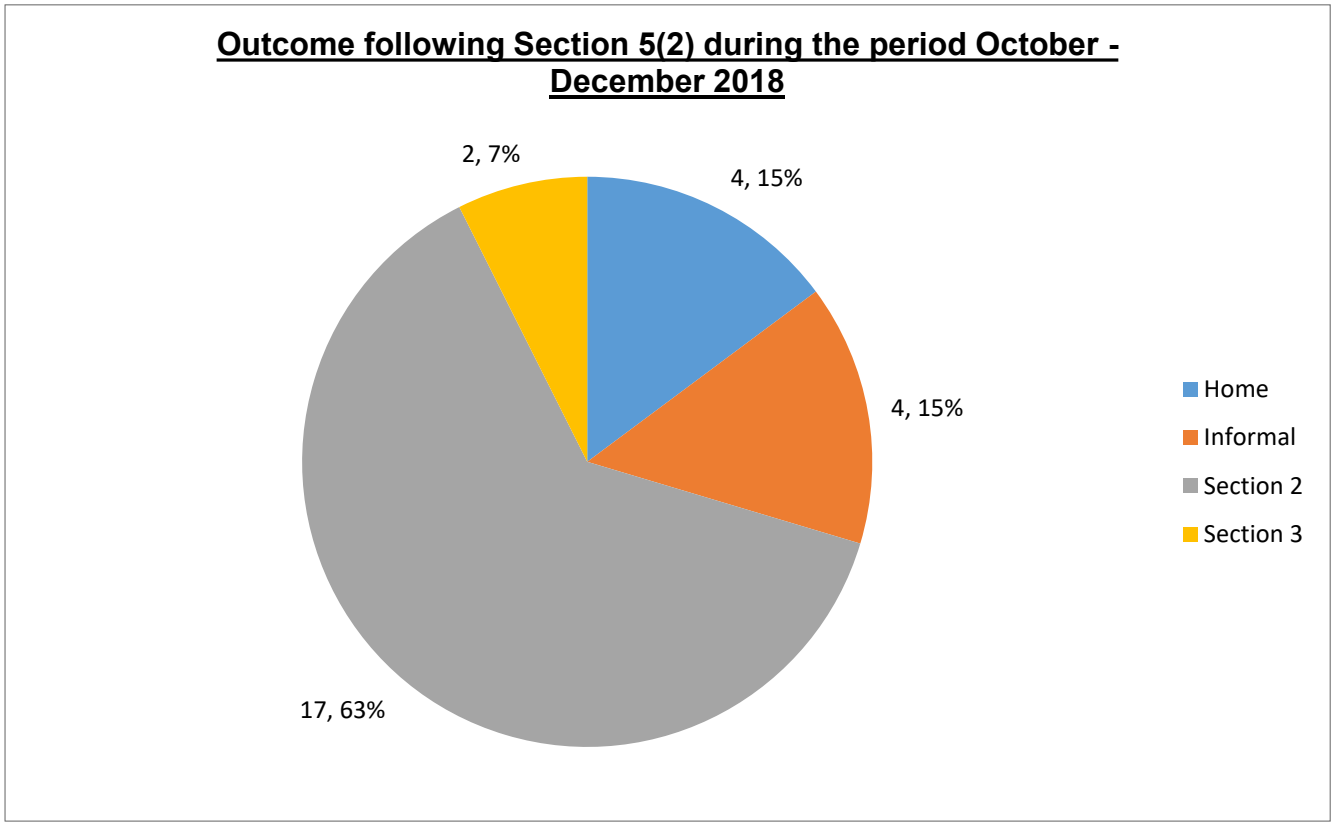




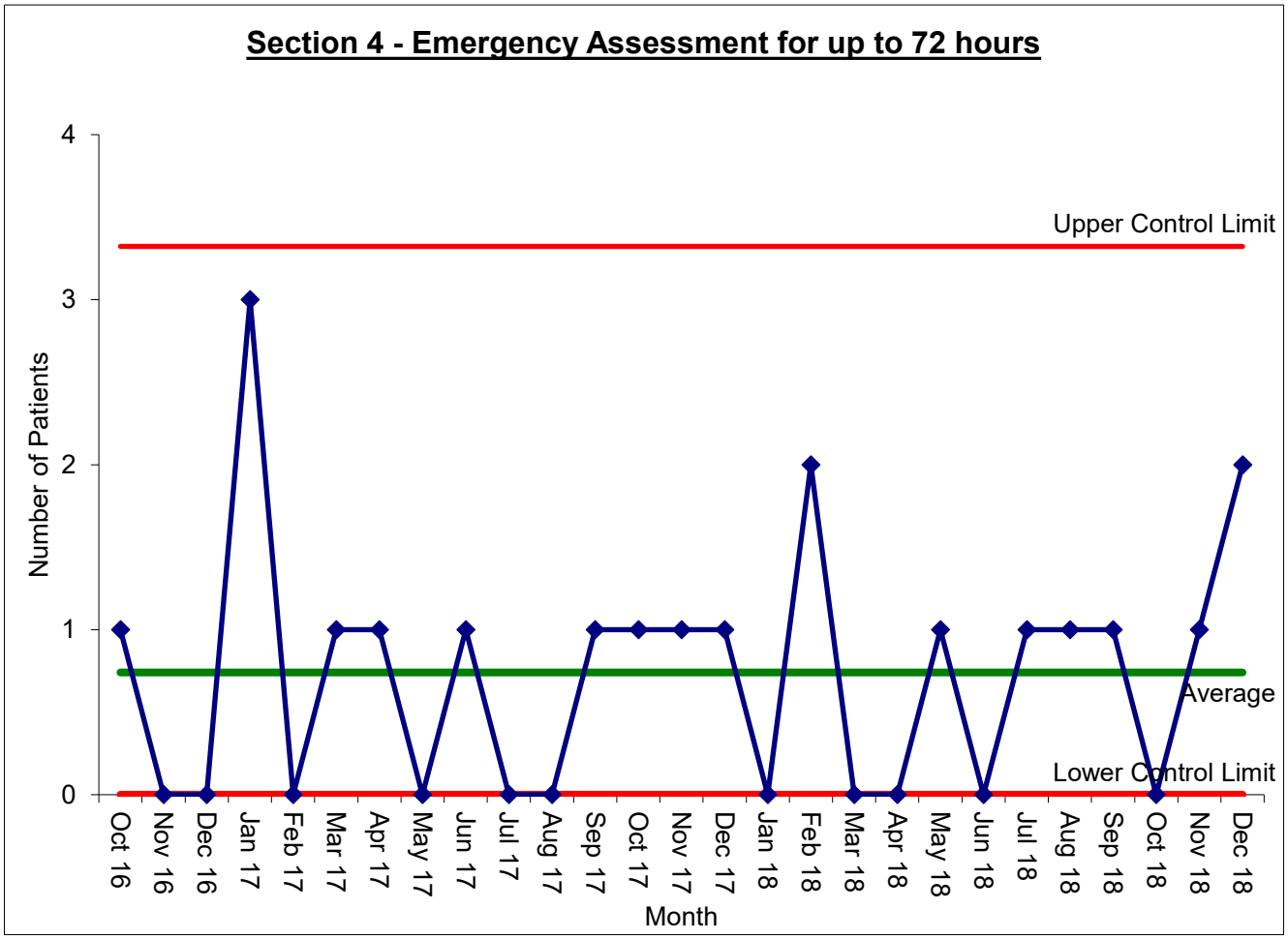
Section 5(2) - Doctors holding power






Outcome following Section 5(2) during the period October - December 2018
2, 7%
4, 15%
4, 15%
17, 63%
Home
Informal
Section 2
Section 3

Section 4 - Admission for Assessment in Cases of Emergency

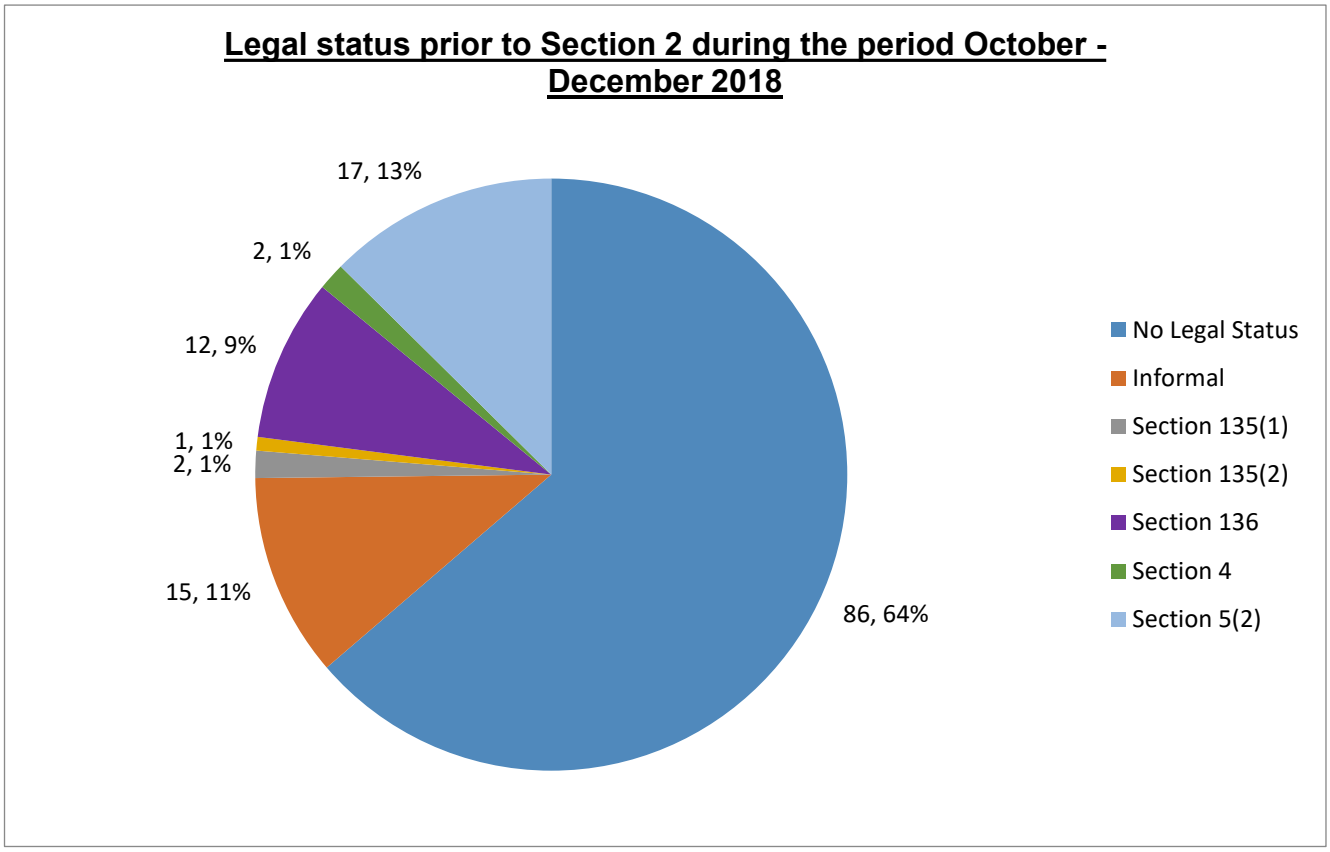


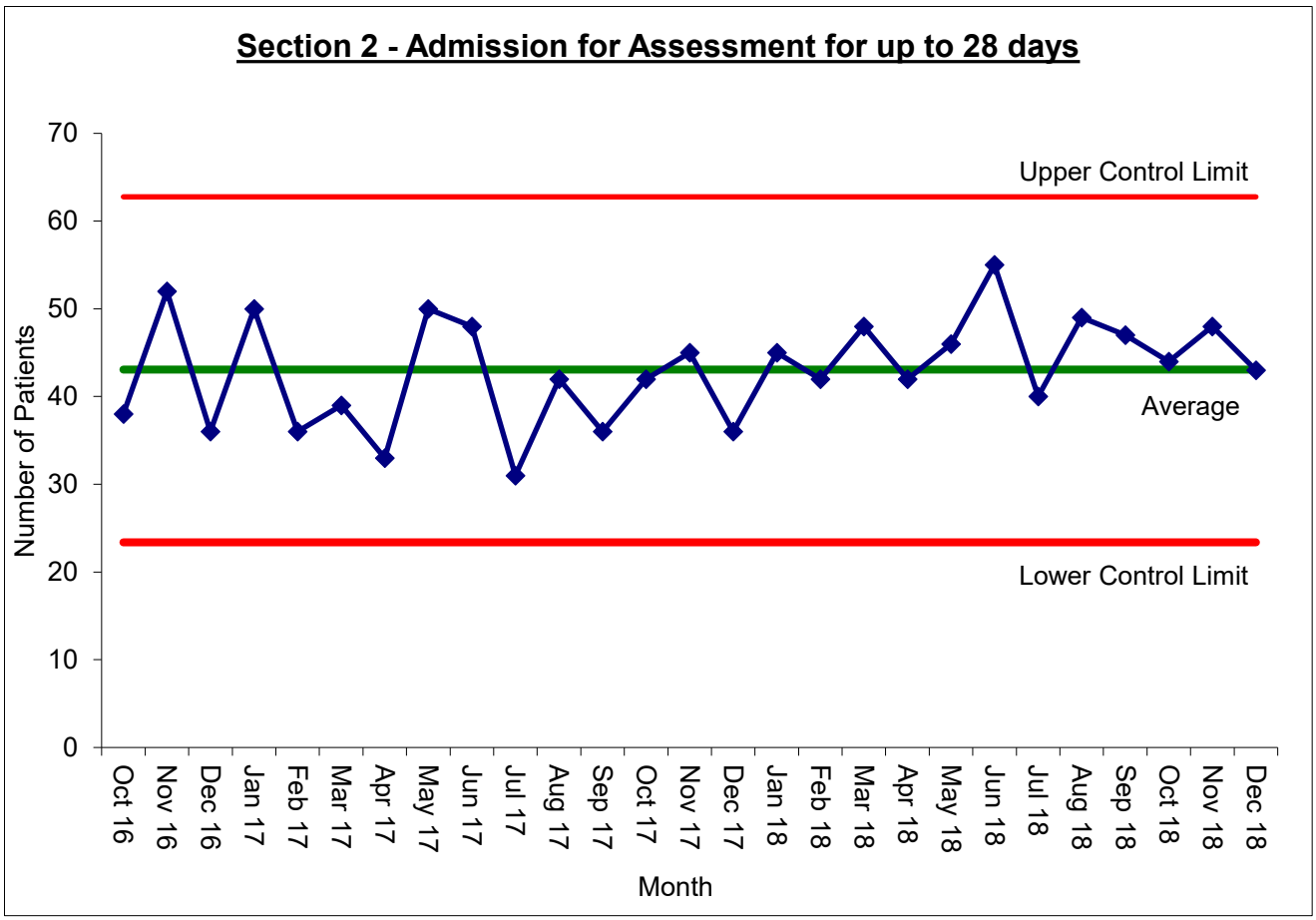
Section 4 was used on three occasions for the following reasons:-

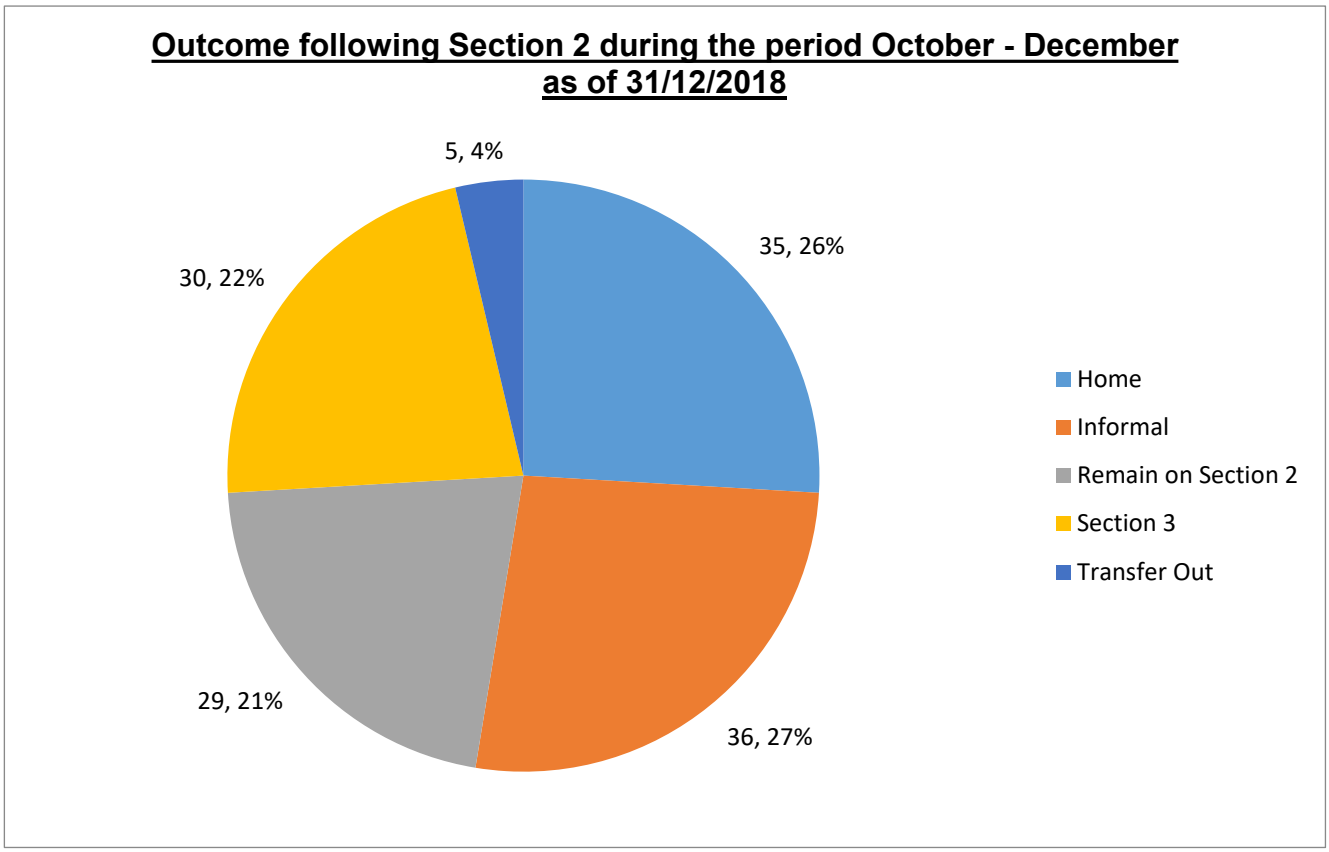
- Two patients posed an immediate risk to themselves and no second section 12 Doctor available.
- One patient posed an immediate risk to themselves and others and no second section 12 Doctor available.

Upon further assessments two patients were subsequently detained under Section 2, the remaining patient was discharged and left the hospital.

Section 2 – Admission for Assessment

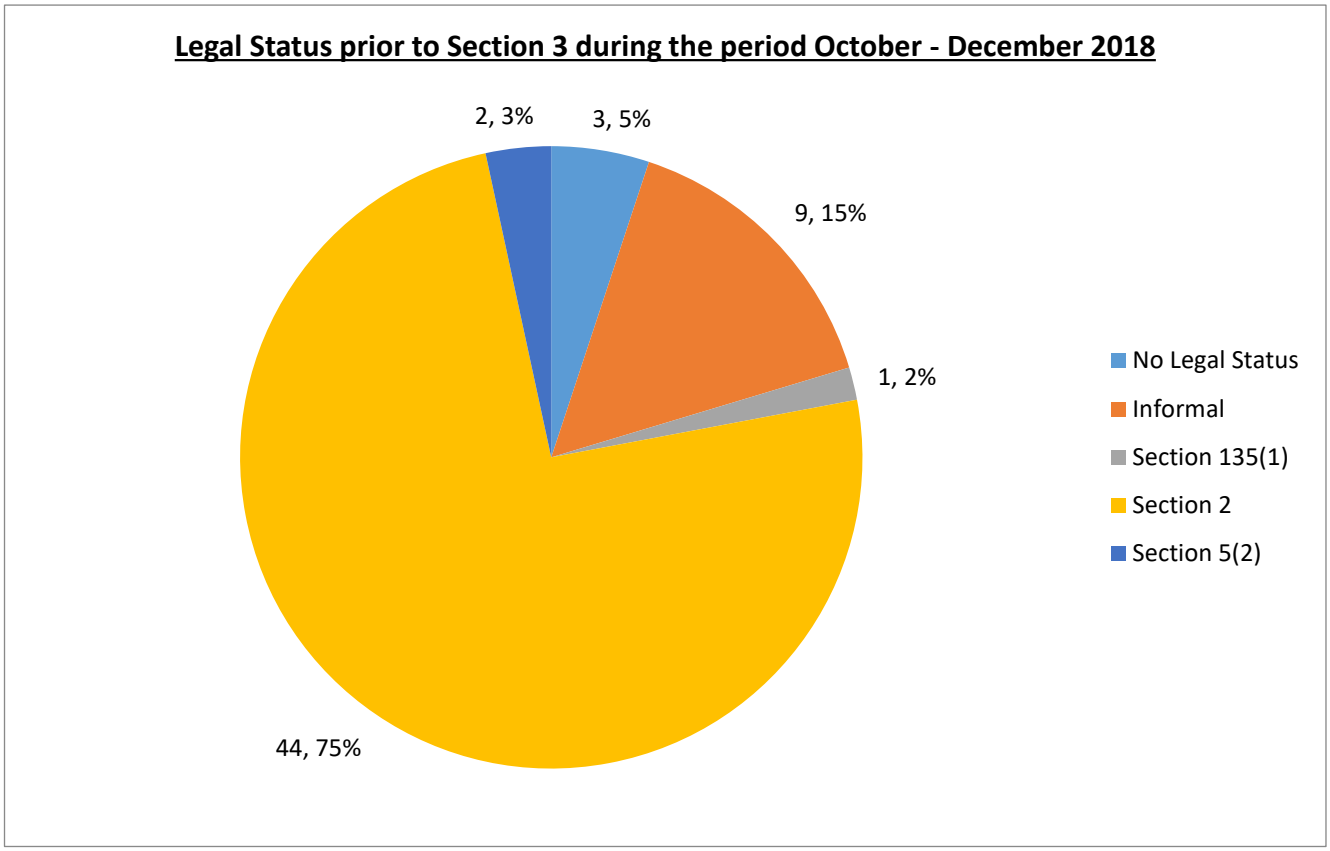


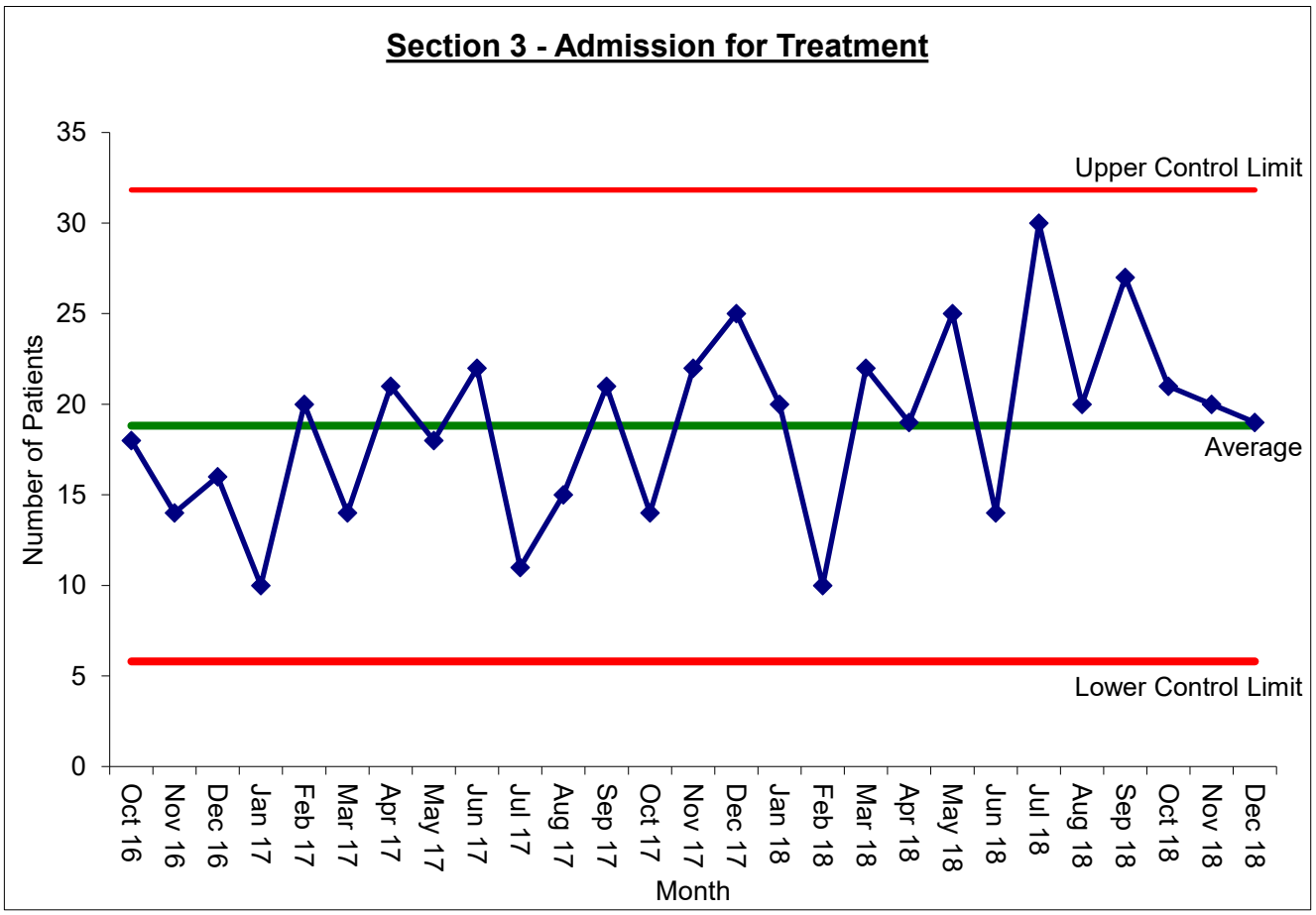


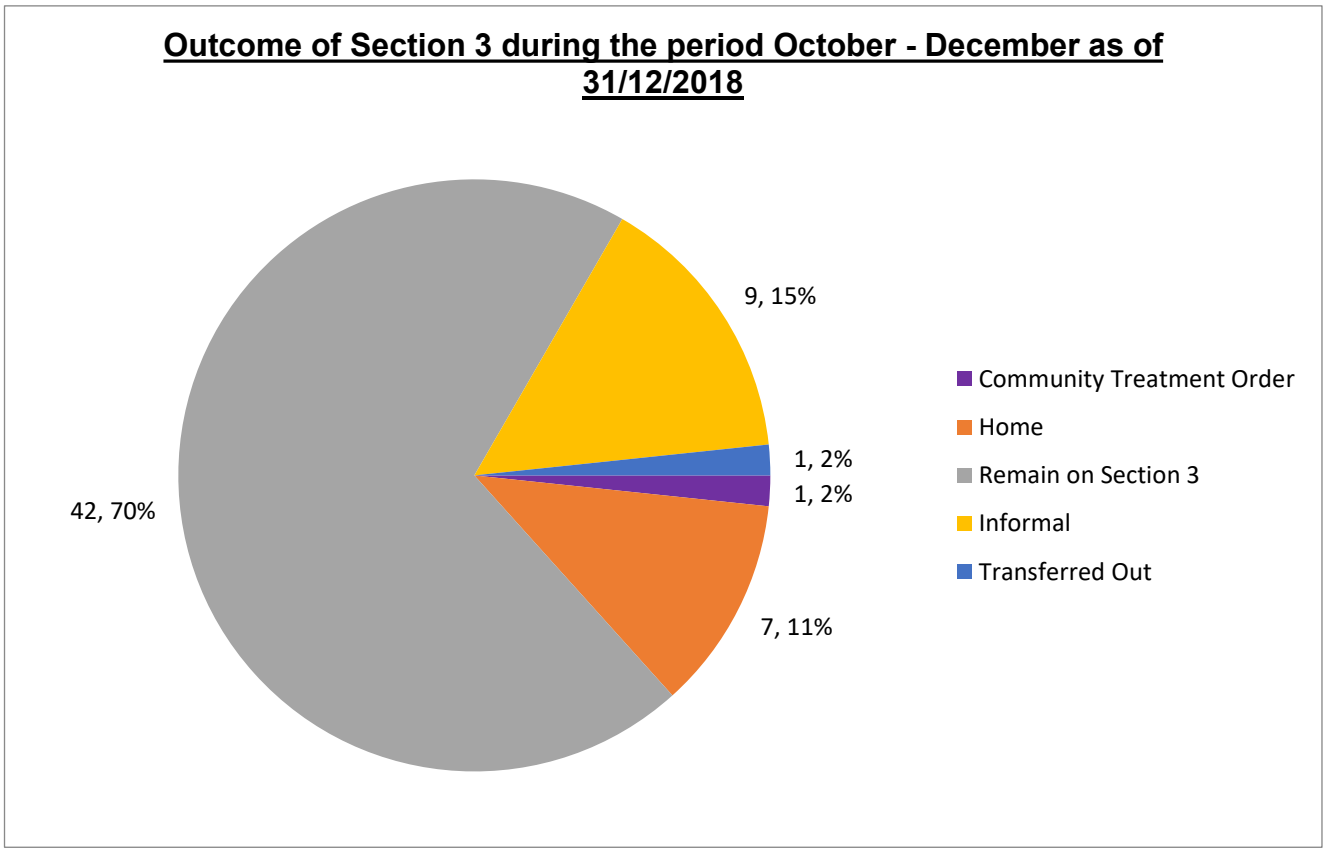


One patient subject to Section 2 lapsed and remained in hospital. They were placed on a Section 3 the following day

Section 3 – Admission for Treatment



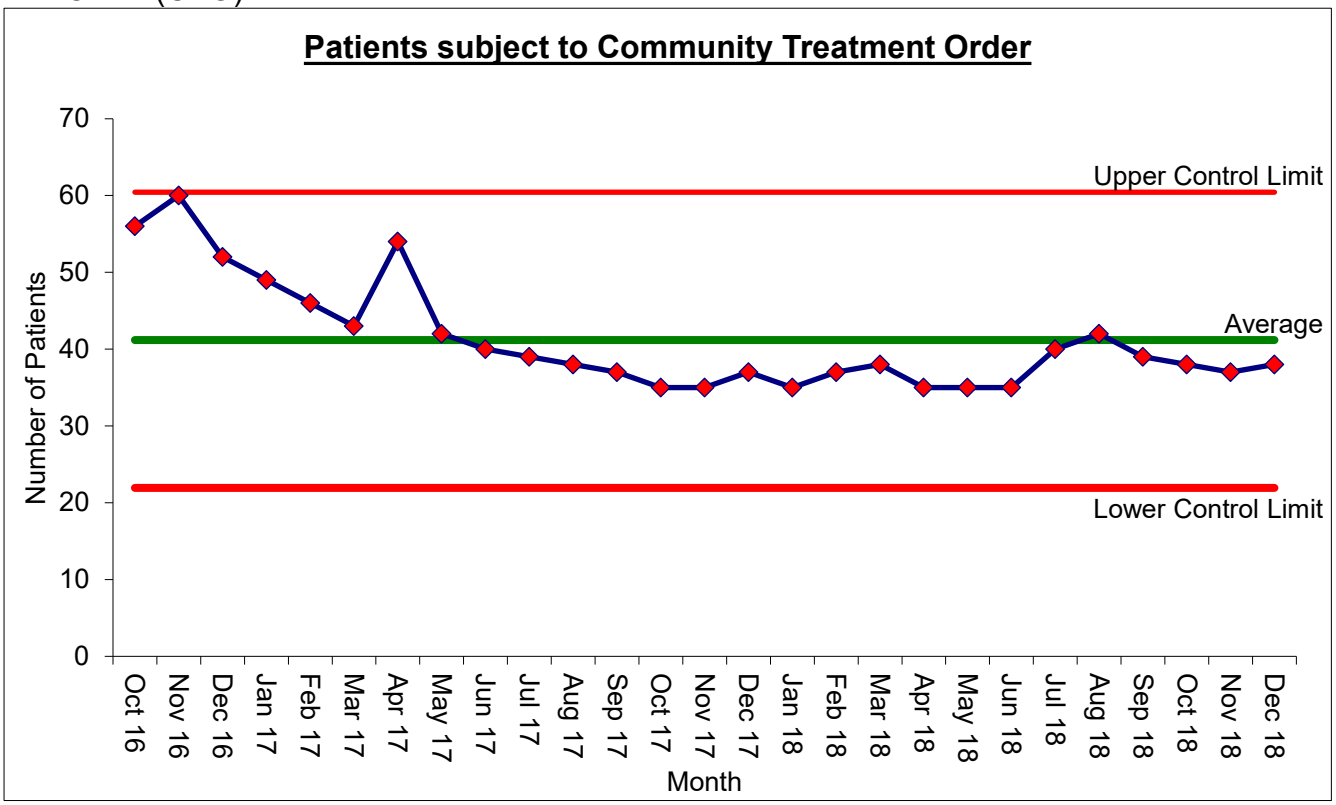


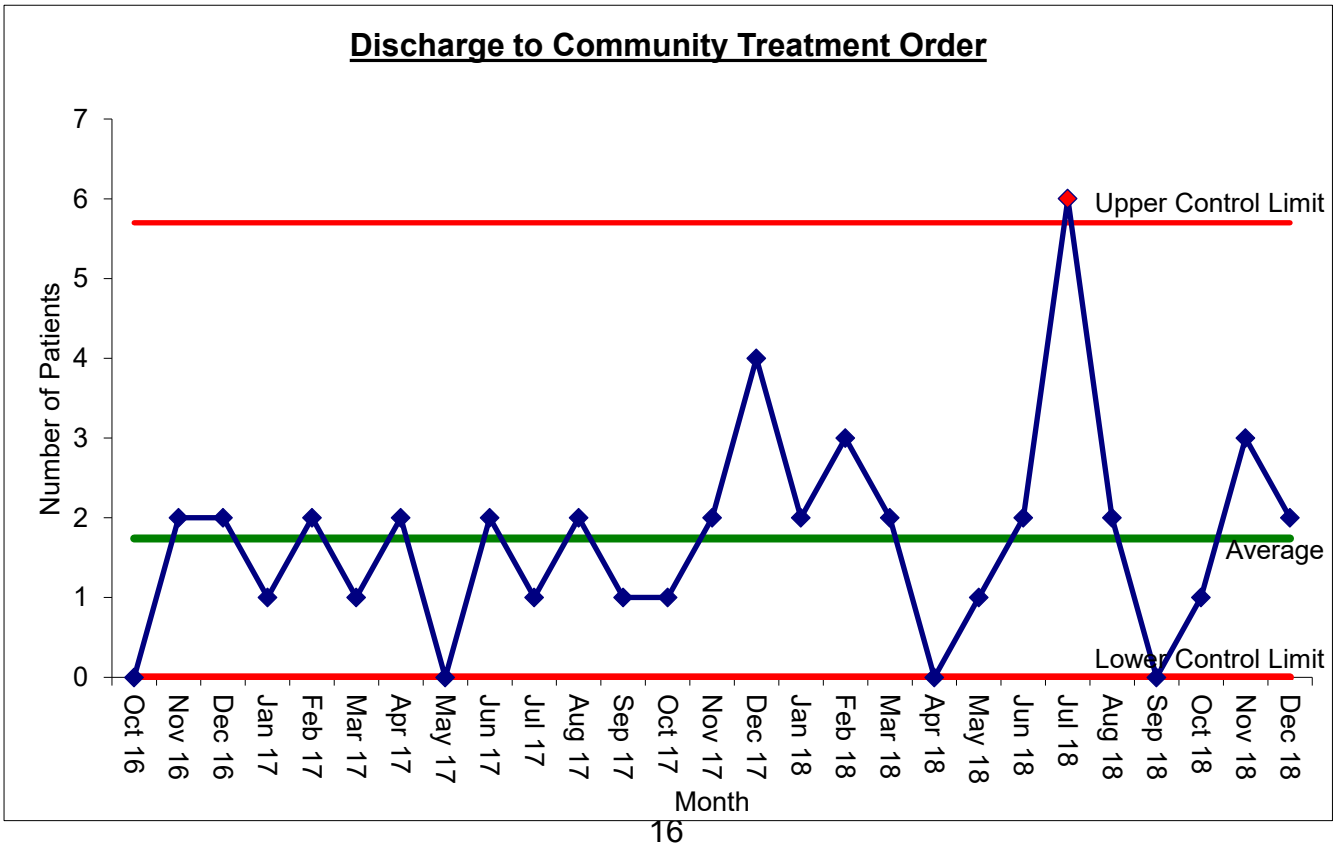

Outcome of Section 3 during the period October - December as of 31/12/2018
9, 15%
1, 2%
1, 2%
7, 11%
42, 70%
Community Treatment Order
Home
Remain on Section 3
Informal
Transferred Out

Community Treatment Order

During the period October - December 2018, six patients were discharged to Community Treatment Order.

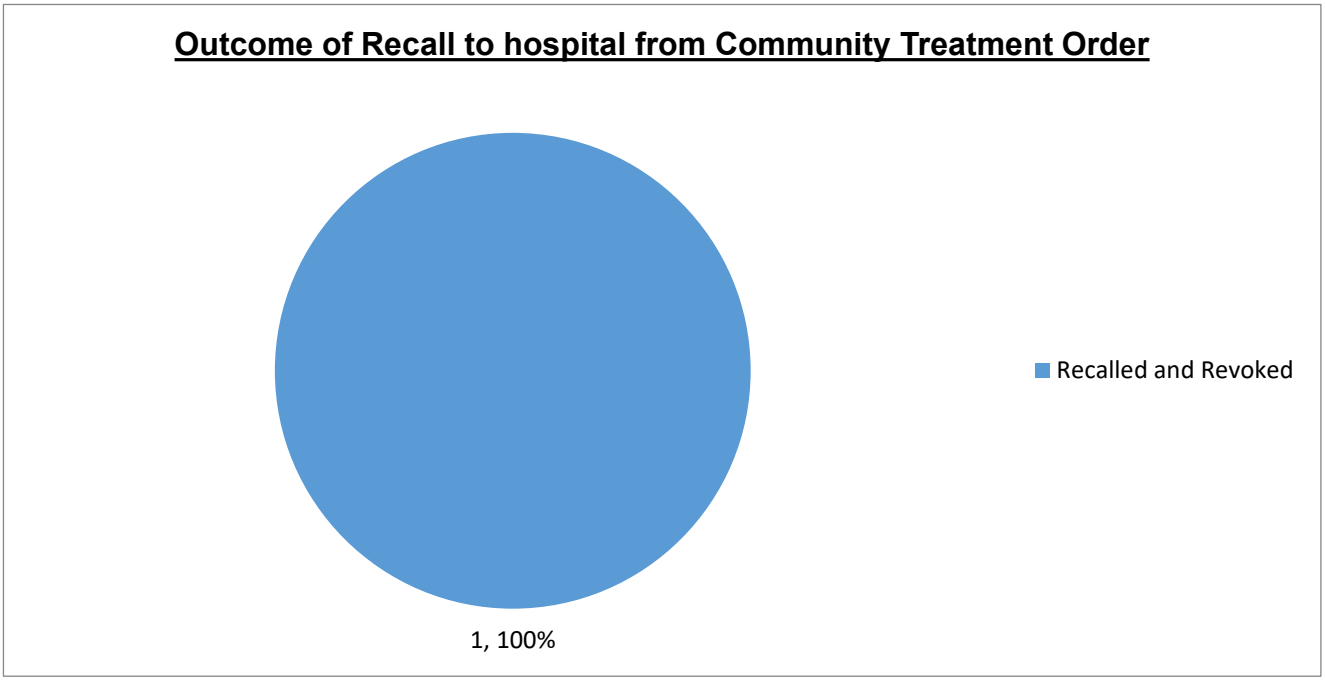
As at 31st December 2018, 38 patients were subject to a Community Treatment Order (CTO).





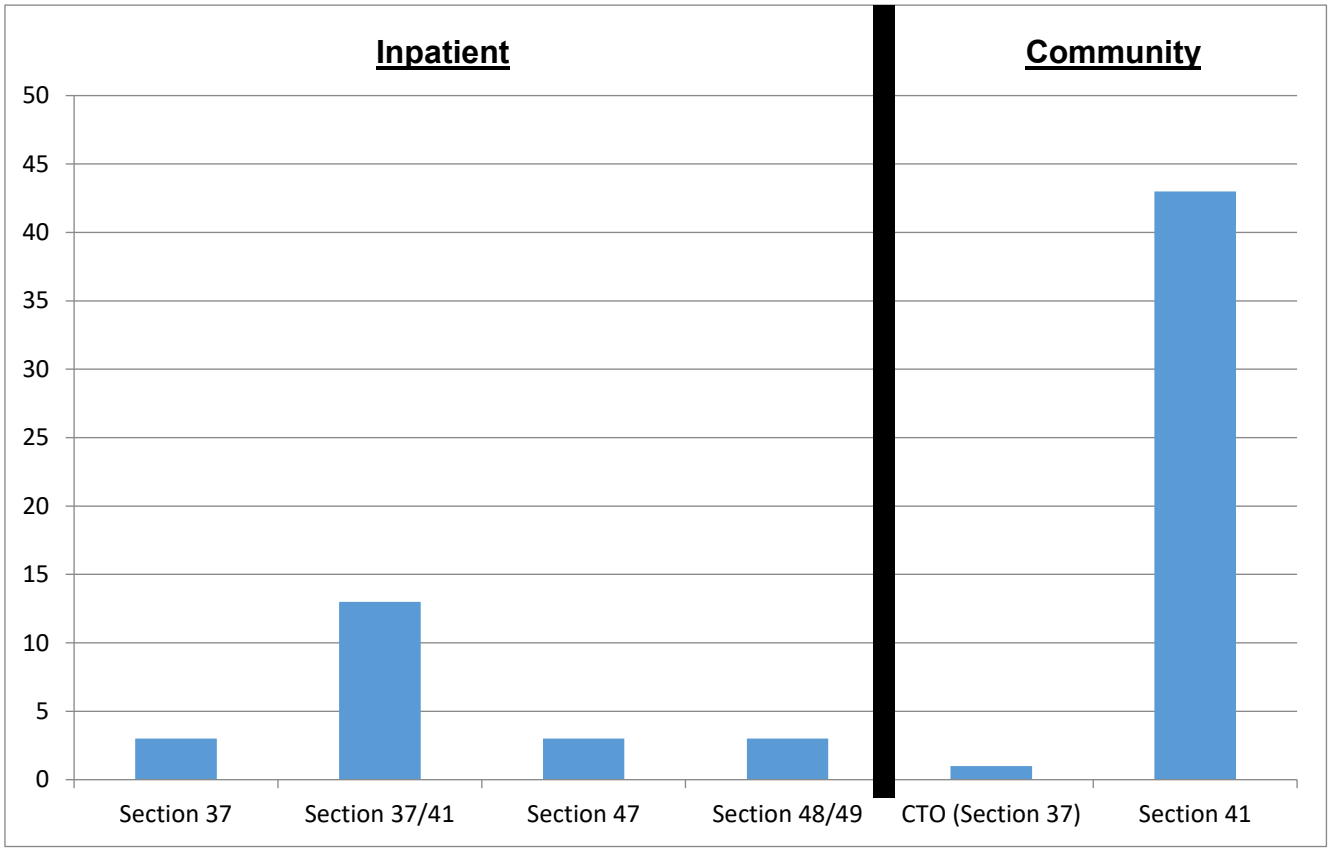
Recall of a community patient under Section 17E

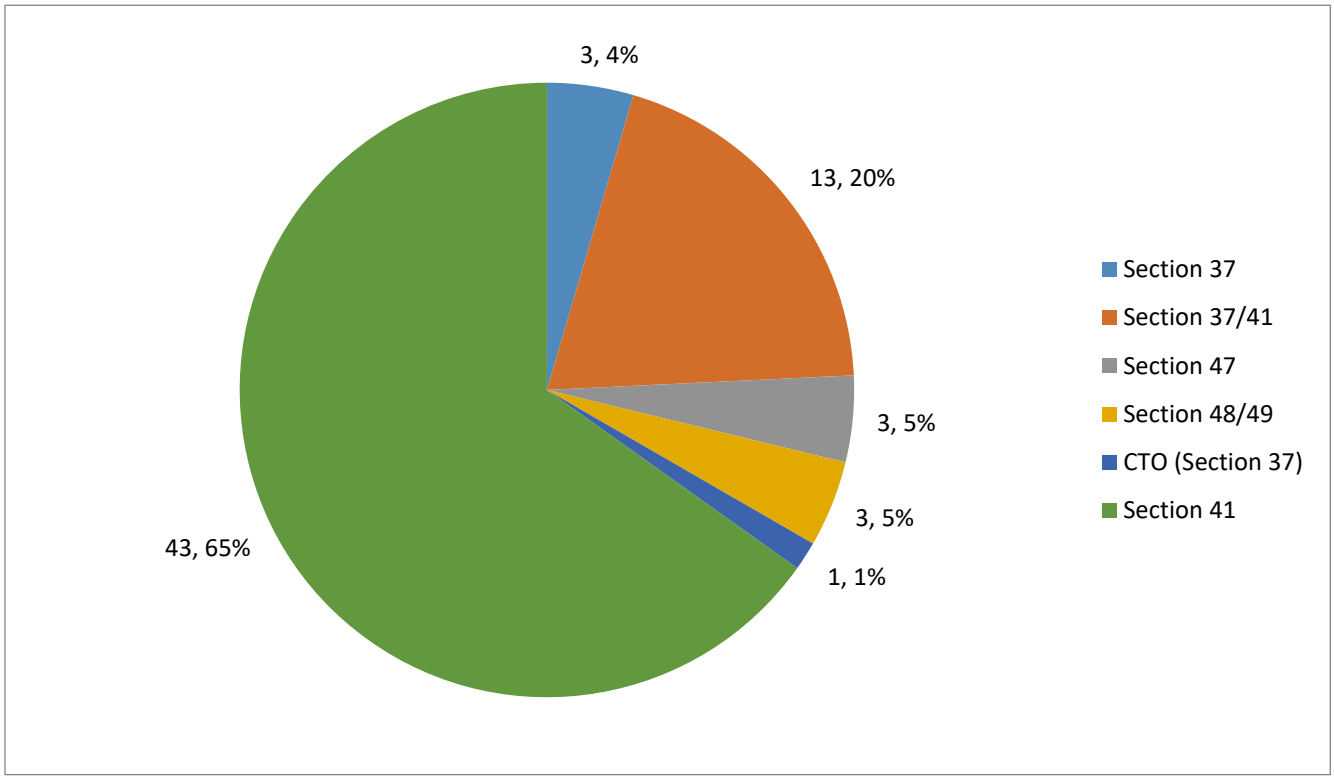
During the period, the power of recall was used on one occasion. .



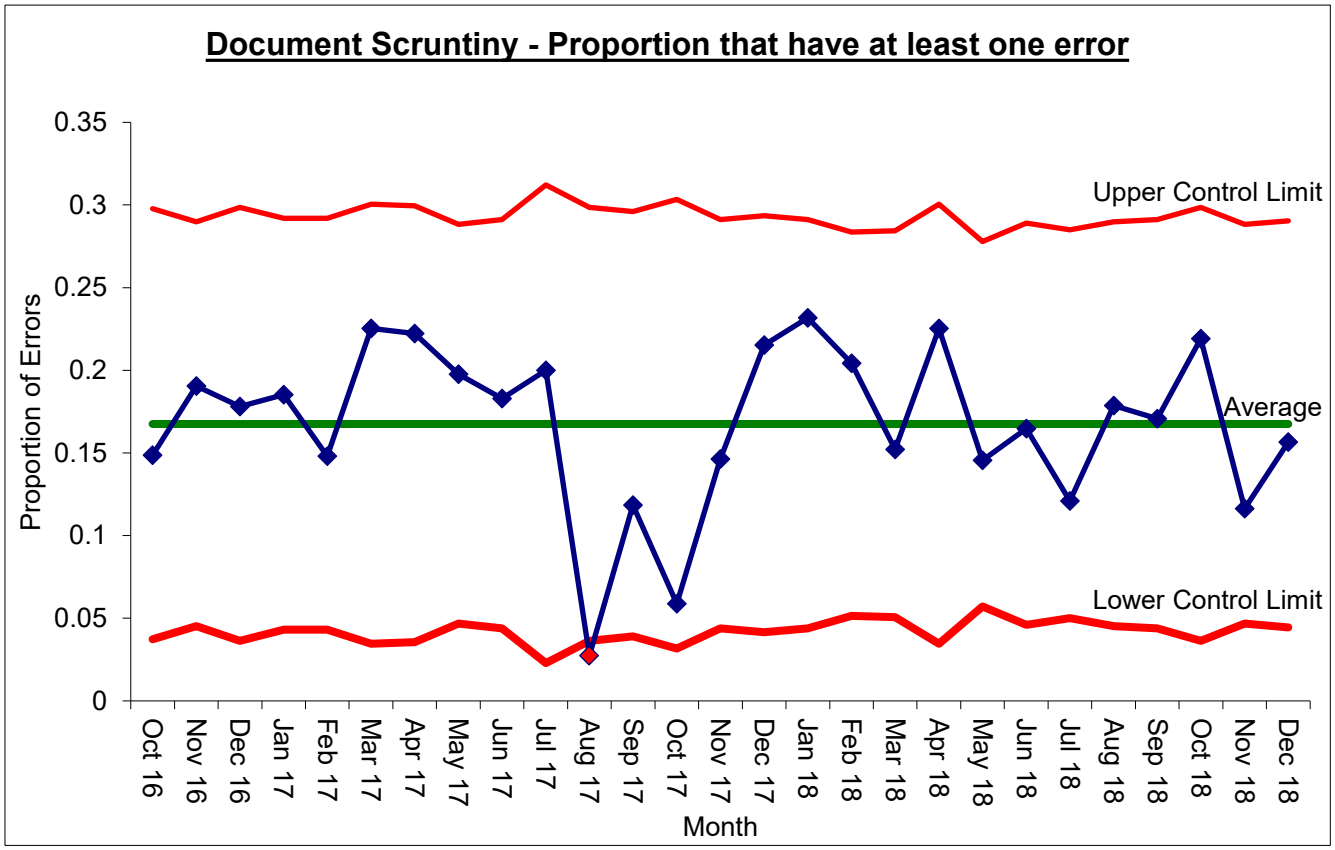
Part 3 of the Mental health Act 1983

The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st December 2018

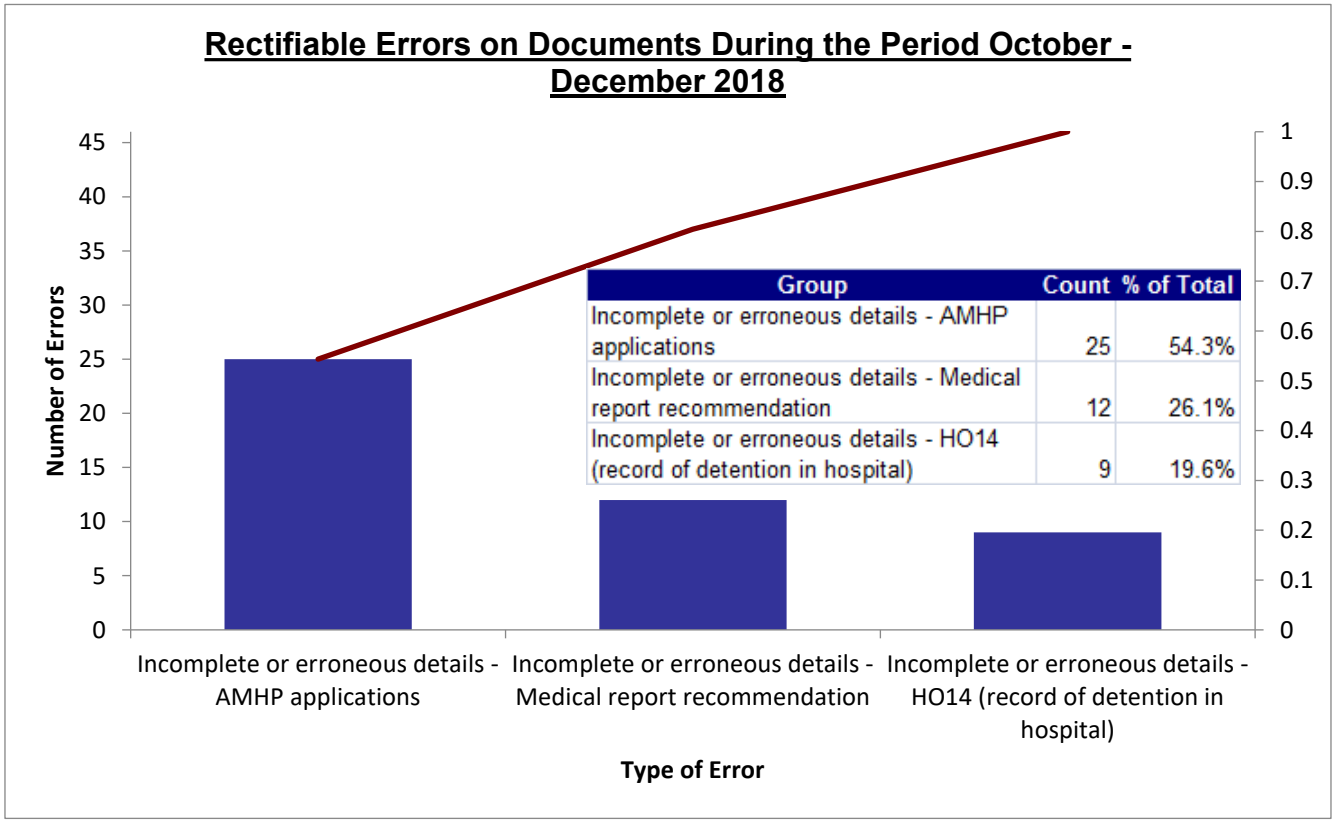




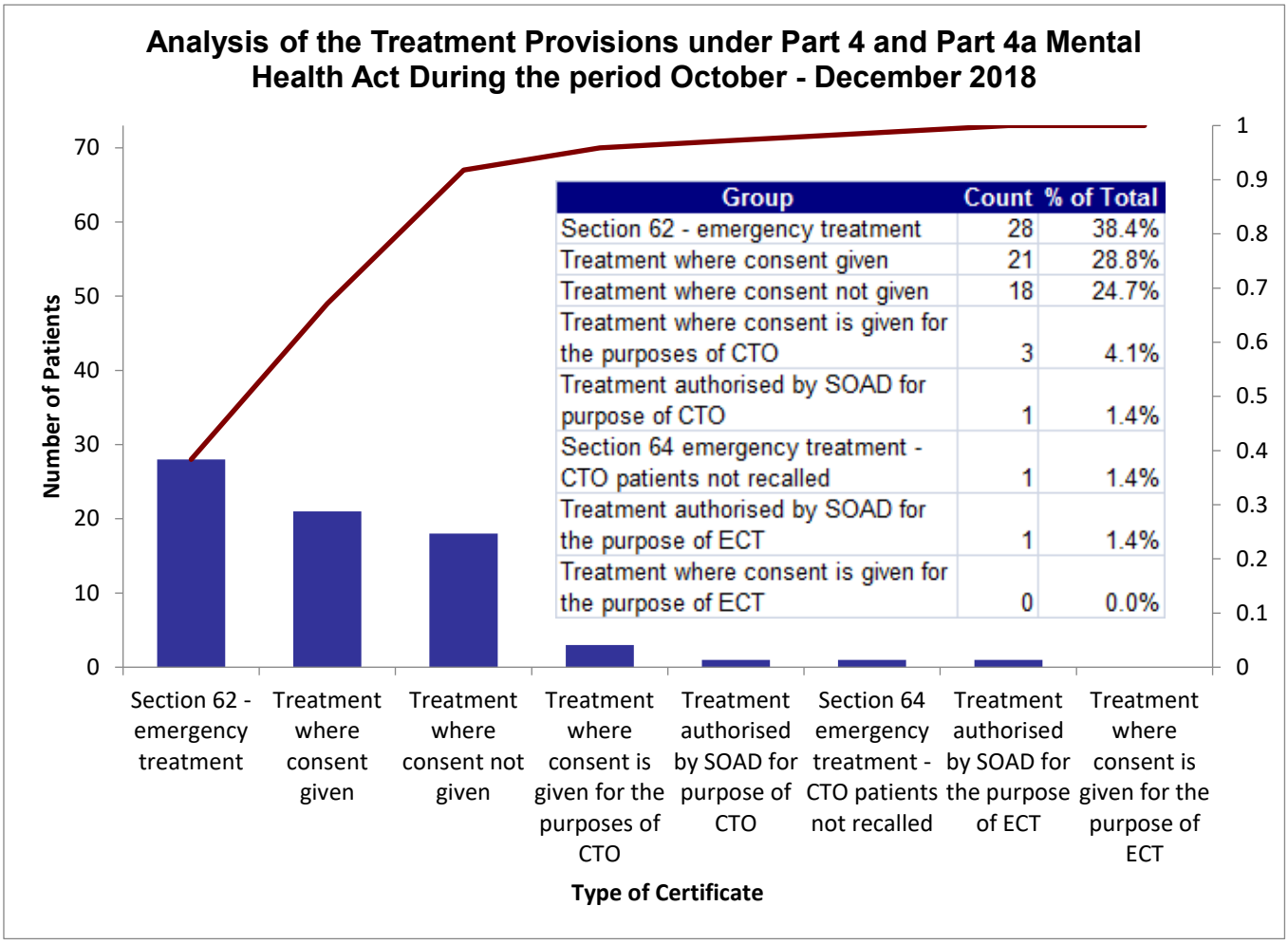
Scrutiny of documents during the period



The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.



Consent to Treatment



Group	Count	% of Total
Section 62 - emergency treatment	28	38.4%
Treatment where consent given	21	28.8%
Treatment where consent not given	18	24.7%
Treatment where consent is given for the purposes of CTO	3	4.1%
Treatment authorised by SOAD for purpose of CTO	1	1.4%
Section 64 emergency treatment - CTO patients not recalled	1	1.4%
Treatment authorised by SOAD for the purpose of ECT	1	1.4%
Treatment where consent is given for the purpose of ECT	0	0.0%

Urgent treatment

There are some circumstances in which the approved clinician may authorise a detained patient's urgent treatment under section 62 however this applies only to patients whose treatment is covered by Part 4 of the Act which is concerned with the treatment of detained patients and Part 4A supervised community treatment patients recalled to hospital.

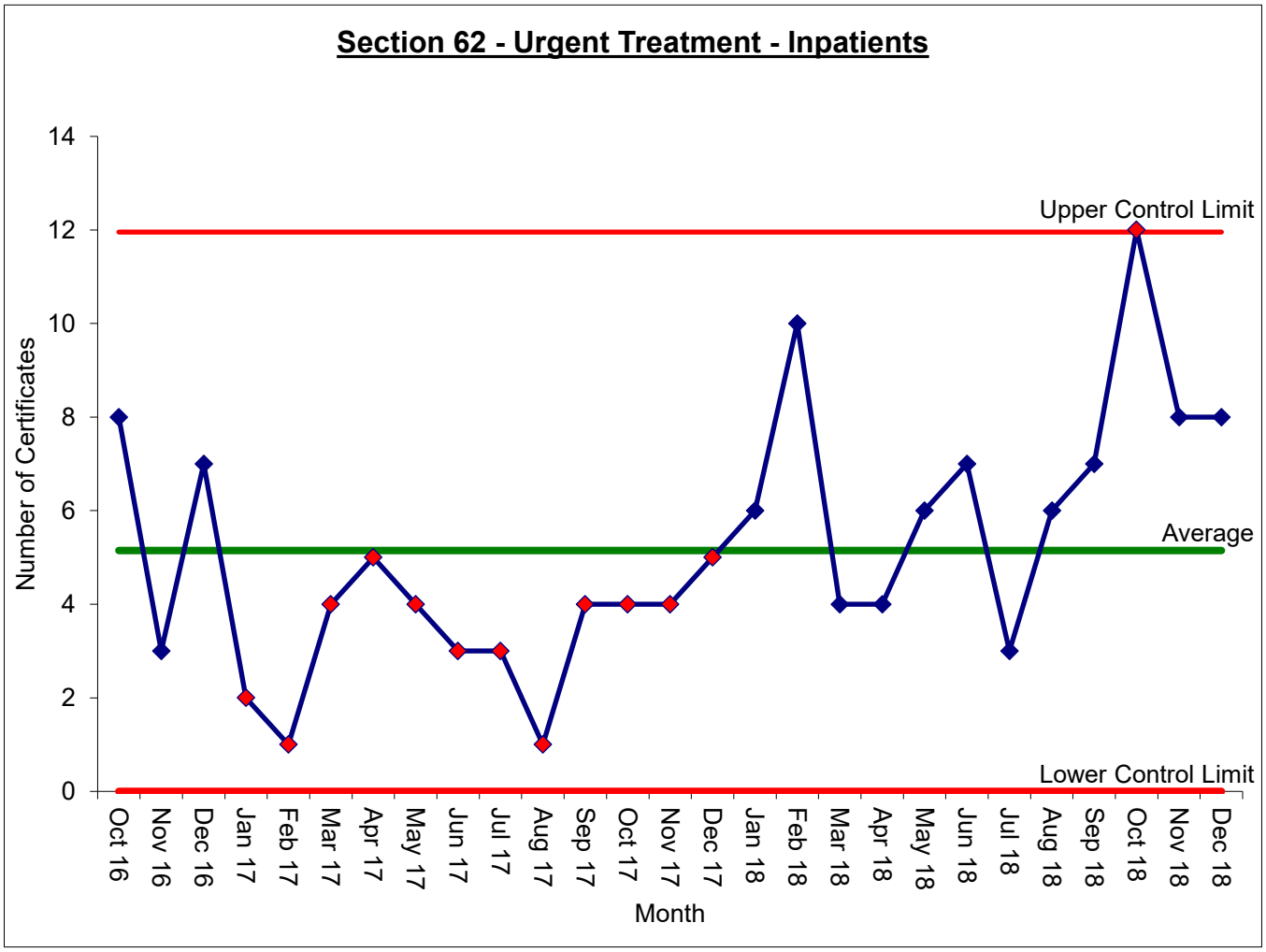
Urgent treatment is defined as treatment that is:

- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That is not irreversible or hazardous but is immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself or others.

A patient's treatment may be continued pending compliance with s.58, if discontinuation would cause serious suffering to the patient.

Urgent treatment can be used in any of the following instances:

- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.

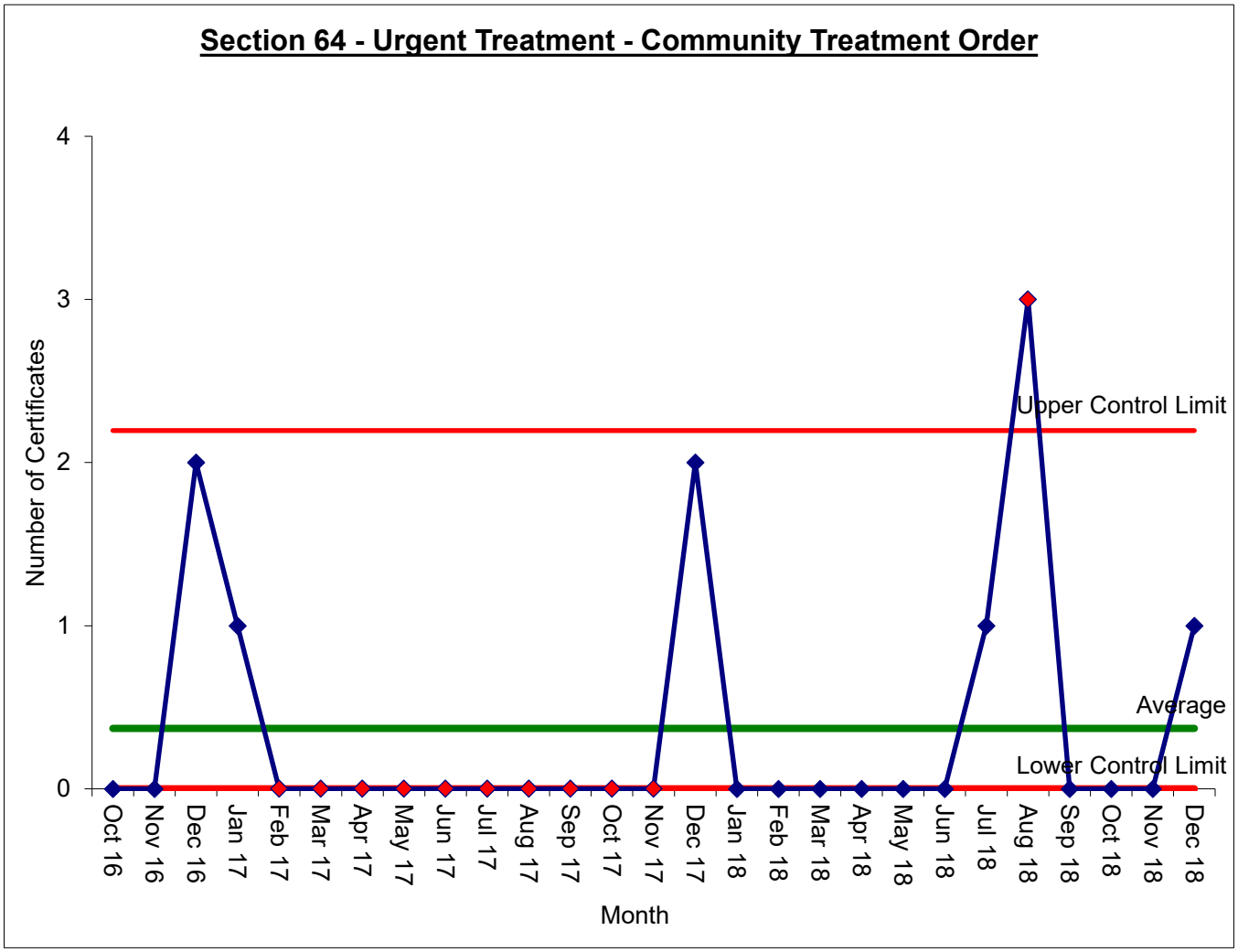


The above chart highlights that Section 62 was used on 28 occasions for the following reasons:

3 month rule x 20

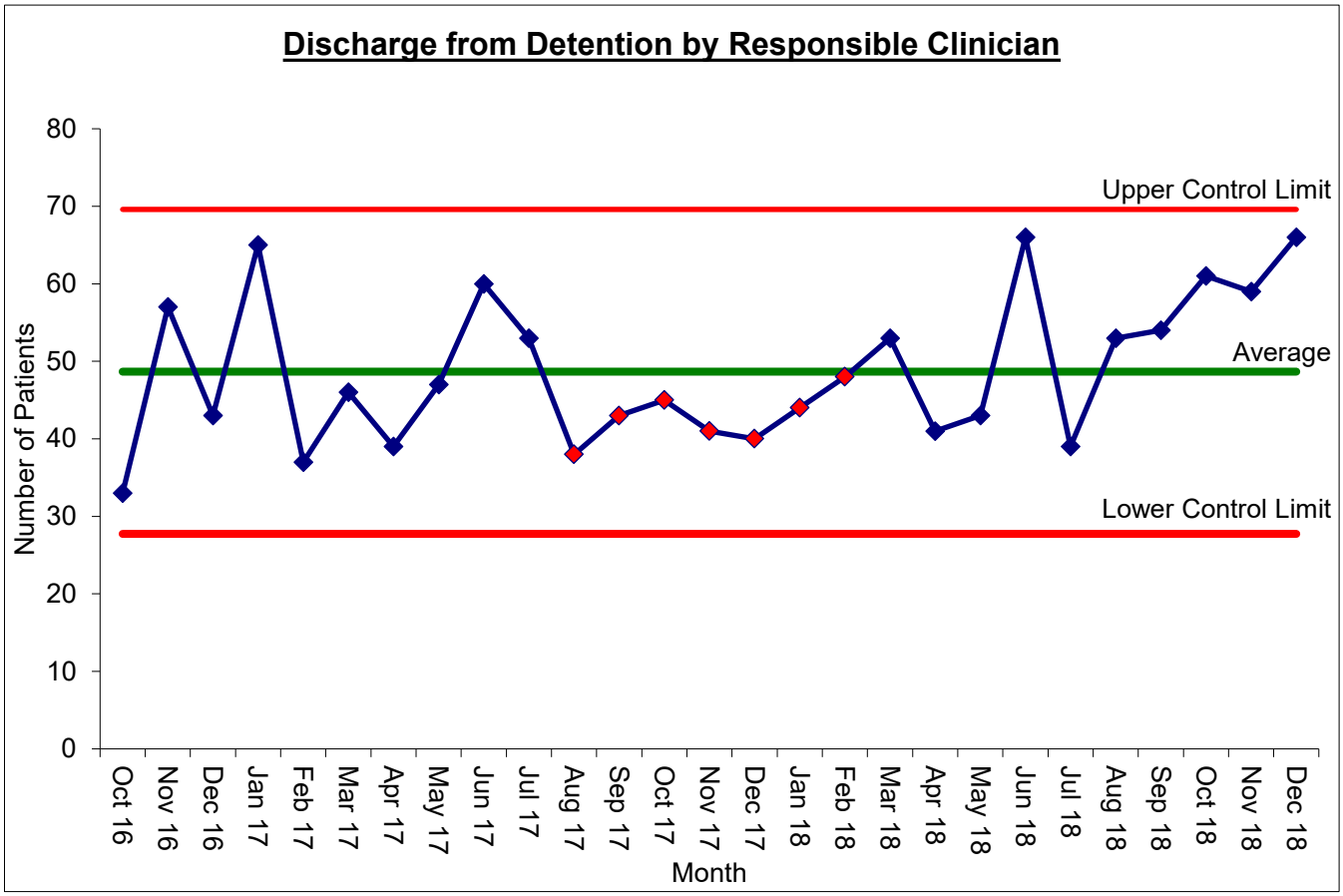
Urgent medication treatment x 7

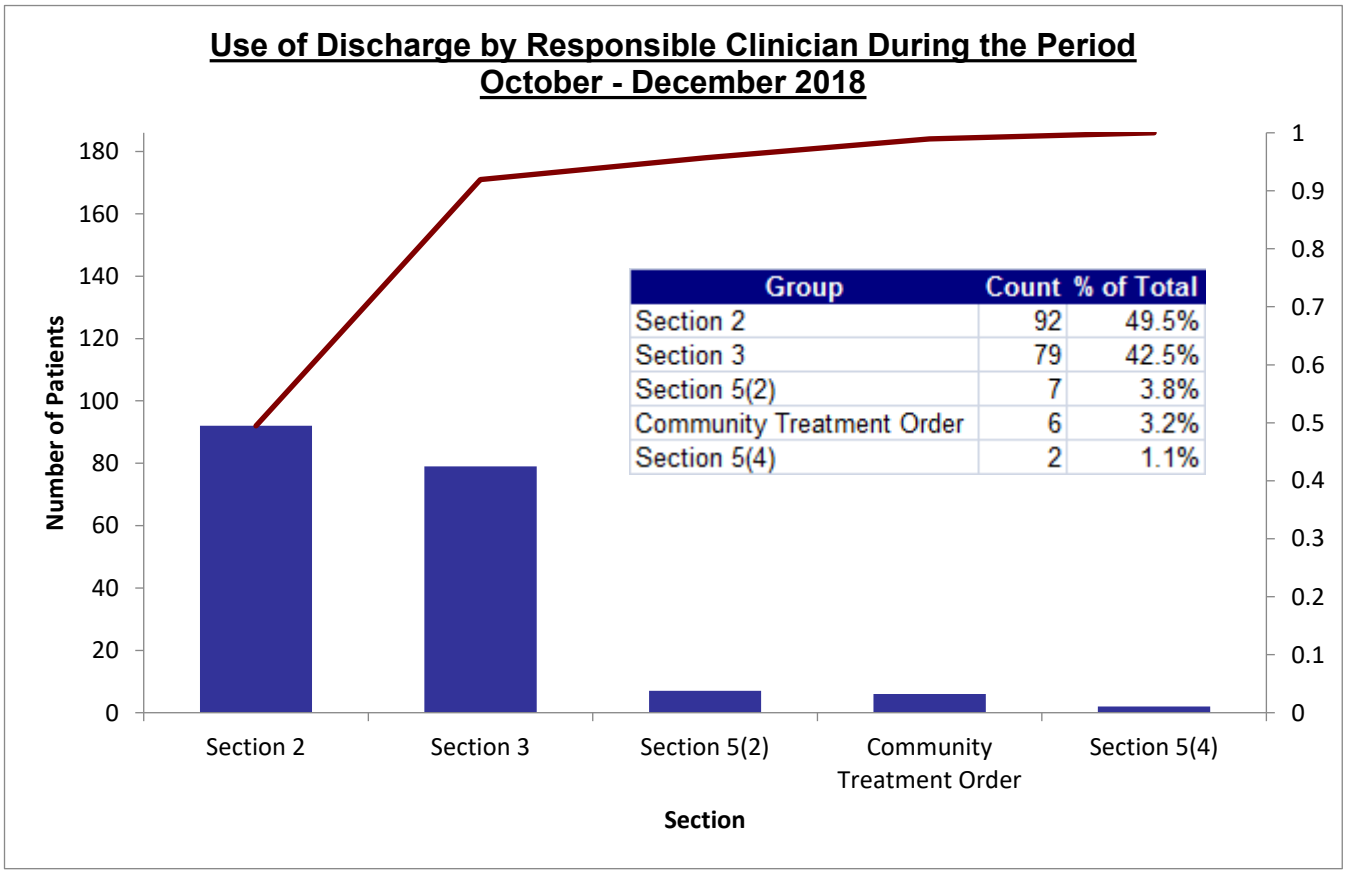
Urgent ECT treatment x 1



The above chart highlights that Section 64 was used on one occasion during the period pending Part 4a certificate being provided by the SOAD.

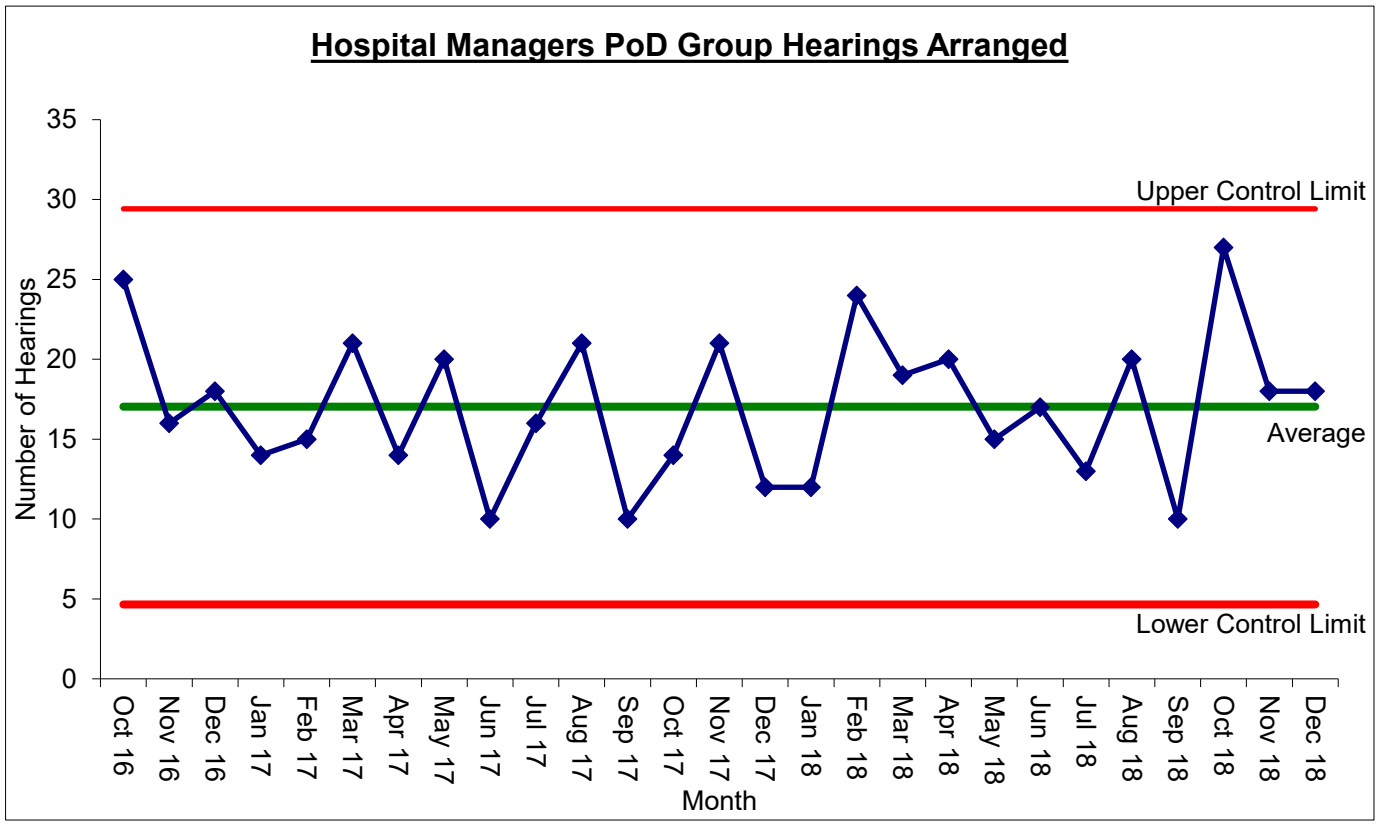
Discharge

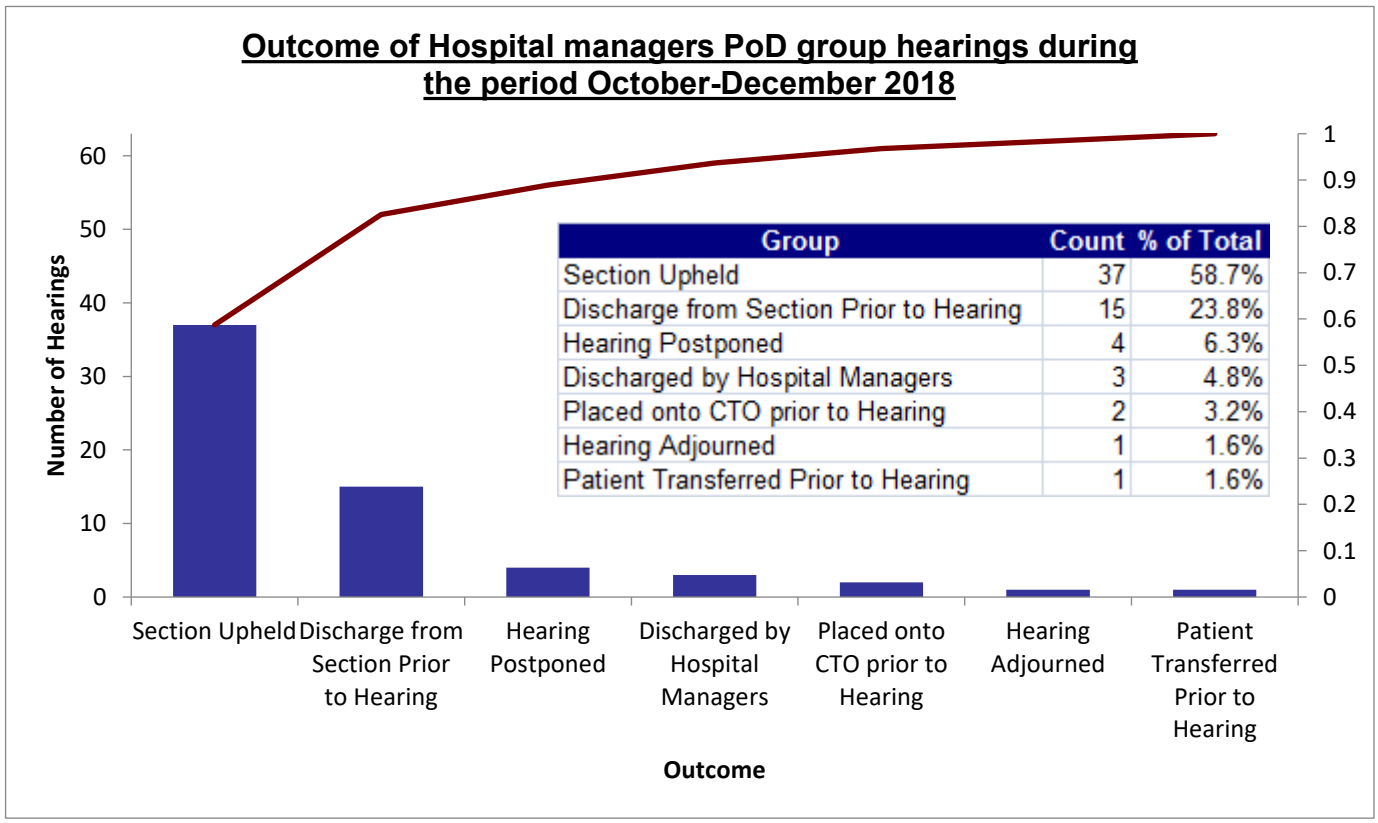




Group	Count	% of Total
Section 2	92	49.5%
Section 3	79	42.5%
Section 5(2)	7	3.8%
Community Treatment Order	6	3.2%
Section 5(4)	2	1.1%

Hospital Managers – Power of Discharge





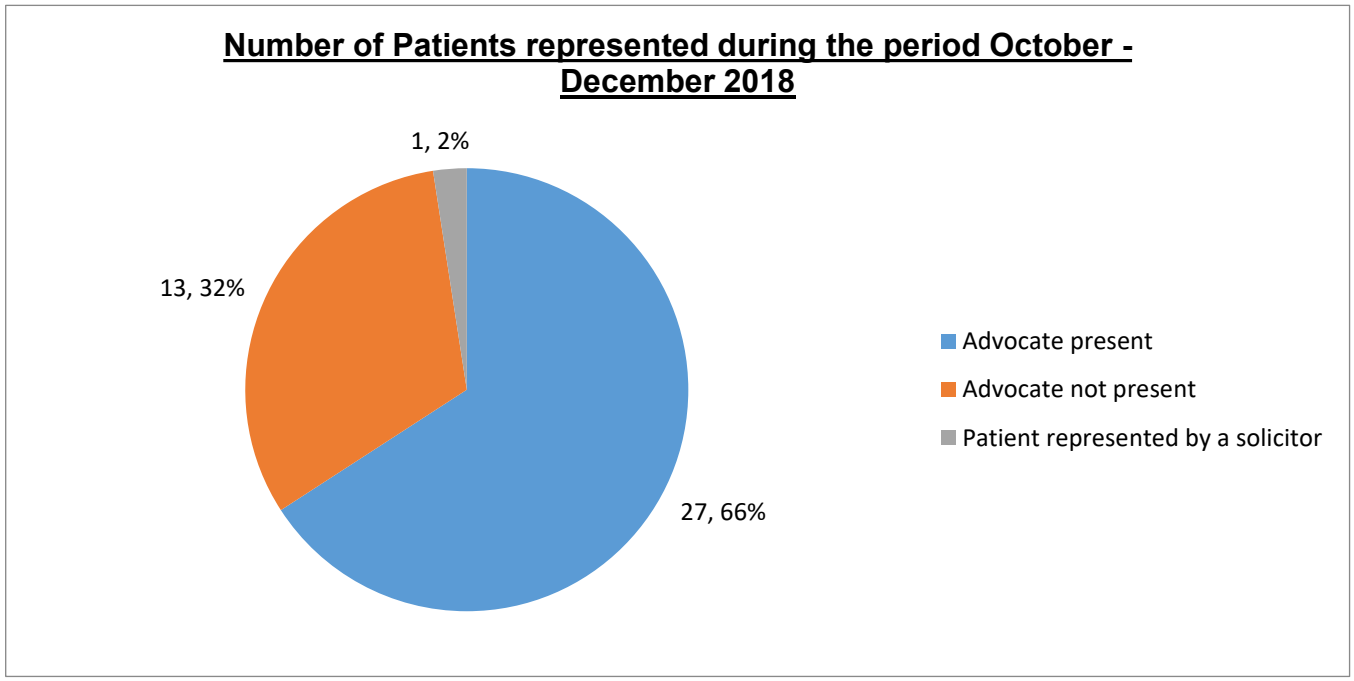
Group	Count	% of Total
Section Upheld	37	58.7%
Discharge from Section Prior to Hearing	15	23.8%
Hearing Postponed	4	6.3%
Discharged by Hospital Managers	3	4.8%
Placed onto CTO prior to Hearing	2	3.2%
Hearing Adjourned	1	1.6%
Patient Transferred Prior to Hearing	1	1.6%

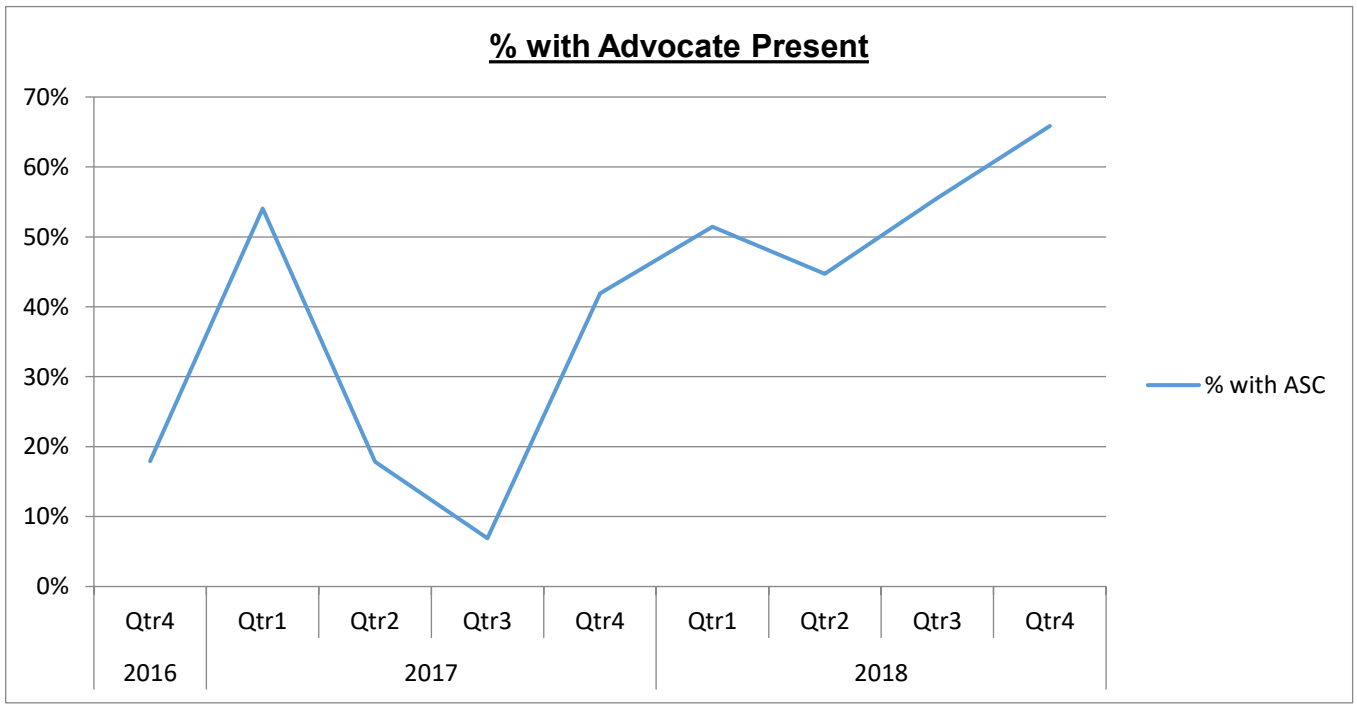
One hearing was adjourned for the following reason:

- The patients Nearest Relative failed to arrive. The patient did not wish to go ahead without them present.

Four hearings were postponed for the following reasons:

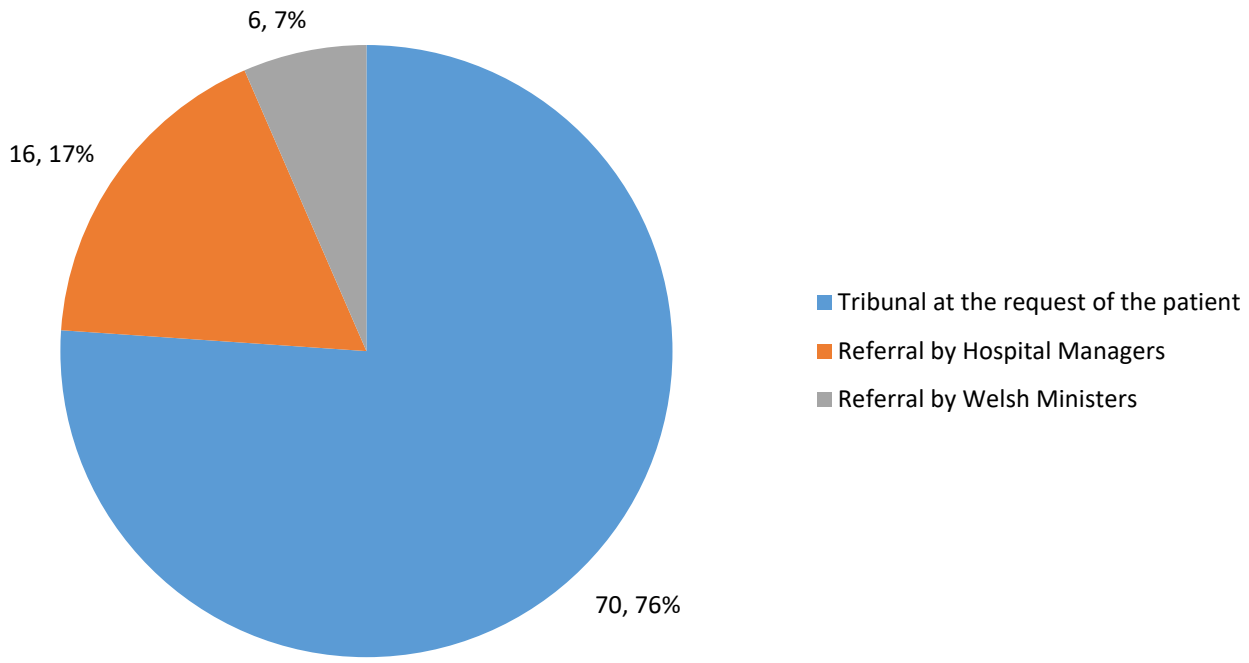
- Responsible Clinician unable to attend.
- No Social Circumstances report submitted.
- Patient too unwell to proceed.
- Nurse required not available to attend.



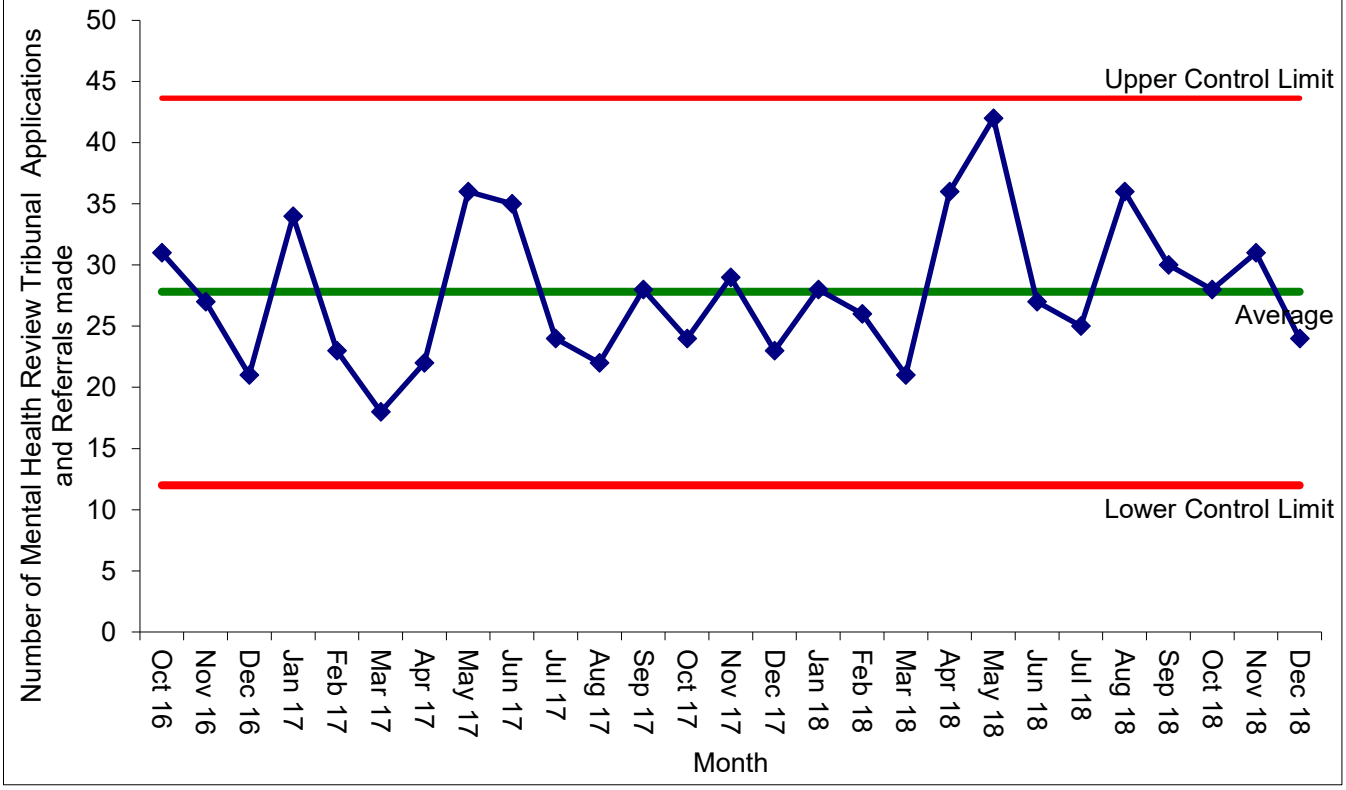


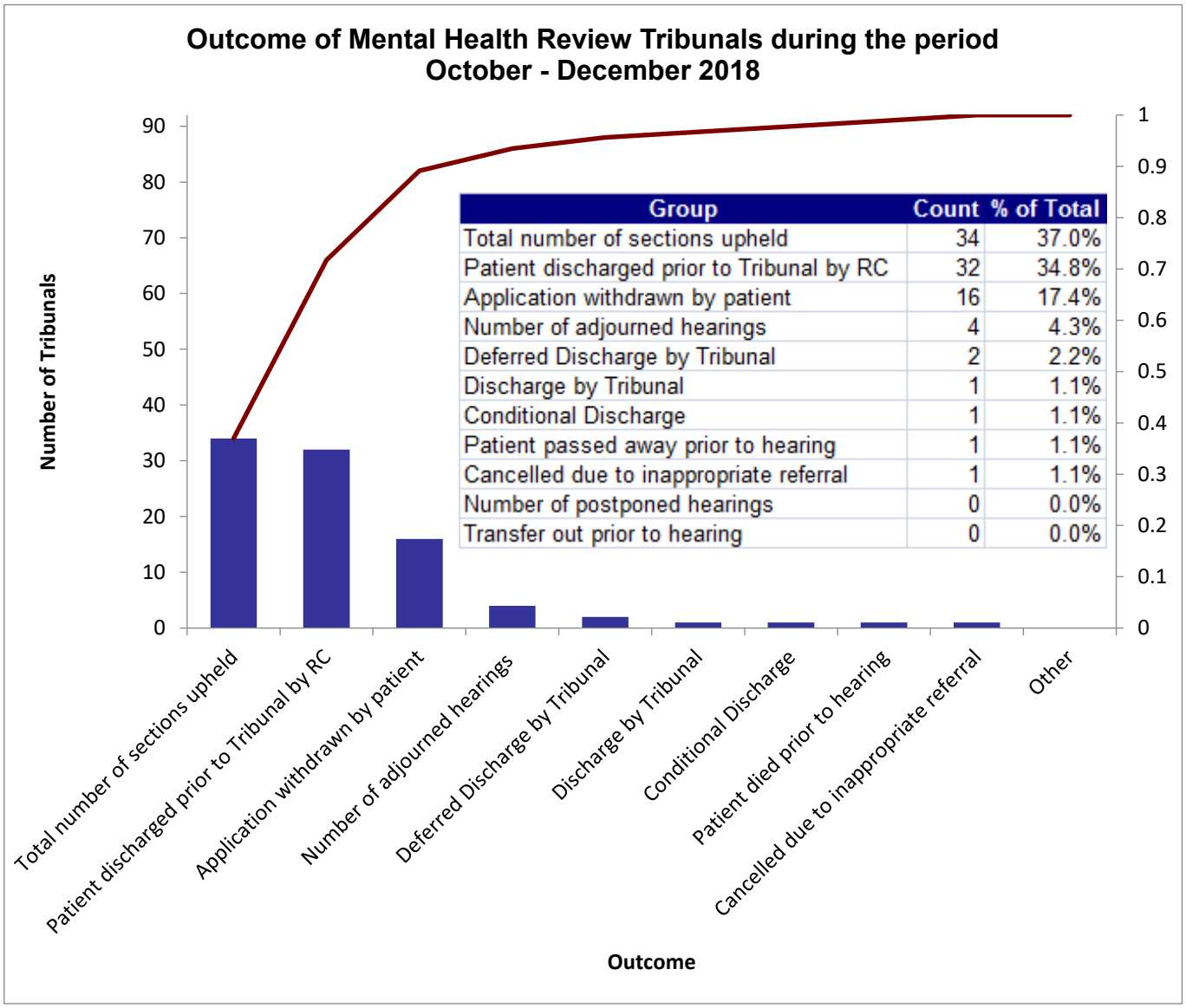
Mental Health Review Tribunal (MHRT) for Wales

Source of applications to the Mental Health Review Tribunal during the period October - December 2018



Number of Mental Health Review Tribunal Applications and Referrals made





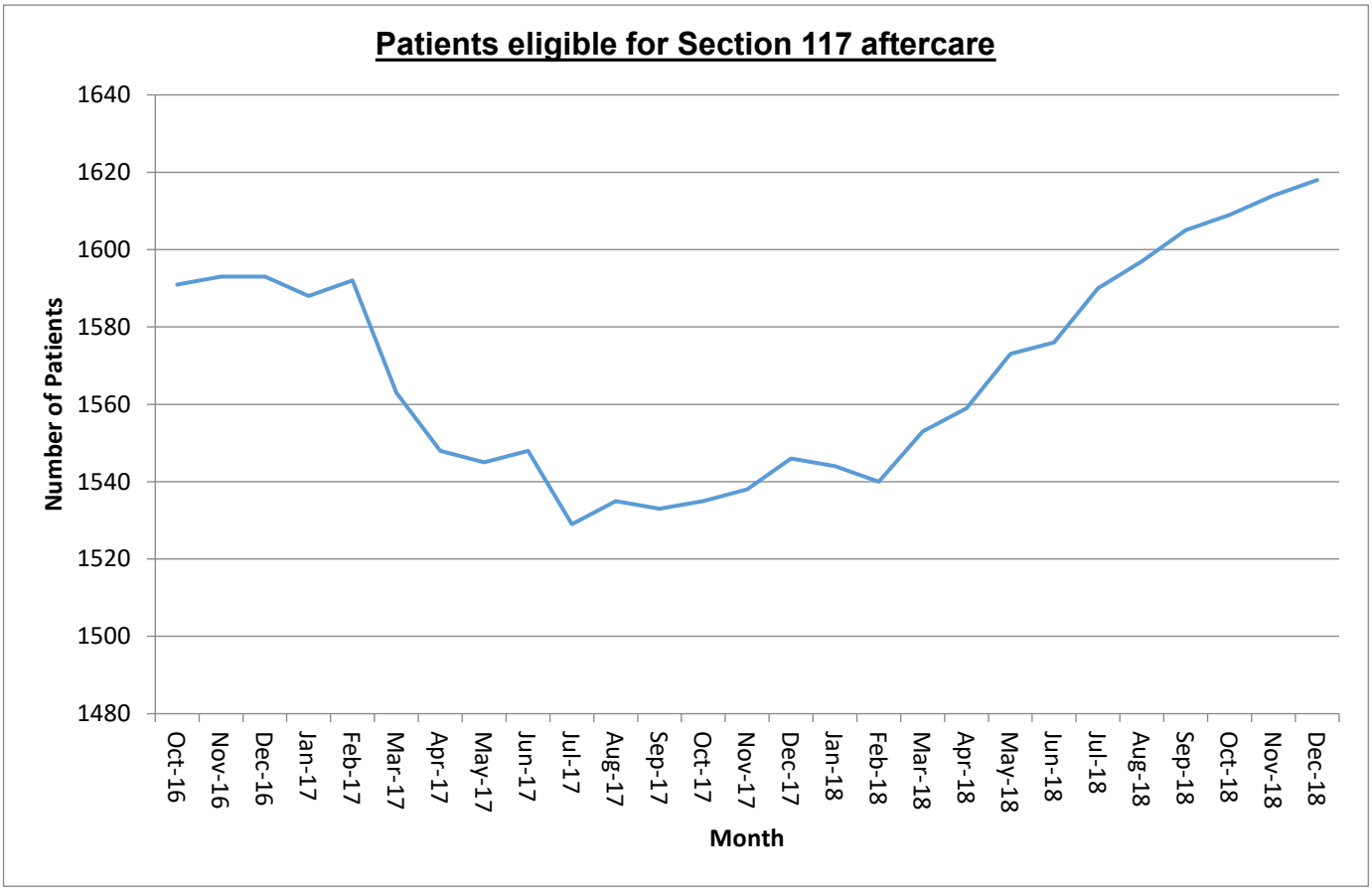
Group	Count	% of Total
Total number of sections upheld	34	37.0%
Patient discharged prior to Tribunal by RC	32	34.8%
Application withdrawn by patient	16	17.4%
Number of adjourned hearings	4	4.3%
Deferred Discharge by Tribunal	2	2.2%
Discharge by Tribunal	1	1.1%
Conditional Discharge	1	1.1%
Patient passed away prior to hearing	1	1.1%
Cancelled due to inappropriate referral	1	1.1%
Number of postponed hearings	0	0.0%
Transfer out prior to hearing	0	0.0%

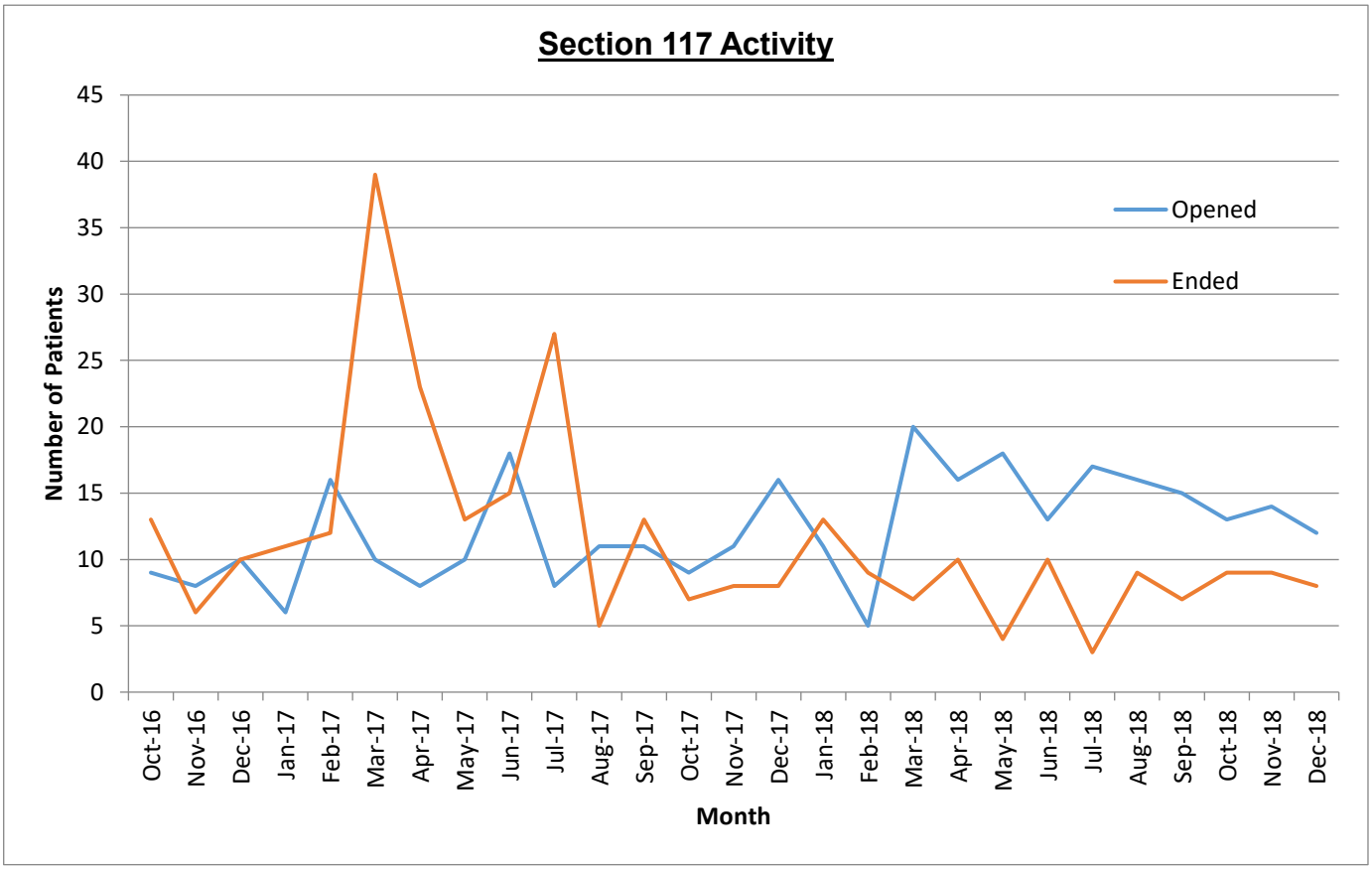
Four hearings were adjourned during the period for the following reasons:

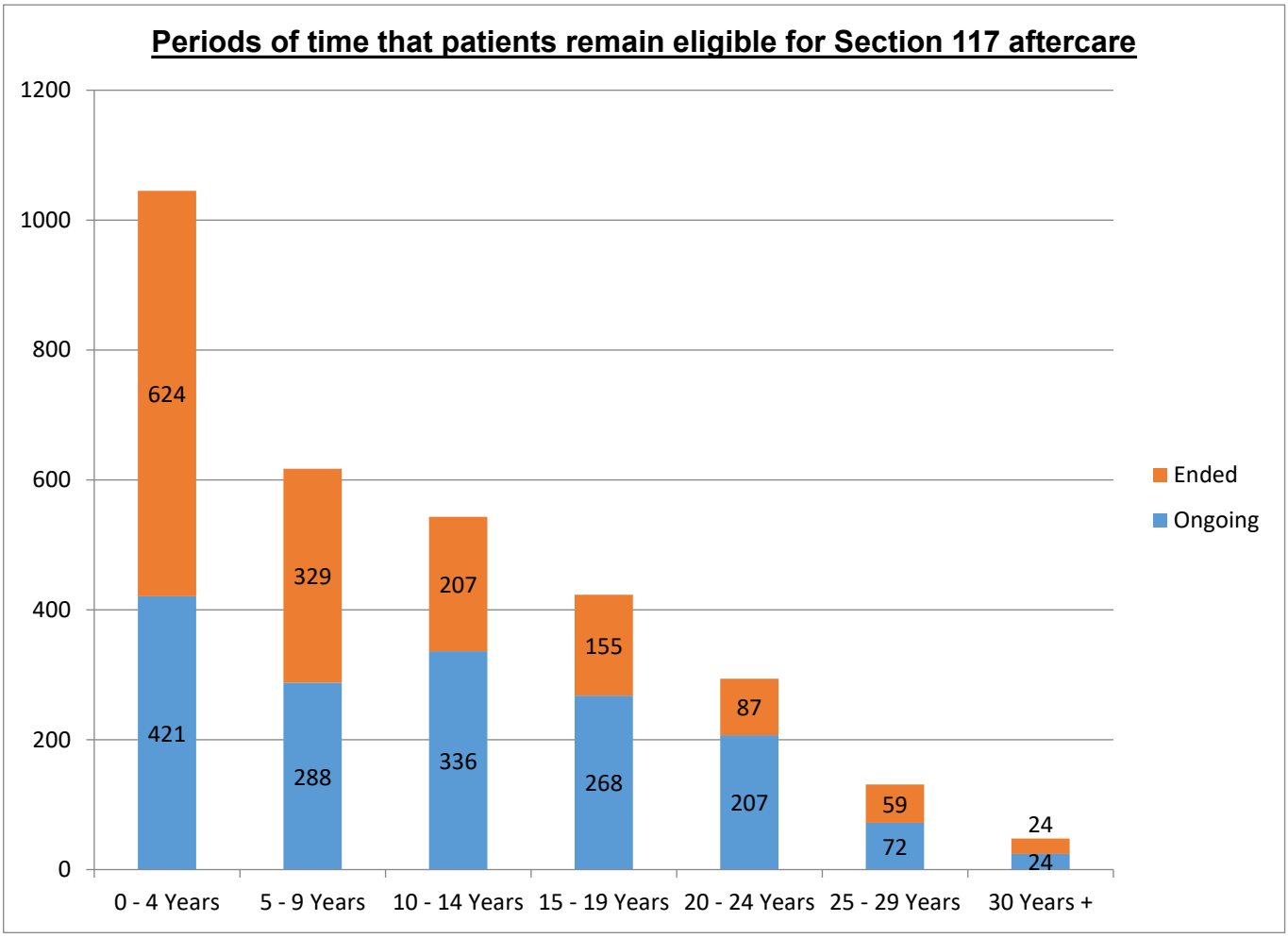
- Further evidence required by the Tribunal panel.
- Nurse present did not have sufficient knowledge of the patient.
- Patient with fluctuating capacity – not capacious at time of Tribunal.
- Change of Responsible Clinician, time required for the doctor to acquaint themselves with the patient and familiarise themselves with the case.

There were no postponements during the period.

Section 117 Aftercare






Periods of time that patients remain eligible for Section 117 aftercare
1200
1000
800
600
400
200
0
624
421
329
288
207
336
155
268
87
207
59
72
24
24
0 - 4 Years
5 - 9 Years
10 - 14 Years
15 - 19 Years
20 - 24 Years
25 - 29 Years
30 Years +
Ended
Ongoing

Summary of other Mental Health Activity which took place during the period October - December 2018

Exclusion of visitors

During the period the Exclusion of Visitors Procedure was not implemented.

Section 19 transfers to and from Cardiff and Vale UHB

During the October – December 2018 period;-

10 Patients under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB

Ten patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers.

Death of detained patients

During the period one patient subject to Section 3 died.

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety for up to 72 hours so that he

	/she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care. The detained person can be transferred to another place of safety as long as the 72 hour period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act. A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.
Section 5(4)	Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required. During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2). Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.
Section 5(2)	Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made.

	The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.
Section 4	In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours. An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor. A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of: • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be made.

	The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.
Section 2	Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship. • The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the

	public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Supervised Community Treatment (SCT)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. SCT provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto SCT.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the

	patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a SCT patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.

Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47

	or s.48.
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for supervised Community Treatment (SCT).
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion. If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for

	mental disorder. If the patient lacks capacity to consent SOAD authorisation is required.
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have

	unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or SCT is due to expire.
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients as well as those who have been absolutely discharged.

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

All Wales Hospital Managers Conference 28 November 2018

Associate Hospital Managers (AHM's) should receive adequate and appropriate training in order to fulfil their role. Whilst Health Boards are able to provide training it is important to recognise that these events provide a legal perspective which gives the opportunity to further consider and reflect upon relevant cases. This contributes to the personal development of AHM's whilst enhancing confidence for this function to be carried out effectively.

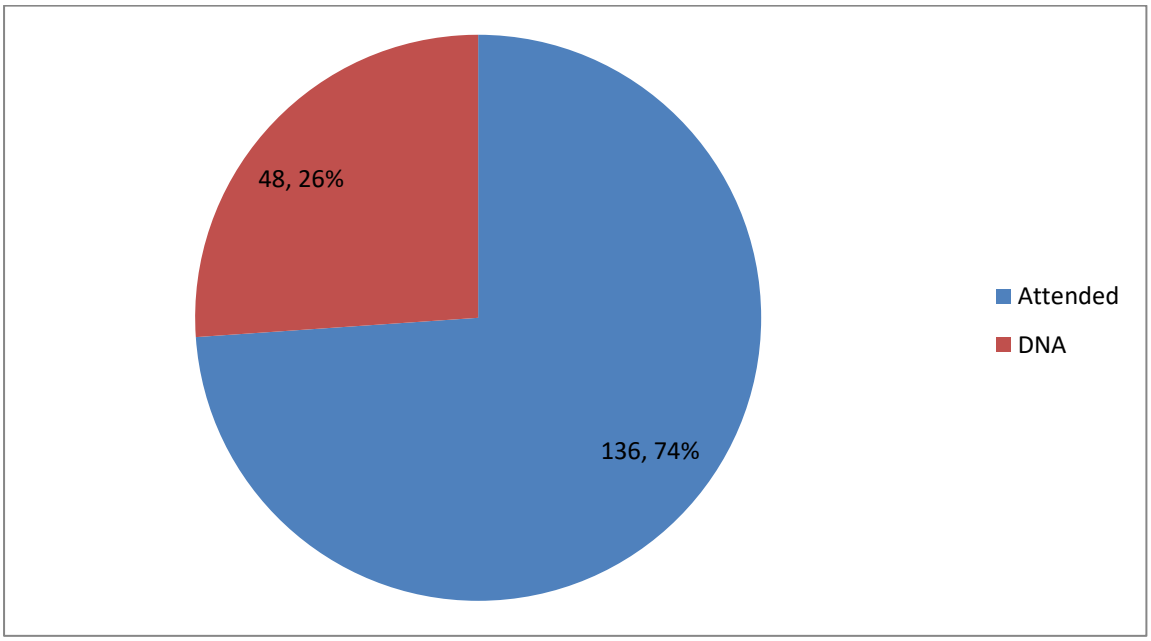
General feedback from discussion with those who attended was very positive. It was felt that future events would be extremely beneficial to the group. However I would suggest that these sessions could be more effective if a work shop approach was taken to make the day more interactive.

This event was primarily for ASM's, however invites were extended to Mental Health Act Administration Teams, the private sector, advocacy and other professionals.

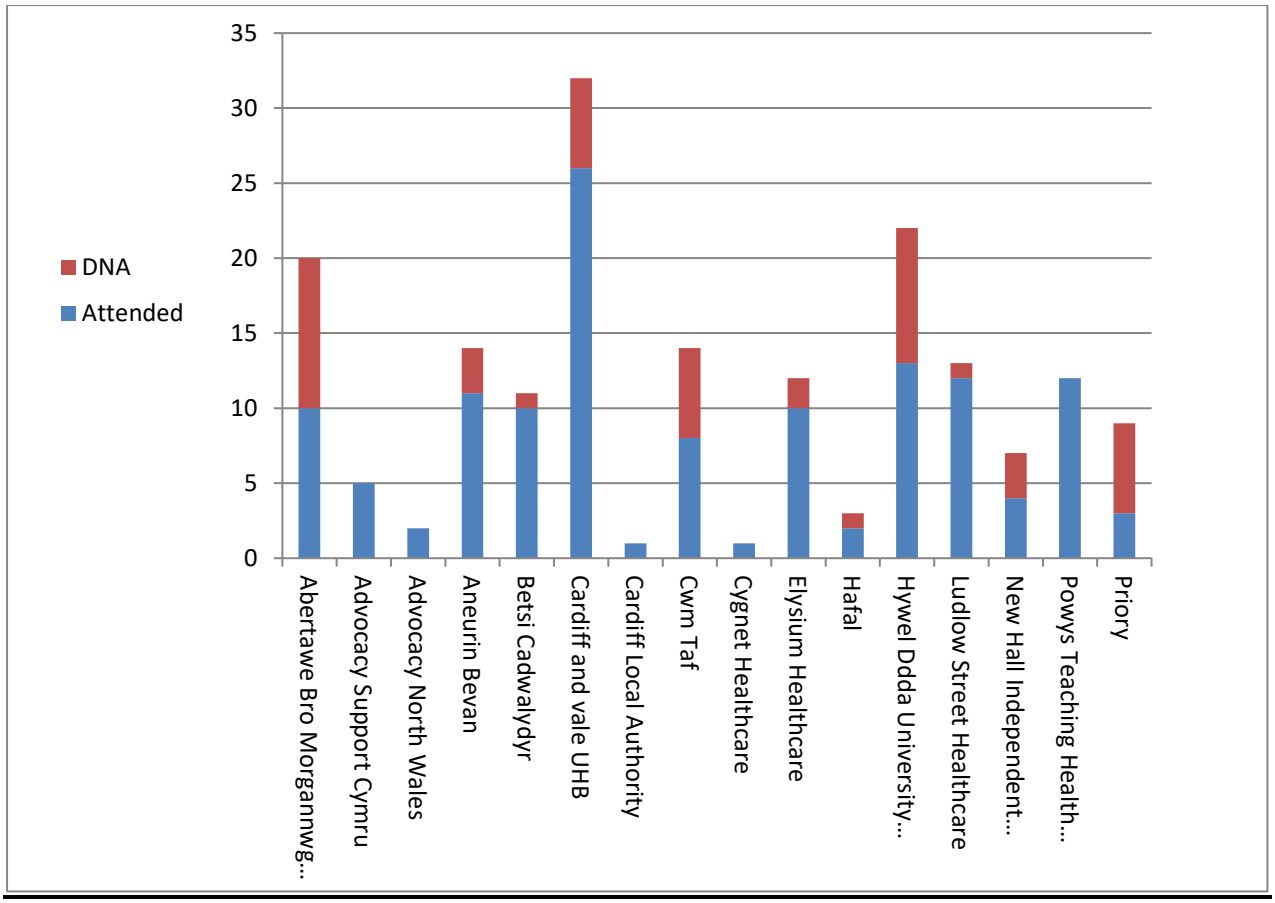
Attendance

This event had a total capacity of 200. 184 responded and confirmed attendance, 136 attended and 48 confirmed attendance but did not attend on the day.

Total numbers of attendees/DNA's

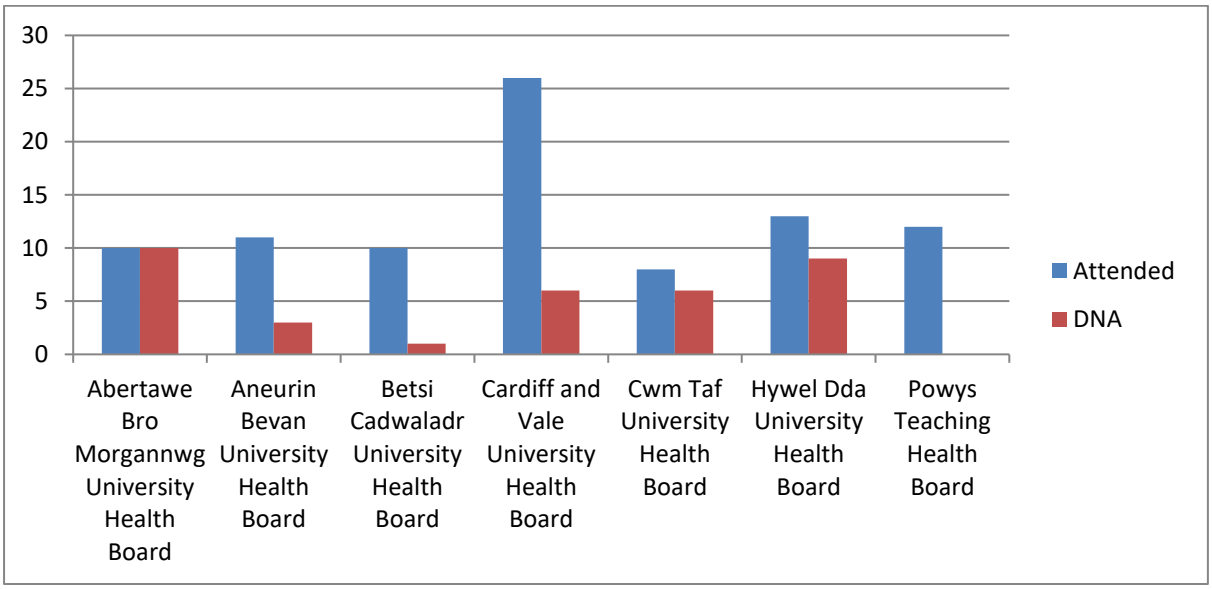


In attendance and DNA by organisation



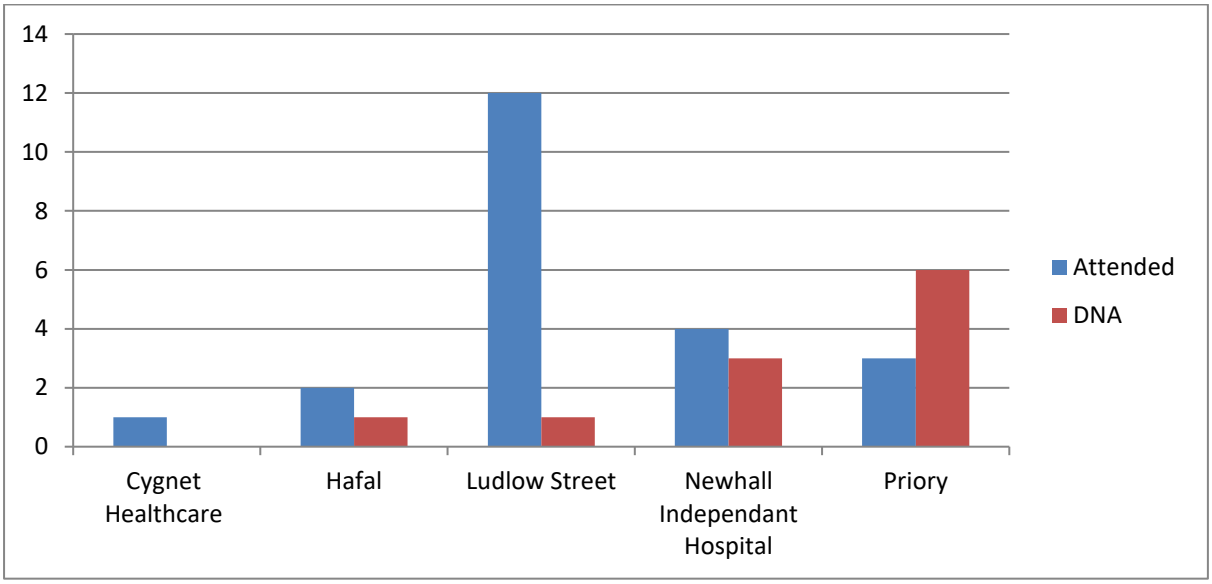
Public sector - Total number of attendee's/DNA's

There were a total of 90 representatives from the public sector in attendance and 35 who confirmed attendance but did not attend on the day.



Private Sector – Total number of attendee's/DNA's

There were a total of 22 representatives from the private sector in attendance and 11 who confirmed attendance but did not attend on the day.

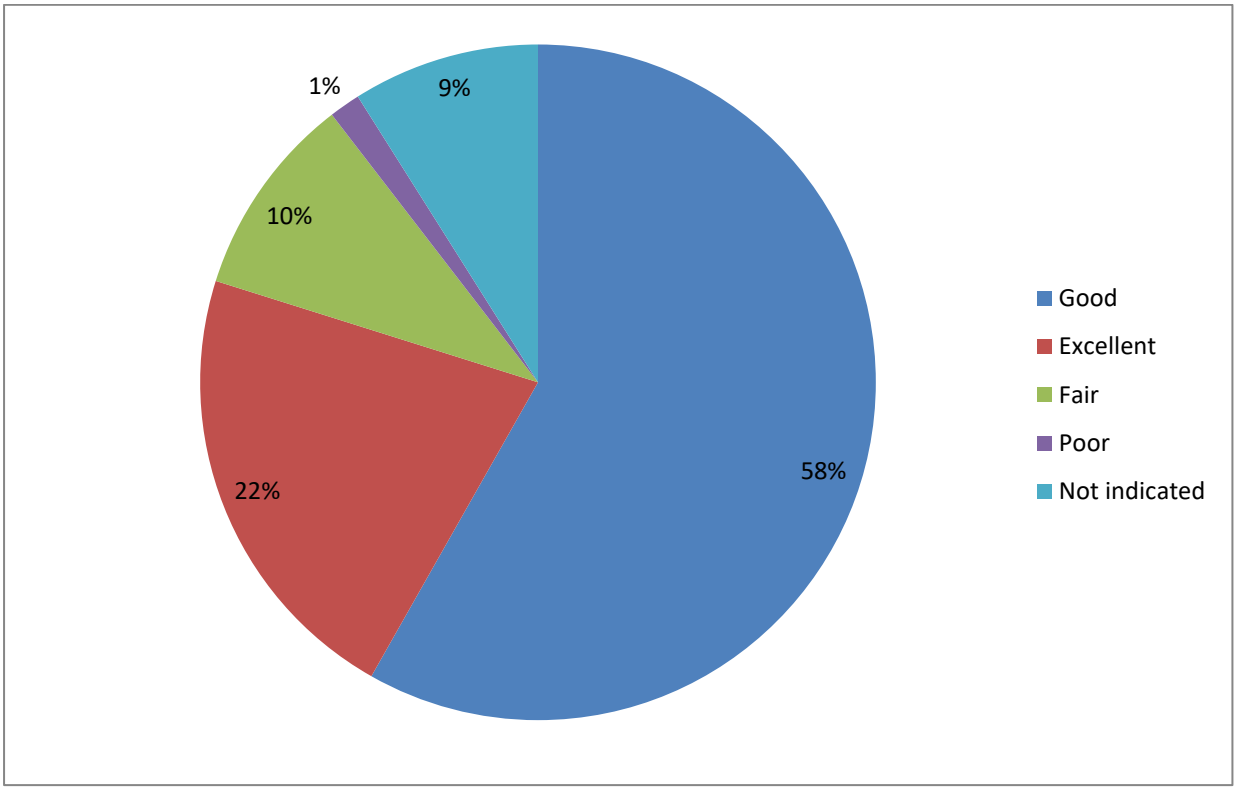


Advocacy

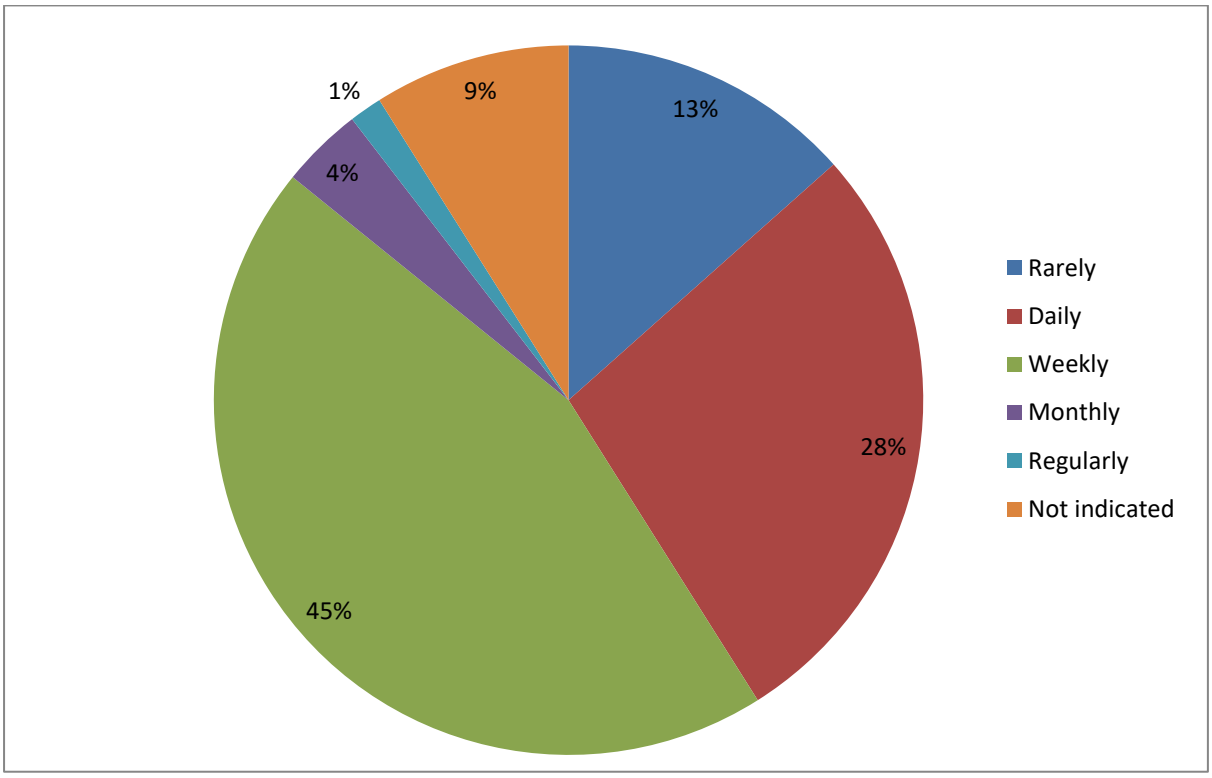
There were 7 advocates in attendance, 5 from South Wales and 2 from West Wales.

Feedback

49% of those in attendance provided the feedback below:



Feedback indicated how often the skills and knowledge gained from the day would be used, see below:



Conclusion

This event was well received, feedback indicated that those present were grateful for this opportunity and would welcome future events like this.

There was a 74% attendance rate with many making a significant journey from north/west Wales to attend the event in Cardiff. 80% of those that left feedback rated the event good/excellent and 73% reported that they would use the skills/knowledge gained from the day weekly/monthly.

Thanks to Welsh Government for supporting this event.

REPORT TITLE:	**Mental Health Act Benchmarking**									
MEETING:	Mental Health Legislation Committee							**MEETING DATE:**	12th February 2019	
STATUS:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**			**x**
LEAD EXECUTIVE:	Chief Operating Officer									
REPORT AUTHOR (TITLE):	Director of Operations and Delivery									

PURPOSE OF REPORT:

This report draws on available benchmarking specific to the mental health act to allow the Mental Health Clinical Board and the Mental Health Legislation committee to consider the position of Cardiff and Vale mental health services and develop improvement plans where necessary.

REPORT:

SITUATION:
Mental Health Services in Cardiff and Vale now have access to a range of benchmearking information as an opportunity to assess its service provision against the national royal college collated annual benchmarking and the more local all Wales benchmarking information coordinated at the C&V MHAct office. The MHCB has …….

BACKGROUND:

Royal College of Psychiatrists UK wide Benchmark report – Appendix 1
It is predicted by WHO experts that, by 2020, mental illness will be the second leading cause of disability in terms of premature deaths and loss of productivity (Kessler et al 2009, Vigo et al, 2016). For more than 6 consecutive years, the NHS Benchmarking Network has been successful in providing Mental Health Trusts in England and Wales, quality and performance data that inform future research, national policies and service transformation. The NHS Benchmarking Network data is presented in an easily interpretable manner to allow direct comparisons with neighbouring Trusts and identify areas of strength compared to the national average, and areas for improvement. These results should be interpreted using a holistic approach

All Wales Benchmarking data July - September 2018: (Collated by C&V) – See Appendix 2
For the past 18 months C&V has been facilitating an All Wales benchmarking exercise where each quarter the C&V MH Act administrator prepares the attached report for circulation and use by local services. In addition, where issues are identified, the local MHLC can be informed of the

MHCB plans to respond.

ASSESSMENT

RCP UK Data – See Appendix1

The attached appendix is a PDF document containing all the benchmarking results for the information/interest of the committee. The Mental Health Act section of the report is from pages 29 to 31. Within this section of the report the benchmarking covers MH Act activity per 100,000 population for admissions, detention activity and length of stay. C&V as MH51 is within average performance parameters for all aspects. There is nothing exceptional to report.

All Wales Benchmarking data July - September 2018: (Collated by C&V) – See Appendix 2

The appendix 2 attachment is the most recent report developed towards the end of 2018 with C&V being UHB number HB 4 Elements of this report to draw out are:

- Appears typical MH Act activity for the population base
- Typical 136 activity with excellent progress across Wales in reducing assessments in police custody. It will be of interest to monitor the new police call centre across the 3 SE Wales UHBs for its impact on 136 activity
- Rectifiable errors in the application of the MH Act appears typical in Cardiff and Vale with fundamentally defective errors showing bench-markable practice from C&V with zero.
- Hospital managers activity appears high in C&V suggesting service users are aware of their rights under the mental health act.

RECOMMENDATION:

For the Mental Health Legislation Committee to note the national benchmarking information.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people		7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X

5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention		Long term	x	Integration	x	Collaboration	x	Involvement		

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Benchmarking Network

NHS Benchmarking Network

Inpatient and Community Mental Health Benchmarking 2017/18

Report for MH51

Final report October 2018

Inpatient and Community Mental Health Benchmarking

Contents

National position

Benchmarking Network

Activity summary - Inpatient

	Adult Acute	Older Adult
	19.2 beds per 100,000 population	**38.9** beds per 100,000 population
	94% bed occupancy excluding leave	**89%** bed occupancy excluding leave
	31.3 average length of stay (days)	**74.3** average length of stay (days)
	9% emergency readmissions	**3%** emergency readmissions
	5% delayed transfers of care	**10%** delayed transfers of care

National position

Benchmarking Network

Activity summary - Community

1598

patients on community caseloads per 100,000 population

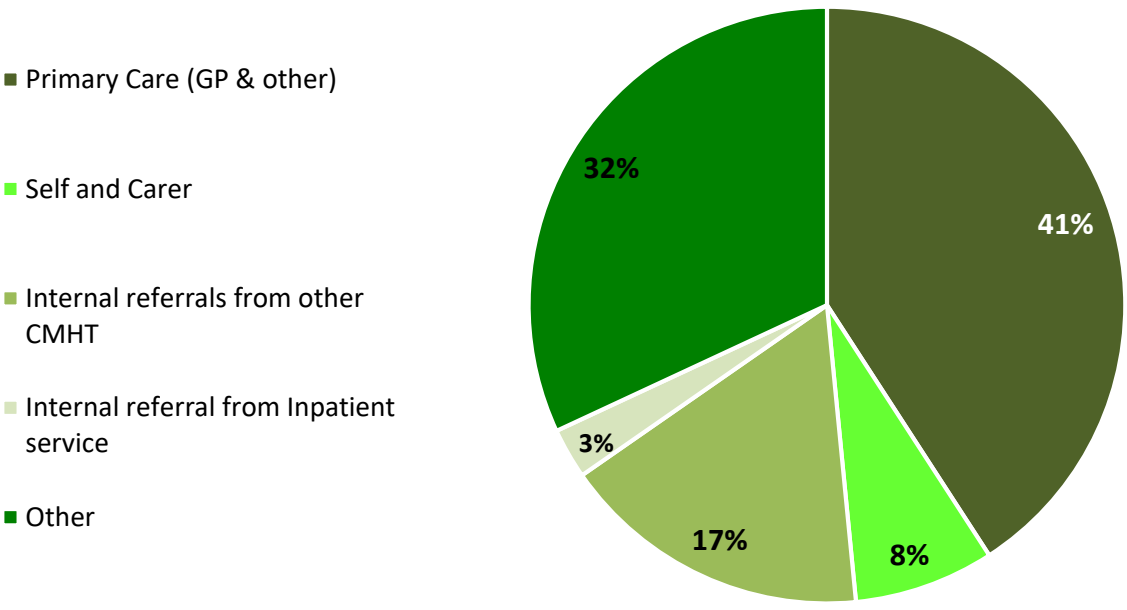
30,817

community contacts delivered per 100,000 population

86%

of Generic CMHT patients have an RTT of less than 18 weeks

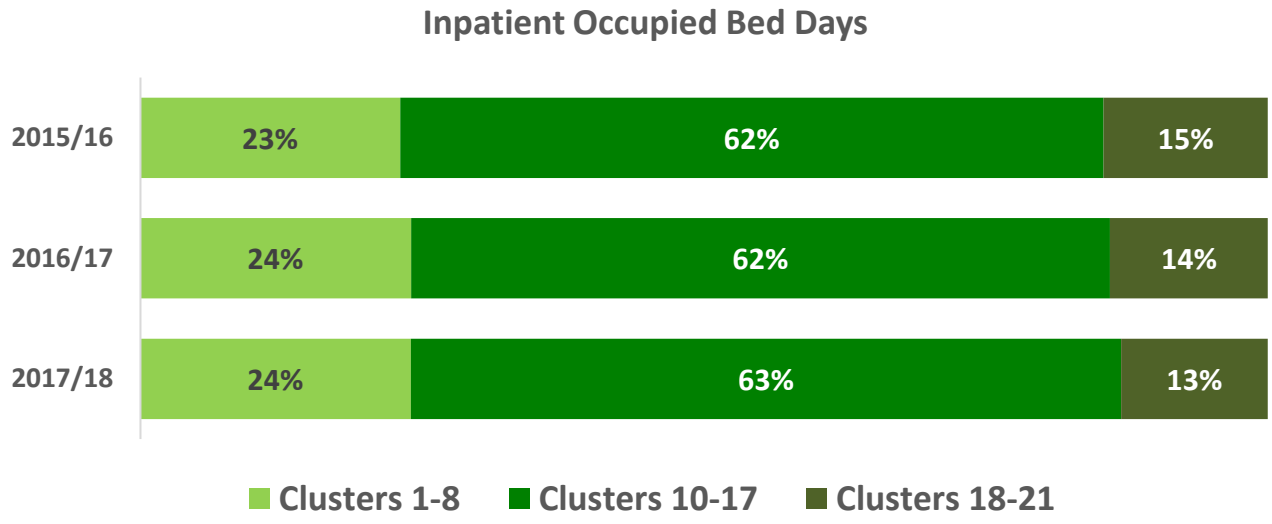
Referral source (all team types)

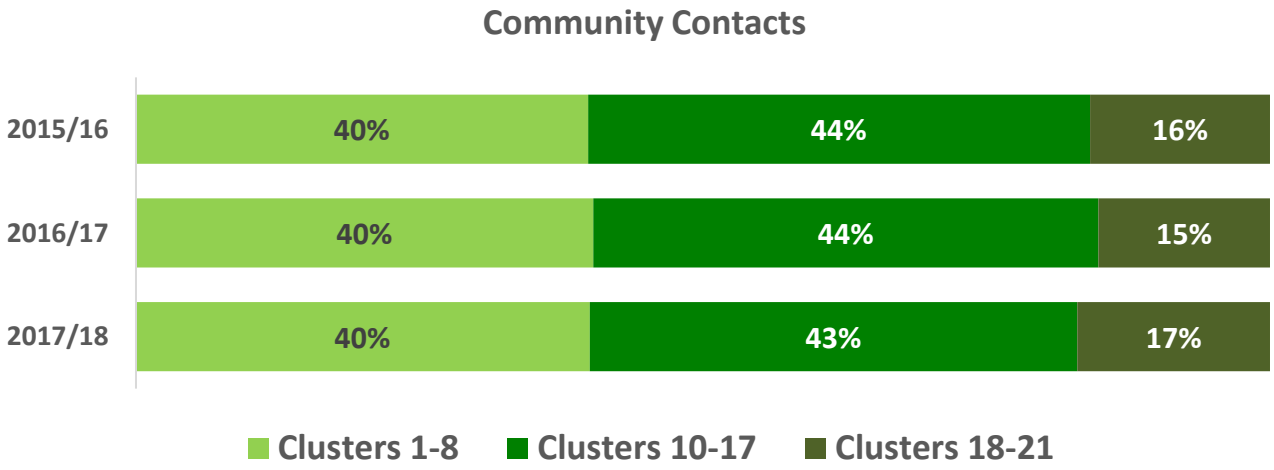


National position

Benchmarking Network

Patient Profile





Participants continue to report that around two thirds of inpatient bed days are occupied by patients in psychosis clusters 10-17.

Community services, however, are accessed by service users with a wider range of conditions, and there is a relatively even split between contacts delivered to those in non-psychosis clusters and those in psychosis clusters (40-43%).

Around one in six contacts are delivered in older adult care, categorised by organic clusters 18 to 21 (17%). Similarly, admissions for these clusters represent fewer than a sixth of all occupied bed days.

National position

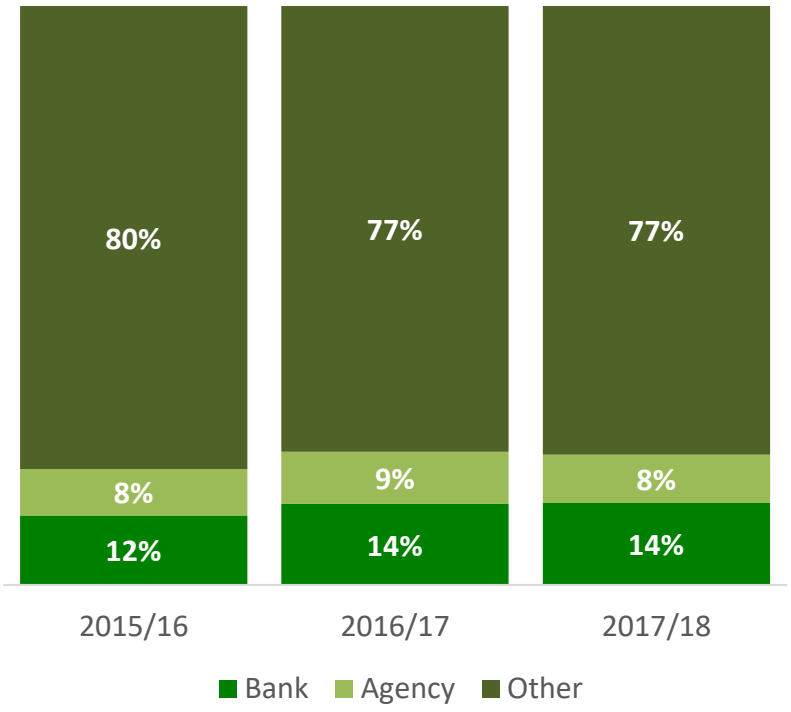
Benchmarking Network

Workforce

	Inpatient	Community
Nursing	38%	49%
Support Workers / HCAs	44%	1%
Medical	4%	10%
Occupational Therapists	3%	7%
Clinical Psychologists	1%	7%
Admin / management	6%	17%
Other	4%	9%

Although both inpatient and community settings are nurse led, greater proportions of clinical psychologists and occupational therapists are reported in community settings.

Bank and Agency (inpatient services)



Bank and Agency costs have averaged between 20% and 23% in recent years, and reflect a substantial element of inpatient service costs.

National position

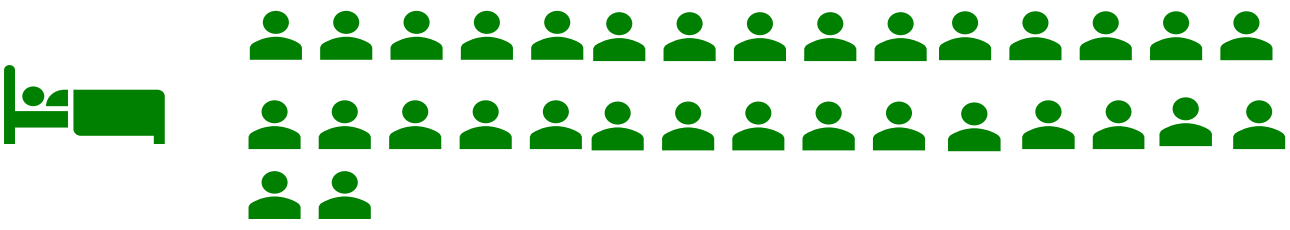
Benchmarking Network

Finance

There continue to be notable differences between costs of inpatient care and costs of community care.

Adult acute bed	£	140,182	cost of one bed per year
Generic CMHT	£	3,367	cost of a year of care for one patient
Ratio		1:42	ratio of costs of a single adult acute bed to a year of community care

Older adult bed	£	134,949	cost of one bed per year
Older people's CMHT	£	4,414	cost of a year of care for one patient
Ratio		1:31	ratio of costs of a single older adult bed to a year of community care



Benchmarking Network

Clinical Introduction

The NHS is the world's largest and most successful healthcare systems and has stood the test of economic and social challenges since its inception 70 years ago.

Mental illness is the single largest burden to the society (Insel T, 2011) and the burden of disease costs around £100 billion per year in the UK (Davies SC 2013, DoH report), yet the spending on mental health is only 13% of NHS Health Care Budget (London School of Economics report 2012). The burden is likely to get worse as it is predicted by WHO experts that, by 2020, mental illness will be the second leading cause of disability in terms of premature deaths and loss of productivity (Kessler et al 2009, Vigo et al, 2016). Although NHS England has strived to improve the mental health spending with the implementation of the Mental Health Investment Standard, CCGs have raised concerns about meeting such expectations when their resource levels have stagnated (King's Fund 2018).

For more than 6 consecutive years, the NHS Benchmarking Network has been successful in providing Mental Health Trusts in England and Wales, quality and performance data that inform future research, national policies and service transformation.

The NHS Benchmarking Network data is presented in an easily interpretable manner to allow direct comparisons with neighbouring Trusts and identify areas of strength compared to the national average, and areas for improvement. NHSBN evidence often forms the basis of discussion during CQC visits and RCPsych accreditation and helps useful dialogue between Trusts and commissioners on mental health performance and commissioning priorities. These results should be interpreted using a holistic approach taking all contributing factors into consideration. For example a shorter LOS may seem good from a financial perspective, however from a quality perspective this can only be seen as good, if the rates of re-admission are low and community systems are well resourced to avoid emergency admissions and excessive use of the Mental Health Act.

According to the NHSBN data, Mental Health Trusts continue to maintain their quality standards for adults of working and older age groups in areas such as patient experience, delayed transfers of care, average length of stay and admission rates. This is a remarkable achievement despite significant reductions to the bed base and additional challenges to meet cost improvement plans.

The CQC's report on state of care in mental health (2018) highlighted concerns around staffing levels and access to services. Whilst there has been a slight reduction in qualified nursing staff in acute wards, support staff have increased significantly in inpatient settings. Capacity within community teams, though, has been declining as providers have disproportionately used community services savings to deliver the requirements of cost improvement plans.

Benchmarking Network

The benchmarking data shows a slight increase in readmission rates, higher than the previous 5 years. Similar findings have also been noted in acute specialities (The Nuffield Trust report 2018). Evidence has shown that housing support and appropriate interventions for alcohol and drug misuse in the community can play a key role in reducing emergency readmissions in mental health (Li et al, 2018, Morris et al, 2018). Appropriate community interventions may help to reduce frequent crisis admissions as the latter have also shown to increase readmission rates in mental health (Moran et al, 2016).

The Five Year Forward View for Mental Health (2016) and the Royal College of Psychiatrist (Wendy Burn, President, RCPsych 2018) and the King's Fund (2018) have emphasised the need to achieve parity of esteem for people with mental health problems to be treated in the same way as those with physical health problems. It is time to recognize the need to improve funding for mental health services as highlighted in the report by the Institute for Fiscal Studies and Health Foundation (2018) and the need to engage and retain community staff and improve their well being (Carter report 2018).

It is hoped that NHS England's upcoming Long Term Plan will address this issue and develop clear proposals for investing in core mental health services.

The NHS Benchmarking Network mental health programme report has been supporting clinicians and senior managers of Trusts in data sharing and implementation of good practice. Such mechanisms for sharing good practice are widely recommended (Carter 2018, Centre for Mental Health 2017, Health Foundation 2017) to provide the best quality care for our patients.

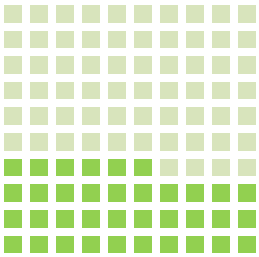
Dr Arokia Antonysamy
October 2018

Bed Profile

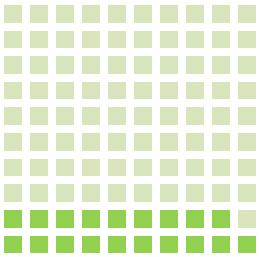
National position

Benchmarking Network

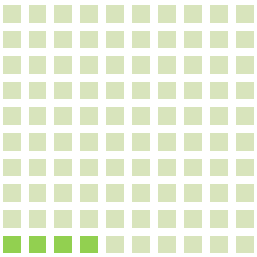
Adult Acute
36%



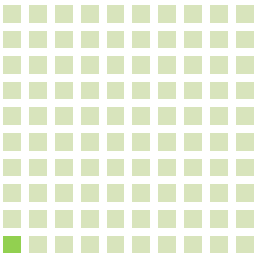
Older Adult
19%



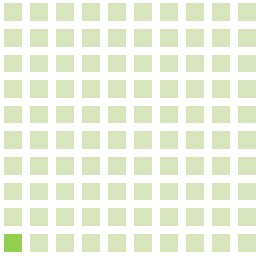
PICU
4%



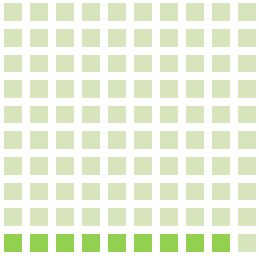
Eating Disorders
1%



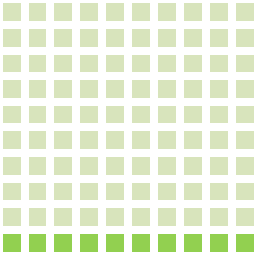
Mother and Baby
1%



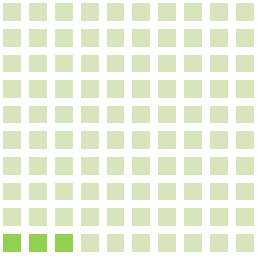
Low Secure
9%



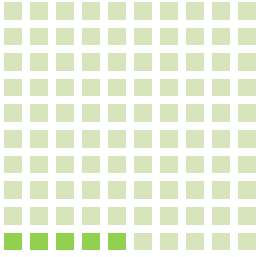
Medium Secure
10%



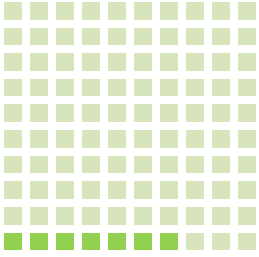
High Secure
3%



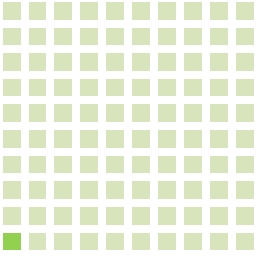
High Dep Rehab
5%



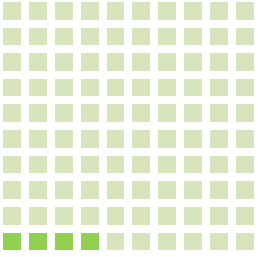
Long Term Complex
7%



Neuropsychiatry
1%



Other MH Beds
4%



Acute admission beds for adults and older adults together represented over 55% of the total bed stock on 31st March 2018.

Just under a quarter (22%) of beds are low, medium or high secure beds, although this position is for NHS providers and does not include a number of independent sector sites who offer specialist beds. These include secure, eating disorder and rehabilitation services.

Introduction

This report examines the state of mental health services in the UK in 2018. It summarises the results of this year's NHS Benchmarking Network mental health collection, and introduces the other outputs available from this detailed work.

This year brings the highest ever level of participation in the project. In addition to every English Mental Health Trust and every Welsh Health Board, we have growing representation from Northern Ireland, Scotland and the Channel Islands. This large number of participants provides the critical mass needed to provide robust and comprehensive data about the state of mental health services. The report examines activity from the 2017/18 financial year, supplemented by a number of year-end stocktake positions (for example staff in post on 31st March 2018).

2017/18 marks the seventh consecutive year of benchmarking data collection on adult and older adult mental health services. Building on last year's report, this document offers expanded time series trend analysis on every metric, and allows participants to explore the direction of travel for both inpatient and community services.

The benchmarking process has been member driven from its inception, and we would like to acknowledge the contribution made both by member organisations and by the Mental Health Reference Group who continue to shape and champion the data collection process.

The following outputs are available from this work:

- bespoke reports featuring registered population analysis for all participants

- bespoke reports featuring weighted population analysis for English participants, using the NHS England PRAMH weighting formula which is used in CCG baseline allocations

- a comprehensive, interactive mental health toolkit which provides over 10,000 comparisons and allows all participants the opportunity to drill down into particular areas of interest

Draft reports for validation were issued in August, and some positions have been updated as a result. This report is a final report, including these changes. Detailed findings will also be presented at this year's mental health benchmarking conference which will take place in London on 9th November 2018.

Julian Emms
Chief Executive
Berkshire Healthcare NHS Foundation Trust
and Chair, NHSBN Mental Health Reference Group

Stephen Watkins
Director
NHS Benchmarking Network

Reference Group

We are grateful to the Mental Health Reference Group for their support and guidance of this work.

Julian Emms	Berkshire Healthcare NHS Foundation Trust
Tracy White	Central and North West London NHS Foundation Trust
Adrian Clarke	NHS Wales
Anna Foster	Northumberland, Tyne & Wear NHS Foundation Trust
Anushta Sivananthan	Cheshire & Wirral Partnership NHS Foundation Trust
Babs Dhillon	West London NHS Trust
Belinda Iringe-Koko	Central and North West London NHS Foundation Trust
Catherine Magee	Berkshire Healthcare NHS Foundation Trust
Chris Lanigan	Tees Esk and Wear Valleys NHS Foundation Trust
Chris Woon	2gether NHS Foundation Trust
Dawn Painter	NHS Wales
Jason Rowlands	Sheffield Health and Social Care NHS Trust
Jayne Flynn	Coventry and Warwickshire Partnership NHS Trust
Joanna Wood	Midlands Partnership NHS Foundation Trust
Kate Bichard	Dorset Healthcare NHS Foundation Trust
Keeley Twigg	NHS Wales
Kevin Wilkinson	Greater Manchester Mental Health NHS Foundation Trust
Lee Cornell	Somerset Partnership NHS Foundation Trust
Leon Leroux	Lancashire Care NHS Foundation Trust

Lindsey White	Dorset Healthcare NHS Foundation Trust
Mark Polczyk-Przybyla	South London and Maudsley NHS Foundation Trust
Michael Harradine	Pennine Care NHS Foundation Trust
Mike Garnham	South West Yorkshire Partnership NHS Foundation Trust
Miranda Washington	Greater Manchester Mental Health NHS Foundation Trust
Mohit Venkataram	East London NHS Foundation Trust
Philip Horner	Lancashire Care NHS Foundation Trust
Puneet Kaura	Mersey Care NHS Trust
Shane Mills	NHS Wales
Vicky Boswell	North Staffordshire Combined Healthcare NHS Trust
Wendy Harlow	Sussex Partnership NHS Foundation Trust
Arokia Antonysamy	Ministry of Defence

Participants

This year, participants include 100% of English Mental Health Trusts, 100% of Welsh University Health Boards and representation from Scotland, Northern Ireland, the Channel Islands and the Independent Sector.

Participant organisations for 2018 are as follows:

England

2gether NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust
Barnet, Enfield and Haringey Mental Health Trust
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull NHS Foundation Trust
Black Country Partnership NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Cheshire & Wirral Partnership NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Coventry & Warwickshire Partnership Trust
Cumbria Partnership NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership NHS Trust
Dorset HealthCare University NHS Foundation Trust
Dudley & Walsall Mental Health Partnership NHS Trust
East London NHS Foundation Trust
Essex Partnership University NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Isle of Wight NHS Trust
Kent and Medway NHS and Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Mersey Care NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust

Northamptonshire Healthcare Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
North West Boroughs NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham, Doncaster and South Humber NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South West London & St George's Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
West London NHS Trust
Worcestershire Health and Care NHS Trust

Wales
Abertawe Bro Morgannwg University Health Board
Aneurin Bevan University Health Board
Betsi Cadwaladr University Health Board
Cardiff & Vale University Health Board
Cwm Taf University Health Board
Hywel Dda University Health Board
Powys University Health Board

Scotland
NHS Greater Glasgow and Clyde

Northern Ireland
Belfast Health and Social Care Trust
Northern Health and Social Care Trust
South Eastern Health and Social Care Trust

Channel Islands
States of Jersey

Other
The Huntercombe Group
Livewell Southwest
St Andrew's Healthcare

Terms of Reference

The terms of reference for the project have been developed by the Mental Health Benchmarking Reference Group. They reflect the project's overall objectives and are reviewed by the reference group on an on-going basis.

The terms of reference for the Mental Health benchmarking project are:

- To develop a specification for benchmarking mental health services
- To support members in collecting consistent data
- To process data and produce comparisons for member organisations
- To validate data and ensure comparisons are robust
- To produce detailed analysis reports for members
- To support a desktop benchmarking toolkit and other reporting formats for members
- To develop conclusions on the results of mental health benchmarking
- To help identify and share good practice amongst member organisations
- To support on-going improvements within the mental health sector
- To facilitate networking and communications amongst member organisations

Wider objectives of contributing to continuous service improvement are taken forward by the NHS Benchmarking Network through the knowledge exchange and networking services provided by the Network.

Mental health is an important aspect of the NHS Benchmarking Network's wider work programme and will continue as an on-going area of project work in future years. The commitment to enhance and develop the Network's mental health workstream in upcoming years provides an excellent platform for future service provision to members and engagement with the wider mental health community.

Members should also note that additional products are available to mental health providers that support further analysis on other aspects of services offered by many mental health providers. Examples include CAMHS benchmarking and a range of bespoke projects undertaken with members, including a national stocktake of both Specialist and Universal Perinatal mental health services, recent work on the size and scope of Community Mental Health Services and a detailed work programme to explore secure mental health services.

Further projects of interest to mental health provider organisations include projects on learning disabilities, community physical healthcare services and pharmacy, which contain elements of relevance to many Trusts and Health Boards. All of these products can be accessed from the NHS Benchmarking Network's website.

www.nhsbenchmarking.nhs.uk

Benchmarking Network

How to read this report

This year, the Inpatient and Community Mental Health Benchmarking project offers a range of outputs including bespoke reports and a toolkit.

The reports draw on data captured since 2011/12 to provide a time series analysis on a number of metrics. The diagram below illustrates the key features of this analysis, to aid the reader in interpretation.

Chart title includes denominator (where used) e.g per 100,000 registered population.

Your organisation is shown in red on the chart, with your figure displayed in the key. Other participants in your region are shown in green, and the rest of the UK in blue.

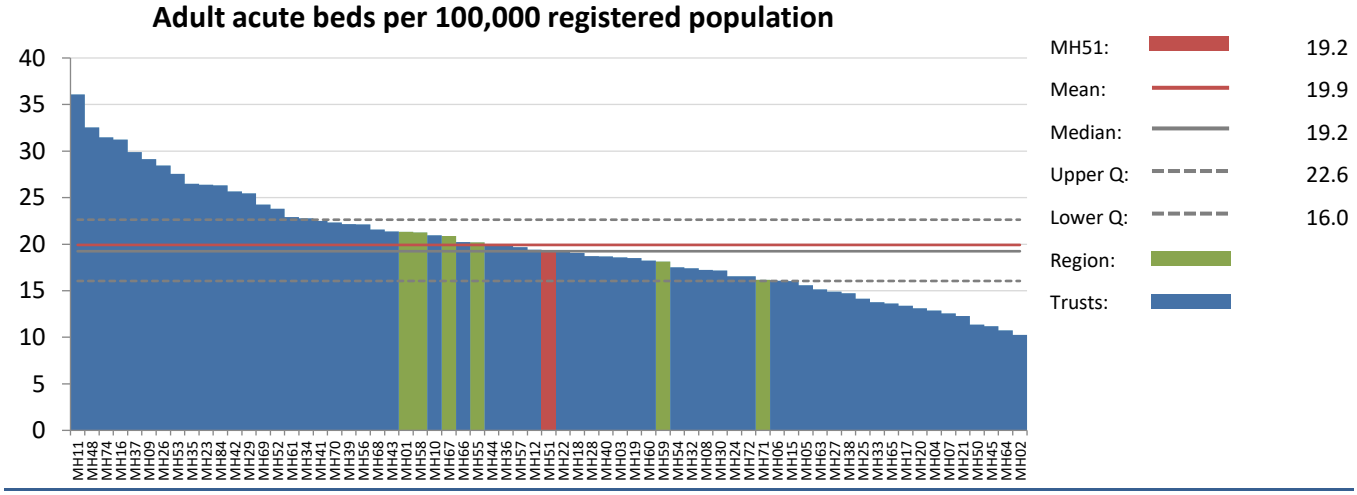


Figure 1

Organisational codes

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	23.0	22.6	20.0	19.0	19.7	19.2	**19.2**	

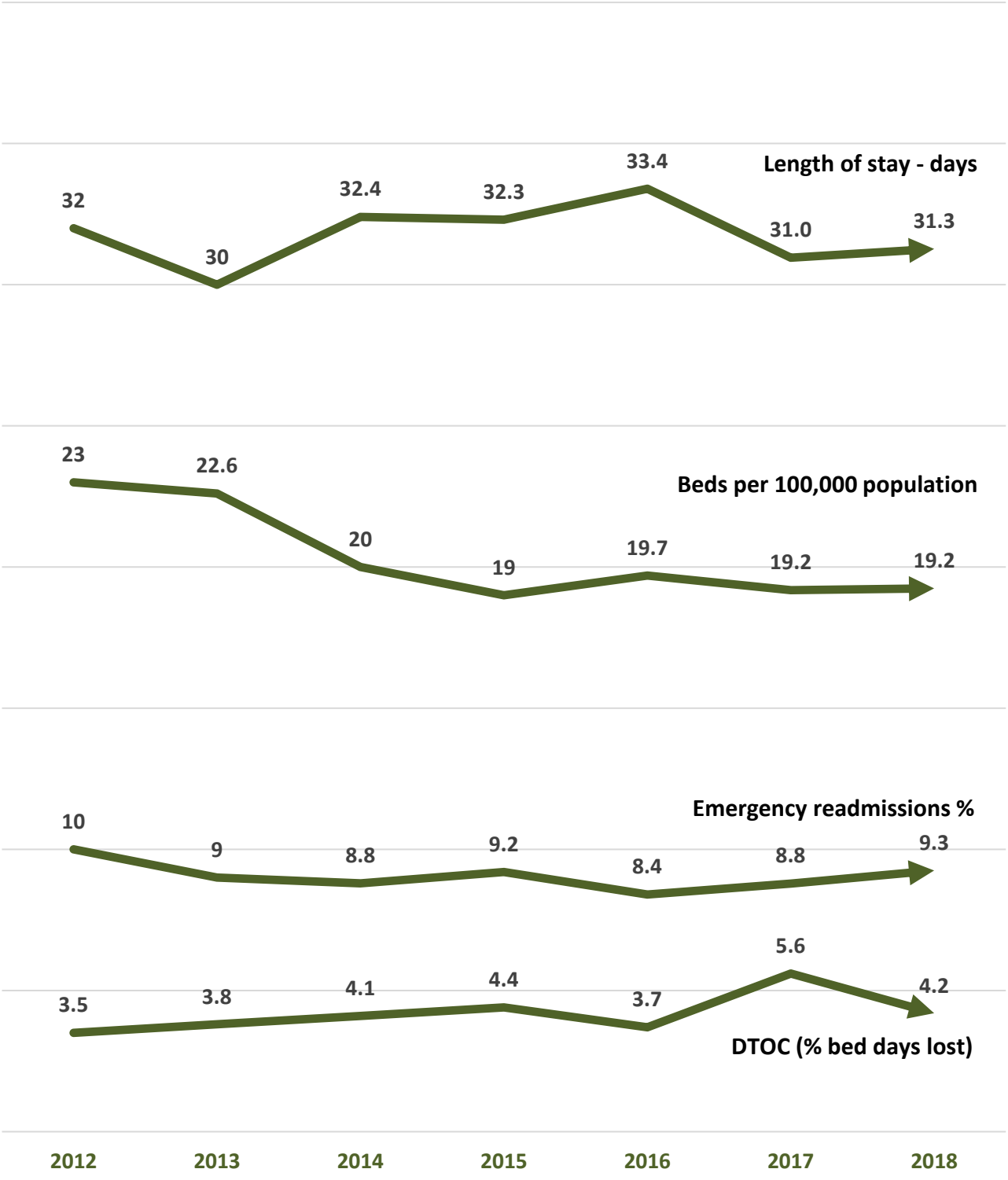
National average positions for this metric.

The general trend for this metric over time.

National position

Benchmarking Network

Adult Acute Bed Trends 2012-2018



Benchmarking Network

Adult Acute Beds

Adult acute beds form part of the core service offer for most mental health providers. Typically, the largest single bed type provided by an organisation is adult acute beds, providing inpatient care for service users who are predominantly in the working age population (age 16-64 years). Older adult acute beds provide similar support to service users aged 65 years and older. These beds are reported in the next section of the report.

Adult acute beds support patients with a wide range of mental health conditions. In addition to these multi-purpose beds, providers may have specialist beds for dedicated conditions such as eating disorders or longer term rehabilitation. These beds are described later in the report.

In recent years providers have reported a reduction in adult acute bed numbers, although this decrease has begun to slow. This year, a median position of 19.2 beds per 100,000 registered population was reported. The chart below shows the position for your organisation, along with regional and national positions. The table below the chart shows the national average trend since 2011/12. Bed numbers have been declining for many years although data from 2014/15 onwards now suggests a steady state position has been reached at around 19 beds per 100,000 population age 16-64.

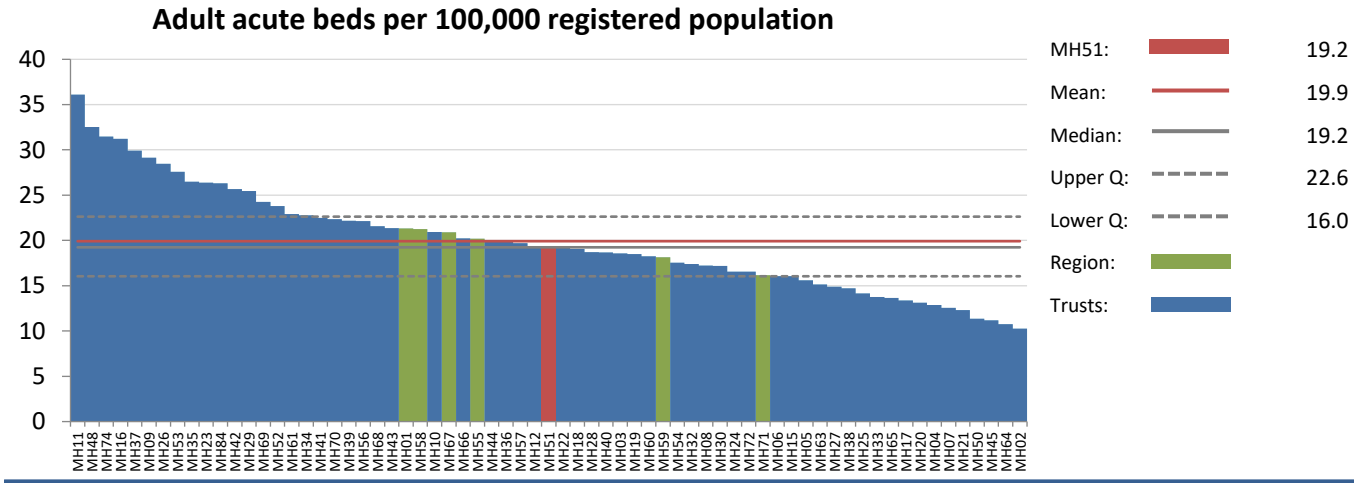
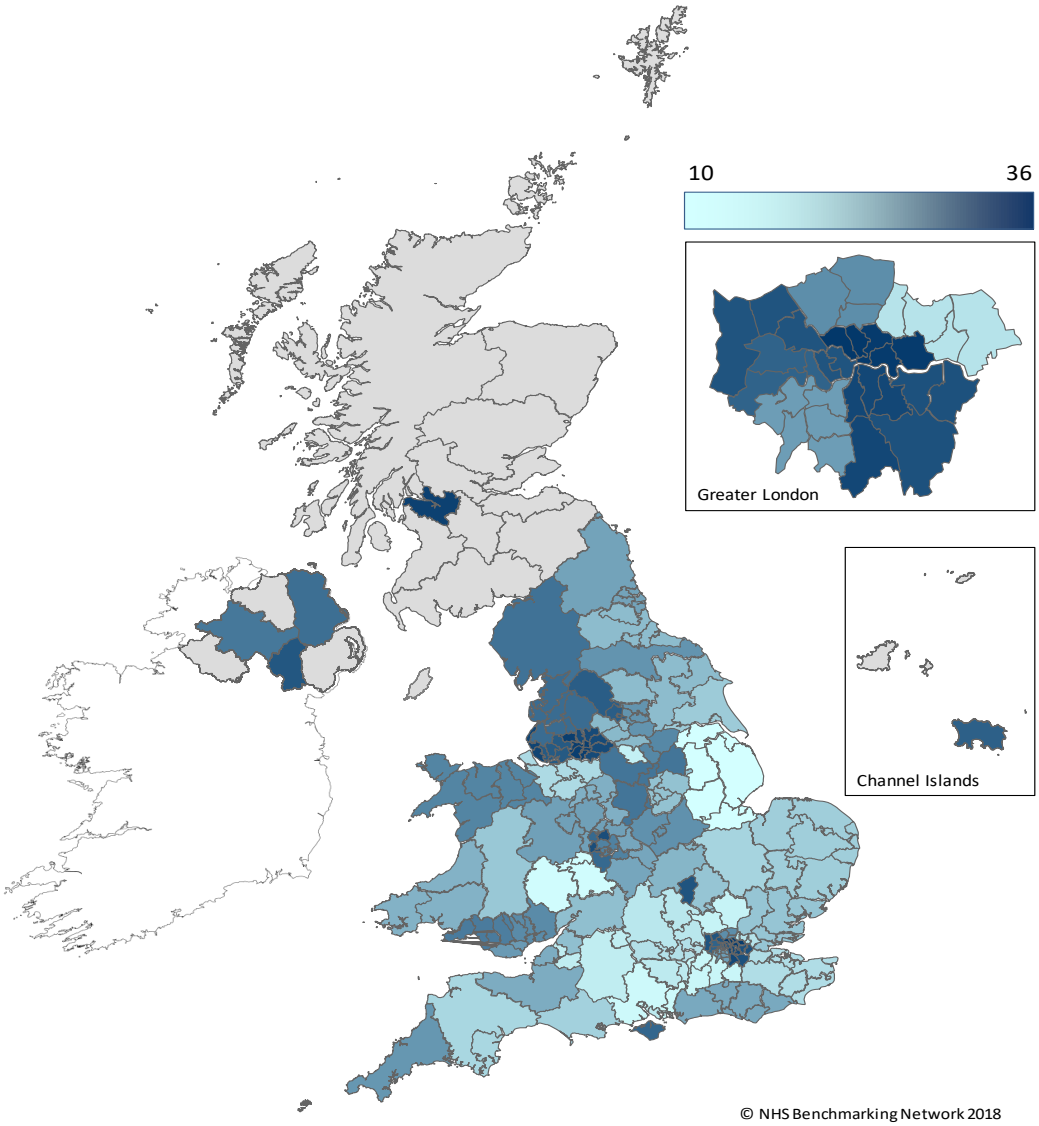


Figure 2

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	23.0	22.6	20.0	19.0	19.7	19.2	**19.2**	

Benchmarking Network

Adult acute beds per 100,000 registered population (age 16-64)



Benchmarking Network

Adult Acute Bed Occupancy

Bed occupancy figures show the number of bed days occupied in a year, as a proportion of all available bed days. In an organisation where every available bed was occupied fully throughout the year, bed occupancy would be 100%. However, NHS Improvement and the RCPsych recommend operating at a level of 85% to ensure beds are available for new admissions when needed.

Adult acute beds report some of the highest bed occupancy rates of any mental health bed type, reflecting the tightness of capacity in most areas. This year's median average of 94.4% suggests broad stability of bed utilisation over the last 5 years.

Bed occupancy can be measured including or excluding patients who are on leave from the hospital. Both of these alternatives are shown in the charts below. Where bed occupancy including leave rises about 100%, this is an indication that a ward was fully occupied by inpatients whilst also having additional patients on leave. While this can be necessary due to local demand for beds, it may increase risks for patients on leave who subsequently need to be readmitted, if a bed is not available at that time. The use of leave is a pragmatic response to scarce bed capacity as well as a tool for managing patient discharge.

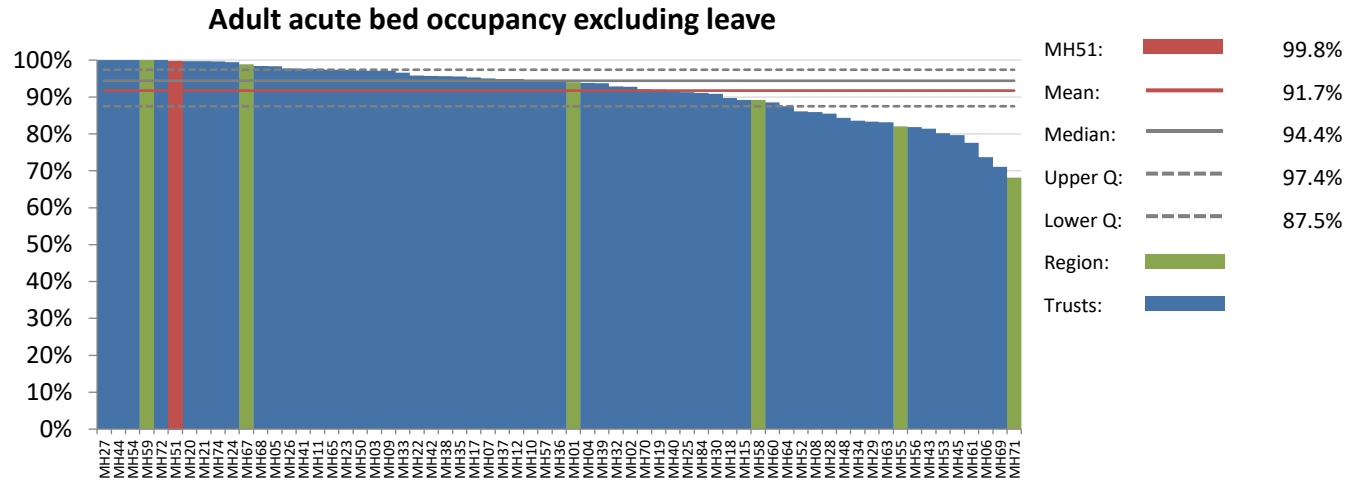


Figure 3

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	91%	89%	93%	94%	94%	95%	94%	

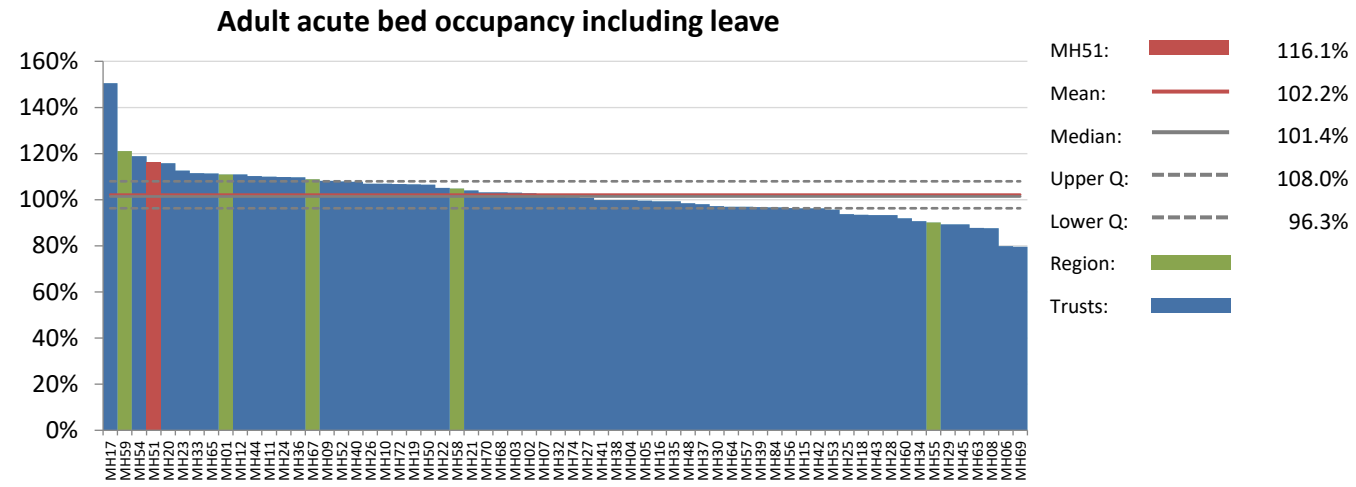


Figure 4

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	x	x	104%	102%	104%	101%	

Adult Acute Admissions

Admission rates are dependent on several factors including background demand rates, bed numbers and length of stay, as well as overall bed occupancy rates.

Recent reductions in bed numbers without significant changes in occupancy or length of stay have resulted in lower numbers of admissions each year. Admission levels have reduced by 16% since 2011/12 and show a continuous marginal reduction each year.

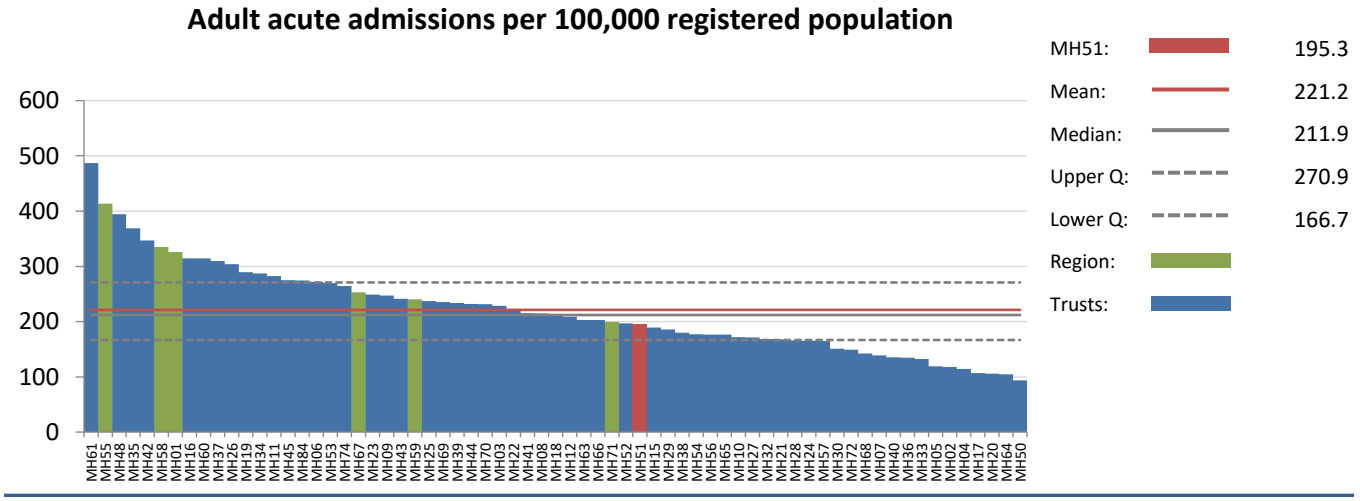


Figure 5

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	252	236	240	228	221	213	212	

Admissions per bed are broadly stable at around 11 per annum. The data suggests wide variation from 7 to 24 admissions per bed across the UK. Admission rates are typically most influenced by average length of stay and bed occupancy rates.

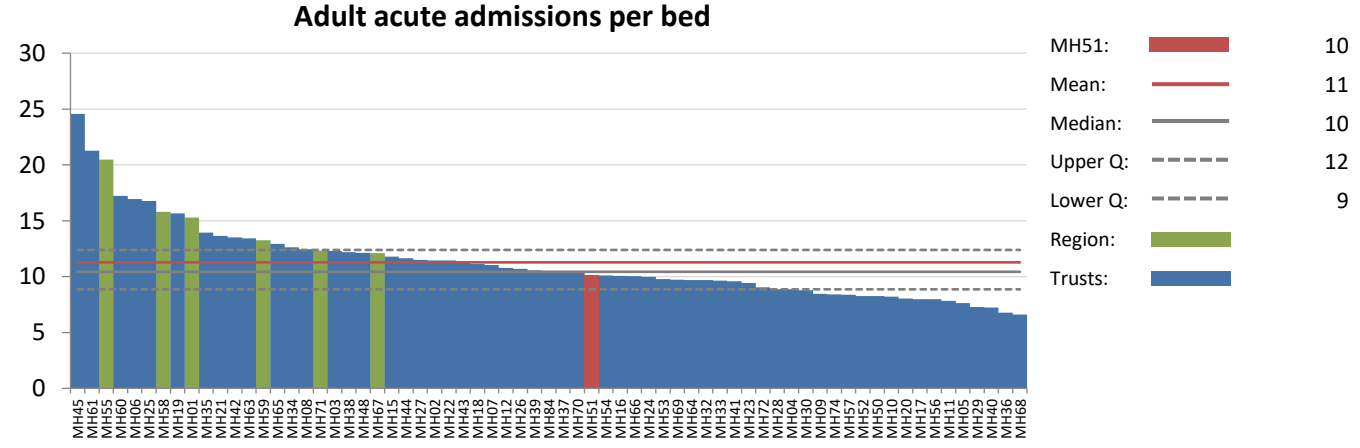


Figure 6

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	11.5	11.3	11.0	11.3	

Benchmarking Network

Profiling admissions can be useful for organisations, and help predict future demand. Two key metrics are the proportion of admissions for patients not previously known to mental health services (through a previous admission or through being on a community caseload) and the proportion of admissions for patients of no fixed abode.

Recent years have seen a reduction in the proportion of admissions for unknown patients. This may be due to more pro-active case finding and pathways in the community, meaning a reduction in number of people whose first contact with services is through an admission in crisis.

Rates of admissions for patients of no fixed abode have been steady in recent years, however notable local and regional variation is seen on this metric.

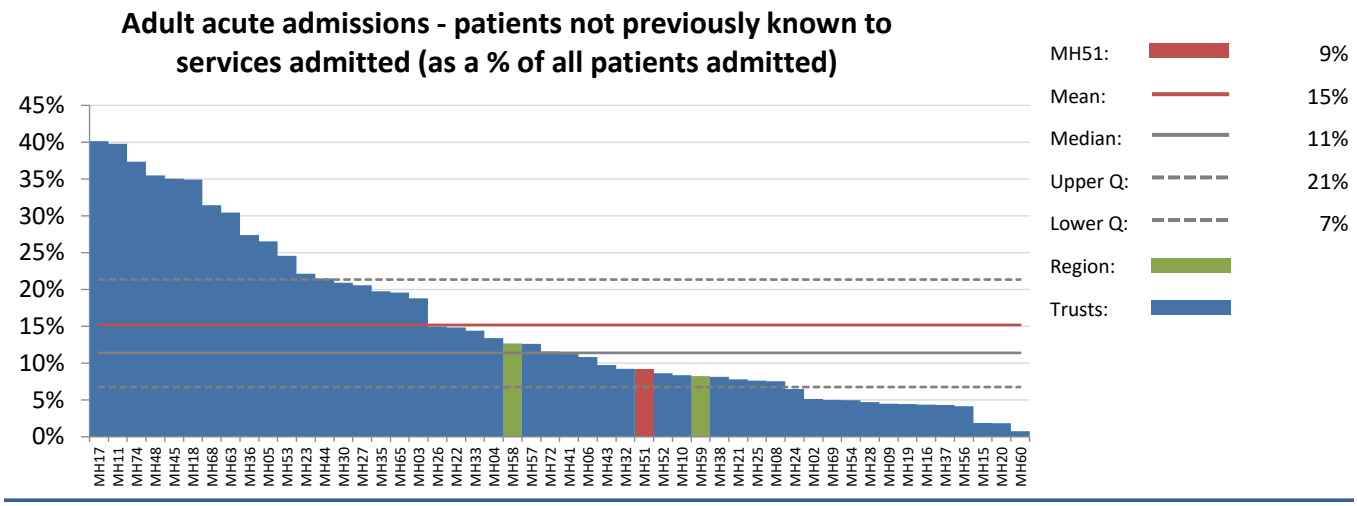


Figure 7

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	x	x	18%	16%	13%	11%	

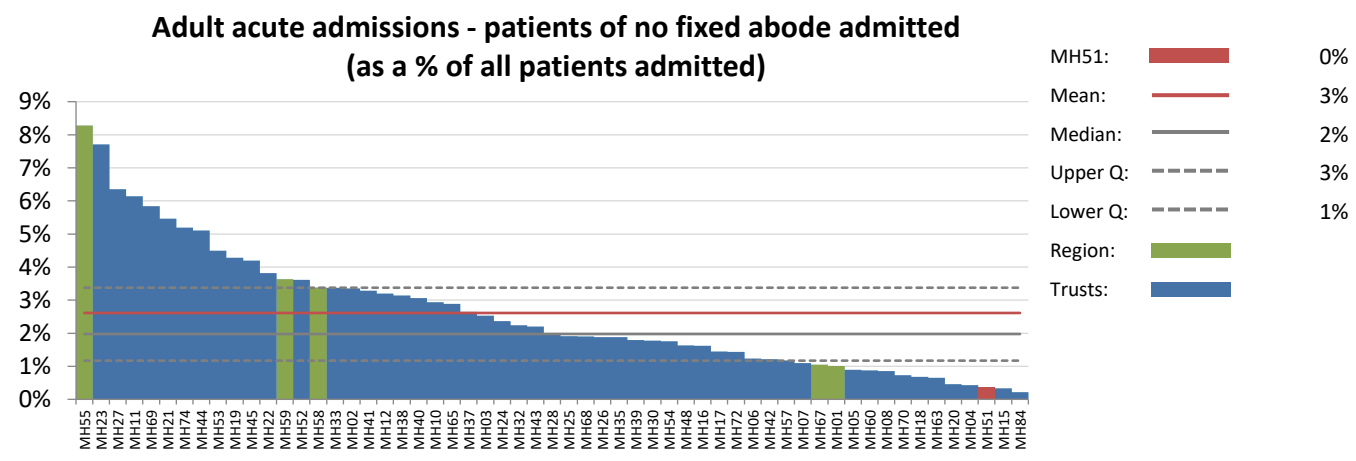


Figure 8

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	2%	2%	3%	3%	

Adult Acute Length of Stay

Participants have reported some fluctuations in length of stay from year to year, though the table below shows a longer time series. This confirms that average figures have only varied between 30 days and 33 days (excluding leave) over the last 7 years. The lower quartile position of 25.7 days in 2017/18 also remains similar to previous years, suggesting a quarter of providers consistently achieve notably lower lengths of stay than the national average each year.

The second chart shows a total position including time spent on leave. This typically adds a small number of extra days to the excluding leave figure, but long term leave appears not to be the norm within an adult acute setting.

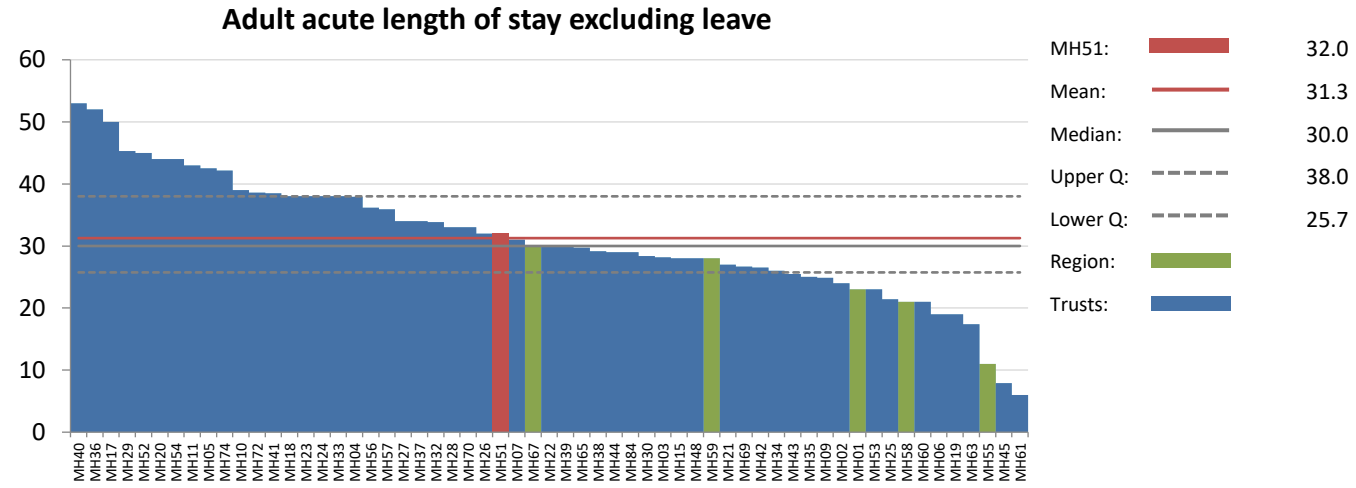


Figure 9

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	32.0	30.0	32.4	32.3	33.4	31.0	31.3	

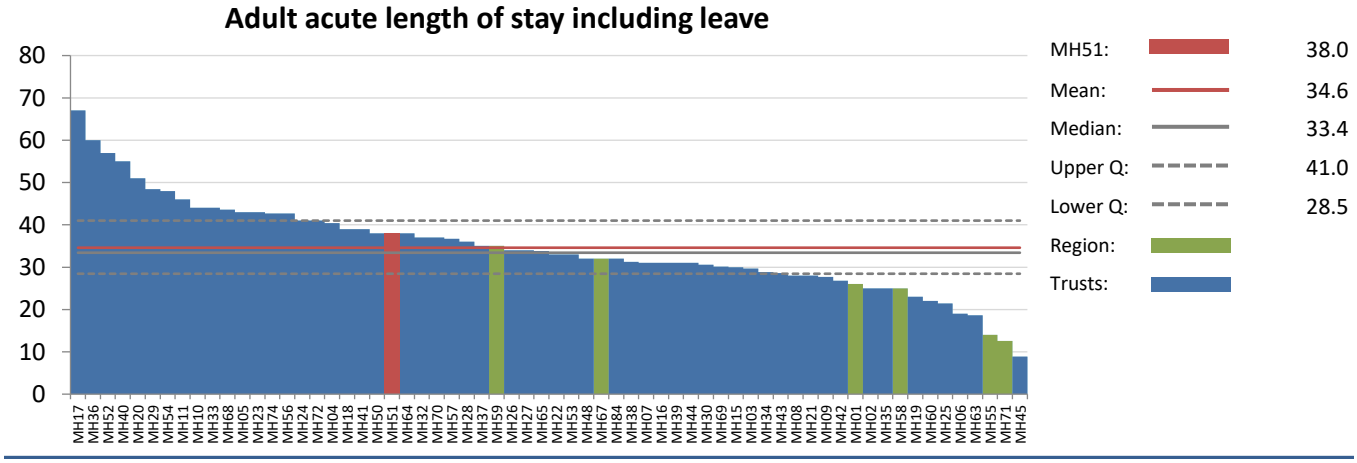
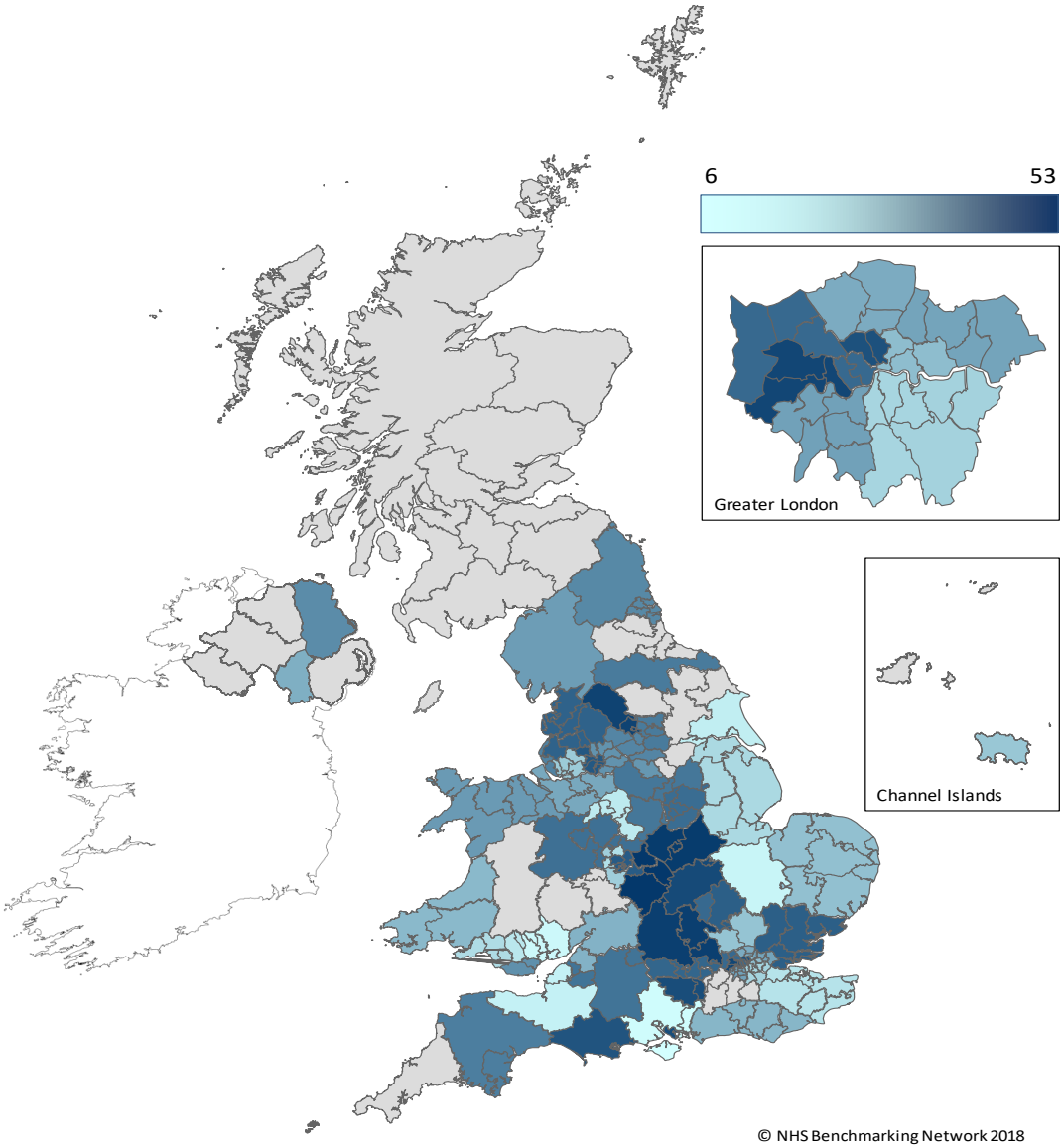


Figure 10

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	37.0	36.6	35.9	35.4	34.6	

Benchmarking Network

Adult acute length of stay (days) - excluding leave



A number of different models of care are evident between and indeed within different providers. Participants in some areas report dedicated short stay wards, offering admission for assessment and rapid intervention for up to a week. These often operate separately to more traditional adult acute wards, though transfer to such a bed may be available if the need for a longer term admission is identified.

The table below shows the proportion of patients staying for different lengths of time nationally, and gives an additional insight into length of stay. Positions for 2016/17 are also shown, and the change between years highlighted, though on the whole this change is minimal. On the following page, charts show individual participant positions for this year.

National position

Length of stay	2016/17	2017/18	Change
0-3 days	16%	16%	→
4 - 13 days	31%	31%	→
14 - 60 days	38%	39%	↑
60 days or longer	15%	14%	↓

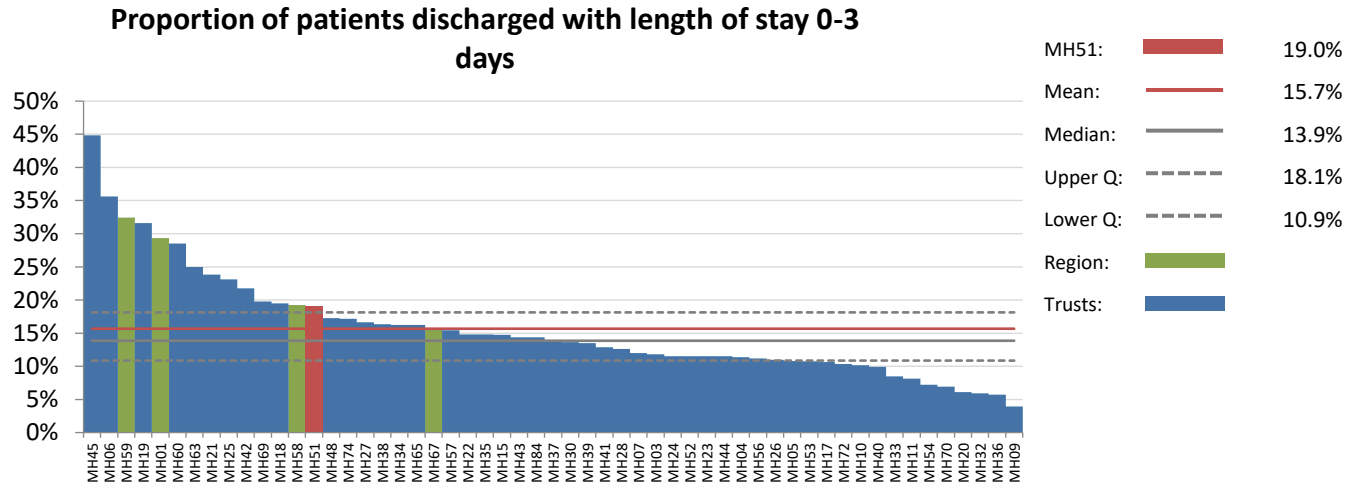


Figure 11

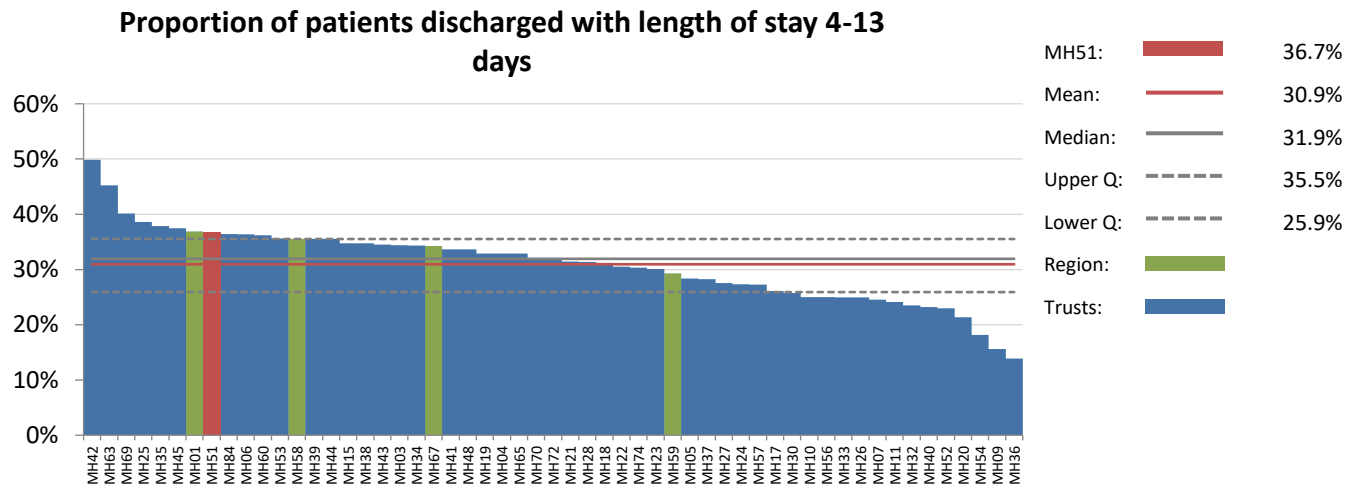


Figure 12

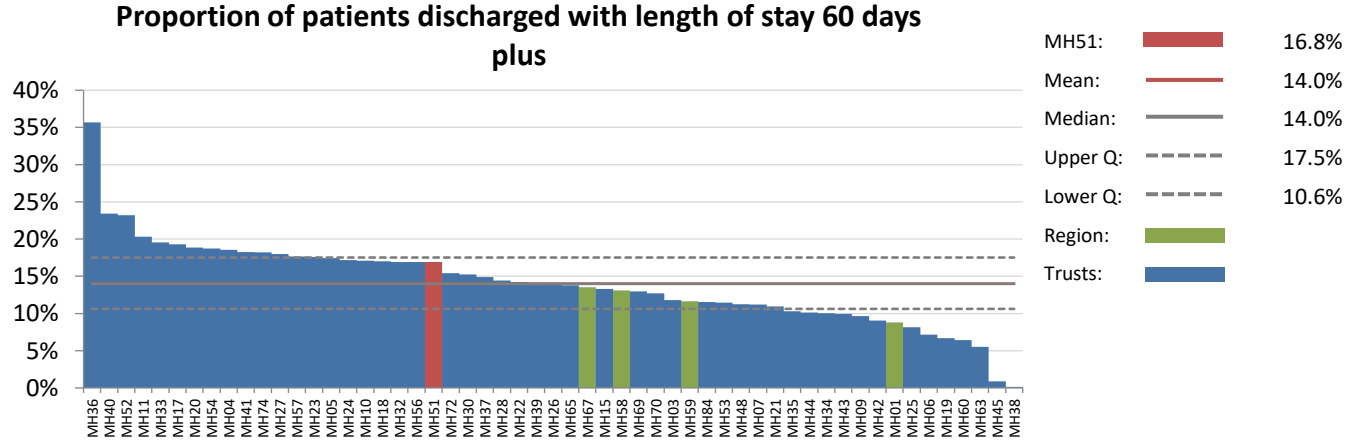


Figure 13

Benchmarking Network

Mental Health Act

Use of the Mental Health Act (MHA) remains an area of much interest and debate nationally. Adult acute admissions under the MHA as a proportion of all adult acute admissions have risen in recent years, though this is largely due to a reduction in overall admission rates. Therefore, it is also helpful to monitor overall rates of Mental Health Act detention per capita, which the second chart below shows. Both metrics confirm marginal upward trends in the data, with increasing use of the Mental Health Act at time of detention.

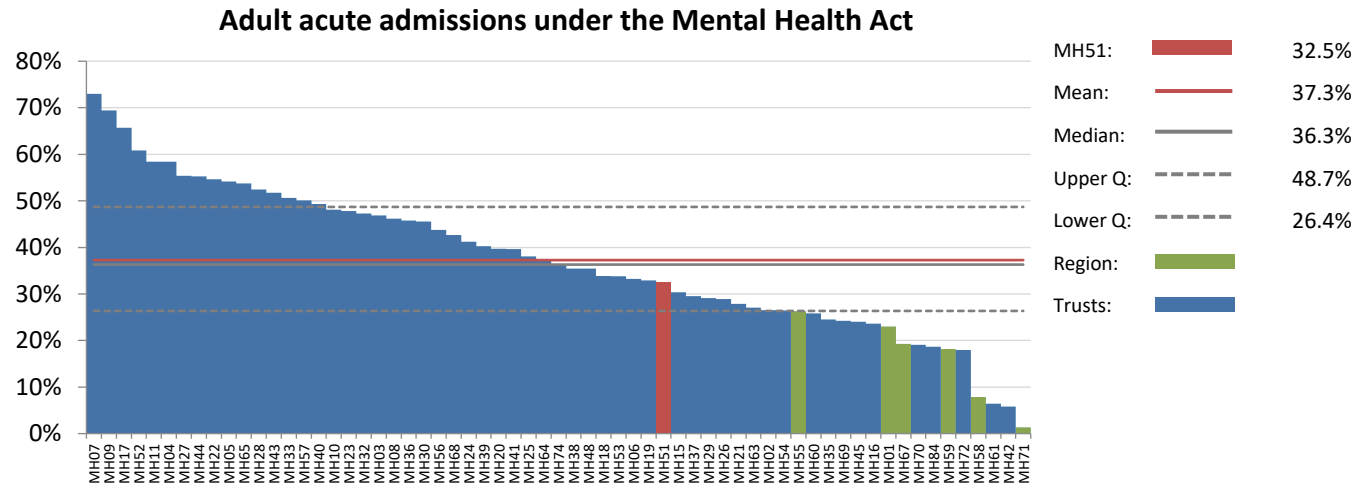


Figure 14

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	25%	29%	29%	33%	35%	36%	37%	

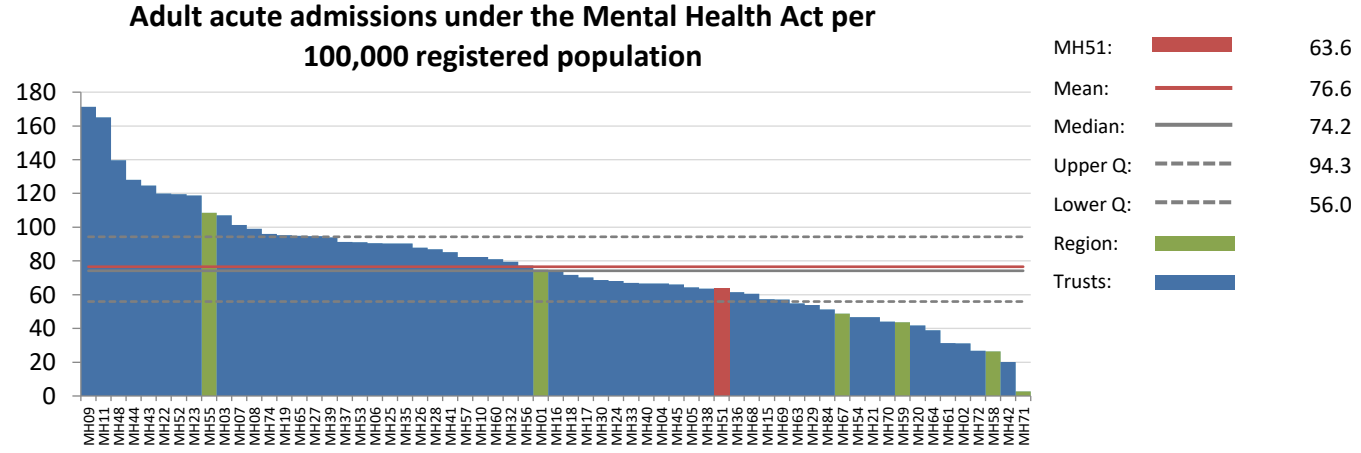
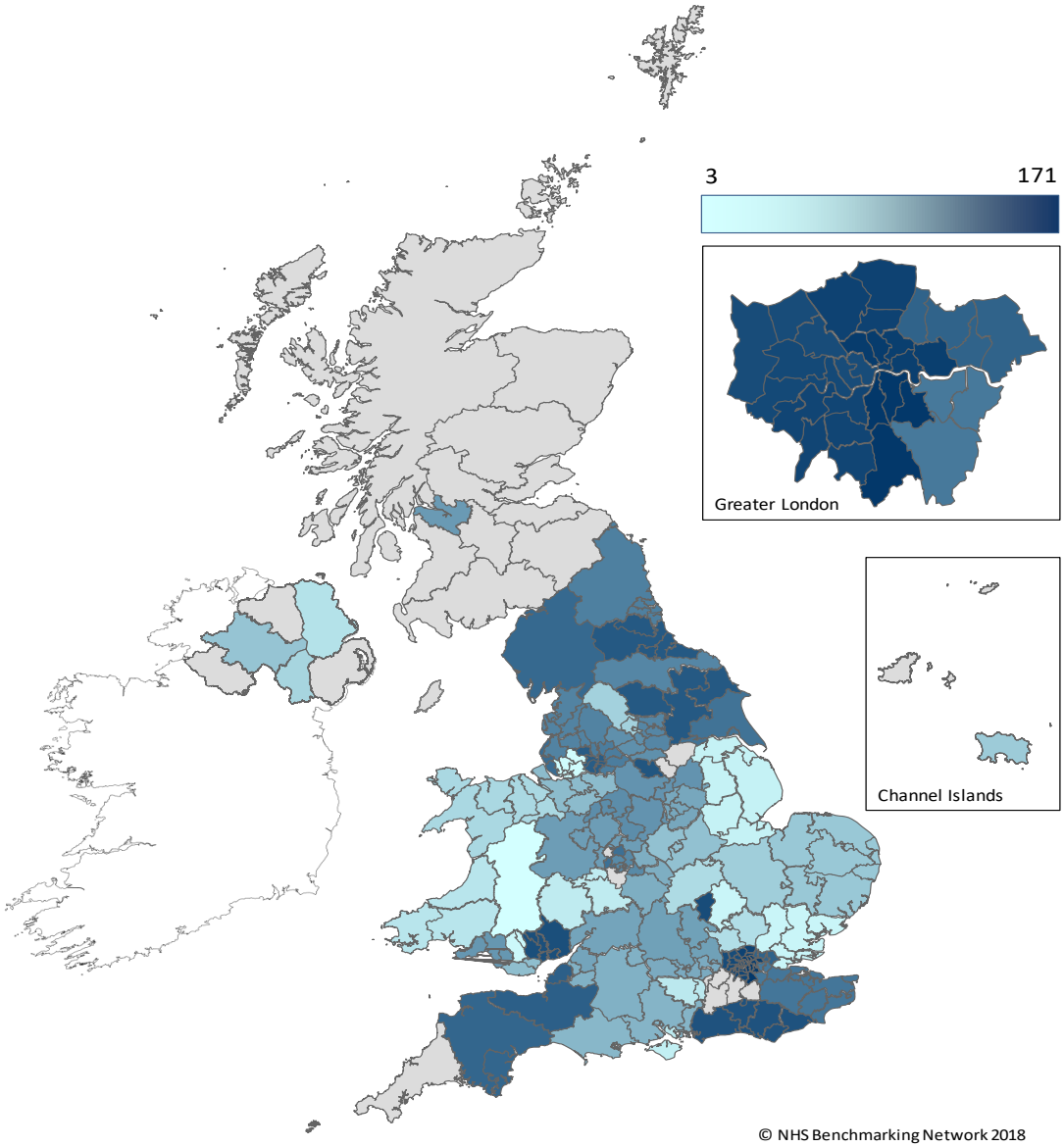


Figure 15

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	68	72	79	75	77	

Benchmarking Network

Adult acute admissions under the Mental Health Act per 100,000 population (age 16-64)



Benchmarking Network

Service users detained under the Mental Health Act at the point of admission generally stay longer than service users admitted to the same bed type on a voluntary basis.

This year's average of 40.6 days for involuntary patients compares to 31.3 days for patients admitted voluntarily.

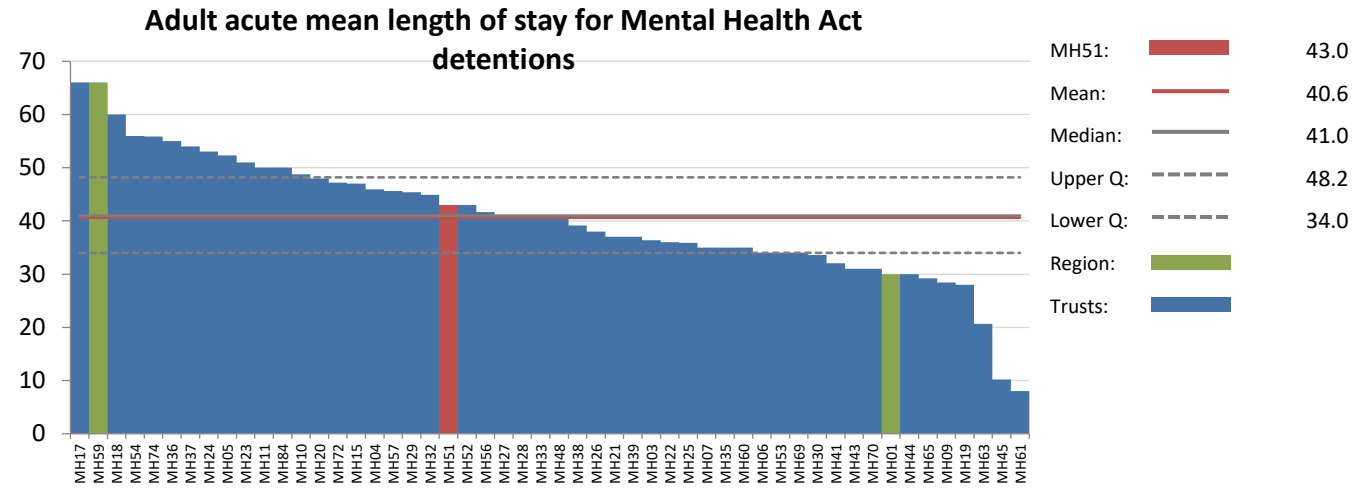


Figure 16

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	45	51	46	45	41	41	

Benchmarking Network

Adult Acute Delayed Transfers of Care

Delayed Transfers of Care (DTOC) occur once a patient is medically fit to be discharged or transferred, but experiences a delay at this point. This may be due to a package of care not yet having been arranged, or bed availability if they are transferring to a different specialty e.g. from adult acute to a rehab bed.

It is widely agreed that DTOC figures are under-reported, and that delays may start earlier than they are formally acknowledged in official reporting.

The chart below illustrates a median average position of 4.2% of bed days occupied by patients in delay. There is a notable range in the data which extends from below 1% in providers with the lowest rate, up to 13% for the provider with the highest DTOC rate.

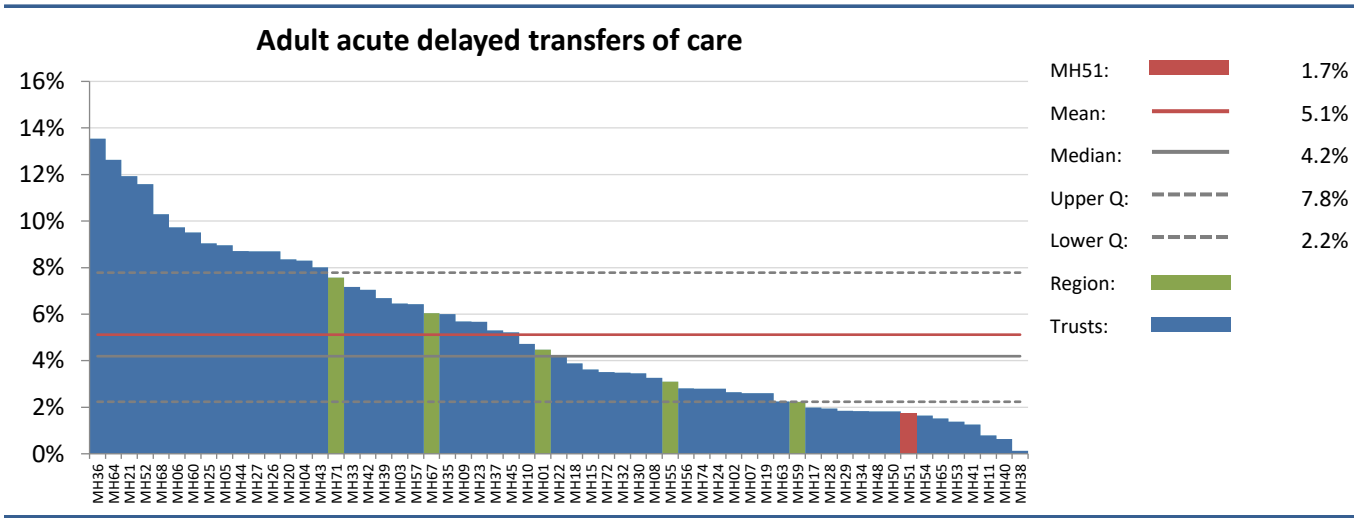


Figure 17

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	3.5%	3.8%	4.1%	4.4%	3.7%	5.6%	4.2%	

Adult Acute Emegency Readmissions

Emergency readmissions are defined as an unplanned or unexpected readmission to the same bed type within 28 days of discharge. Calculated as a percentage of overall admissions, the chart below shows 9.3% of admissions last year were emergency readmissions. This figure has been falling in recent years, from a position of 10% in 2011/12. This year's position of 9.3% marks a slight upward trend from the 2016/17 readmission rate of 8.8%.

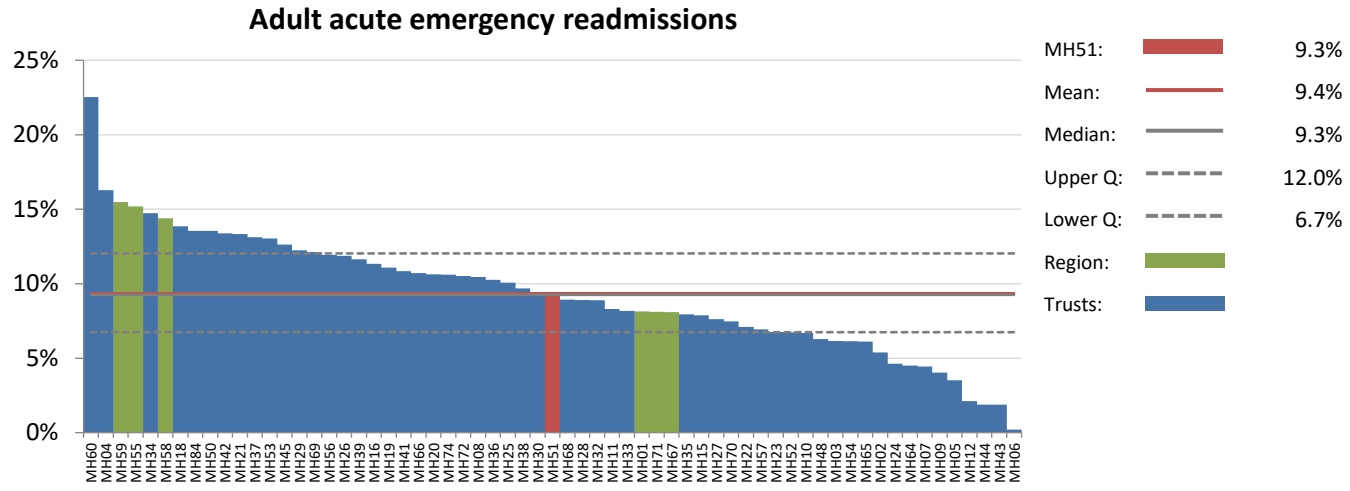


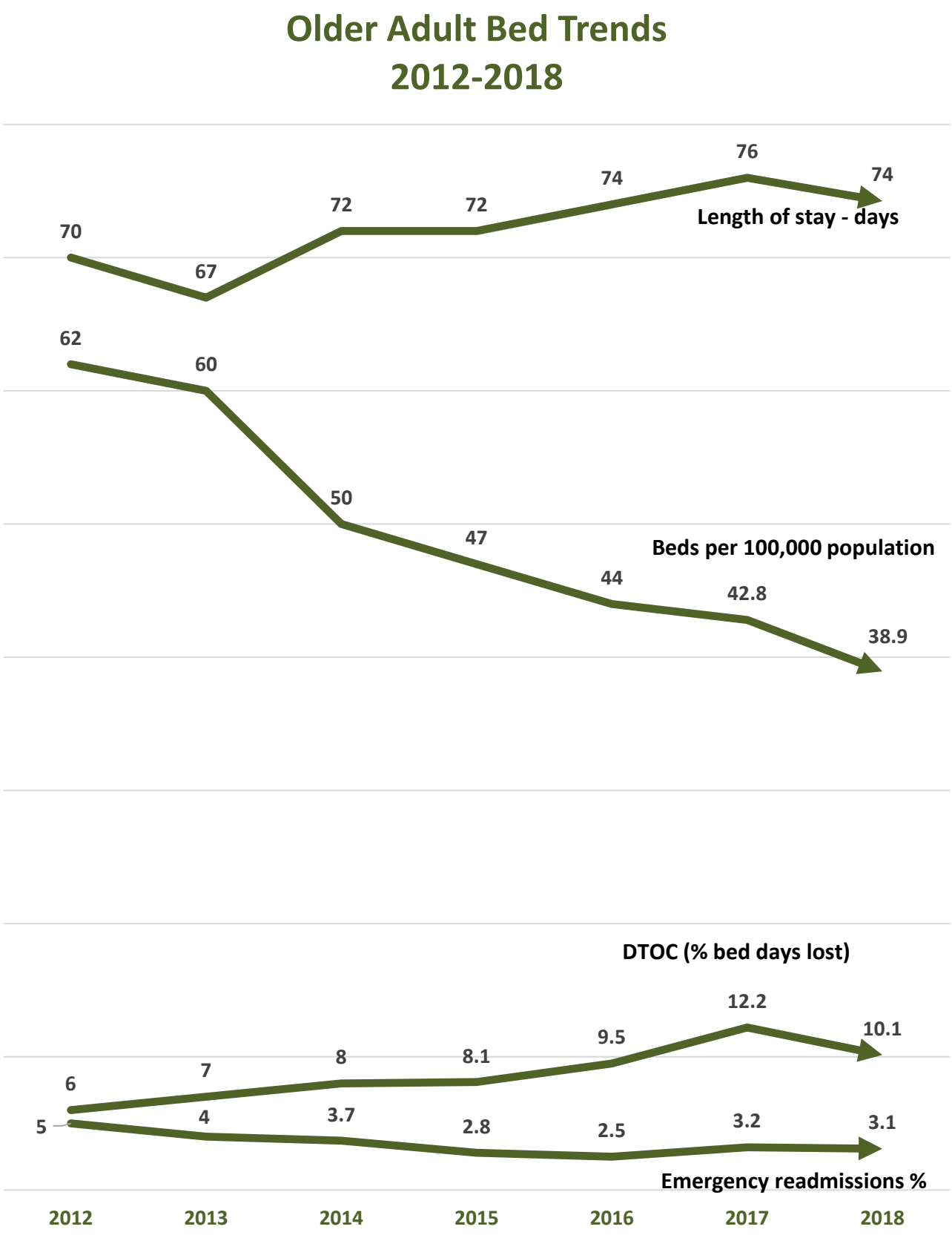
Figure 18

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	10.0%	9.0%	8.8%	9.2%	8.4%	8.8%	9.3%	

National position

Benchmarking Network

Older Adult Acute



Older Adult Beds

Older adult bed numbers per capita are higher than those for similar beds for working age adults. Adult acute beds this year averaged 19.2 per 100,000 population age 16-64, compared to 38.9 per 100,000 population age 65+.

However, the number of older adult beds has also been decreasing rapidly in recent years. The decrease has been more rapid than for other bed types, due to the large opening bed stock. This reduction has continued this year, with the lowest ever number of older adult acute beds reported. This should be viewed in the context of community provision for this cohort, and the provision of longer term beds for complex care and rehabilitation which have not seen such steep reductions in numbers. Old age bed numbers have reduced by 37% since 2011/12.

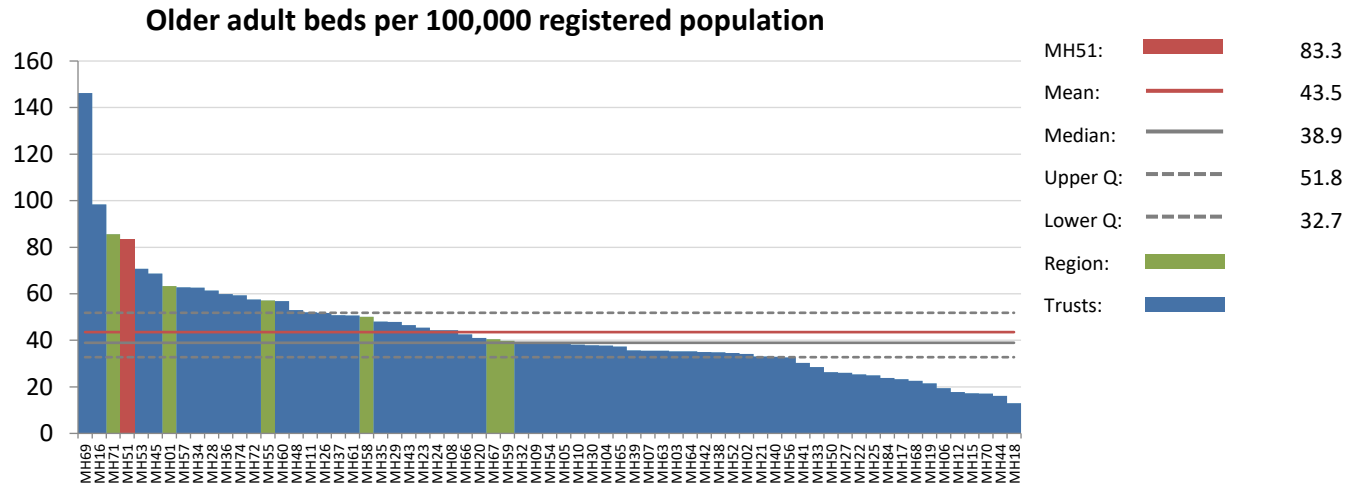


Figure 19

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	62.0	60.0	50.0	47.0	44.0	42.8	38.9	

Benchmarking Network

Older Adult Bed Occupancy

Bed occupancy for older adult beds has increased in recent years as the number of beds has reduced, however this bed type still reports lower bed occupancy. This year's position of 88.6% compares to 94.4% in adult acute beds.

The bed occupancy including leave figure, shown in the second chart, suggests bed occupancy in most providers rarely rises above 100% in this bed type, even when leave days are included, with bed occupancy settling around 90% most years.

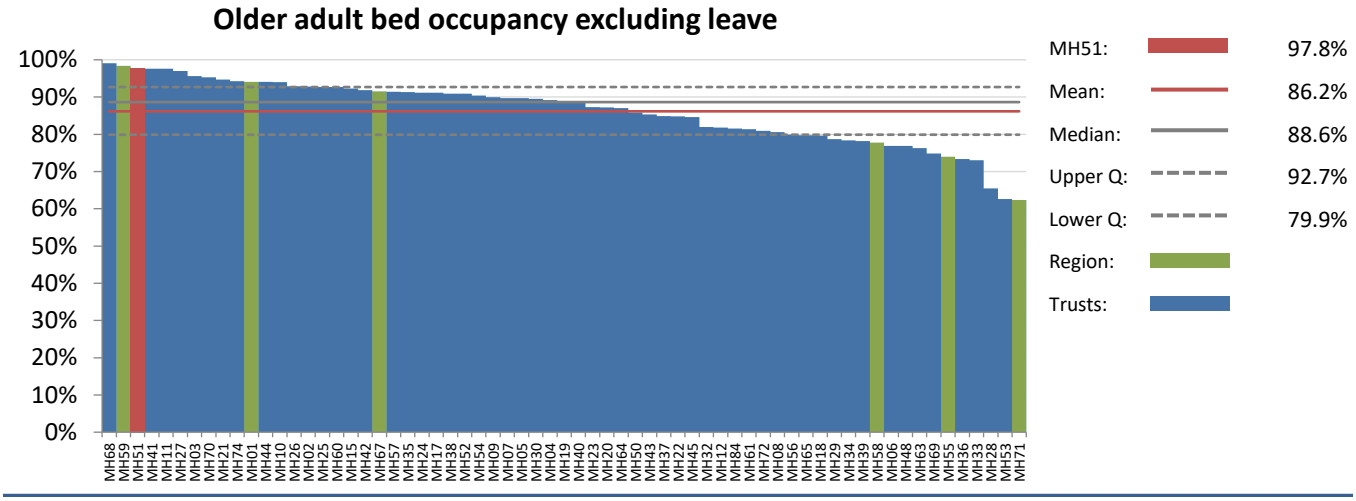


Figure 20

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	81%	82%	85%	85%	87%	89%	89%	

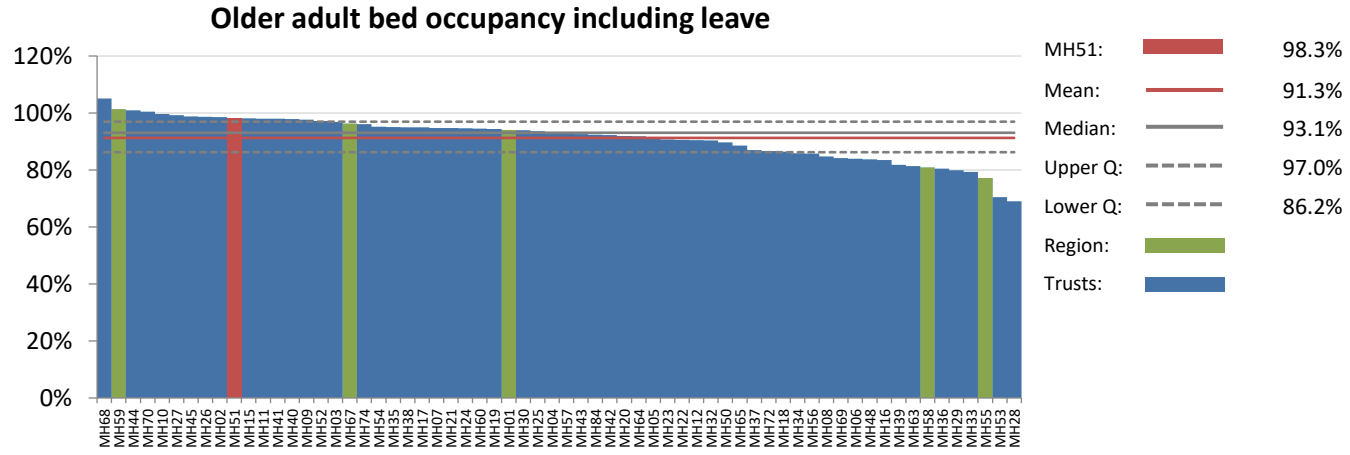


Figure 21

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	x	x	90%	91%	93%	93%	

Older Adult Admissions

Admissions to older adult beds have followed a similar trend to bed numbers, and reduced year on year. Participants reported around 40% fewer older adult beds in 2017/18 compared to 2011/12, though the rate of decrease appears to be slowing. There are opportunities for organisations to reduce bed numbers if there is investment in adequate community provision locally.

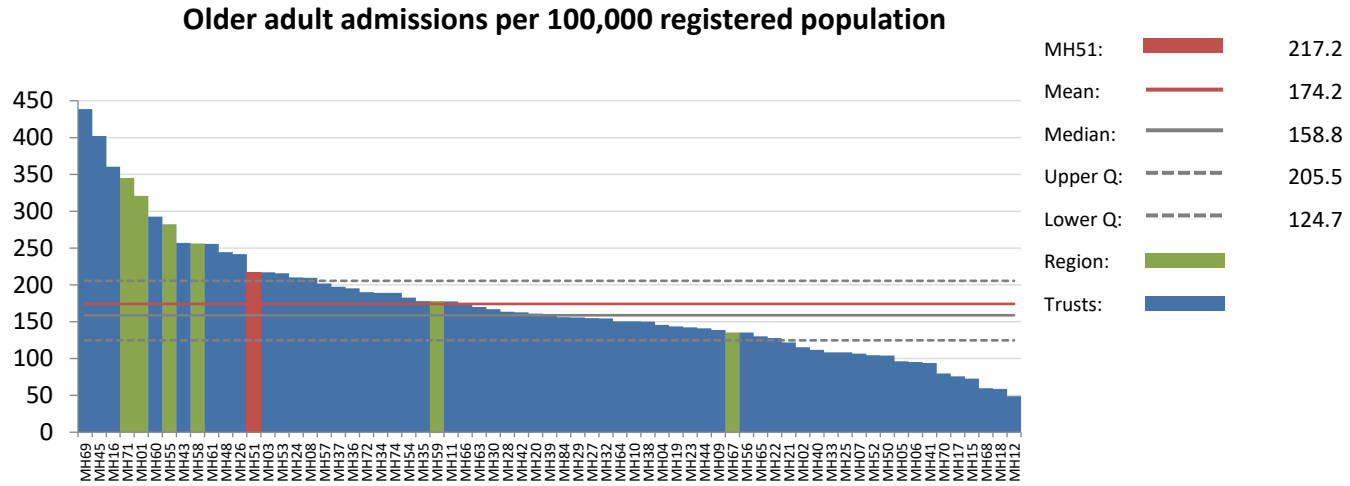


Figure 22

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	259	256	225	197	174	161	159	

Benchmarking Network

Older Adult Length of Stay

Length of stay for older adult beds is typically more than twice the figure seen for adult acute beds. This year, the average for older adults is 74.3 days compared to 31.3 days for working age adults. In the top quarter of participants, length of stay exceeds 87.0 days. When leave is included, the average position rises to 78.4 days.

Length of stay for older adults has increased in recent years. This may reflect the reduction in bed numbers and admission rates reported, resulting in increased admission thresholds and complexity of cases.

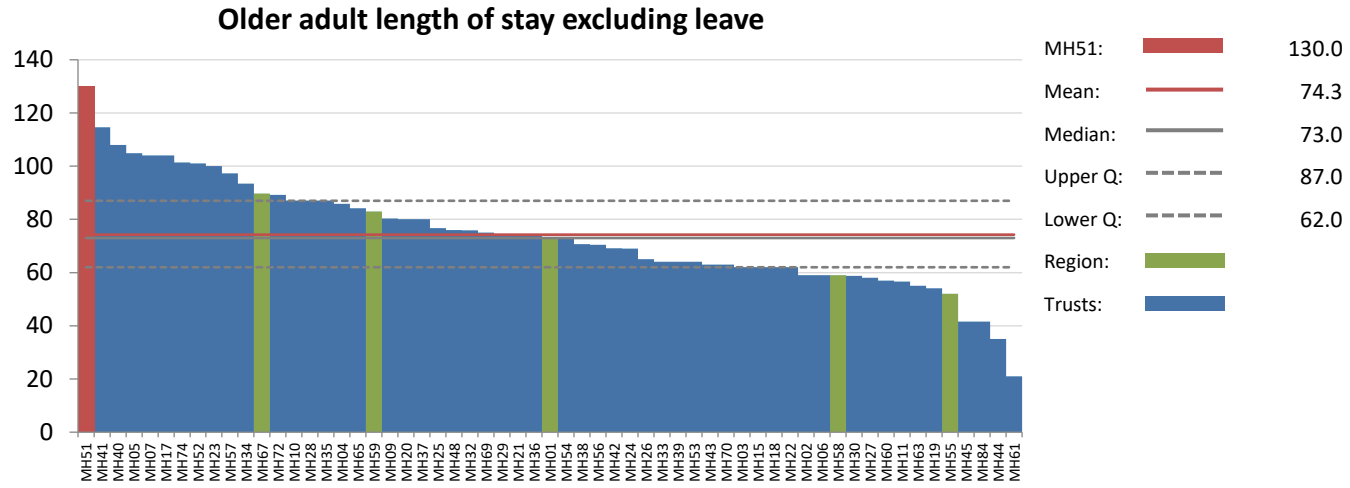


Figure 23

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	70.0	67.0	72.0	72.0	74.0	76.0	74.3	

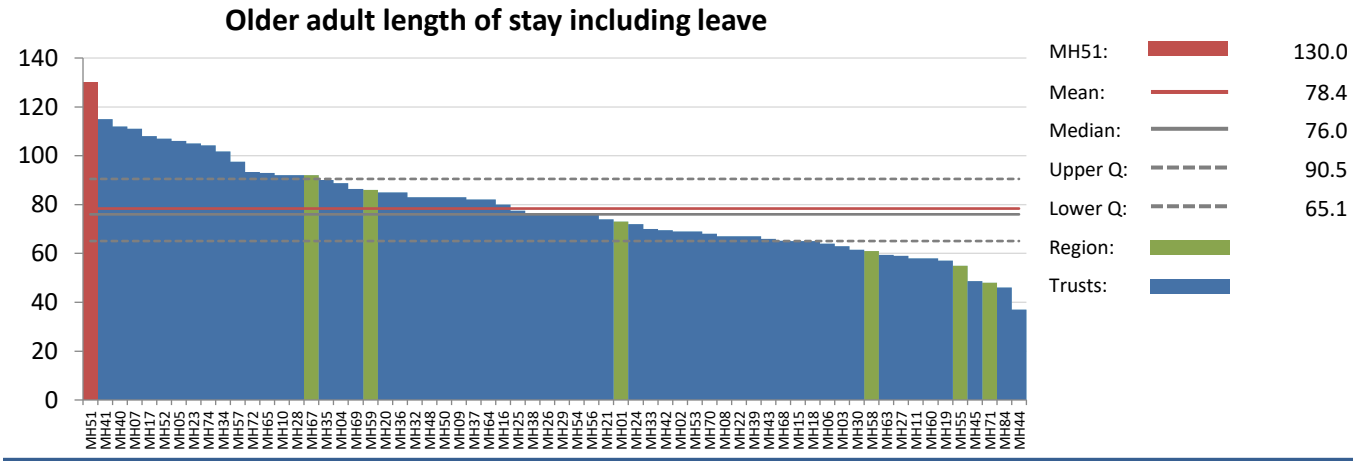


Figure 24

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	80.0	81.0	84.8	80.0	78.4	

Older Adult DTOC

Delayed transfers of care occur more frequently in older adult care, as more complex arrangements are often required prior to discharge. For this reason, the percentage of days lost to DTOC (10.1%) in older adult beds is greater than the equivalent proportion of days lost in adult acute beds (4.2%).

The DTOC figure for older adults has been rising in recent years. This may represent better reporting of this data, growing demand on the system for ongoing support post-discharge, and reductions in the level of social care support provided by Local Authorities.

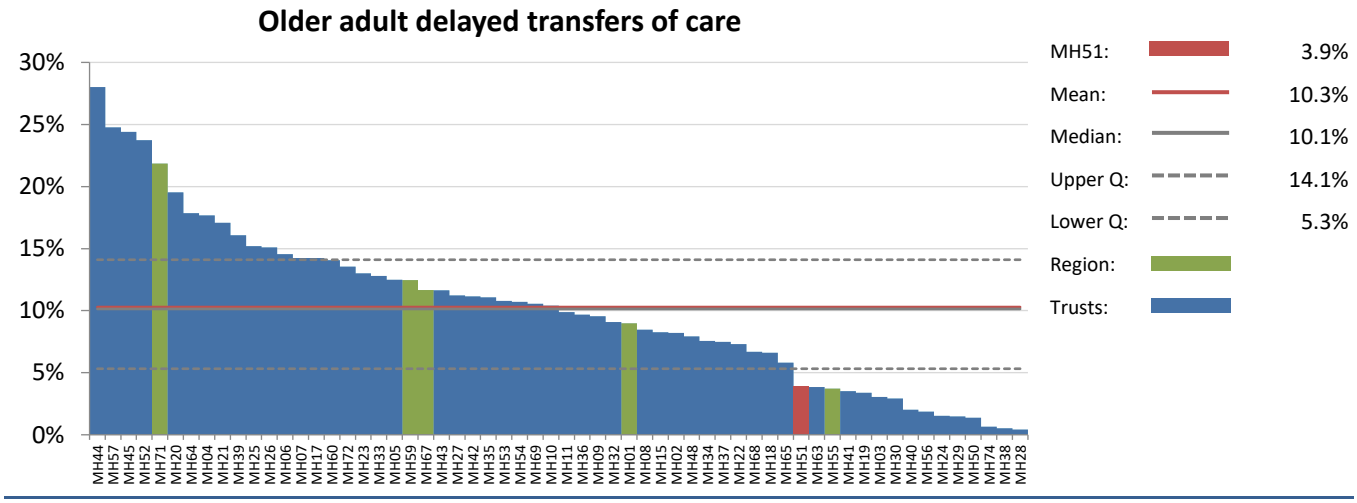


Figure 25

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	6.0%	7.0%	8.0%	8.1%	9.5%	12.2%	10.1%	

Benchmarking Network

Older Adult Readmissions

Emergency readmissions to older adult beds are not a frequent occurrence for most providers. This may be due to the higher level of support offered post-discharge to this cohort, through ongoing packages of care or residential placements.

The average position of 3.1% can be compared to 9.3% in adult acute beds, where emergency readmissions occur three times more frequently. The chart shows a notable range from less than 1% to 9%, suggesting good practice in some health systems and systemic problems in others.

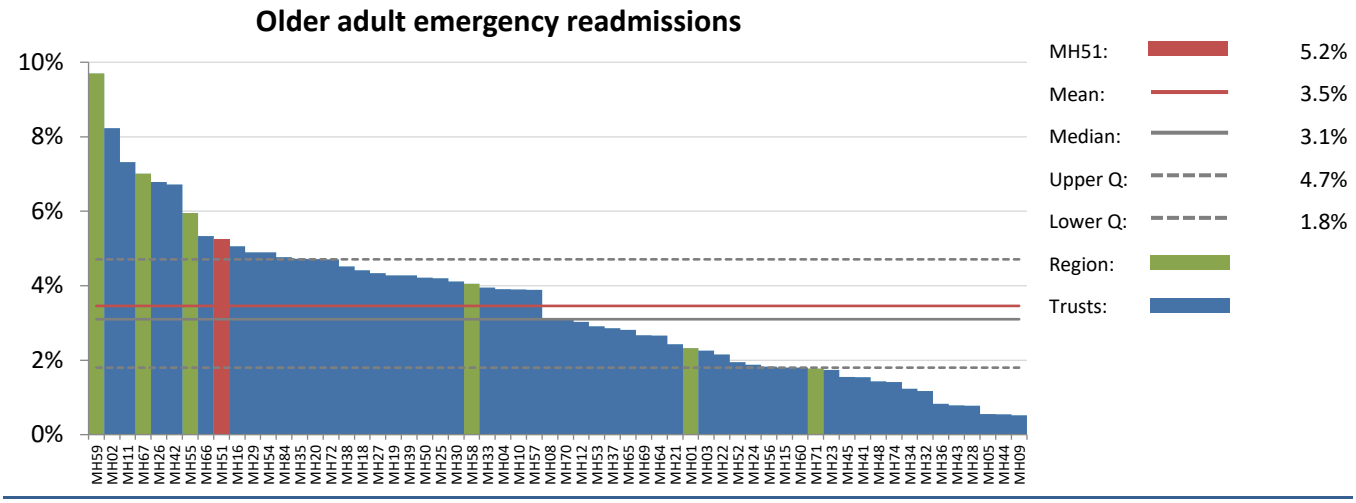


Figure 26

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	5.0%	4.0%	3.7%	2.8%	2.5%	3.2%	3.1%	

Specialist Beds

PICU

Psychiatric Intensive Care Units provide targeted care during the periods where service users are most unwell. National averages for length of stay in PICU have remained around the 50 day mark for the last 6 years, however notable variation between participants is reported with a small cohort reporting lengths of stay of around 25 days or less and a small group of providers reporting ALOS of over 100 days. This may reflect local care models or bottlenecks in the system limiting the speed with which service users can step down to an acute or rehabilitation bed following their time in PICU.

PICU bed occupancy has increased in recent years. The average position now is 86%.

Figure 27

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	49.0	43.0	45.0	50.0	46.0	46.4	

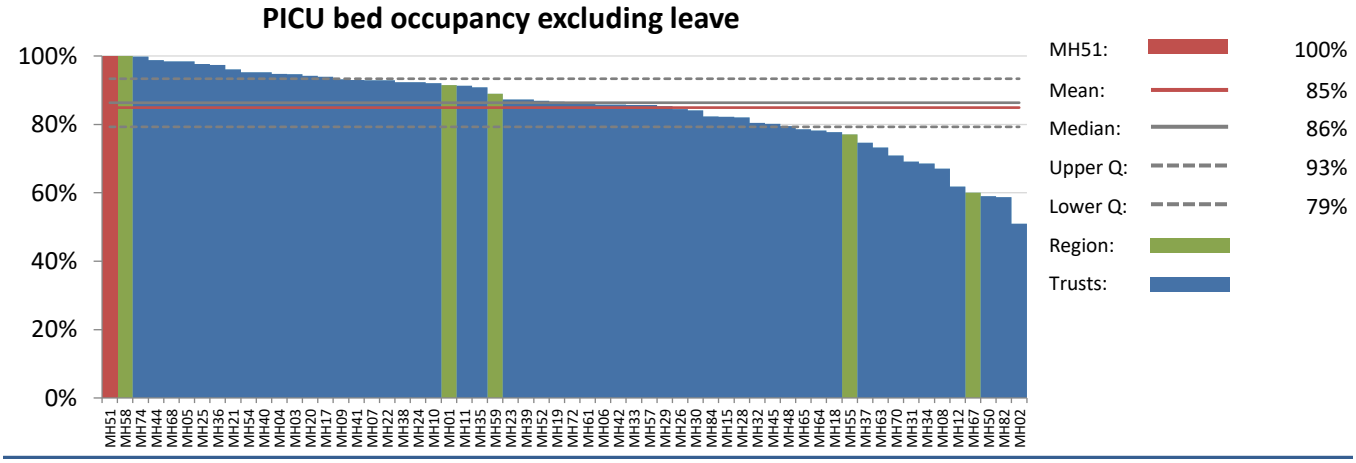


Figure 28

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	82%	85%	86%	86%	88%	86%	

Eating Disorders

Eating disorder services shown here are specifically targeted towards adults. Information on services for adolescents is available in the NHS Benchmarking CAMHS report. Adult eating disorder services have shown increases in length of stay over recent years, with the average position now 106 days.

Bed occupancy for eating disorder services remains one of the lowest of all bed specialties, allowing services the freedom to use authorised periods of leave as part of a recovery pathway without fearing a bed will be unavailable if needed at short notice.

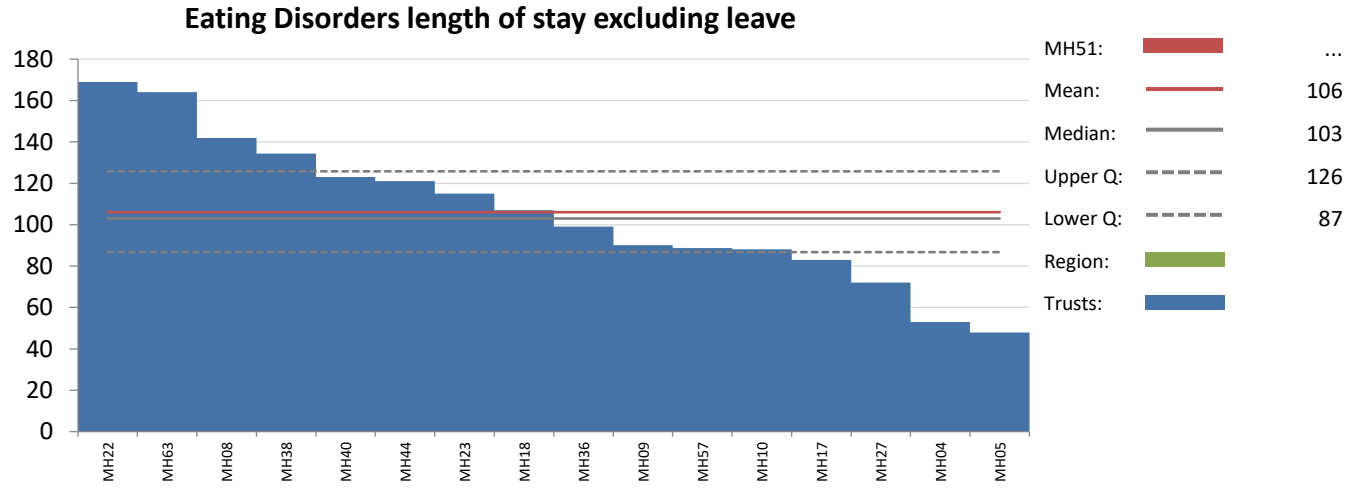


Figure 29

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	79	88	100	108	104	106	

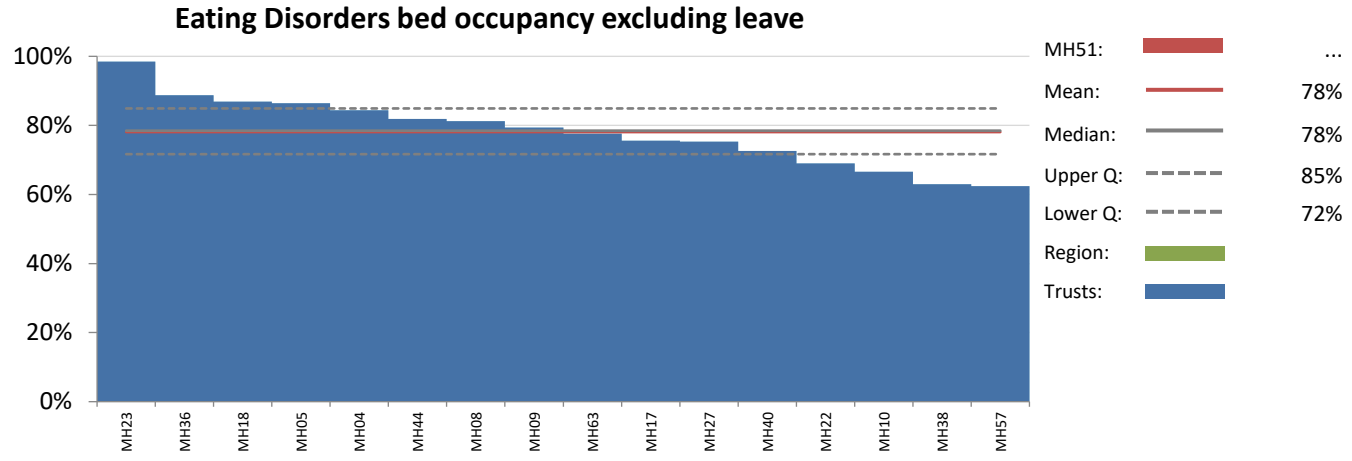


Figure 30

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	77%	80%	82%	81%	78%	78%	

Low Secure

Length of stay in low secure services is calculated from patients discharged or transferred within year, which is often a relatively small cohort. For this reason, one or two long stay patients whose episode has now ended may impact on averages for participants.

Average length of stay in 2017/18 has increased to 710 days.

Bed occupancy within low secure services stabilised at 91% in 2017/18. This is consistent with the bed occupancy target in national NHS England contracts.

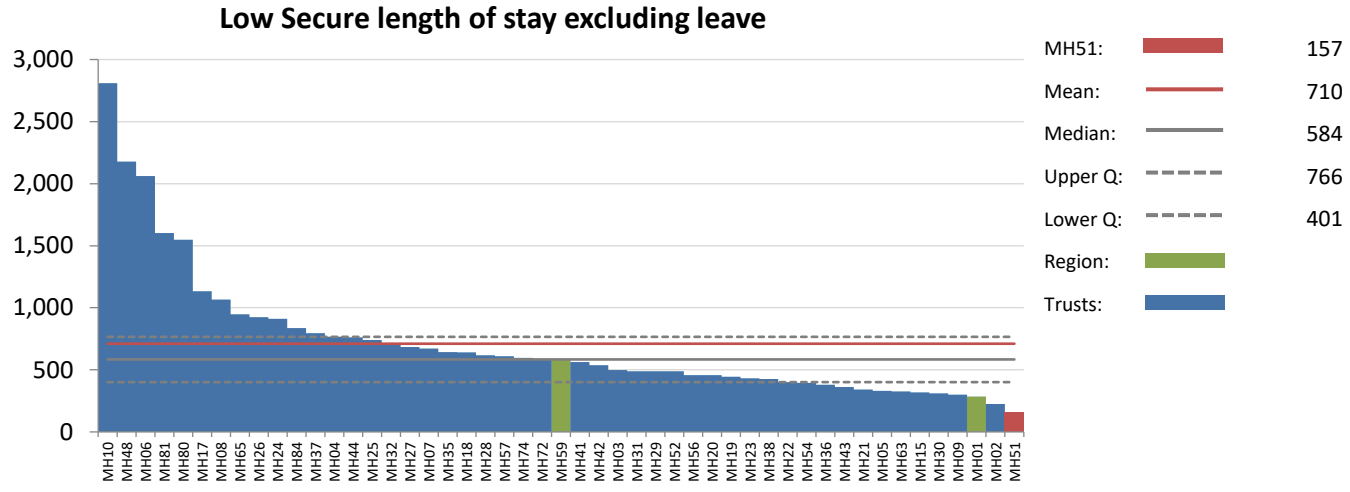


Figure 31

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	471	472	594	584	617	710	

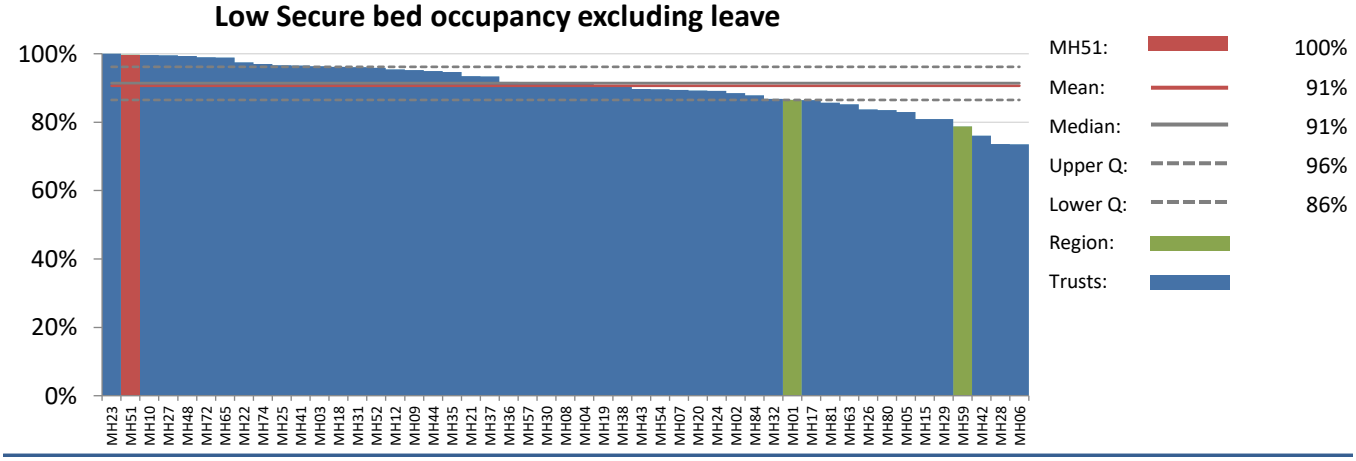


Figure 32

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	89%	90%	91%	91%	91%	91%	

Medium Secure

Medium secure length of stay is subject to the same influences as low secure services, discussed on the previous page. Average length of stay at 648 days for 2017/18 has been increasing and reflects the growing demand for medium secure care.

While length of stay in medium secure services has been increasing in recent years, bed occupancy rates have remained consistent at 93% to 95%.

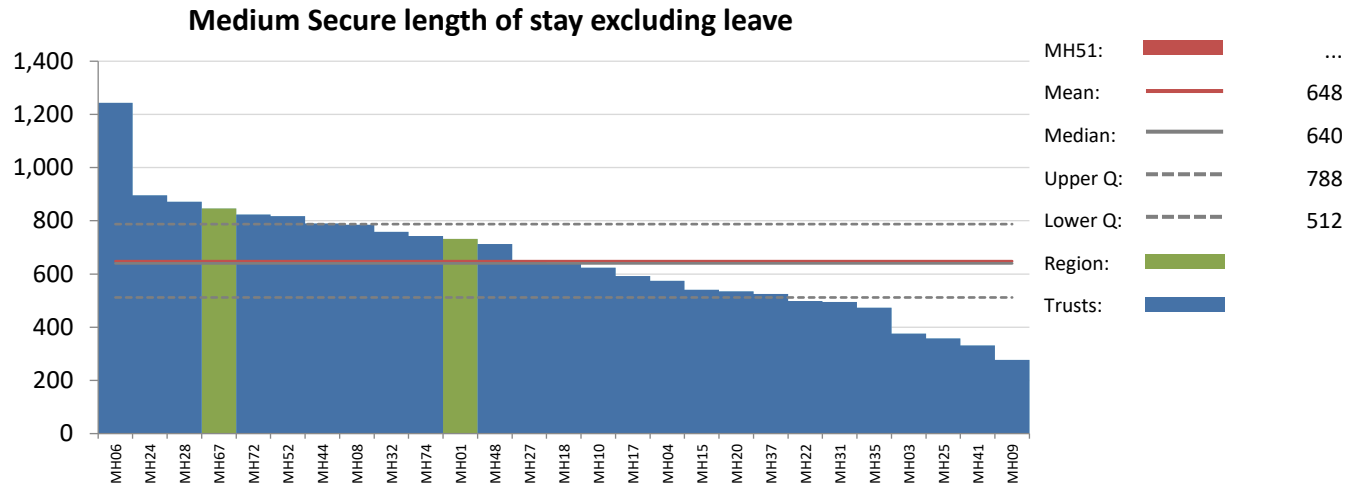


Figure 33

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	574	521	548	620	657	648	

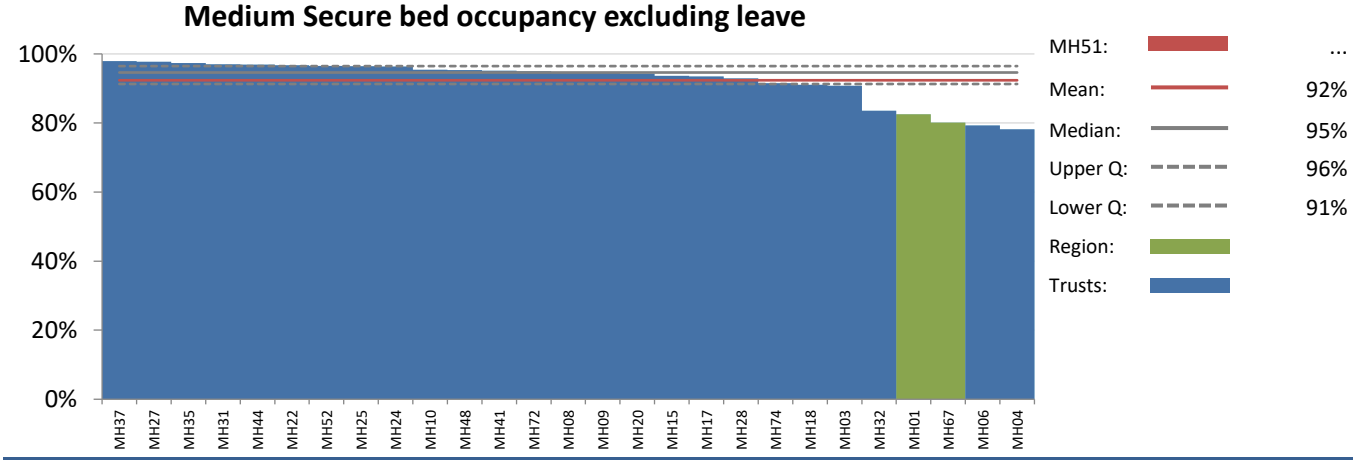


Figure 34

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	90%	91%	93%	94%	94%	95%	

High Dependency Rehabilitation

High dependency rehabilitation services report different service models, which is reflected in the length of stay chart below. There is around 10 months difference in the length of stay for the lowest and highest quartiles. Average length of stay has fallen to around 1 year with greater throughput of patients evident.

Bed occupancy across this bed type has remained reasonably static in recent years, never rising above 88%. This year's position is 87%.

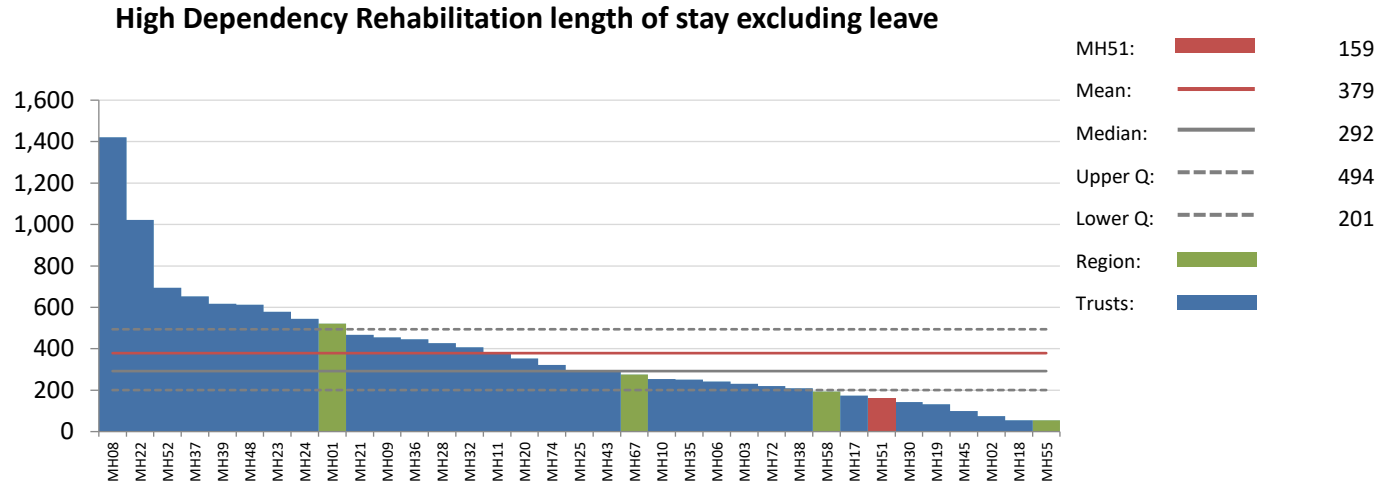


Figure 35

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	362	466	409	499	372	379	

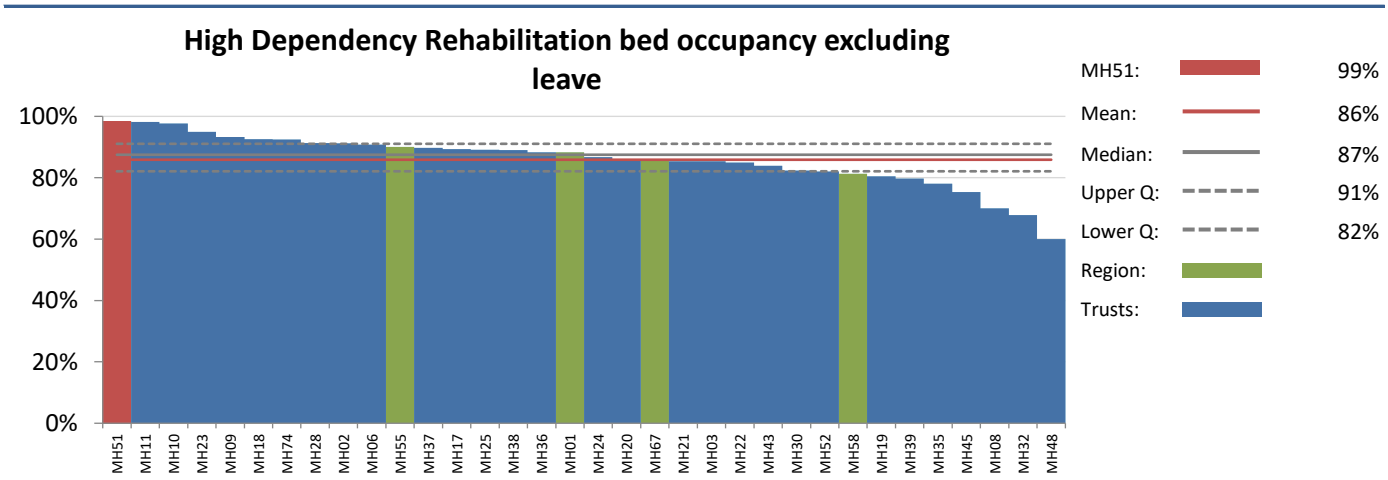


Figure 36

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	84%	87%	86%	88%	88%	87%	

Longer Term Complex / Continuing Care

There is notable variation in length of stay between providers of longer term complex and continuing care beds, with almost 18 months difference between the upper and lower quartiles.

Bed occupancy in this area has remained stable in recent years, and longer term complex and continuing care is one of only a few services who operate around the 85% level recommended by RCPsych and NHS Improvement.

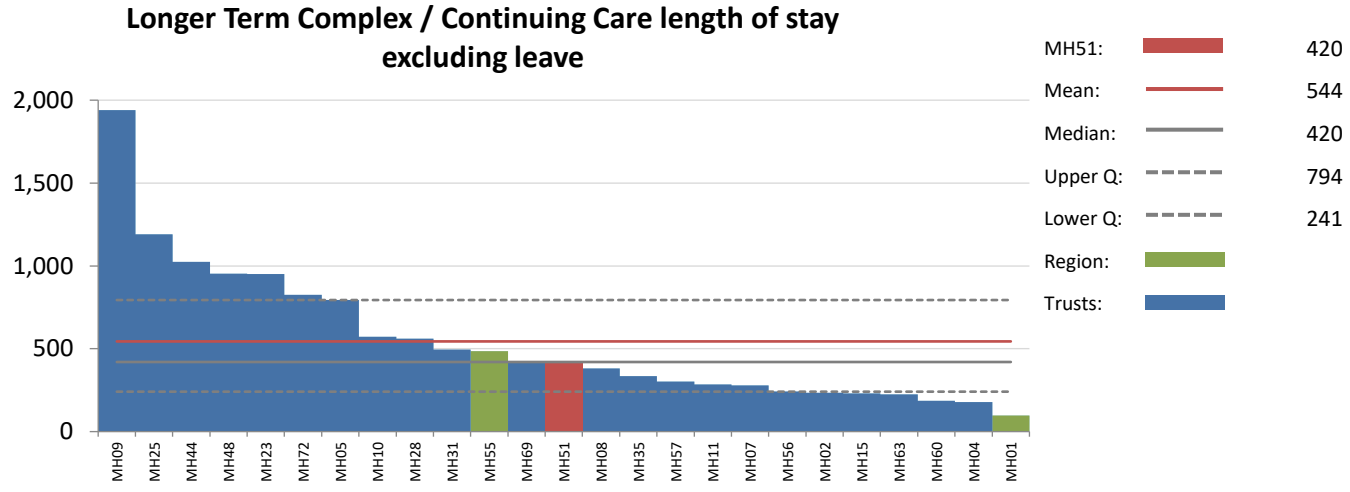


Figure 37

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	475	582	409	546	653	544	

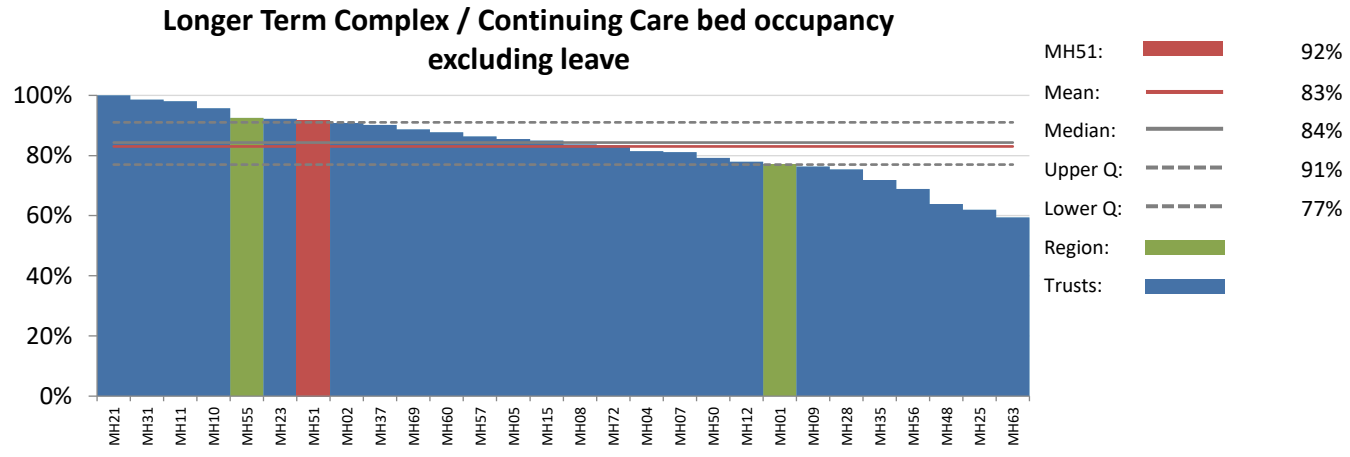


Figure 38

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	82%	88%	86%	84%	85%	84%	

Clustering

Care clusters are used in the NHS in England to capture the needs of people who use specialist mental health services. These clusters can be grouped into 3 main categories:

Non-Psychosis
1 Common mental health problems (low severity)
2 Common mental health problems
3 Non-psychotic (moderate severity)
4 Non-psychotic (severe)
5 Non-psychotic (very severe)
6 Non-psychotic disorders of overvalued ideas
7 Enduring non-psychotic disorders (high disability)
8 Non-psychotic chaotic and challenging disorders

Psychosis
10 First episode in psychosis
11 Ongoing or recurrent psychosis (low symptoms)
12 Ongoing or recurrent psychosis (high disability)
13 Ongoing or recurrent psychosis (high symptom and disability)
14 Psychotic crisis
15 Severe psychotic depression
16 Dual diagnosis (substance abuse and mental illness)
17 Psychosis and affective disorder difficult to engage

Organic
18 Cognitive impairment (low need)
19 Cognitive impairment or dementia (moderate need)
20 Cognitive impairment or dementia (high need)
21 Cognitive impairment or dementia (high physical or engagement)

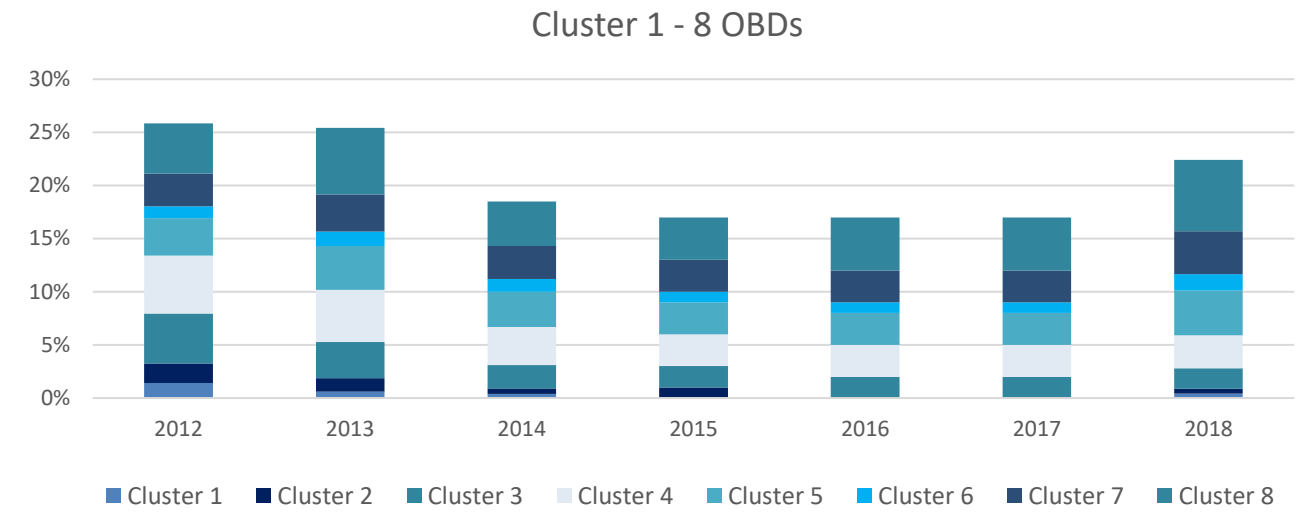
The charts on the following pages show how beds were occupied by patients in each cluster group. Calculated on a daily basis, this shows the cluster each patient was in for each bed day during their stay. All bed types are included in this analysis, and participants may find their individual bed complement influences their position on these charts.

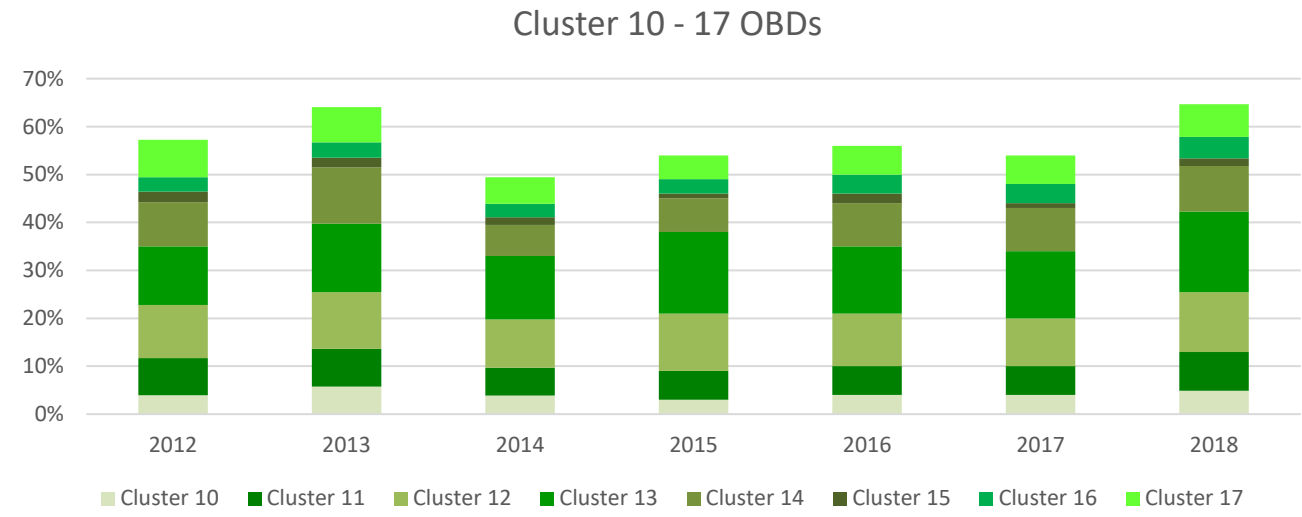
The sustained reduction in OBDs for clusters 18 to 21 mirrors the reduction in older adult specific beds over this period. For adult services, there is a reduction in the use of beds for non-psychosis patients and an increased utilisation for patients with a diagnosis of psychosis.

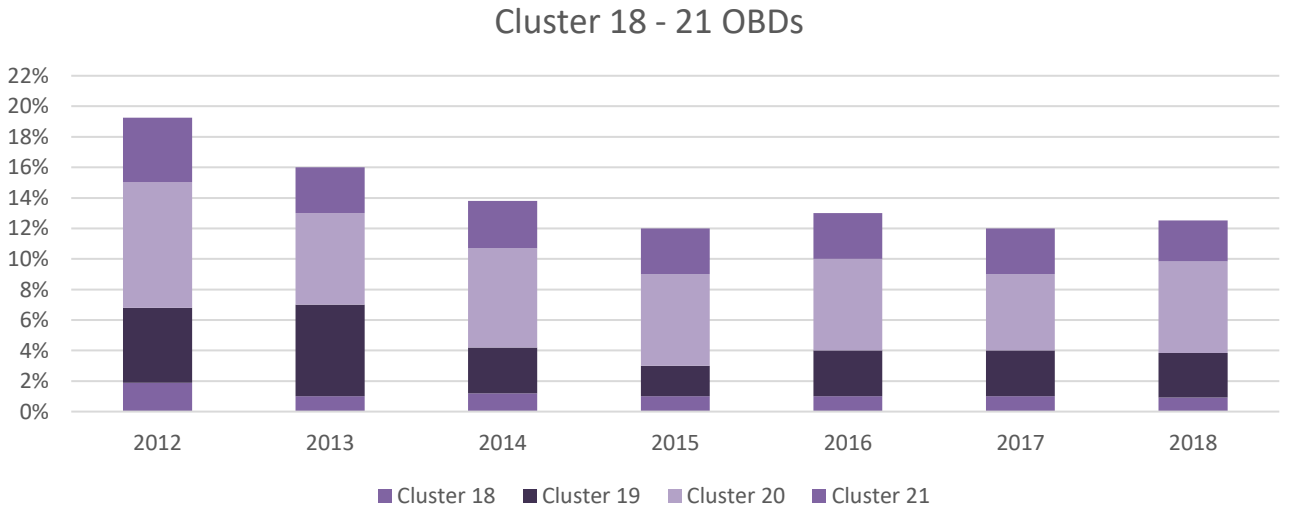
Participants from outside England can find detailed analysis by condition using ICD 10 codes in the Mental Health Benchmarking Toolkit.

National position

Benchmarking Network







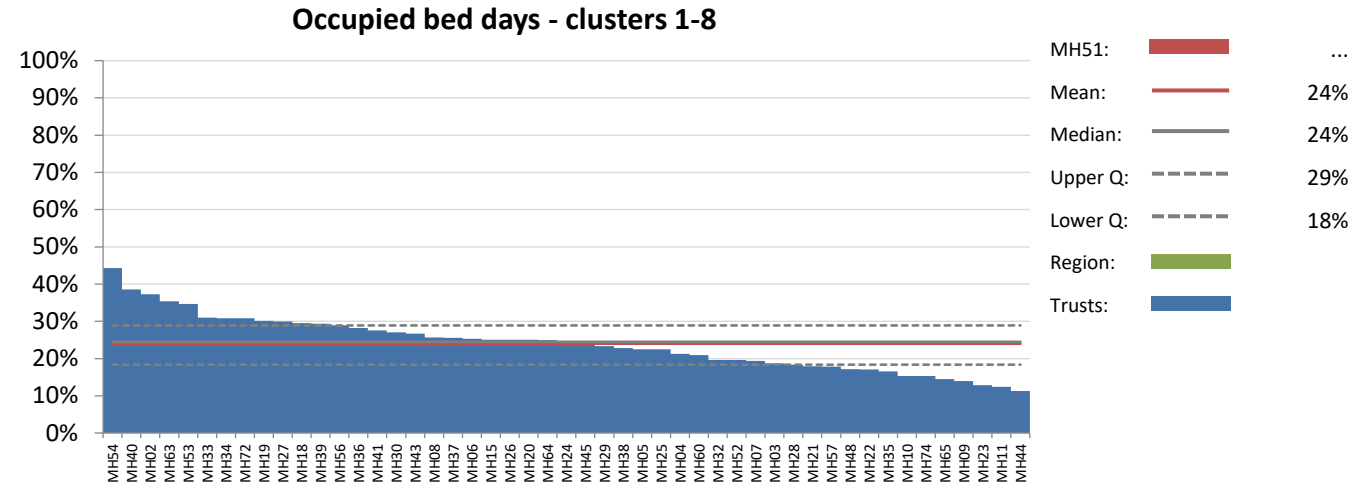


Figure 39

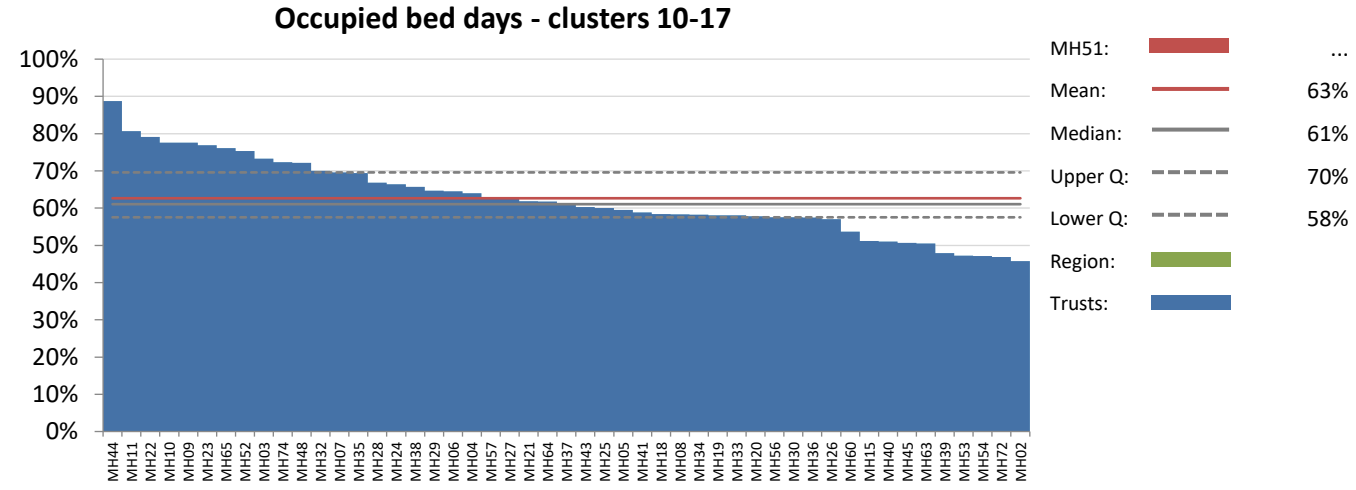


Figure 40

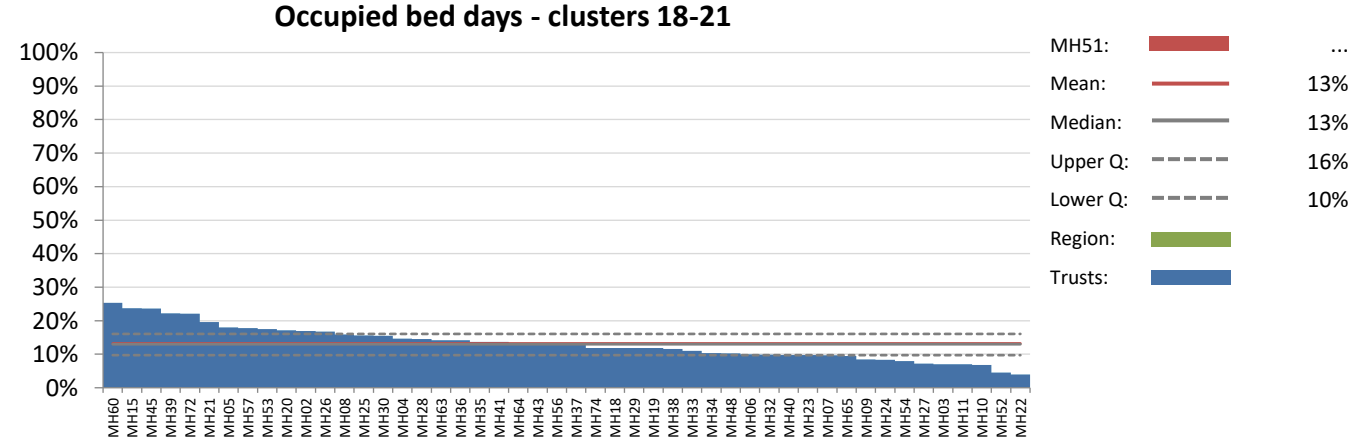


Figure 41

Community Caseloads

Over recent years, participants have reported a downward trend in caseload size. This year, on average 1,598 people per 100,000 registered population were on community caseloads at year end.
Community caseloads have seen a reduction in patients on clusters 1 to 4 in recent years. This cohort, reporting mild to moderate, non-psychotic mental health issues, may now be supported in services such as IAPT. There has been a sustained growth in the number of people accessing IAPT in England over the last 4 years, and in 2017/18 over 1 million people received support from these services. Some of these people may previously have received support from a secondary care specialist community mental health team.

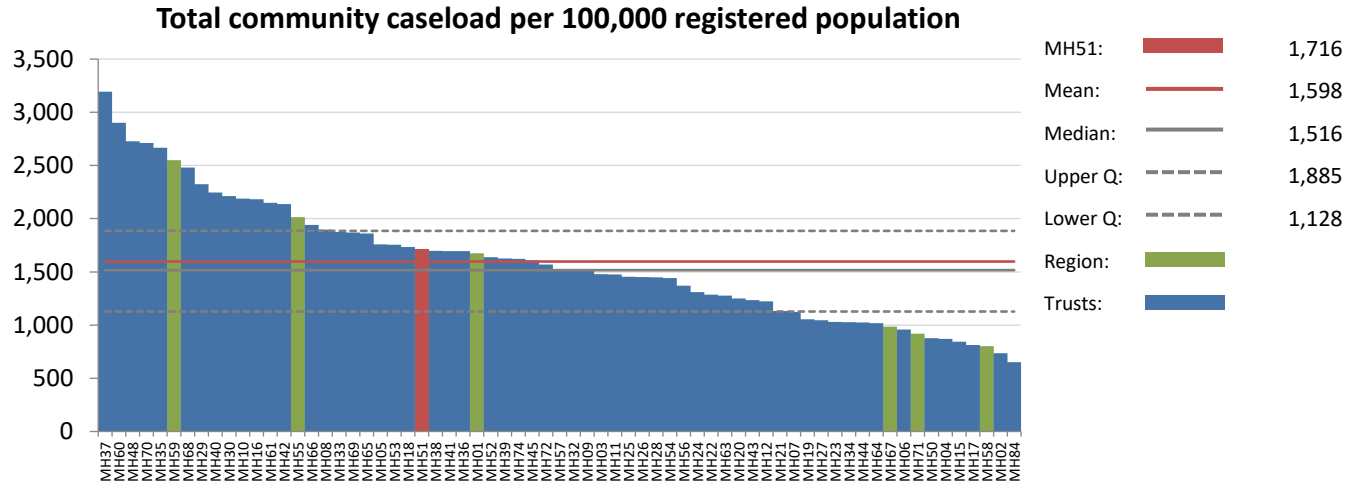
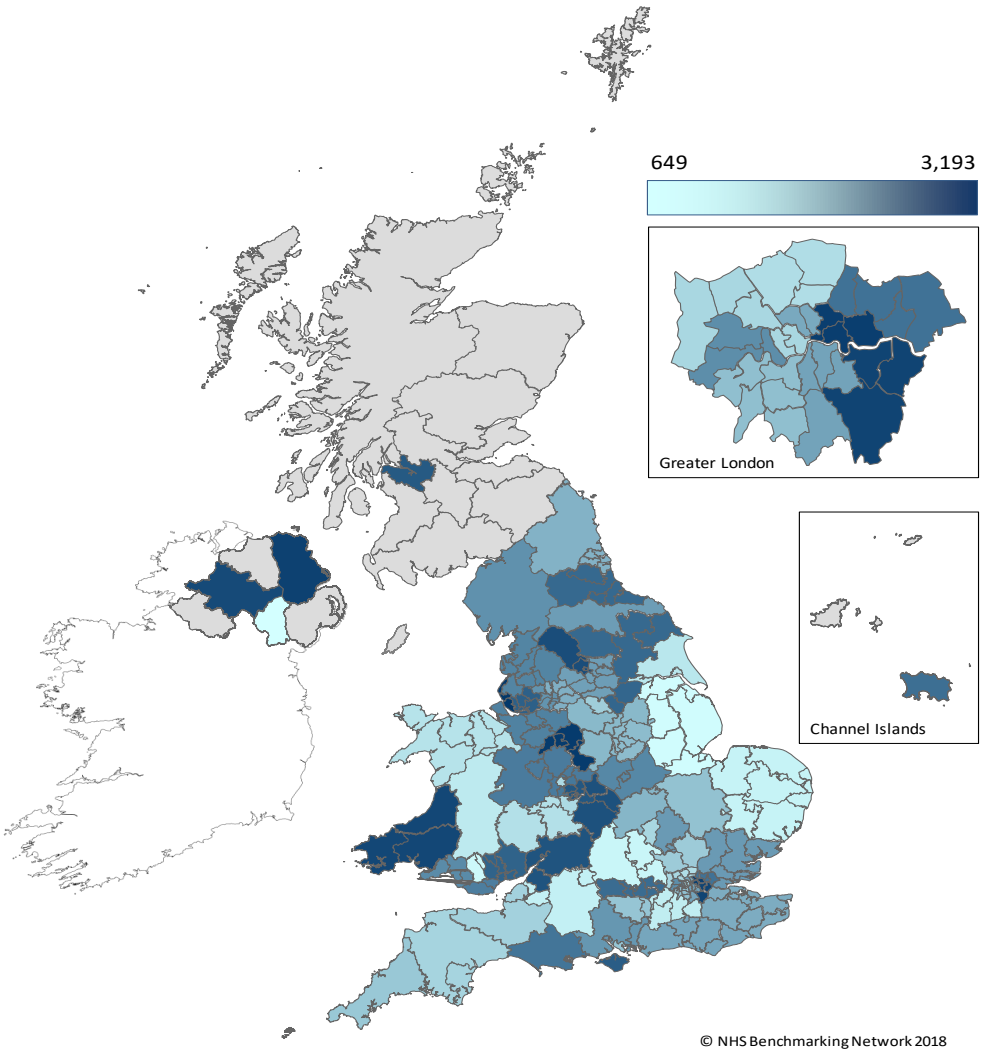


Figure 42

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	1781	2163	1709	1803	1614	1598	

Benchmarking Network

Community caseload on 31st March 2018 per 100,000 population (age 16+)



In 2014/15, our reporting started to split working age adult community teams from those serving older adults, to identify any particular trends. Caseloads for working age adults in 2017/18 are at levels marginally below that reported in 2014/15 while there has been a notable reduction for older adult services. The reduction in capacity for older adults is therefore evident in both inpatient and community services. This data suggests that there has not been a substitution from beds to community services in a manner that would guarantee parity of access to services for older people.

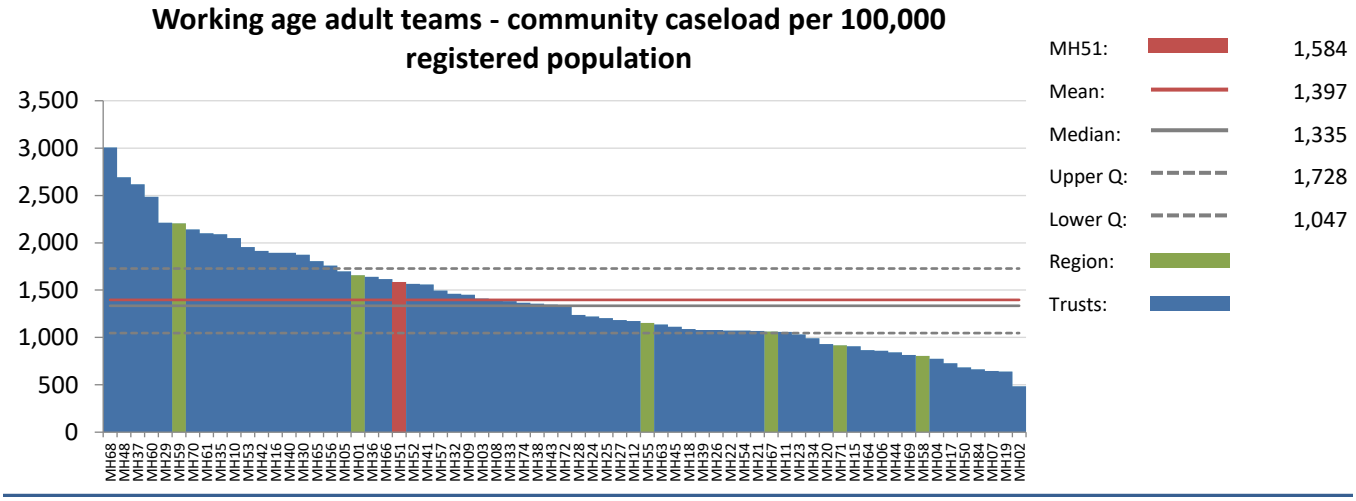


Figure 43

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	1435	1473	1400	1397	

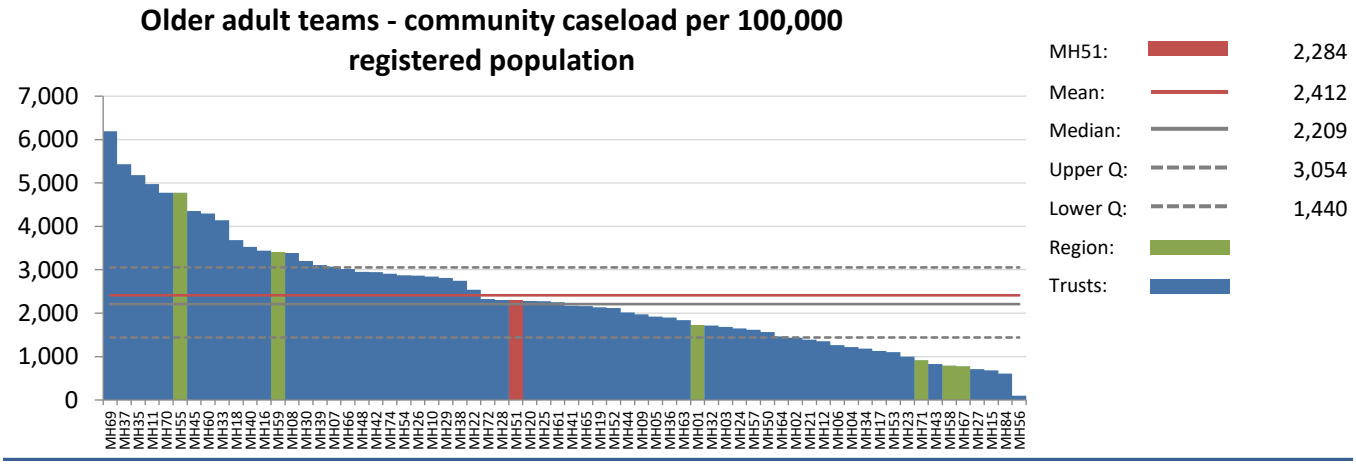


Figure 44

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	2800	2838	2544	2412	

Benchmarking Network

Community Contacts

Community contacts are shown below per 100,000 population. This includes both face to face and non face to face contacts, from all professionals.

In addition to a reduction of people on community caseloads, participants have reported fewer community contacts being provided in recent years. Compared to 3 years ago, participants reported the following reductions:

National position

Reduction 2014/15 - 2017/18

	Total	Working age	Older adult
Caseloads	**-7%**	**-3%**	**-14%**
Contacts	**-5%**	**-3%**	**-16%**

Reductions in both caseloads and contacts are most evident for older people, suggesting that issues around equity of access may be starting to appear between working age adults and older people.

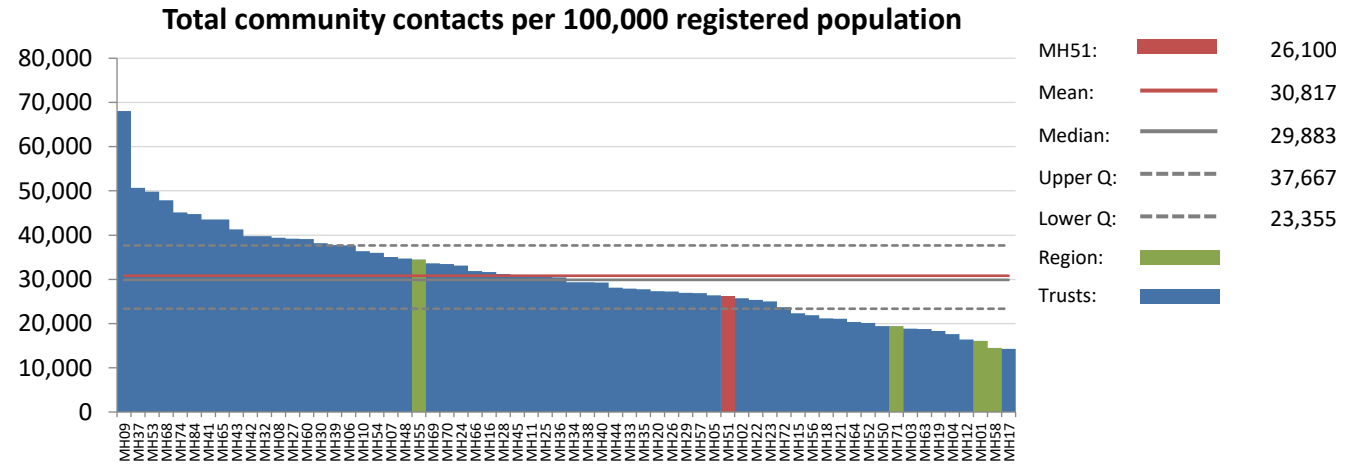
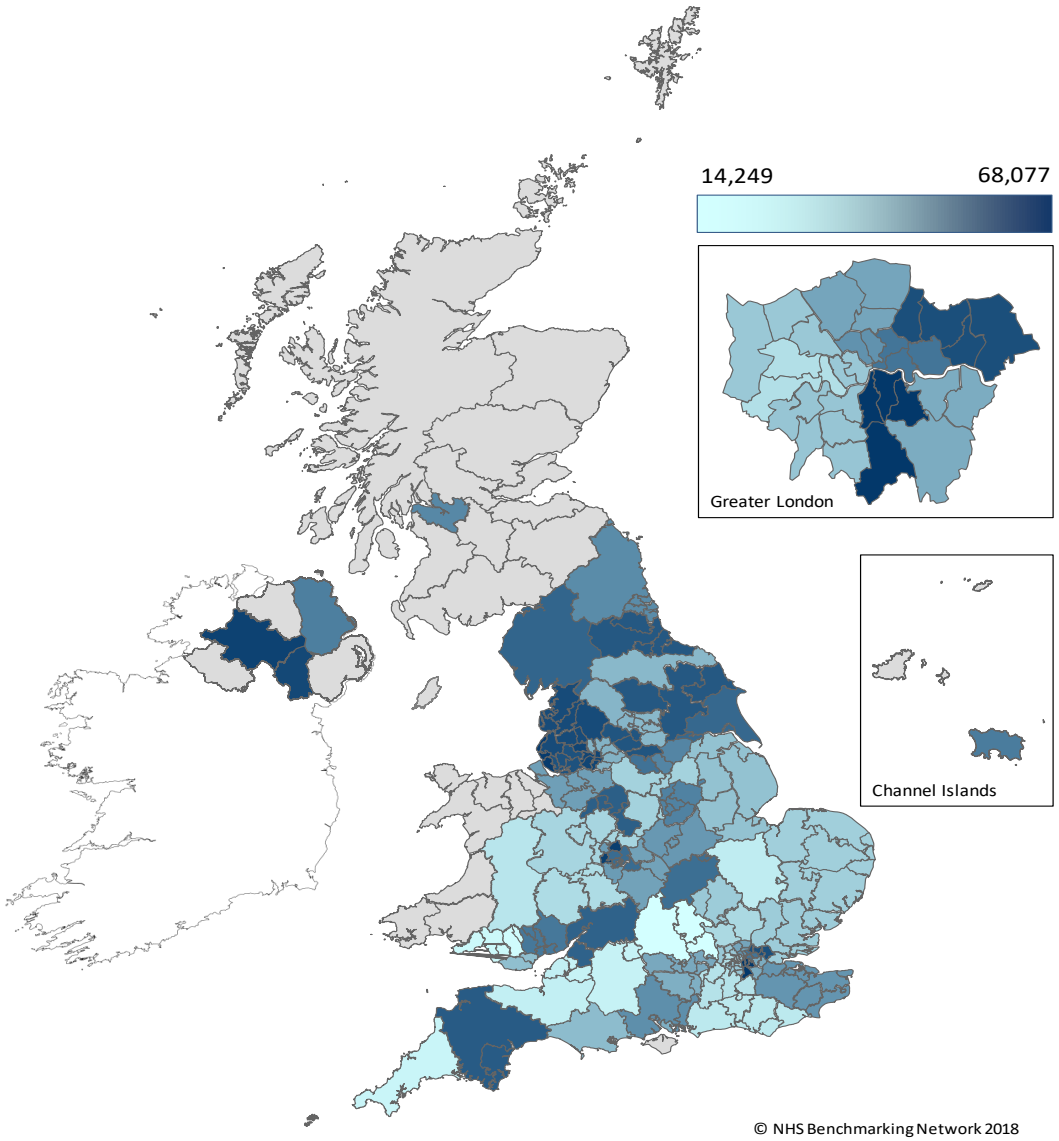


Figure 45

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	**x**	**36,329**	**35650**	**32,497**	**35,203**	**31,965**	**30,817**	

Benchmarking Network

Community contacts per 100,000 population (age 16+)



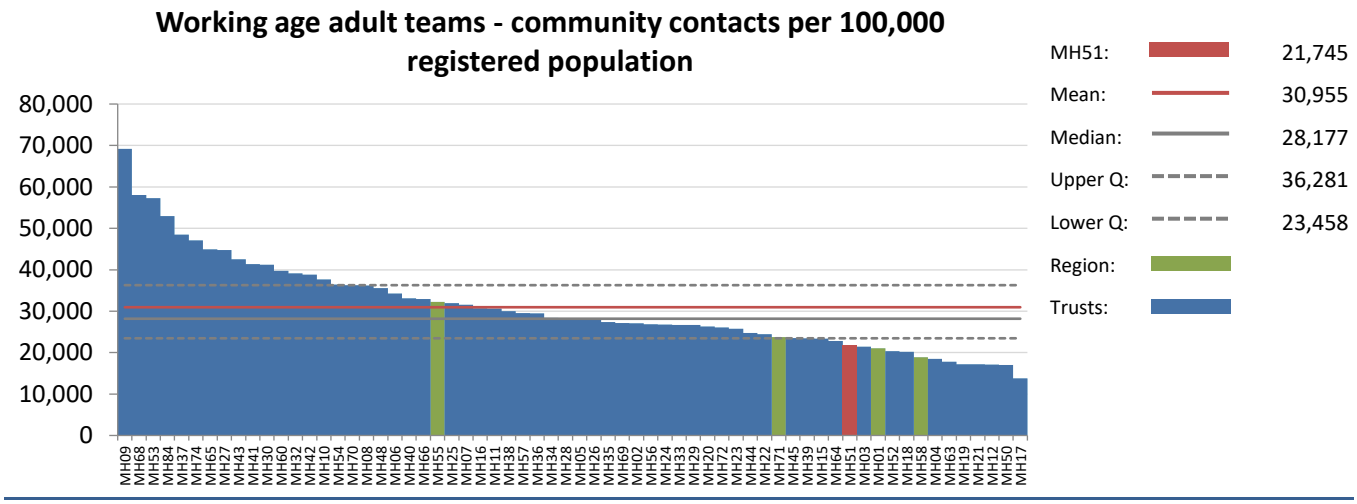


Figure 46

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	32,013	34,420	32,330	30,955	

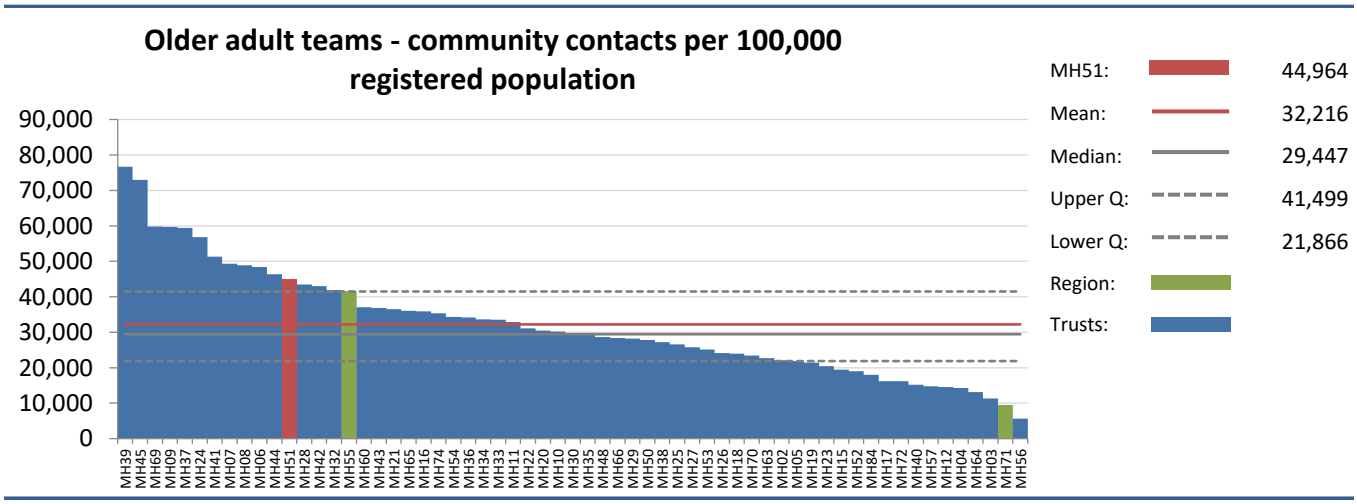


Figure 47

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	38,375	39,266	32,670	32,216	

Benchmarking Network

Waiting Times

The table below shows the proportion of service users, nationally, who had an RTT of under 4 weeks. This represents the time taken from referral to the team, to the patient having their 2nd face to face appointment and entering onto caseload. Last year's national average positions are shown alongside to highlight the change between years. Teams where rapid access is critical, such as CRHT and Early Intervention, report the best performance on this measure. Green arrows represent a greater proportion of people achieving a 4 week RTT; red arrows show deterioration on this measure.

National position	RTT under 4 weeks		
	2016/17	2017/18	Change
Generic CMHT	34%	35%	↑
CRHT	98%	99%	↑
Assertive Outreach	53%	65%	↑
Early Intervention	70%	70%	↑
Assessment and Brief Intervention	45%	57%	↑
Rehabilitation and Recovery	67%	58%	↓
Forensic	54%	44%	↓
Eating Disorders	38%	33%	↓
Mother and Baby	46%	50%	↑
Older People	46%	47%	↑
Memory Services	21%	19%	↓
Other Adult CMHTs	37%	36%	↓

Benchmarking Network

The chart below shows the total proportion of patients nationally who had an overall RTT of 18 weeks or less. Across most teams these figures are largely similar to last year's positions. Services for older people and forensic patiens have the longest waiting times.

Participants can view their individual positions in the mental health toolkit.

National position

Early Intervention in Psychosis

As one of the priorities of NHS England's **Five Year Forward View** for Mental Health, Early Intervention in Psychosis services have been under increased scrutiny in recent years.

With the introduction of an all age waiting time target, many services abolished their previous age limits of being a 14 - 35 years service. As a result, many services have reported increases in referrals, as service users who may previously have been picked up by a Generic CMHT due to their age are now funnelled through EIP instead.

Referral acceptance rates have remained relatively static at around 81% - 83% in recent years, and therefore caseloads have also risen in line with increases in referrals. There has been a 12% increase in caseloads since 2013/14.

Staffing levels have responded to this increase in demand and are 18% higher than in 2013/14.

Contact rates per patient remain high at 35 per patient per annum, reflecting the intensity of EIP provision, although there has been gradual annual decrease in this metric for the last four years.

Length of time on caseload, at 14 months, is fractionally higher than the figure for the previous three years.

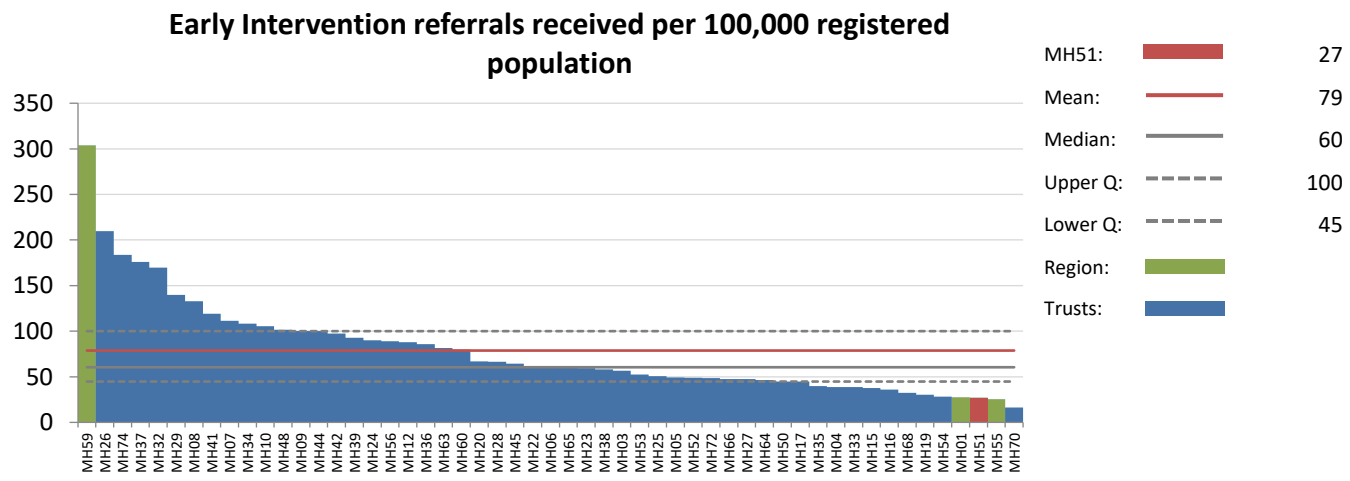


Figure 48

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	x	x	57	49	55	66	60	

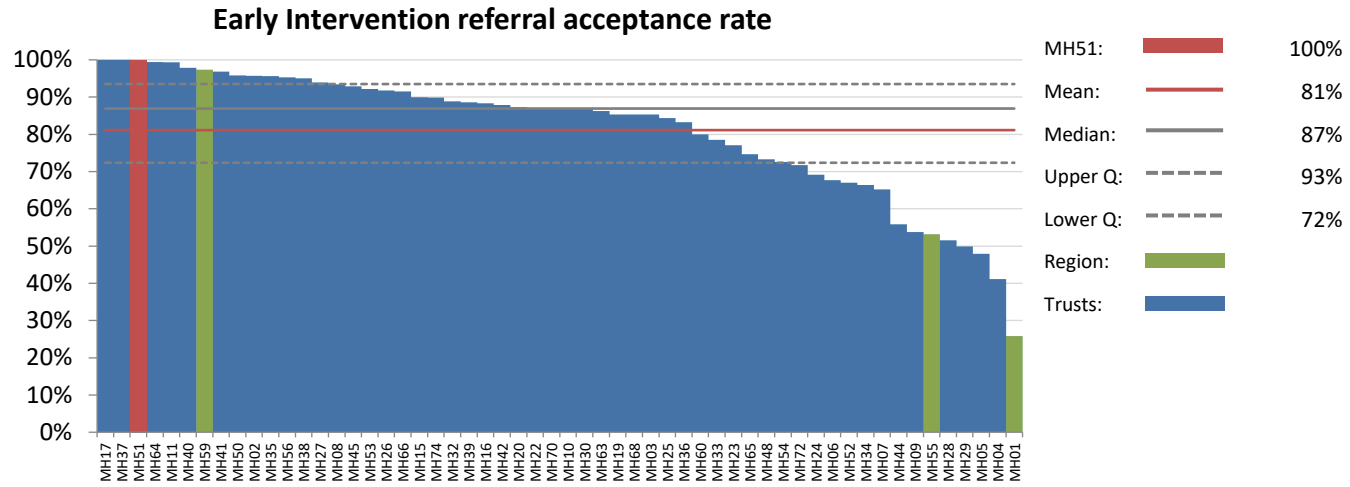


Figure 49

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	81%	83%	82%	83%	81%	

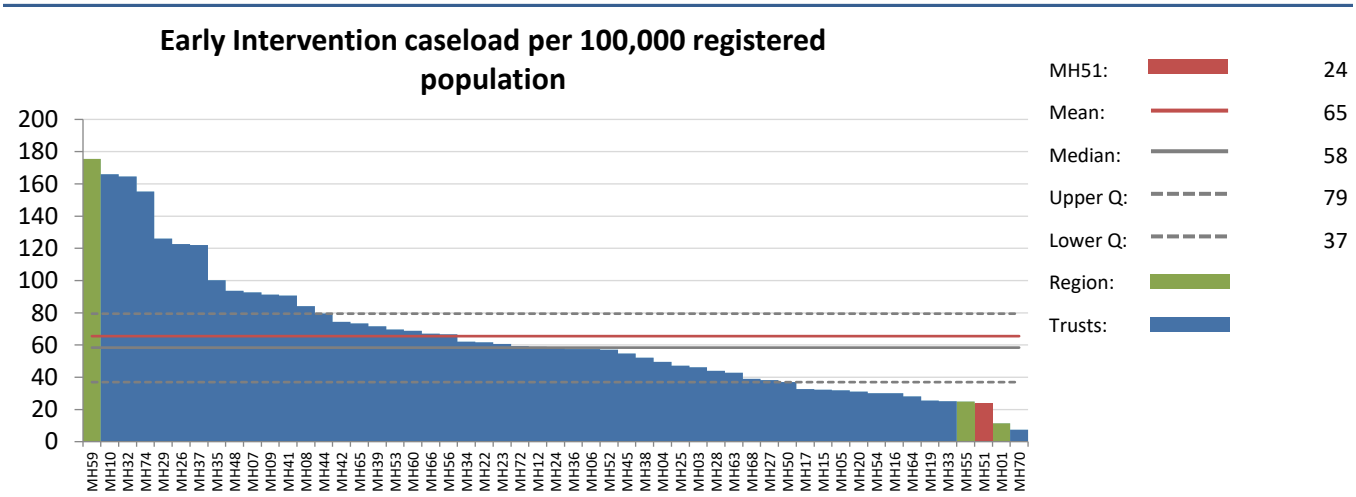


Figure 50

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	58	56	61	64	65	

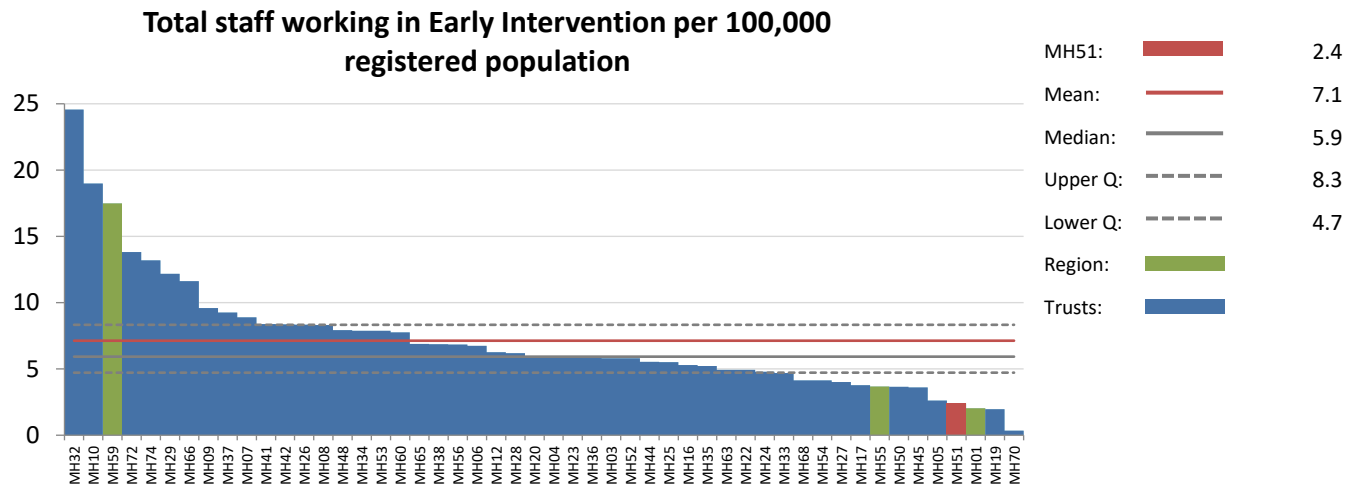


Figure 51

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	6	5.7	6.2	6.1	7.1	

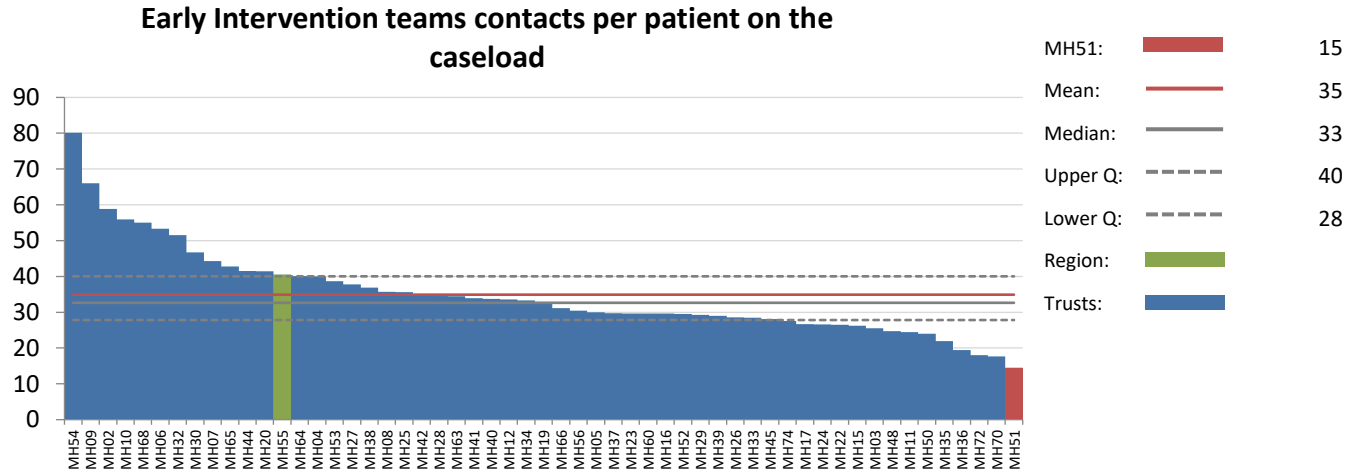


Figure 52

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	38	37	36	35	

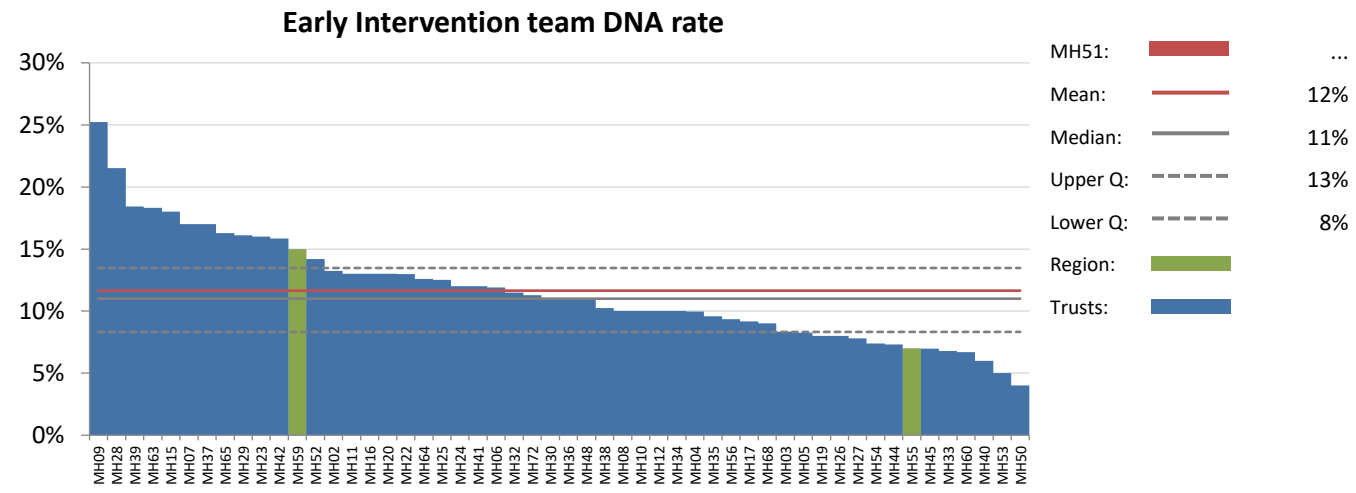


Figure 53

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	10%	9%	9%	11%	11%	12%	

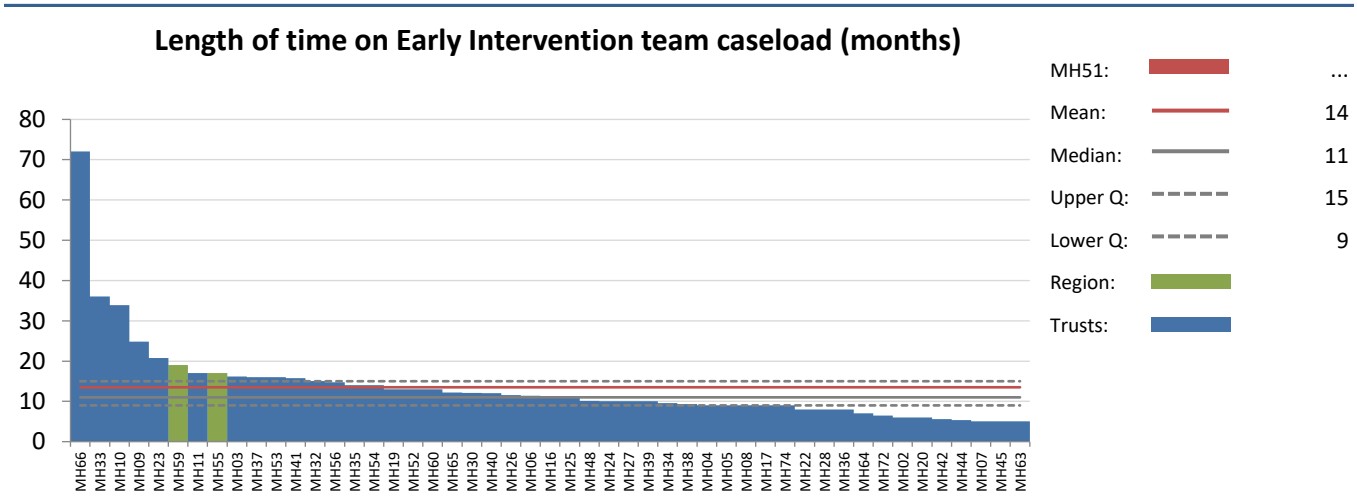


Figure 54

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	15	16	13	13	13	14	

Crisis Care

Crisis Resolution and Home Treatment teams have reported a decline in contacts delivered in recent years, though this year's figure is a 5% increase on 2016/17 and may mark the start of an increase.

Over the same period, Psychiatric Liaison activity was increasing to offer an alternative response option for many patients in need of urgent care. However this year a notable decline in contacts was reported.

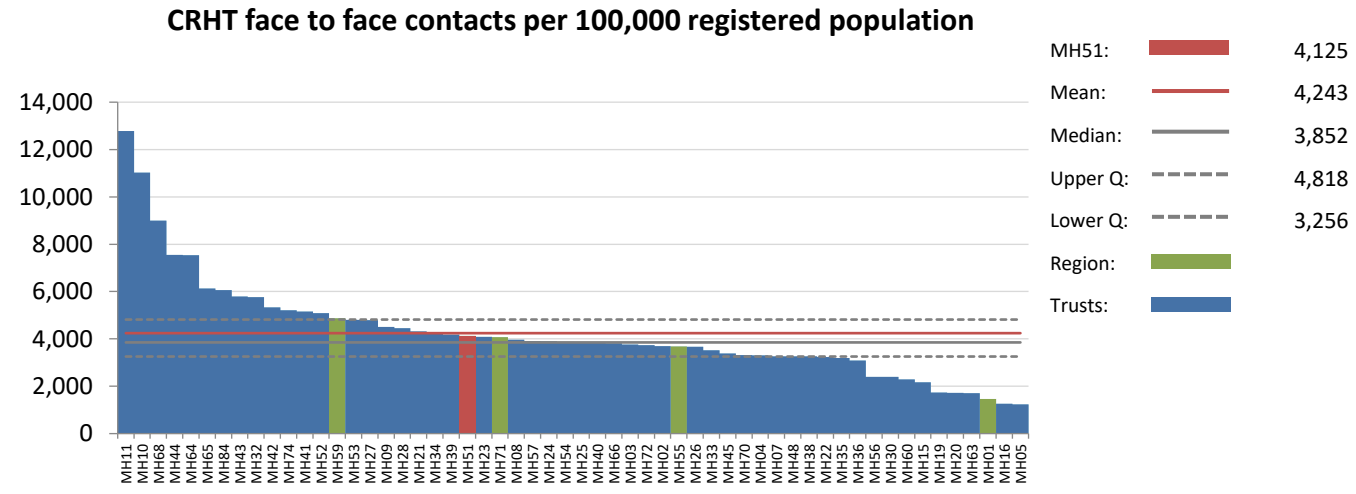


Figure 55

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	4440	4339	4270	4122	4055	4243	

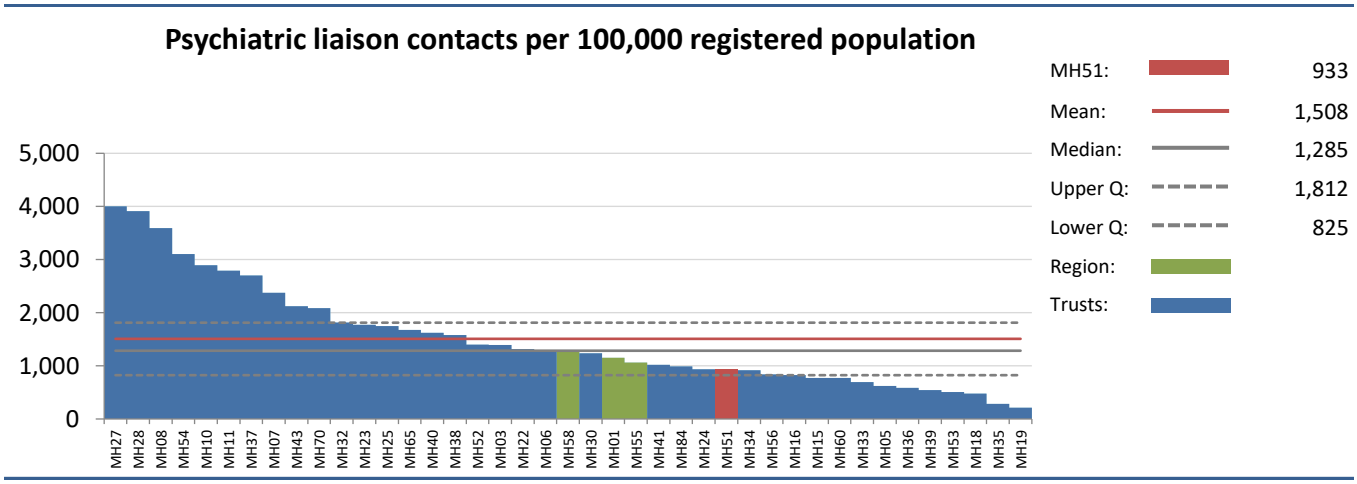


Figure 56

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	1288	1242	2096	1932	1508	

The staffing of CRHT teams in 2017/18 was the joint highest position reported over the last 6 years, at 17 WTE per 100,000 population. Psychiatric liaison staffing has also increased from 5 WTE in 2014/15 to 6 WTE per 100,000 population in 2017/18. It should be noted that not all providers offer liaison services, whereas CRHT is delivered in over 95% of UK providers.

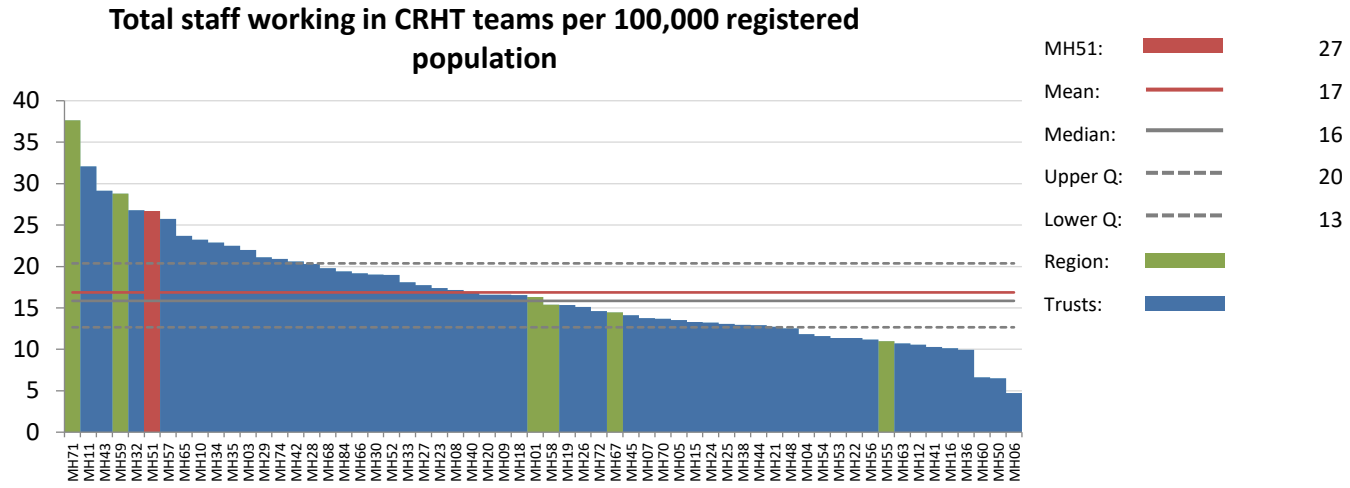


Figure 57

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	16	16	15	17	15	17	

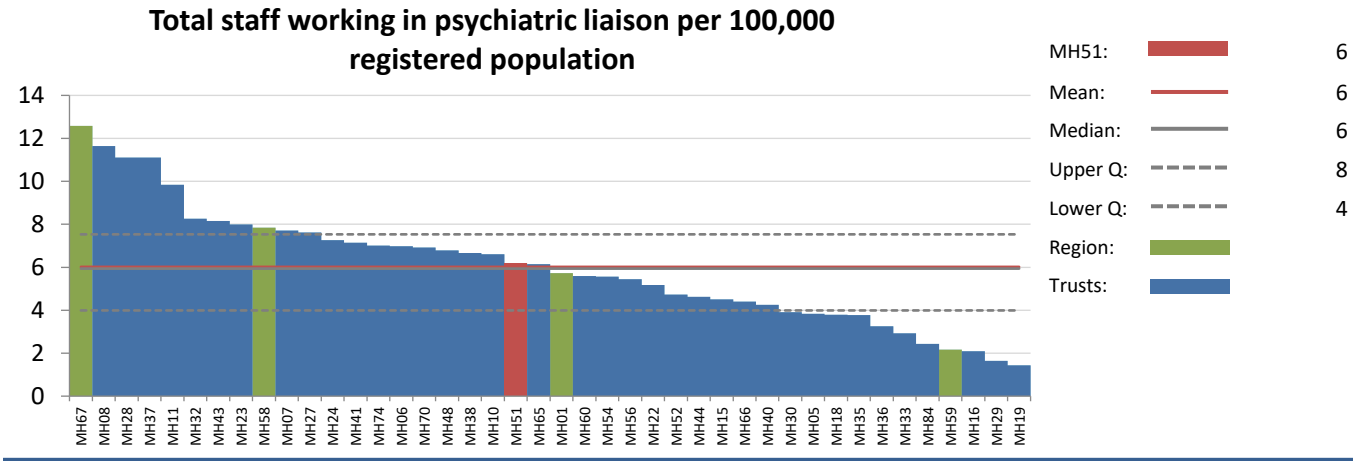


Figure 58

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	5	5	6	6	

There has been a steady increase in the number of section 136 assessments reported by participants, from 45 per 100,000 population in 2013/14 to 79 per 100,000 population this year. This reflects an increase in mental health awareness as well as an ongoing need for urgent care capacity in all aspects of the mental health system.

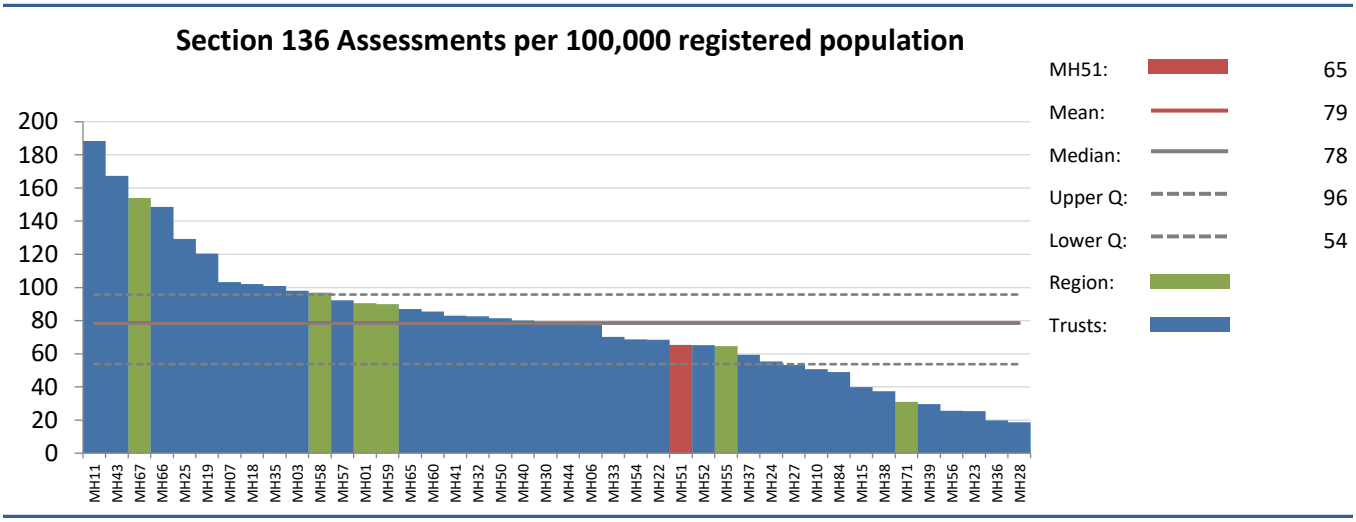


Figure 59

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	45	50	58	57	79	

Benchmarking Network

Community Clusters

Analysis of care clusters is possible for the delivery of community based mental healthcare in England. The profiling of care cluster data supports the analysis of caseload complexity by provider.

The proportion of caseload in clusters 10-17 acts as a general proxy for complexity, whilst high caseload numbers in clusters 1 - 4 can be seen as a converse measure, where broad access or support for mild to moderate mental health problems is available in CMHTs.

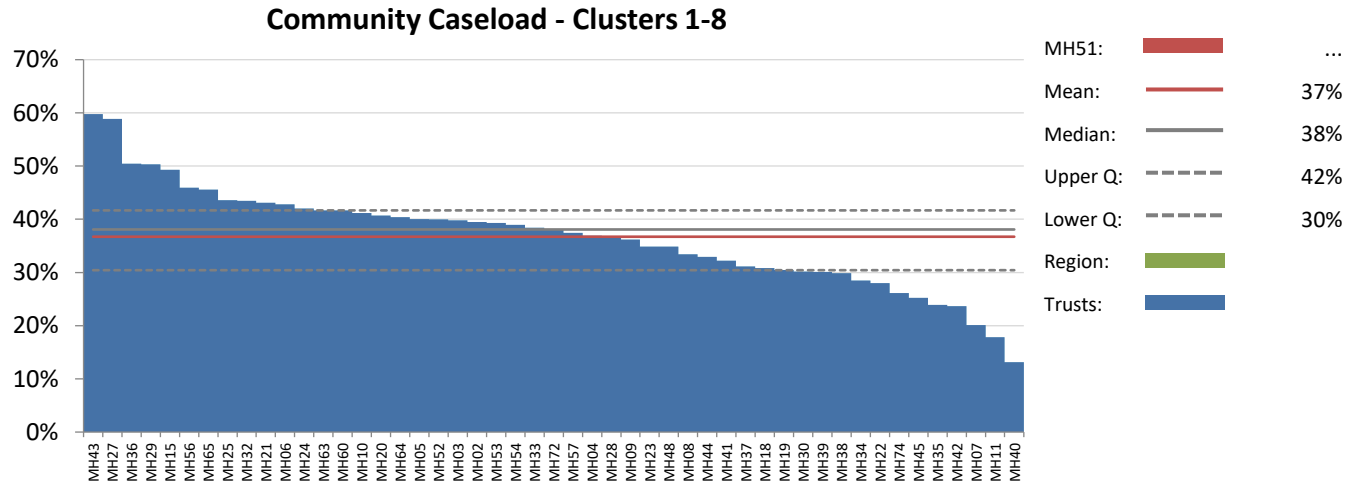


Figure 60

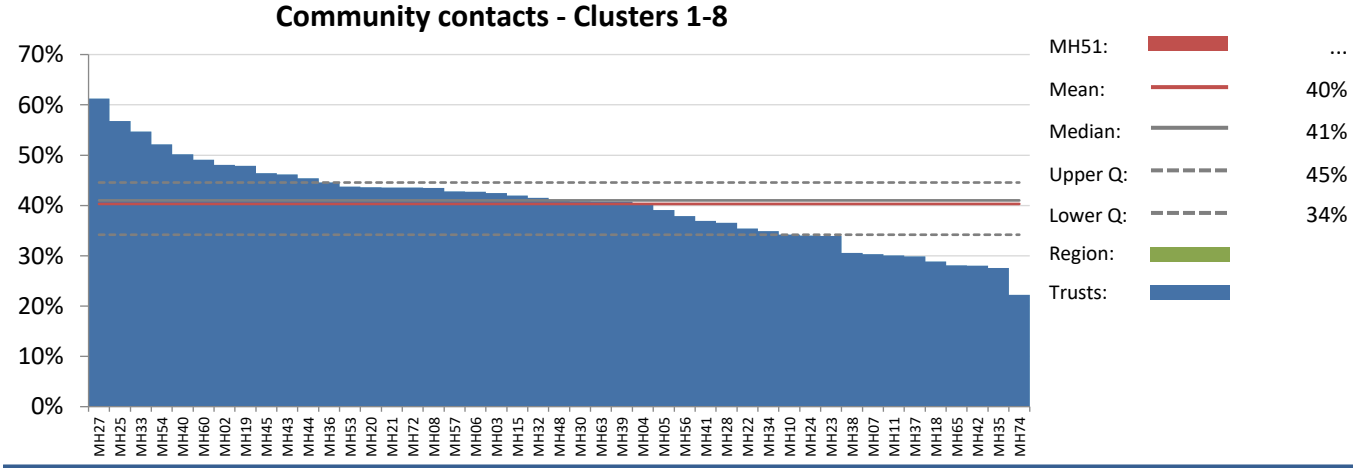


Figure 61

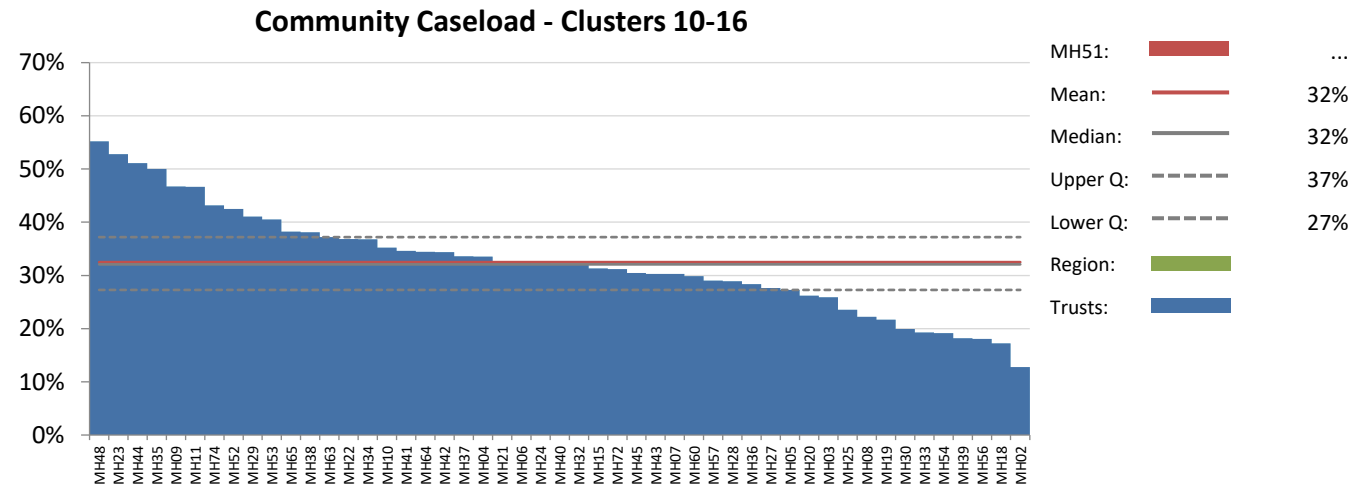


Figure 62

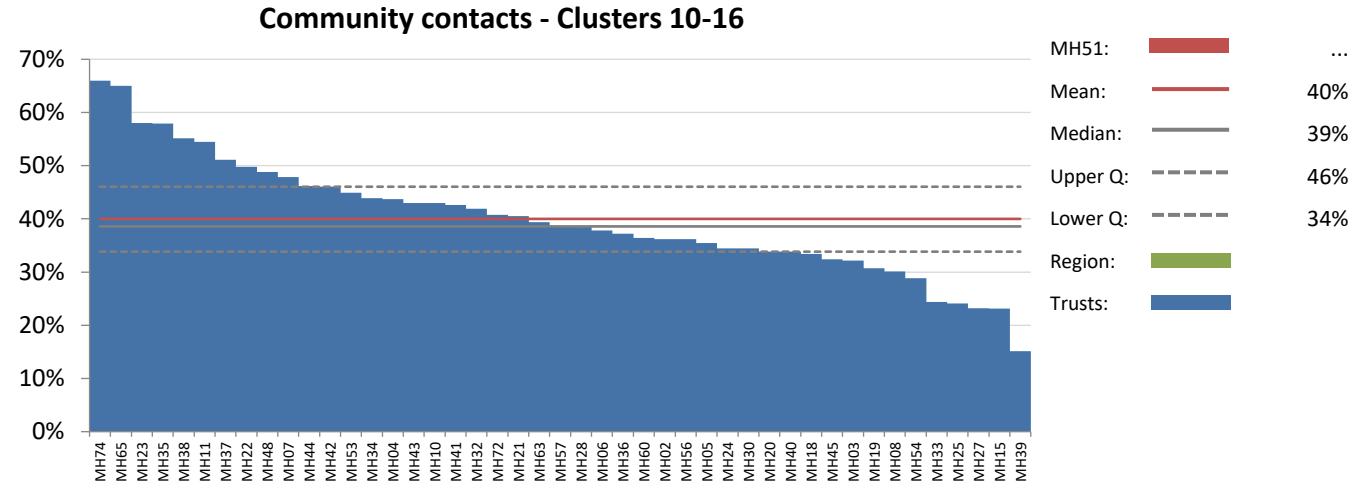


Figure 63

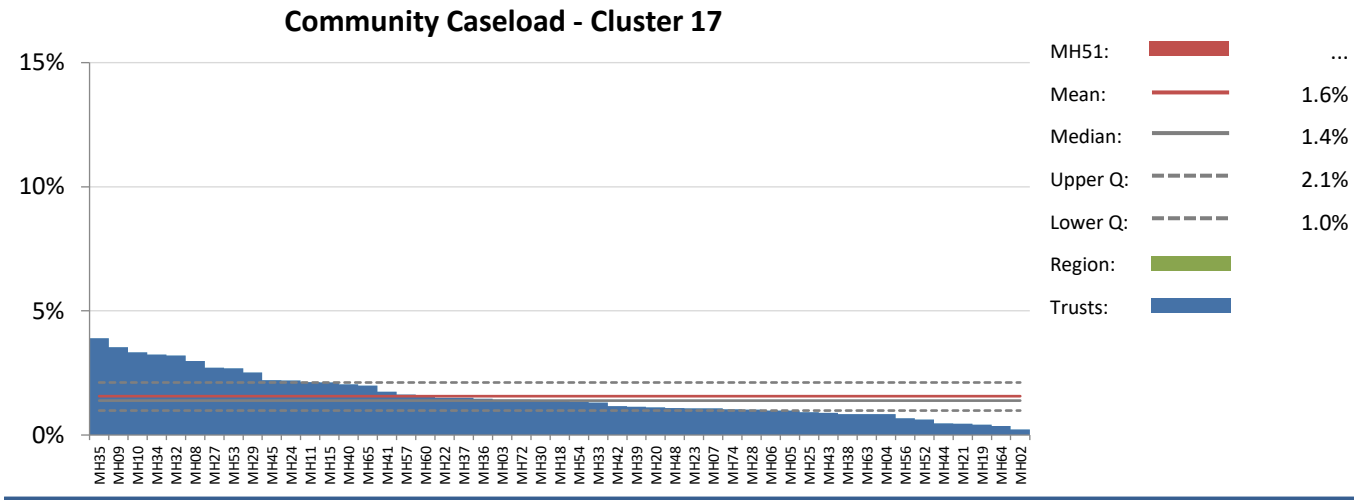


Figure 64

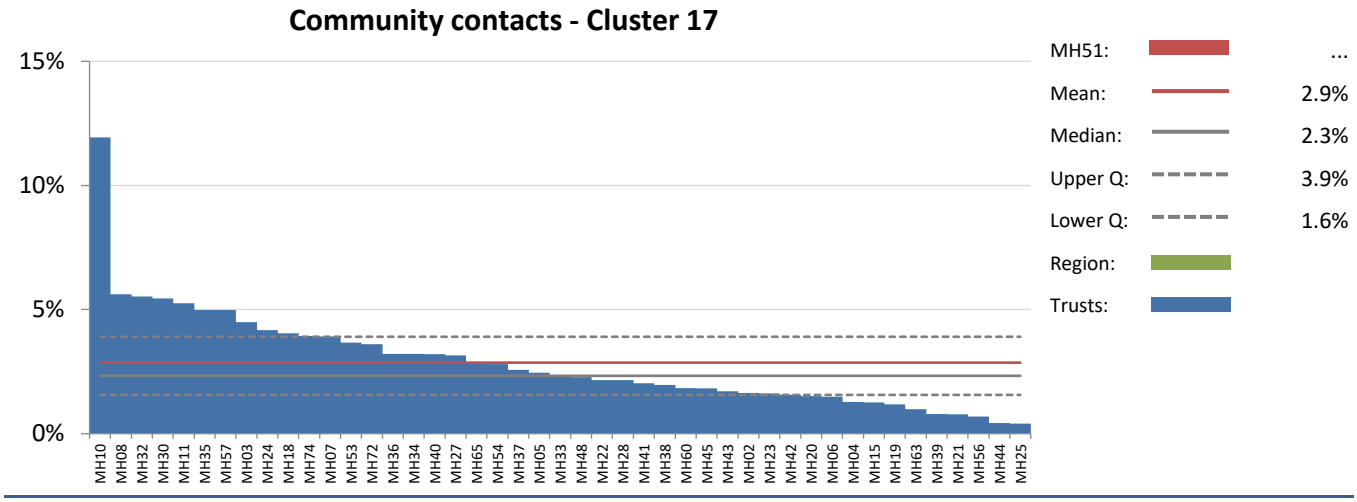


Figure 65

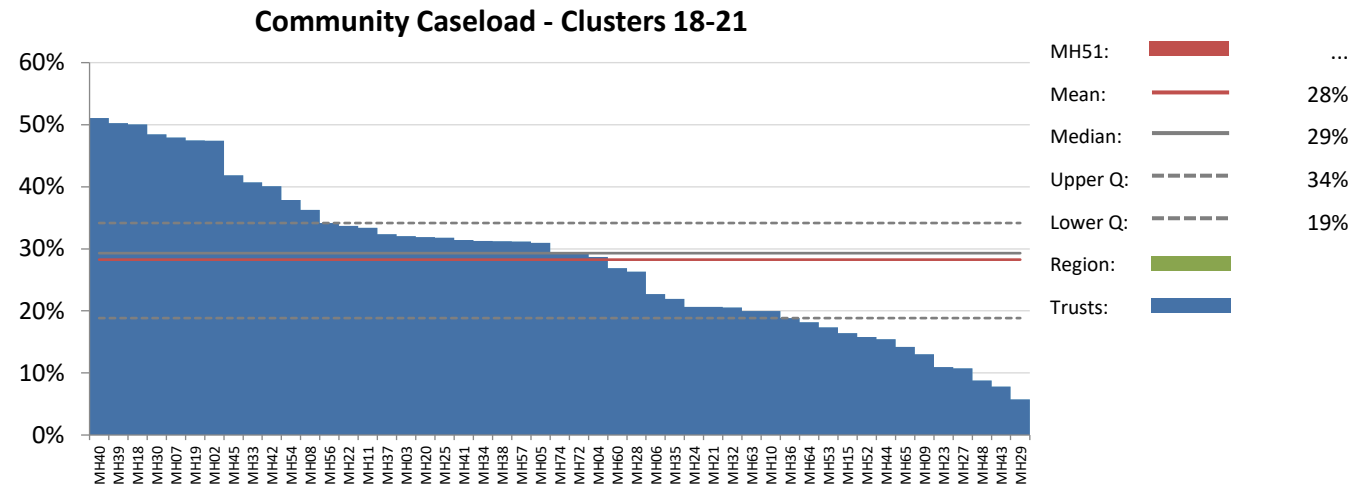


Figure 66

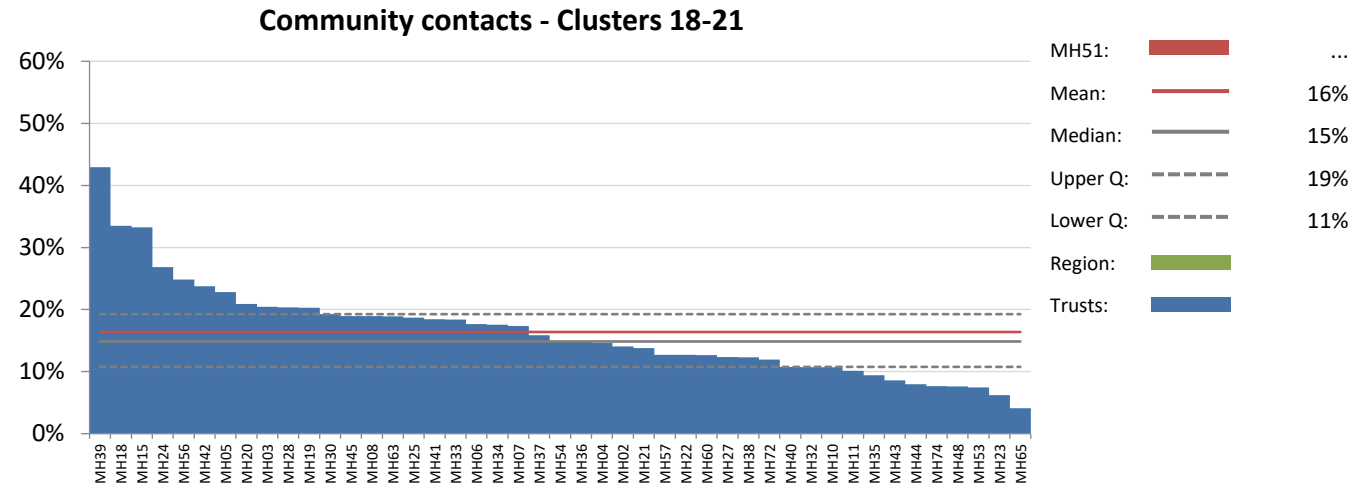


Figure 67

Workforce

The Consultant Psychiatrist workforce appears to be broadly stable with 0.6 WTE available per 10 adult acute beds and 0.5 WTE per 10 older adult beds. Both these values have been consistent over the last 3 years.

Other specialties also show broad consistency across years although it should be noted that workforce capacity and intensity differ across specialties. For example, PICU at 0.8 WTE per 10 beds has twice the capacity of both High Dependency Rehabilitation and Longer Term Complex / Continuing Care which both report 0.4 WTE per 10 beds.

Registered nursing levels also demonstrate broad consistency in recent years. Levels of input and intensity do differ between mental health specialties and marginal movements in staffing levels are evident in some areas.

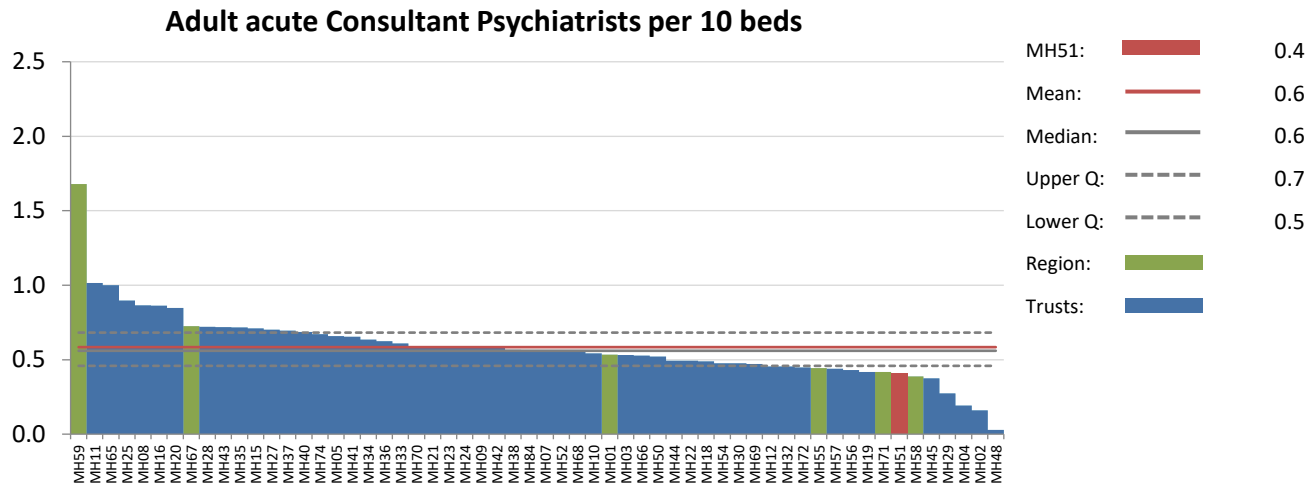


Figure 68

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.5	0.5	0.6	0.6	0.6	

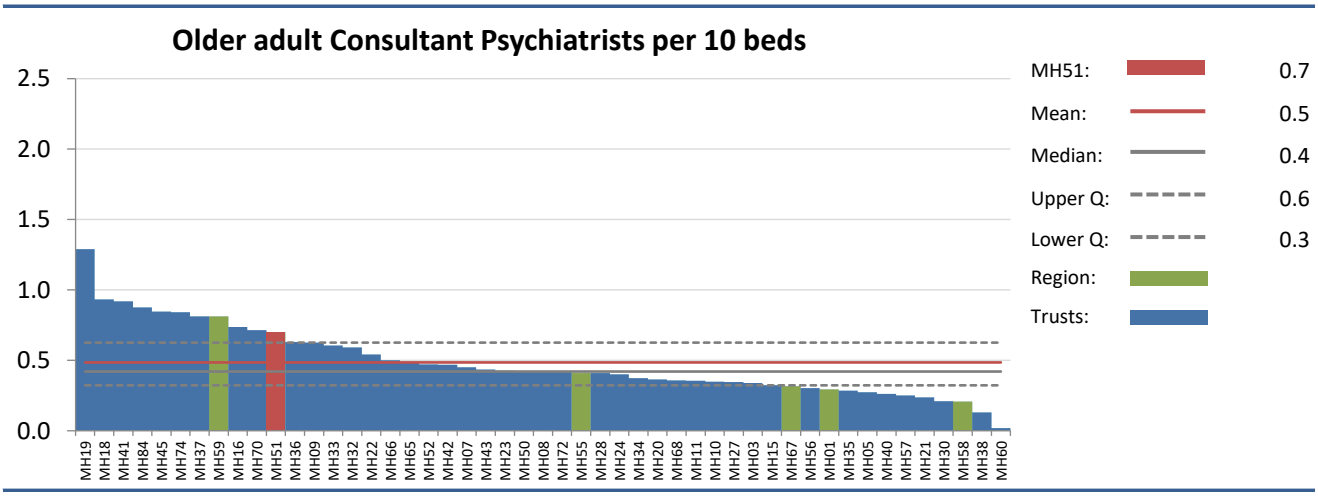


Figure 69

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.5	0.5	0.5	0.5	0.5	

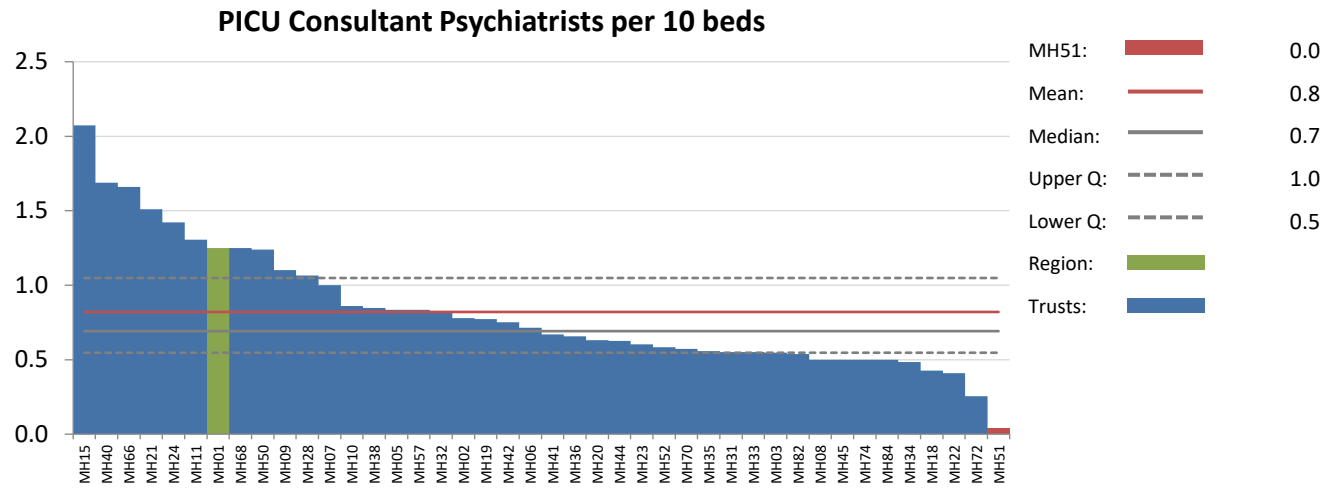


Figure 70

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.7	0.7	0.8	0.8	0.8	

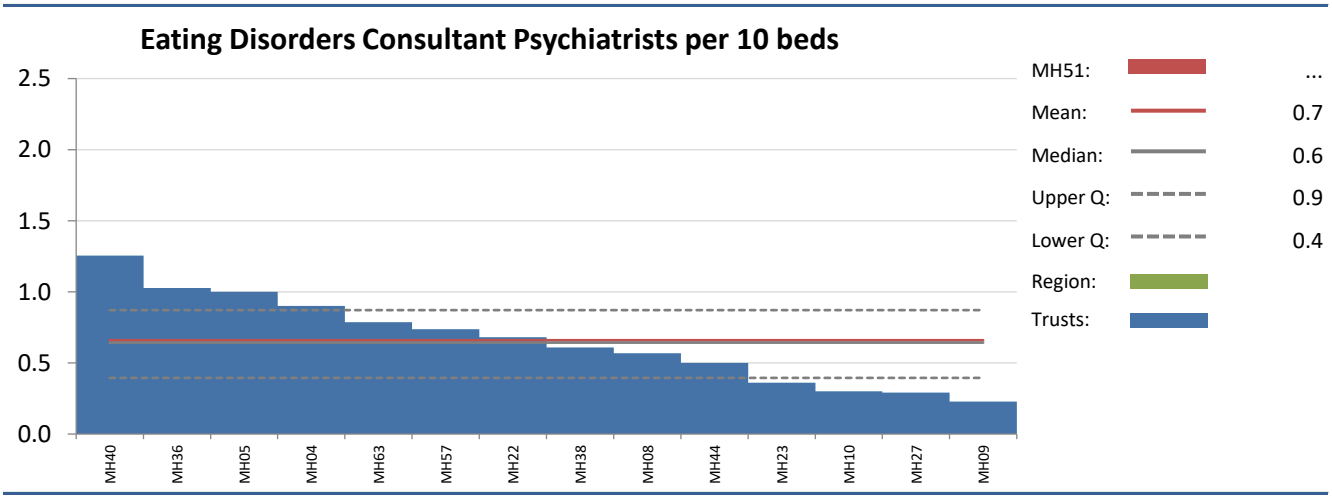


Figure 71

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.6	0.8	0.6	0.6	0.7	

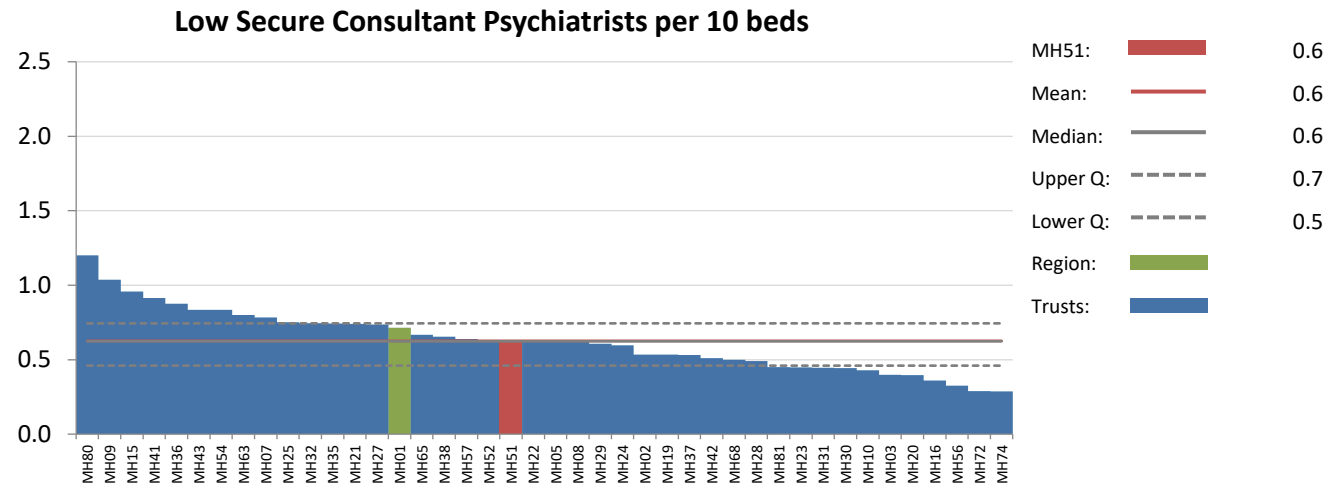


Figure 72

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.6	0.7	0.7	0.7	0.6	

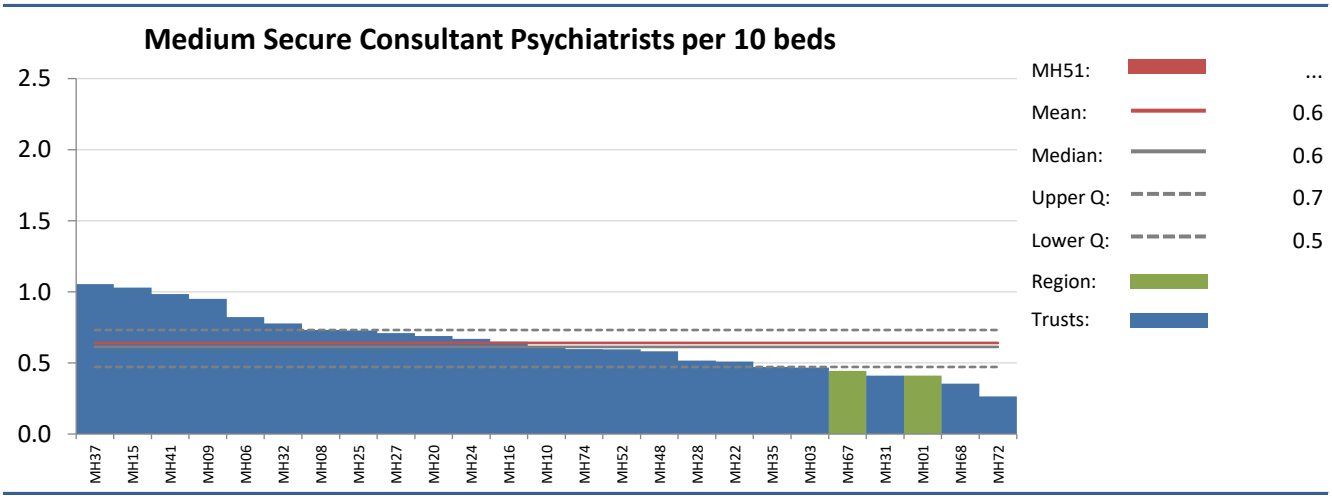


Figure 73

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.7	0.7	0.7	0.7	0.7	

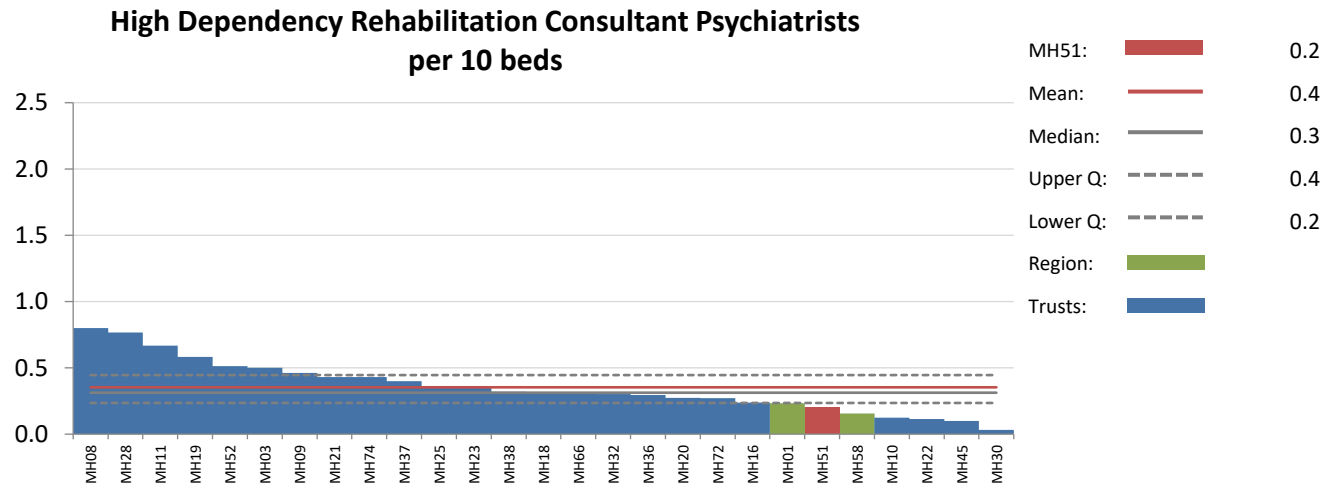


Figure 74

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.3	0.3	0.4	0.5	0.4	

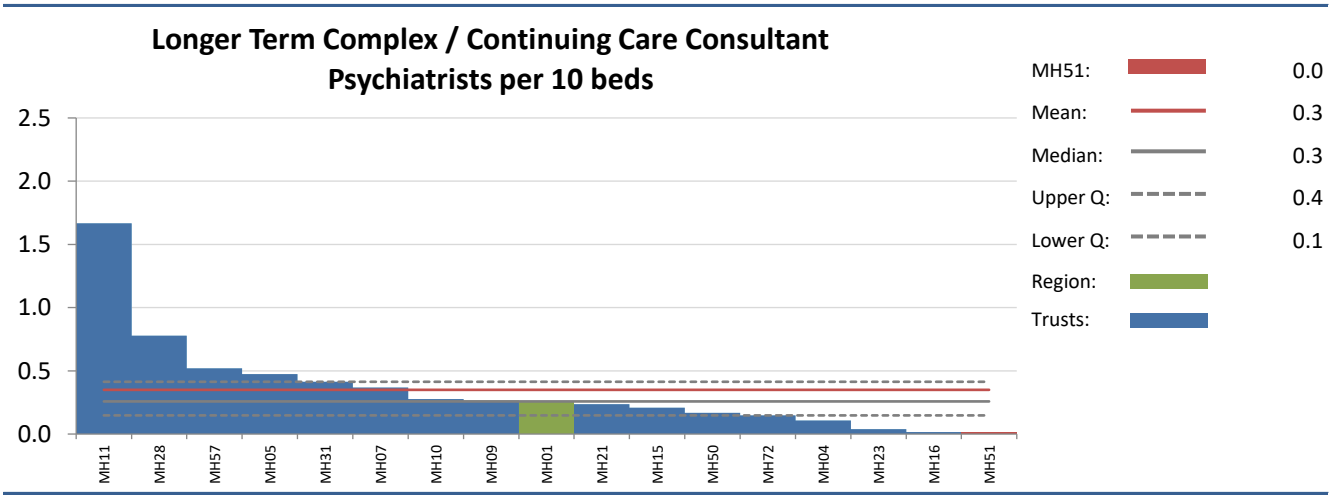


Figure 75

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	0.2	0.3	0.3	0.3	0.3	

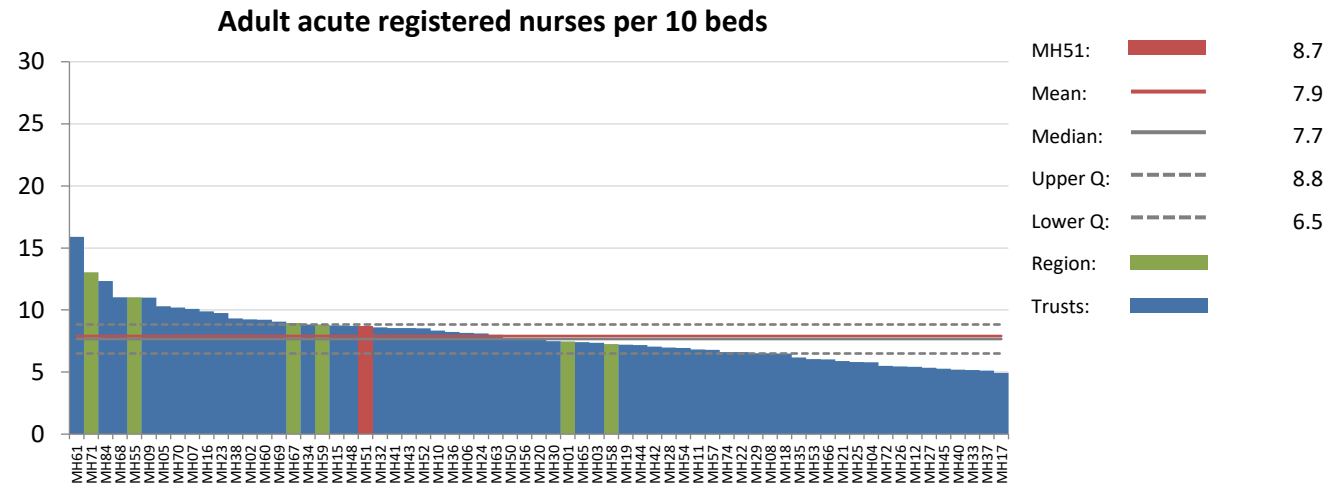


Figure 76

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	7.6	7.3	8	7.9	

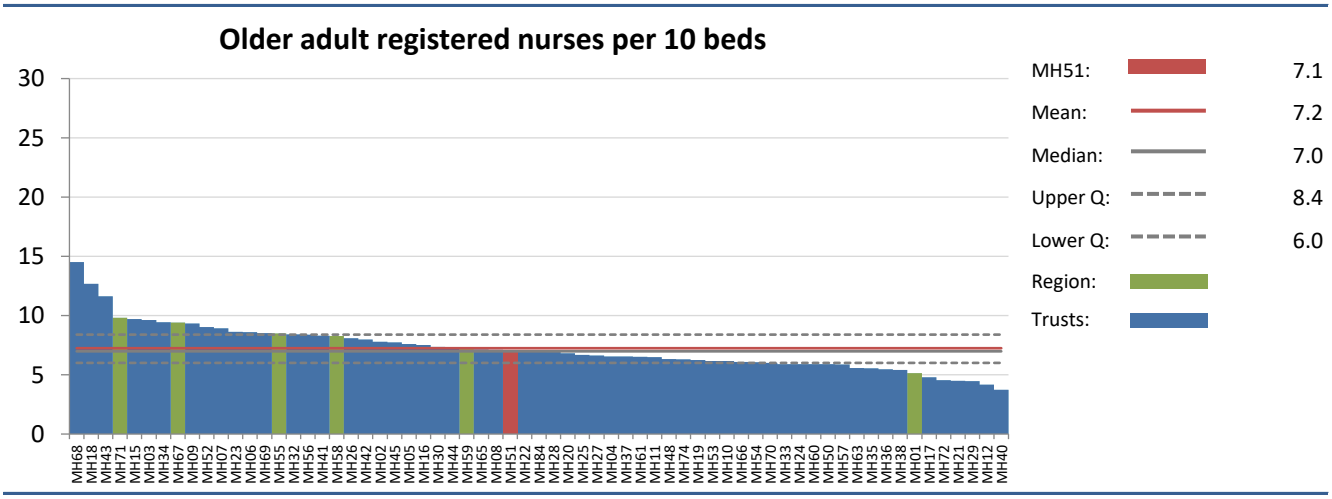


Figure 77

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	7.6	7.1	7.4	7.2	

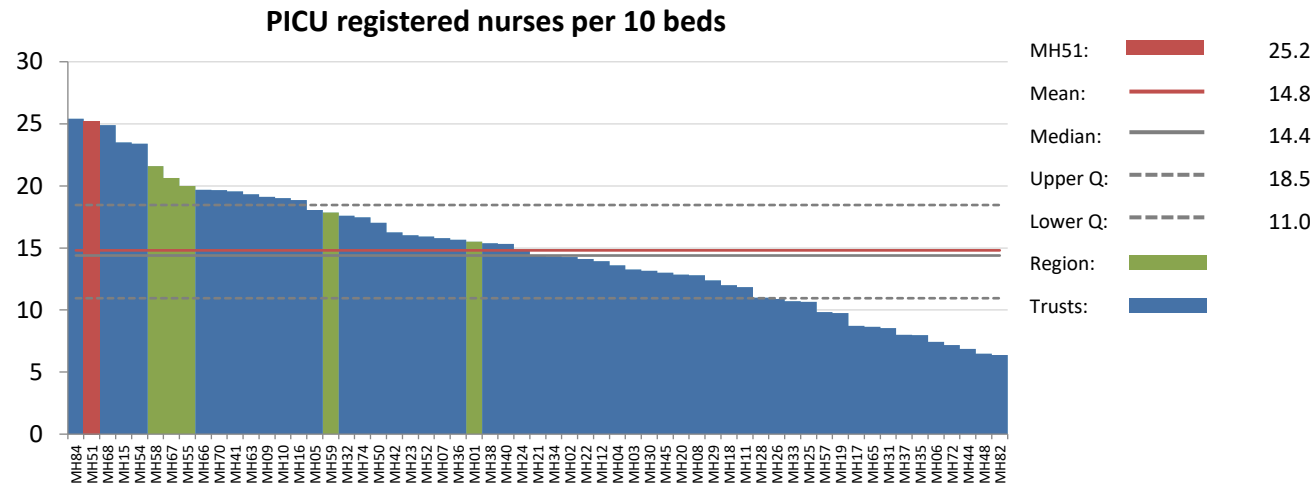


Figure 78

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	13.8	14.2	14.3	14.8	

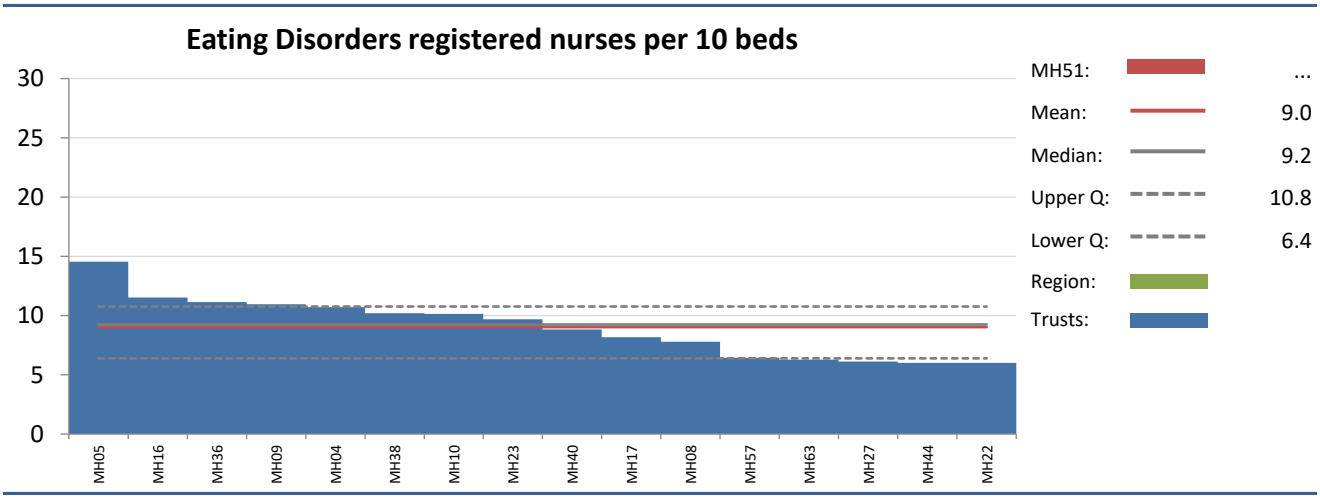


Figure 79

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	10	8.9	8.6	9.0	

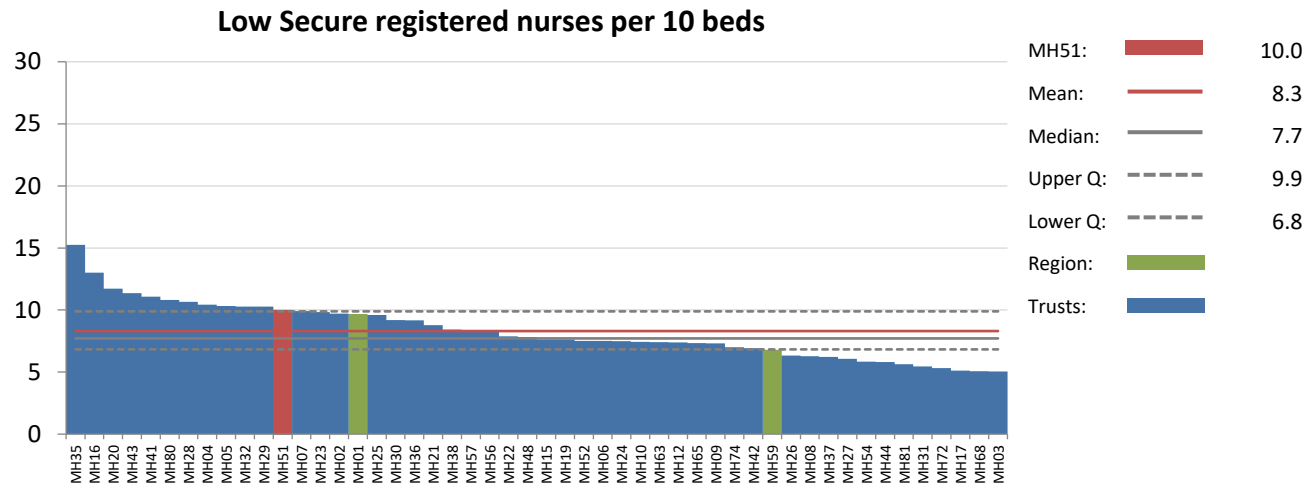


Figure 80

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	8.4	8.4	8.3	8.3	

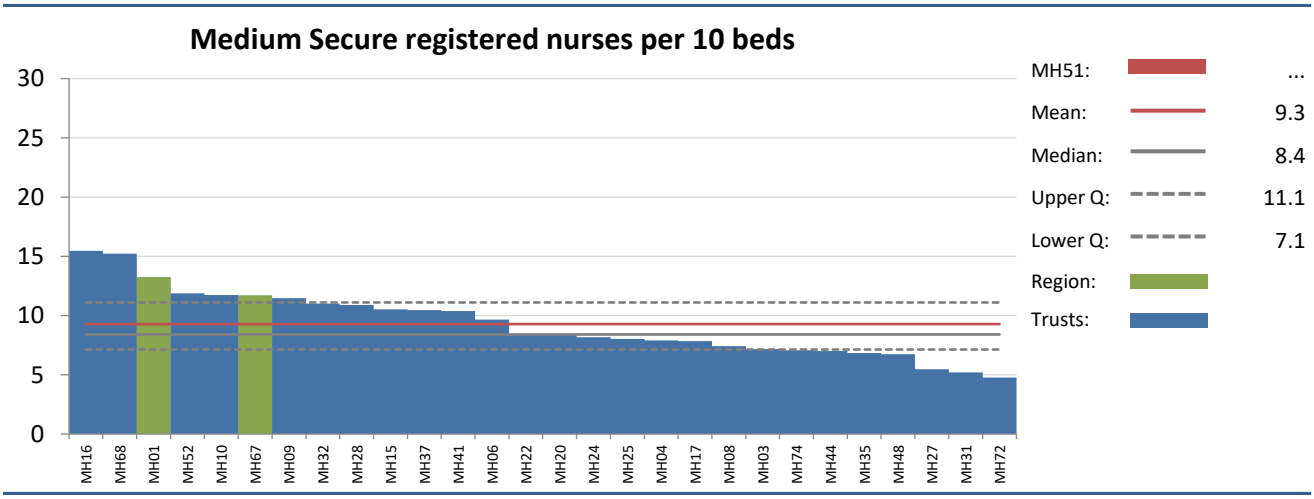


Figure 81

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	9.4	9.5	10	9.3	

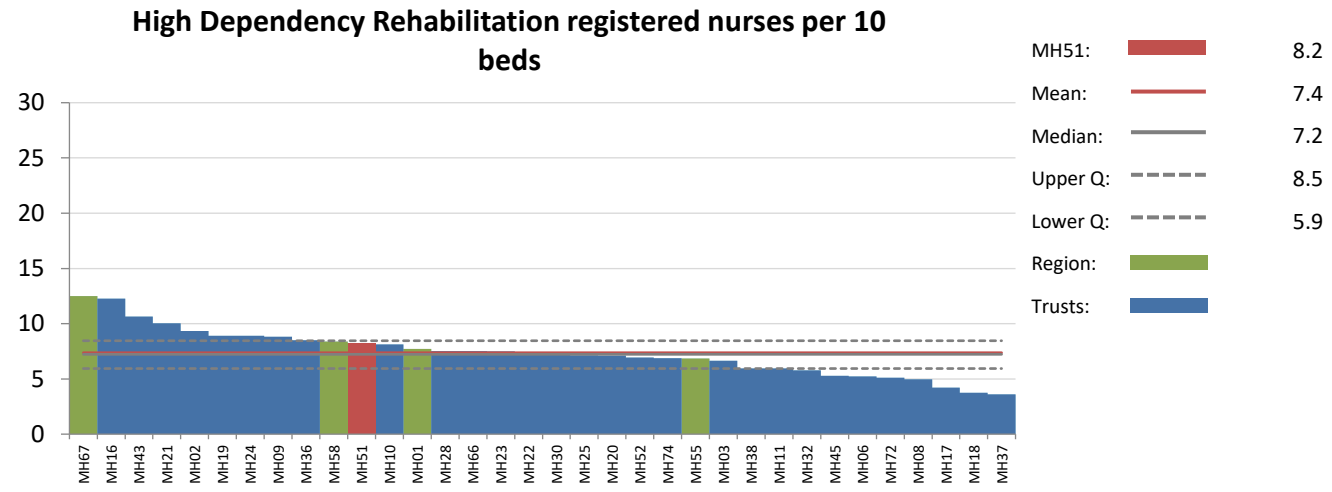


Figure 82

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	6.7	7.4	7.6	7.4	

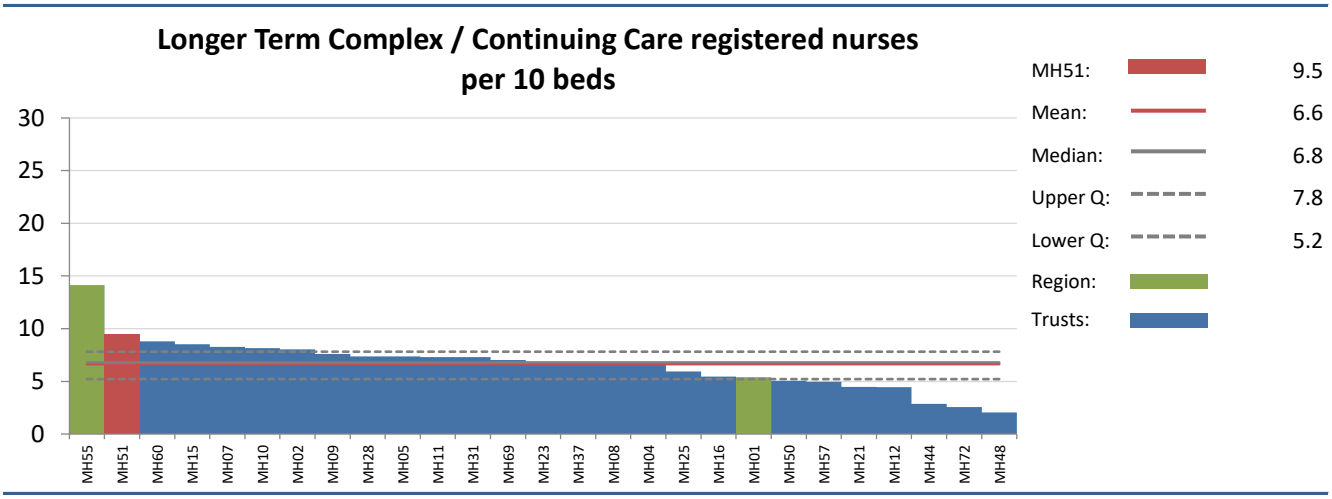


Figure 83

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	6.6	6.8	7.5	6.6	

Workforce metrics

Workforce metrics such as vacancies, sickness absence and turnover give a feel for the stability of the workforce in a particular organisation.

Despite changes in other areas, these metrics have changed little over recent years. Sickness absence and turnover remain at similar figures to 2013/14. Vacancies, however, have begun to increase after several years at the 13% mark. This year's position is 17% in the adult acute setting. The range in provider performance is also striking with lower quartile providers reporting 8% vacancies and upper quartile providers reporting 22%. The organisation with the highest vacancy rate reports a rate of 40%. Readers should also consider regional variations in the data which reflect wider labour markets within the UK.

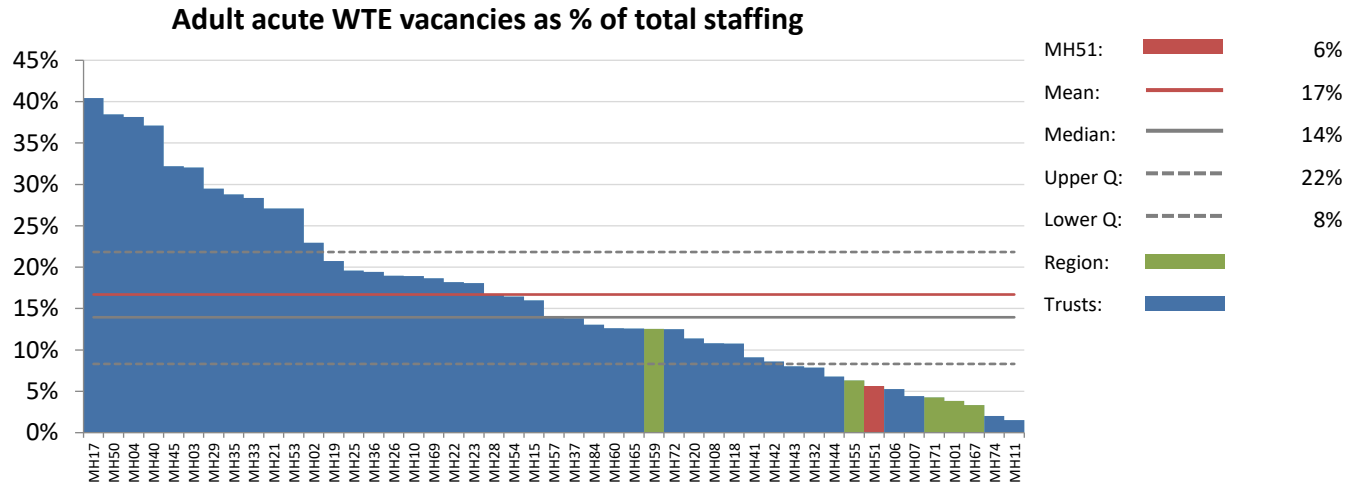


Figure 84

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	13%	13%	13%	13%	16%	17%	

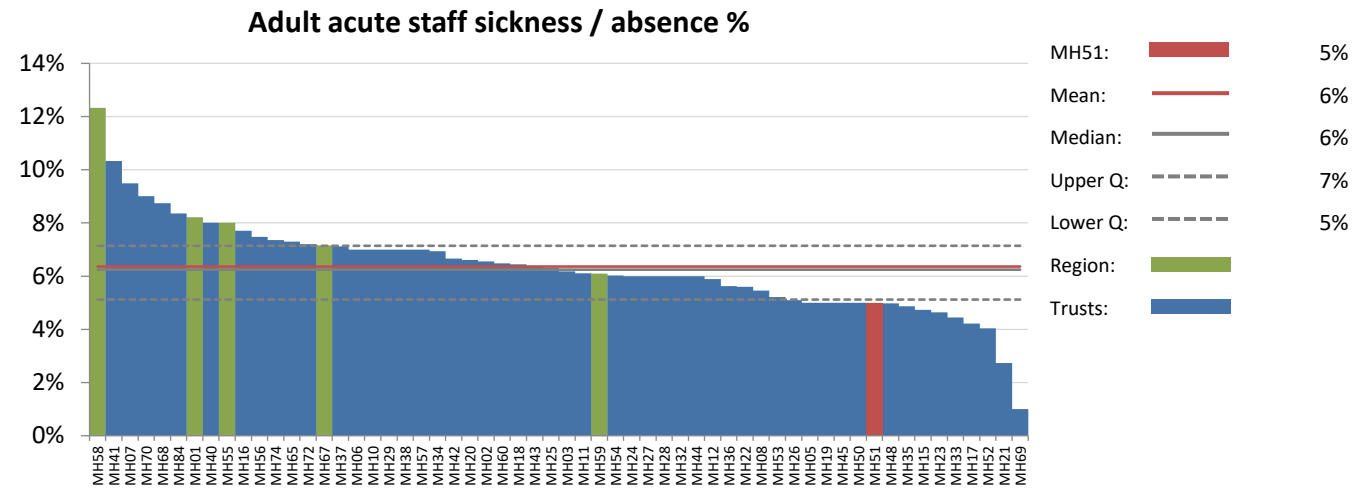


Figure 85

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	6%	6%	7%	6%	6%	

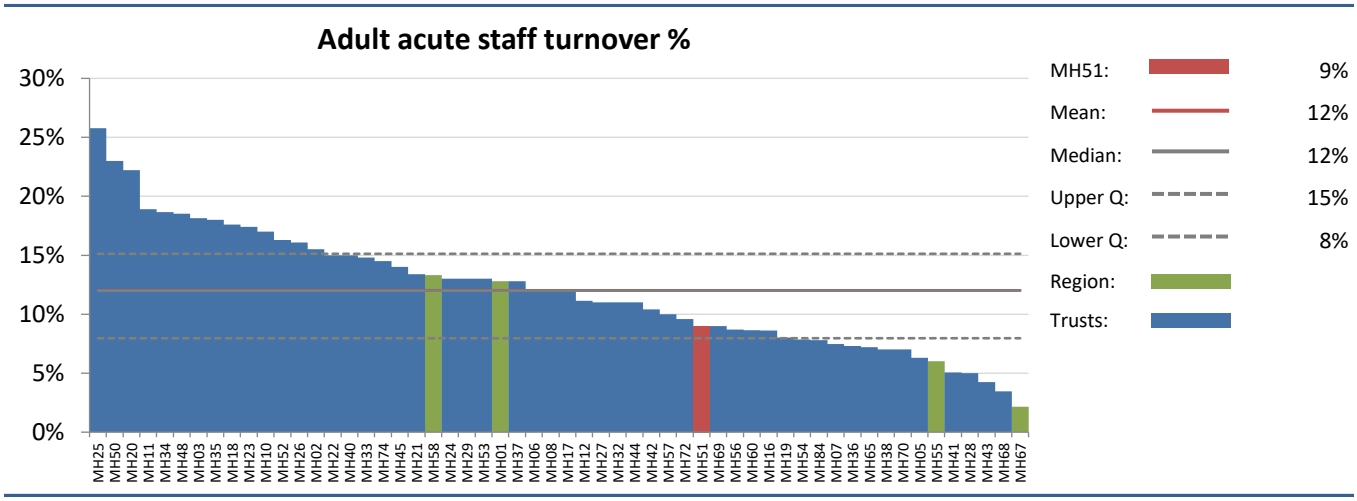


Figure 86

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	10%	13%	12%	11%	12%	

Bank and Agency

Bank and agency use is shown here by the financial impact it incurs. The charts show the proportion of pay costs which were pay for bank or agency cover. This year's position is 23% of total costs, though the elevated cost of temporary cover means this money is unlikely to have supplied 23% of the workforce in terms of head count.

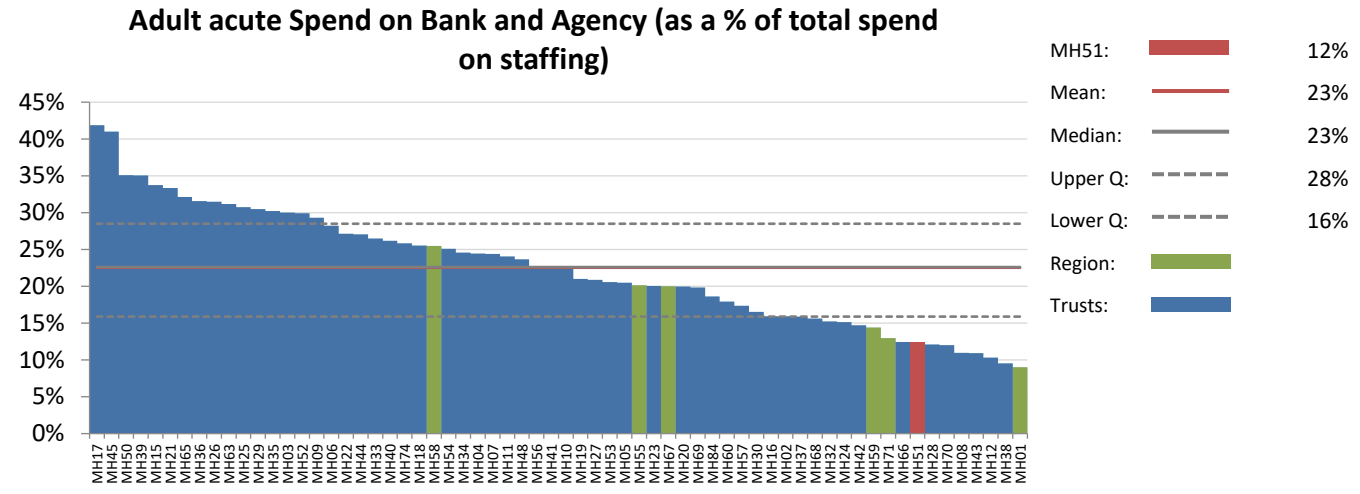


Figure 87

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	16%	19%	23%	23%	

Within this, internal bank staffing are often deemed preferable to external agency staff, due not only to the fees involved but also the continuity of care and familiarity with hospital systems internal bank staff can often provide.

Internal bank staffing continues to contribute the bulk of costs to total bank and agency spend. Within adult acute services, 14% of total team pay costs were for bank staff, and 8% for agency staff. Agency costs have remained static in recent years, although bank costs have increased, as shown by the tables on the following page.

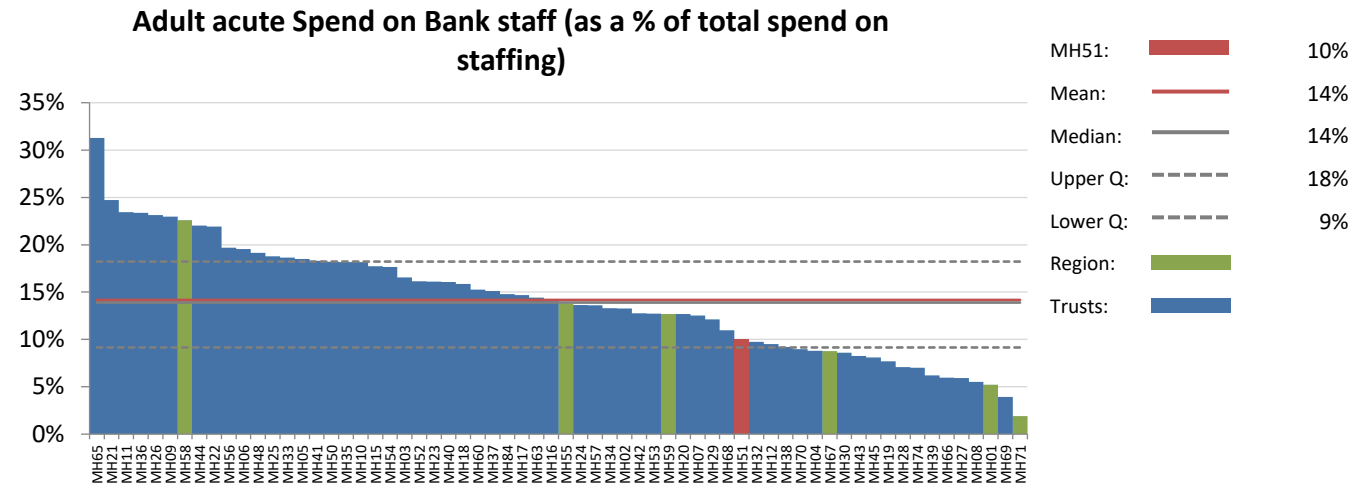


Figure 88

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	x	12%	14%	14%	

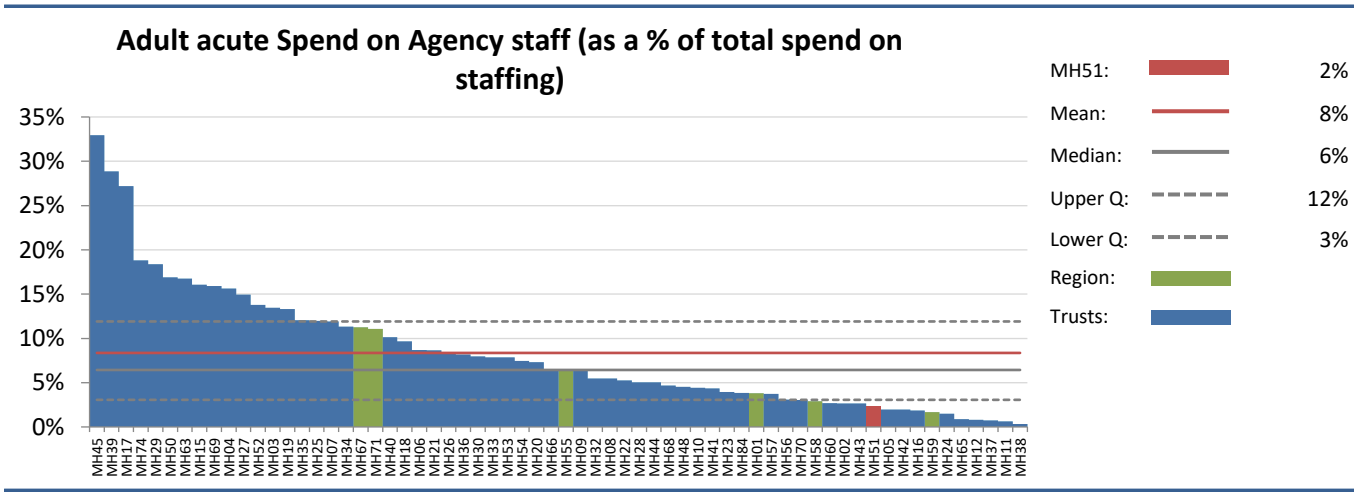


Figure 89

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	x	x	x	8%	9%	8%	

Finance

Across the board, participants have reported increases in costs for both inpatient and community services. The mental health benchmarking toolkit allows further exploration of these measures against different benchmarks such as cost per bed day or per admission.

The charts below show the average cost of operating one bed for one year. These costs have risen 28% since 2012/13 for adult acute beds, and 19% for older adult beds over the same period. A 25% increase in the cost of providing a year of care to one patient on a Generic CMHT caseload is also reported over this period.

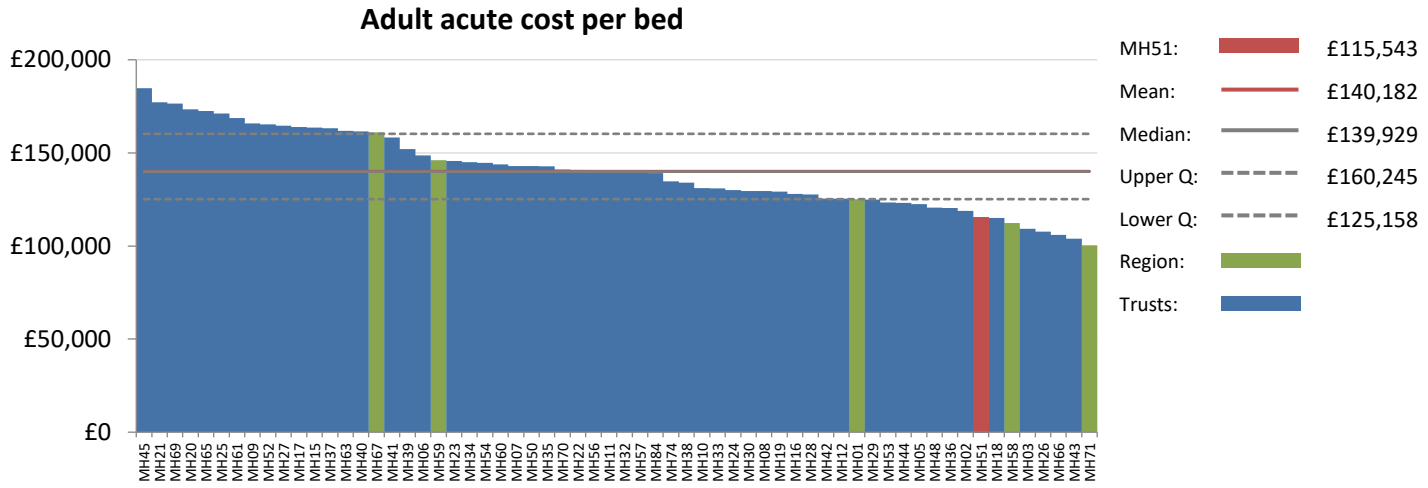


Figure 90

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	£113,055	£117,559	£124,475	£131,267	£139,289	£140,182	

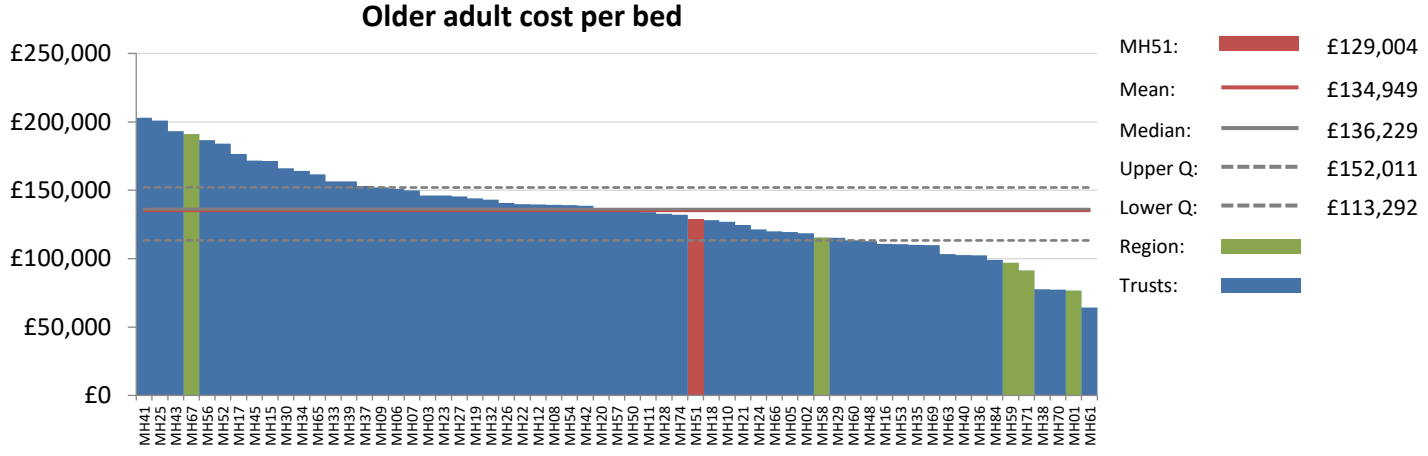


Figure 91

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	£113,565	£121,832	£134,156	£129,458	£132,032	£134,949	

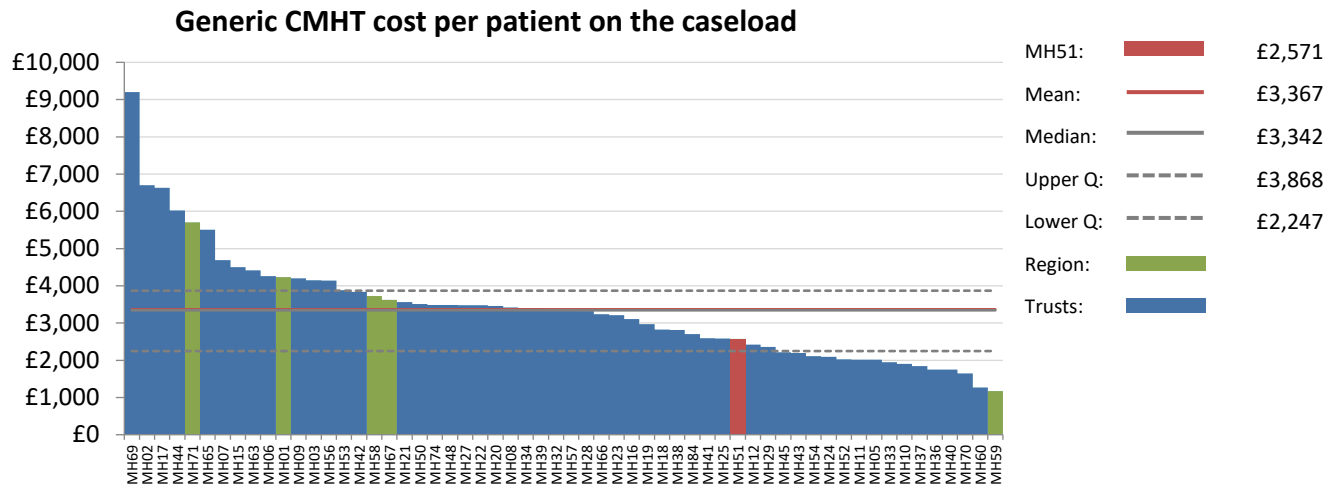


Figure 92

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Mean	x	£2,702	£2,977	£2,806	£2,880	£3,360	£3,367	

Quality

Satisfaction of both employees and patients and their families can be measured in a number of different ways.

The CQC report a measure of patient satisfaction for community mental health services. This figure has consistently been between 69% and 73% in recent years. This year, the average figure is 71%.

Data from the NHS Friends and Family Test shows an improvement in 2017/18 with an increase in patient satisfaction scores to 88%.

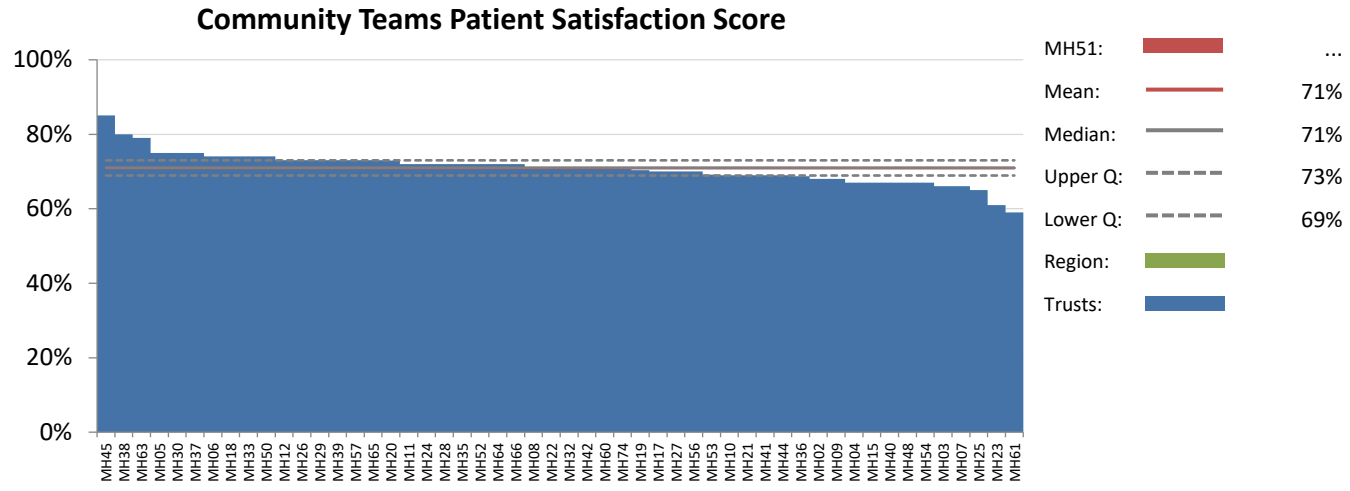


Figure 93

	National trend

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Mean	x	70%	73%	69%	71%	70%	71%

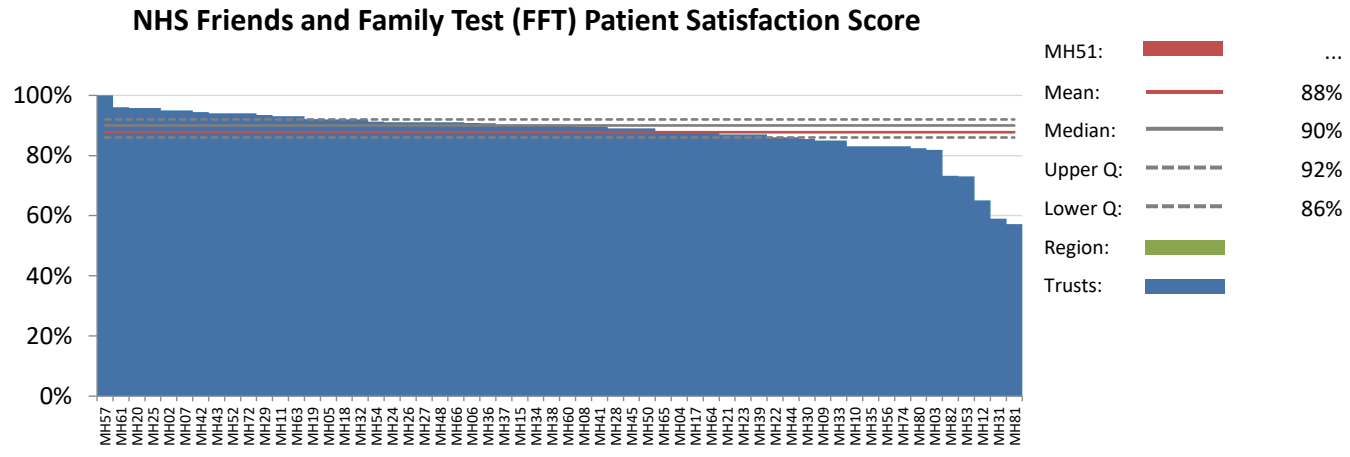


Figure 94

	National trend

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Mean	x	x	x	x	x	85%	88%

Incidents

In addition to outcome measures, it is useful to track adverse events across time to see if and where improvements are being made.

The Mental Health Benchmarking return includes a number of incident metrics including:

- use of restraint
- use of prone restraint
- use of seclusion
- violence towards staff
- violence towards other patients
- ligature incidents

Earlier work highlighted the importance of comparing these at bed type level, rather than across the organisation as a whole. For this reason, since 2016/17, participants have reported in this way due to notable differences between rates in different bed types.

The following pages detail the change in incident rates between 2016/17 and 2017/18 for adult acute, older adult and PICU wards. Additional bed types are profiled in the mental health toolkit.

In many cases, rates of incidents have risen since last year. Red arrows highlight deterioration (through an increase in incidents) and green arrows show improvement (through reductions) at a national level. An example chart below each table shows individual participant positions for the use of restraint in 2017/18.

Benchmarking Network

Incidents - Adult Acute

All rates per 10,000 occupied bed days (excluding leave)

	National position		
National position	2016/17	2017/18	Change
Restraint	110	103	↓
Prone restraint	20	20	→
Violence towards staff	50	55	↑
Violence towards patients	30	30	→
Ligature incidents	39	42	↑

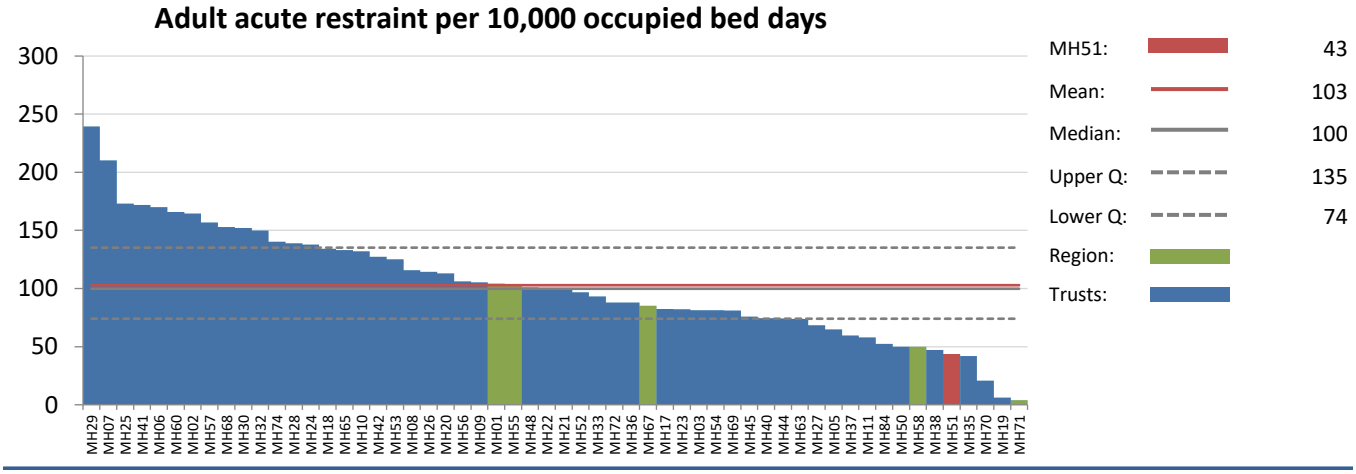


Figure 95

Benchmarking Network

Incidents - Older Adult Acute

All rates per 10,000 occupied bed days (excluding leave)

National position	2016/17	2017/18	Change
		National position	
Restraint	81	87	↑
Prone restraint	4	3	↓
Violence towards staff	96	95	↓
Violence towards patients	50	50	→
Ligature incidents	2	1	↓

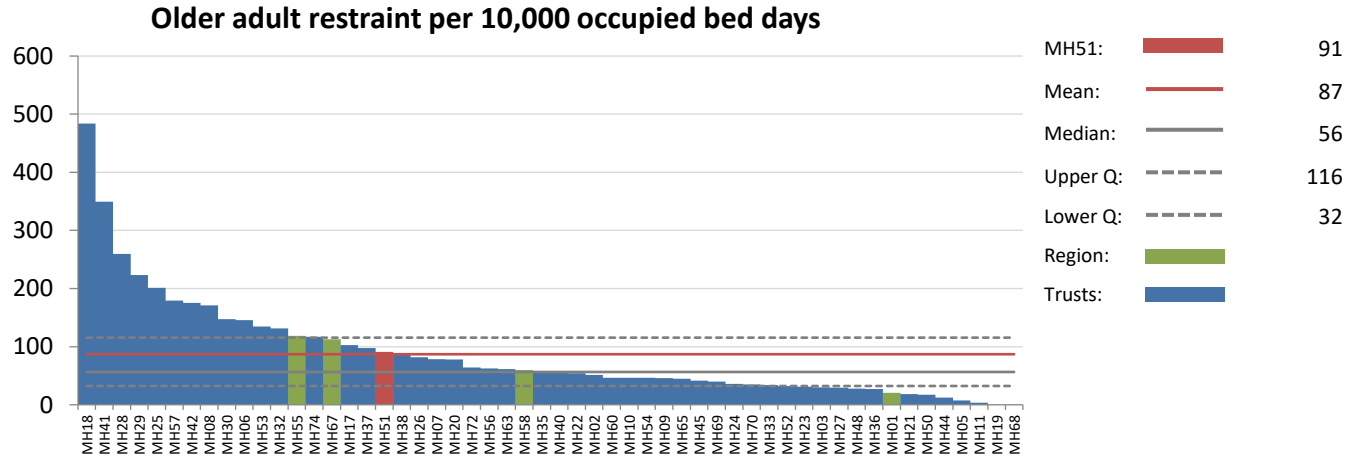


Figure 96

Incidents - PICU

All rates per 10,000 occupied bed days (excluding leave)

National position	National position 2016/17	National position 2017/18	Change
Restraint	428	437	↑
Prone restraint	103	102	↓
Violence towards staff	209	218	↑
Violence towards patients	98	100	↑
Ligature incidents	49	77	↑

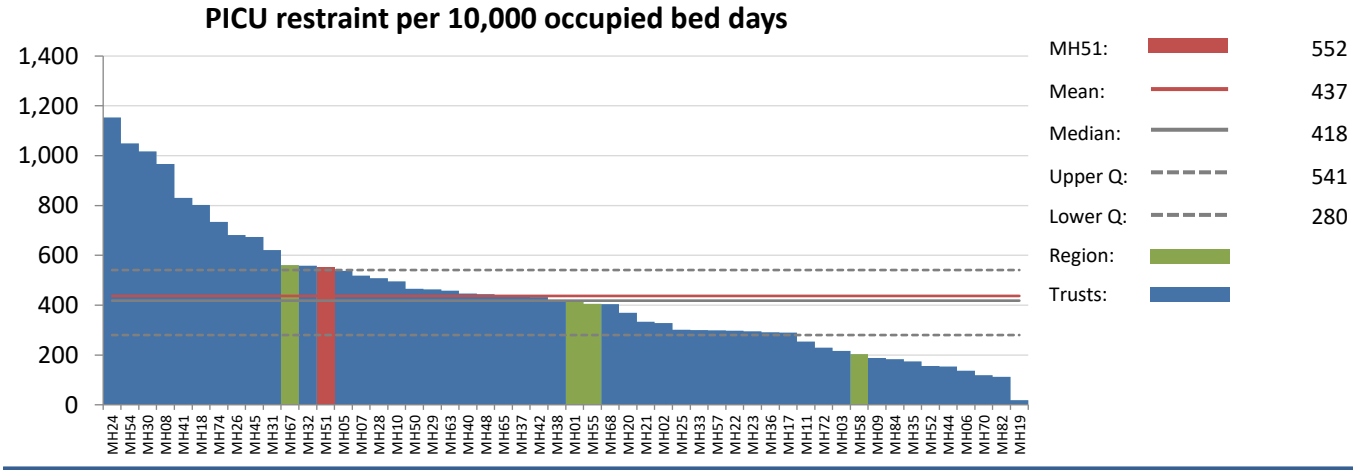


Figure 97

Balance of Care

There have been small but sustained changes in the balance between inpatient and community services in recent years.

The balance of financial investment has seen a marginal increase in spend on community services as a proportion of overall investment. However the balance of workforce has moved in the other direction, likely as a result of safer staffing initiatives dictating minimum levels for inpatient environments (a noticeable increase took place in 2014/15). The balance of activity has remained largely unchanged over the period.

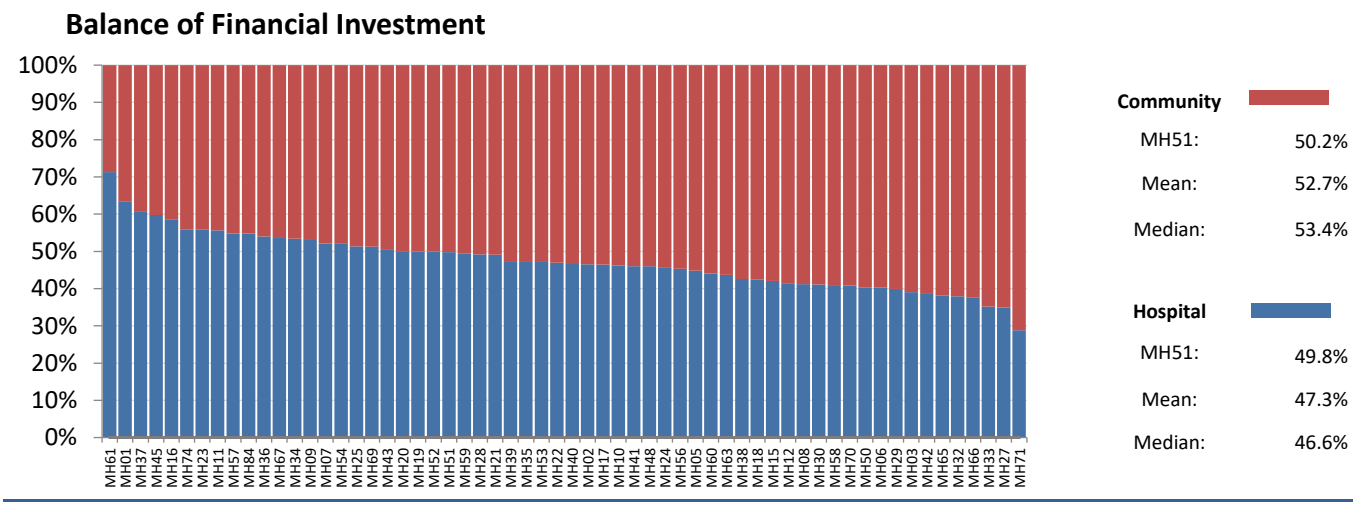


Figure 98

		2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	Community	51%	52%	52%	53%	53%	
	Inpatient	49%	48%	48%	47%	47%	

Benchmarking Network

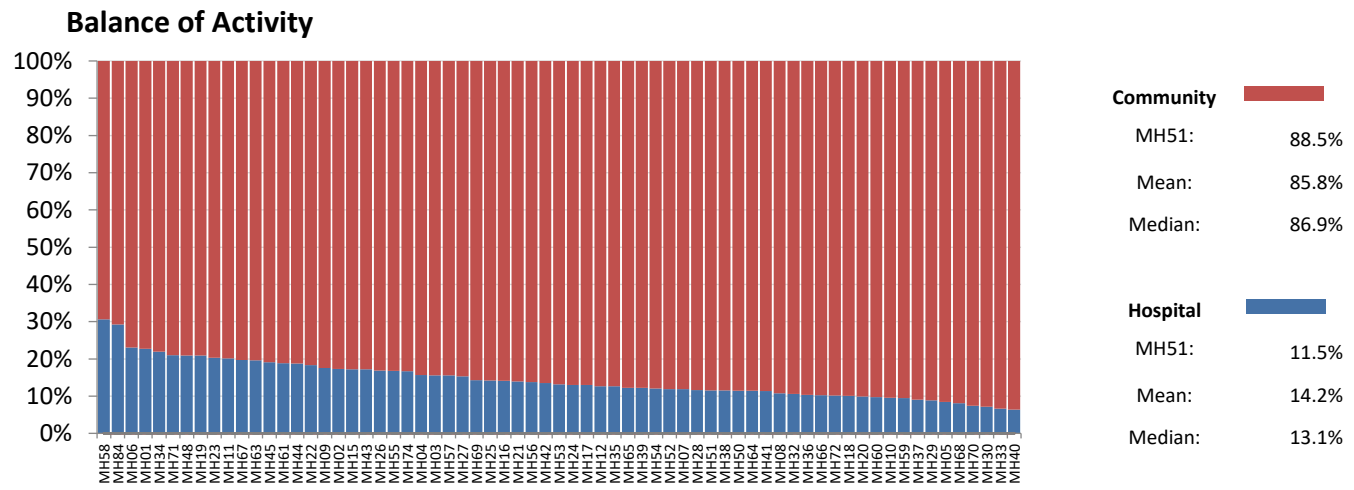


Figure 99

		2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	Community	86%	87%	88%	87%	87%	
	Inpatient	14%	13%	13%	14%	13%	

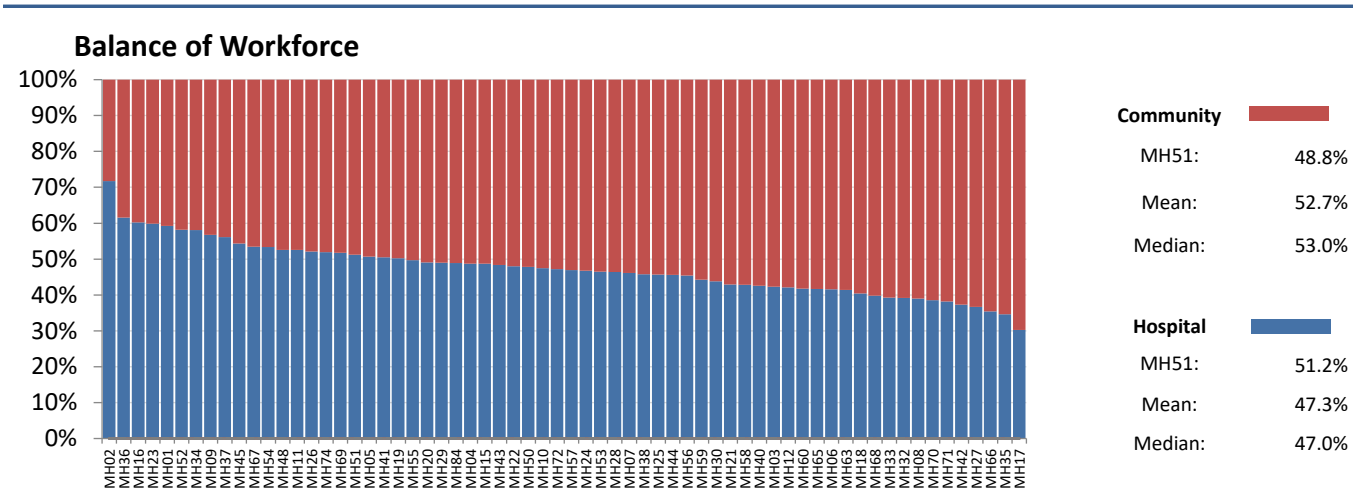


Figure 100

		2013/14	2014/15	2015/16	2016/17	2017/18	National trend
Median	Community	61%	55%	54%	53%	53%	
	Inpatient	39%	46%	46%	47%	47%	

Conclusion

We would like to express our thanks to all contributors in the 2018 mental health benchmarking process which has again revealed interesting findings for the NHS. The depth and breadth of the data helps to generate confidence in the comparisons discussed in this report. Due to the consistent positions of many data items the focus on interpreting the data has shifted in many places to one of describing time-series changes in the data observed over the last 7 years of annual benchmarking. The 7-year benchmarking horizon allows firm conclusions to be made about overall trends in service demand and provision across the UK over this period.

The discussion of findings often begins with inpatient care and the debate around bed numbers. Data from 2017/18 shows a broad stabilisation in capacity for Adult services although bed reductions continue to take place in Older People's care. The overall level of change reported since 2011/12 is a 17% reduction in adult acute beds and a 40% reduction in older adult beds. The reduction in bed numbers has contributed to an overall decline in admission rates with 15% fewer adult acute admissions this year than in 2011/12. The gradual reduction in admissions has been mitigated by the increase in bed occupancy which while creating some operational problems for providers, has enabled services to respond to local demand levels. The discussion for providers may well become one of sub-optimal patient flow due to high occupancy levels rather than a more simplistic discussion of relative efficiency. The holding of a UK wide position of 94% bed occupancy for acute mental health beds represents a real achievement for providers.

Each year our benchmarking results reaffirm the position that most service users receive their care in the community setting. In 2017/18 around 700,000 adults were supported by specialist community mental health teams across the UK. The overall number of people on caseloads (and associated contact levels) has been reducing in recent years against a background of pressures from cost improvement programmes and the introduction of IAPT in the NHS in England. The growth of IAPT provides rapid service access for people with common mental health problems which is also matched by demonstrable expansion in specialist services for people with first episode psychosis, perinatal mental health problems, and people in need of specialist psychiatric liaison services.

Waiting times for community-based care are again similar to those delivered for NHS physical healthcare. Around 90% of service users requiring community care receive treatment within 18 weeks of referral. Analysis of waiting times data does though reveal that the longest waits for treatment are now in services dedicated to supporting older people. This increase in waiting times when aligned with reductions in older people's bed capacity and community team caseloads raises concerns about parity of esteem for older people's mental health services.

The mental health workforce appears generally static in 2017/18 data with providers relying on high levels of bank and agency staff in the inpatient environment. Variations are evident in workforce size and shape which link closely to wider trends in the UK labour market.

Analysis of service quality metrics reveals a gradually improving position across most providers. Data from the Friends and Family test in England confirms that 88% of service users say they would recommend services to their friends and family. Analysis of service quality metrics reveals a commitment to transparency in reporting of adverse incidents. Further reductions in the use of prone restraint are particularly pleasing.

One of the central themes of the benchmarking work is to encourage providers to explore the balance of care between inpatient services and community care. Providers are encouraged to consider how best to ensure an appropriate balance of care between acute and community services. Data on the deployment of the mental health workforce and associated investment confirms an approximately equal split between bed and community-based services. The ability to achieve an appropriate system balance can be tested in the benchmarking data by reference to key metrics including; waiting times to access community based care, extent of use of out of area acute beds, and perceptions of service quality reported by service users and carers. In future years we anticipate that the shift to value-based healthcare will continue with pace with an increased focus on patient reported outcomes and experience measures.

It is an ongoing privilege for the NHS Benchmarking Network to be able to analyse data from member organisations. We hope that the process is a rewarding one for members that provides crucial intelligence for both local assurance and strategy development processes. We look forward to the opportunity to discuss this year's benchmarking findings with members at our annual mental health benchmarking conference in London on 9th November 2018.

Further comments or questions on any aspect of this report should be addressed to either Stephen Watkins or Zoe Morris on s.watkins@nhs.net or zoe.morris@nhs.net

Index of Charts

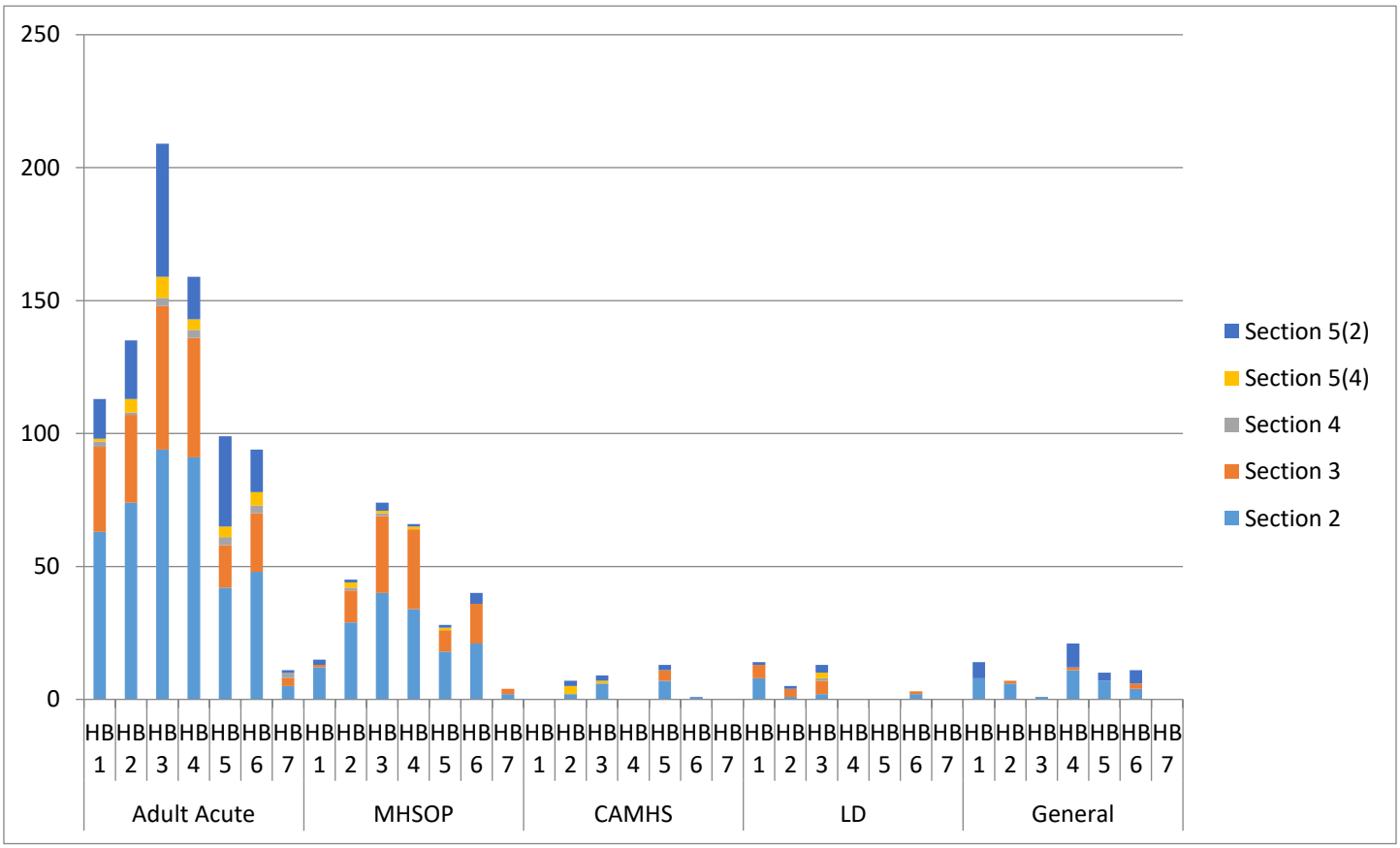
Appendix 2

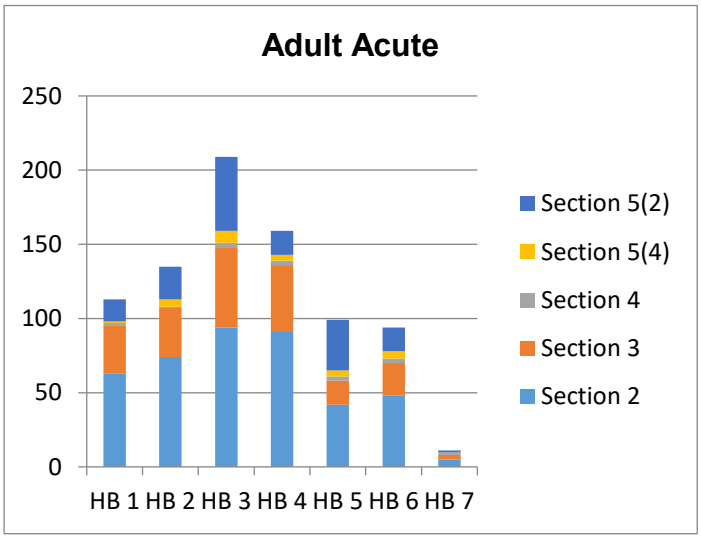
Benchmarking data July - September 2018:

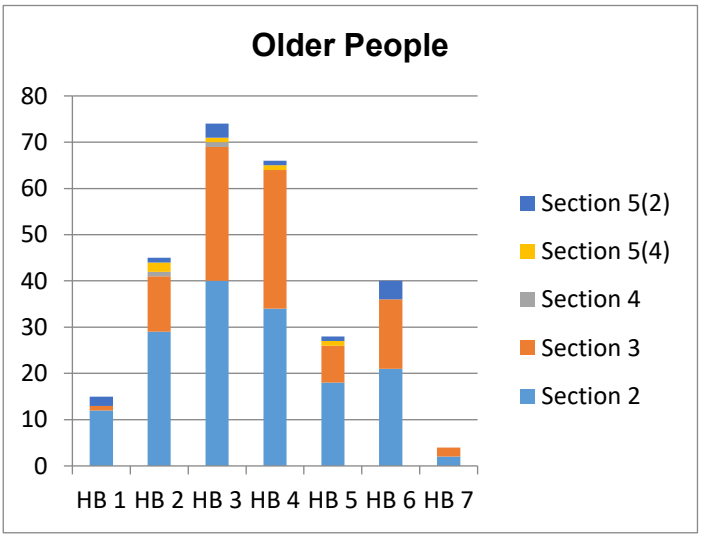
Health Board	Population
Abertawe Bro Morgannwg University Health Board	531,858
Aneurin Bevan University Health Board	587,743
Betsi Cadwaladr University Health Board	696,284
Cardiff & Vale University Health Board	493,446
Cwm Taff University Health Board	299,080
Hywel Dda University Health Board	384,239
Powys Teaching Health Board	132,515
Total Population of Wales:-	3,125,165

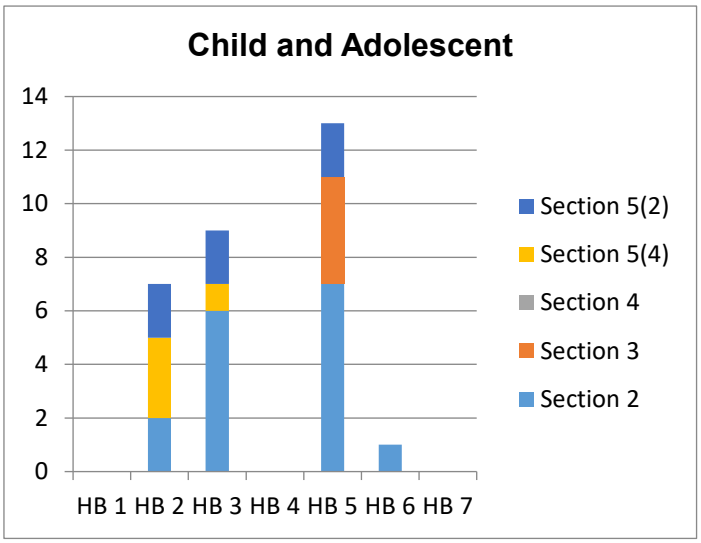
Part 2 MHA Activity

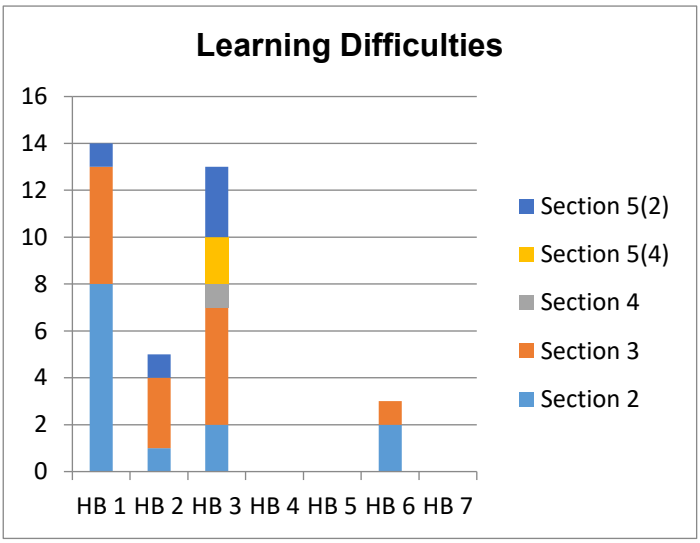
During the period a total of 1221 patients were made subject to the part 2 provisions of the MHA 1983 across Wales.

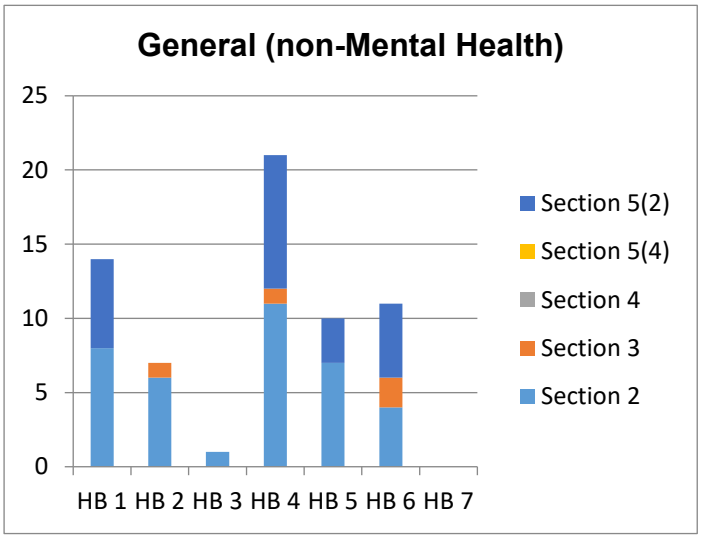


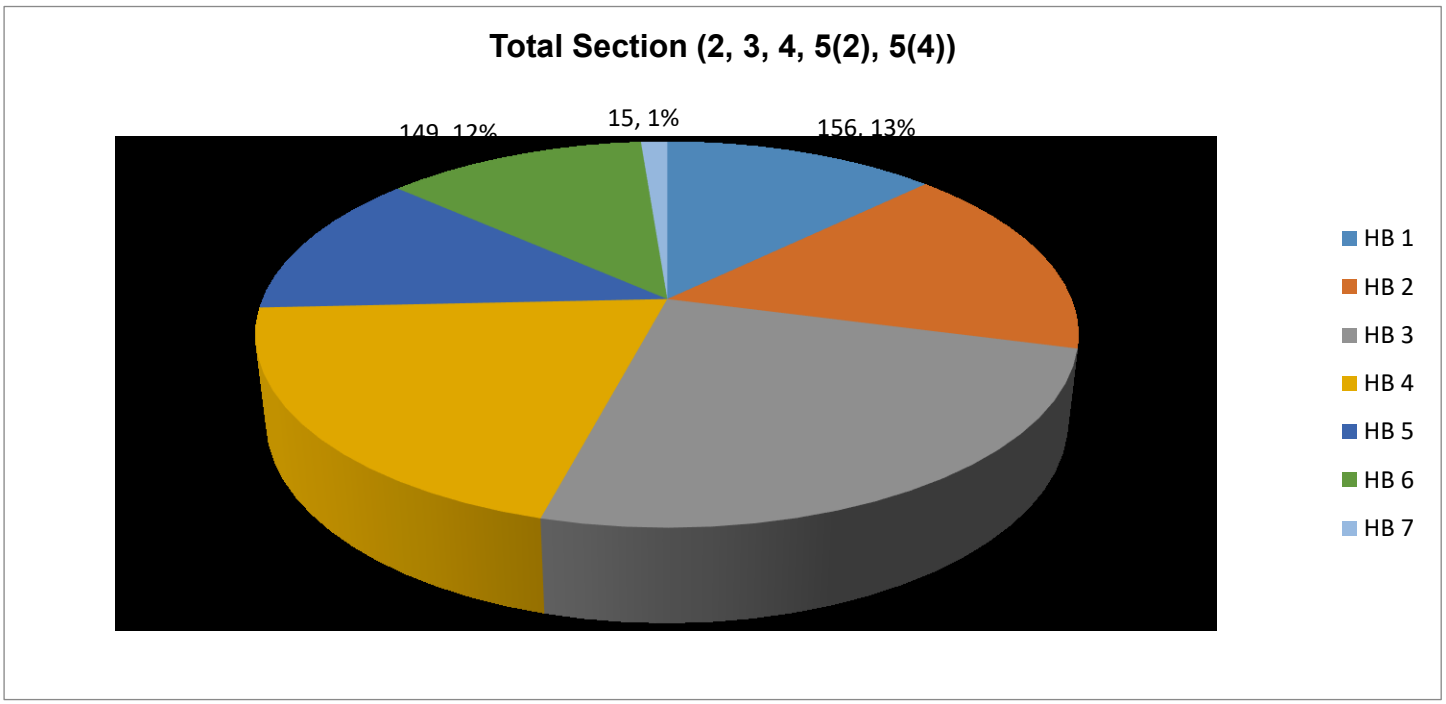





Child and Adolescent
14
12
10
8
6
4
2
0
HB 1 HB 2 HB 3 HB 4 HB 5 HB 6 HB 7
Section 5(2)
Section 5(4)
Section 4
Section 3
Section 2


Learning Difficulties
16
14
12
10
8
6
4
2
0
HB 1 HB 2 HB 3 HB 4 HB 5 HB 6 HB 7
Section 5(2)
Section 5(4)
Section 4
Section 3
Section 2


General (non-Mental Health)
25
20
15
10
5
0
HB 1 HB 2 HB 3 HB 4 HB 5 HB 6 HB 7
Section 5(2)
Section 5(4)
Section 4
Section 3
Section 2

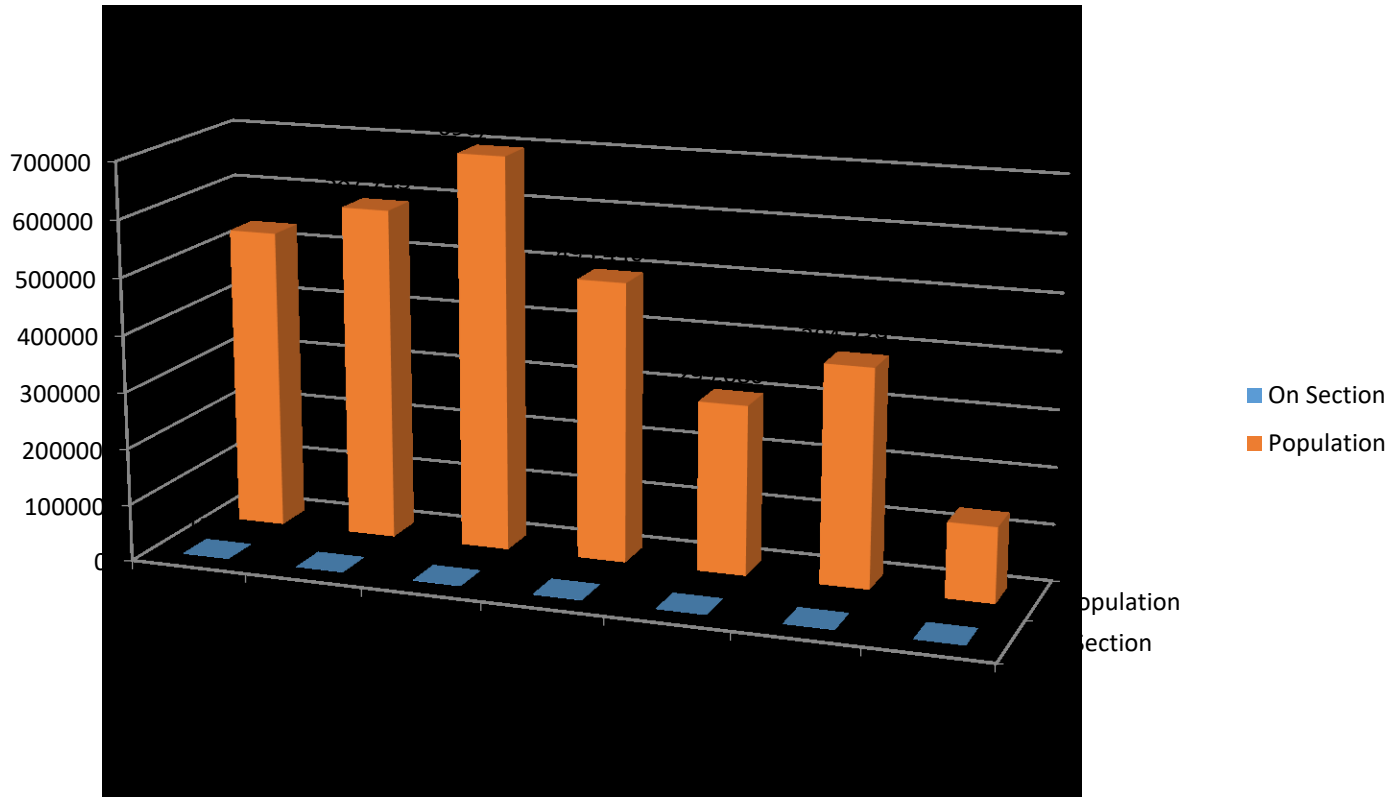

Total Section (2, 3, 4, 5(2), 5(4))
149, 12%
15, 1%
156, 13%
HB 1
HB 2
HB 3
HB 4
HB 5
HB 6
HB 7

Part 2 MHA Activity Compared to Health Board Population

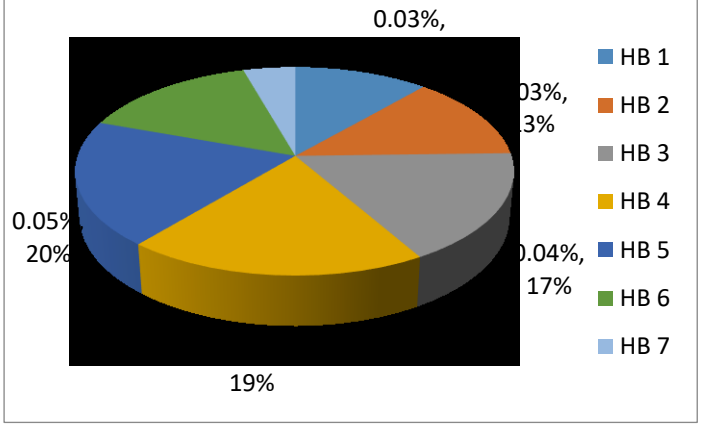
Population figures taken from https://statswales.gov.wales

The latest available population by Health Board figures available at the time of writing were mid-2017.

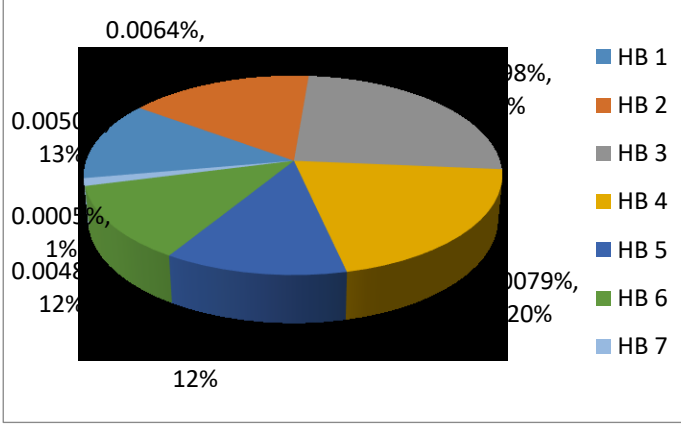
Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to Health Board Population



Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to Health Board Population

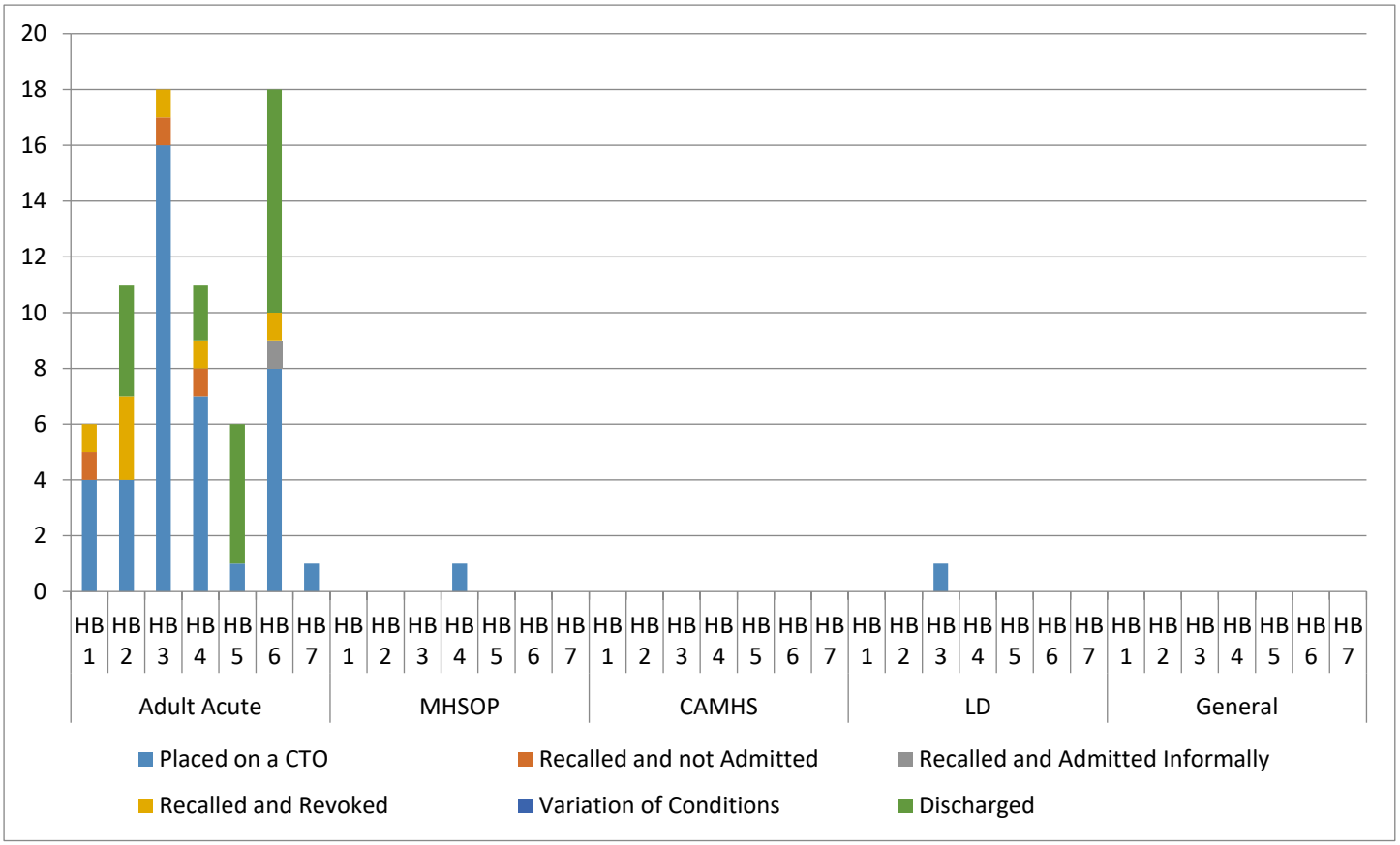


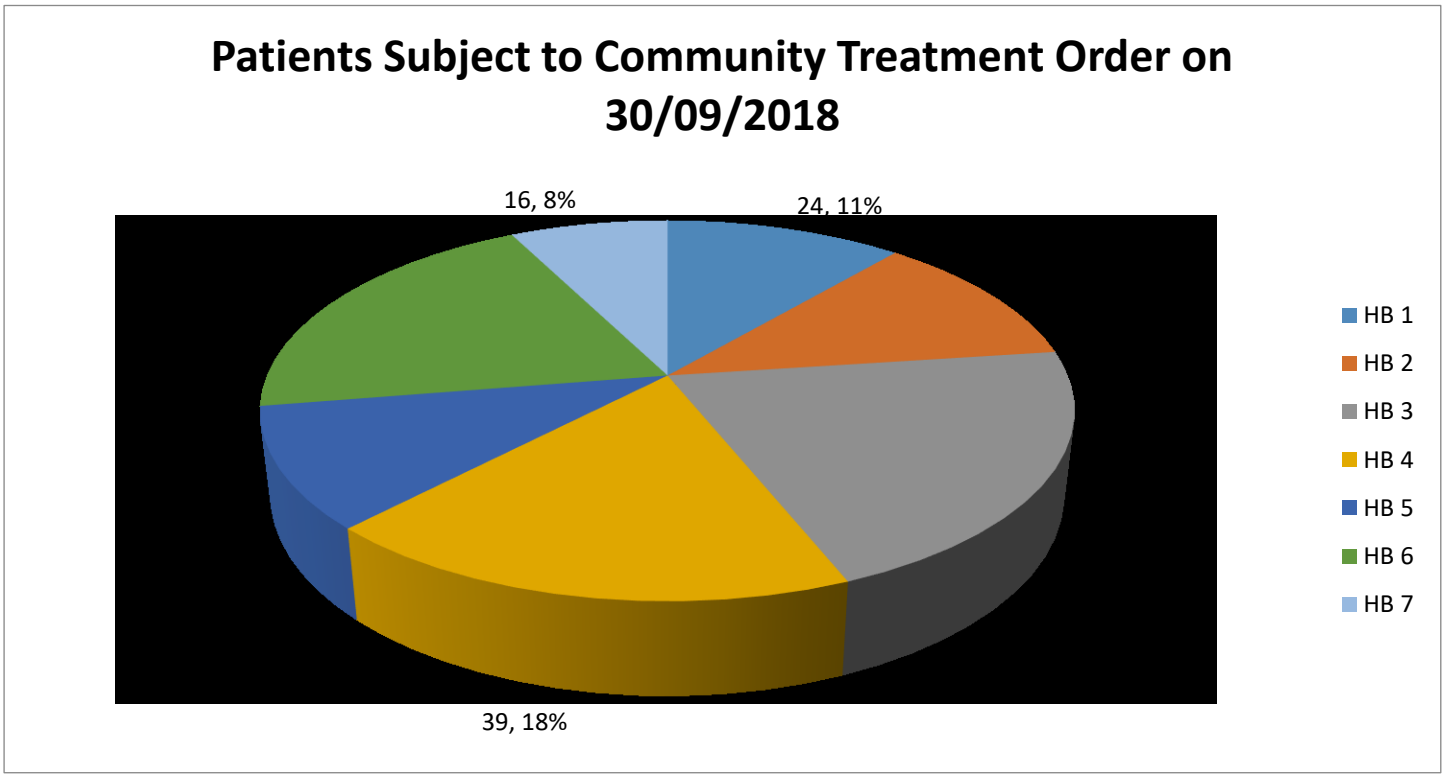
Inpatient Formal Sections (2, 3, 4, 5(2), 5(4)) Compared to the Population of Wales

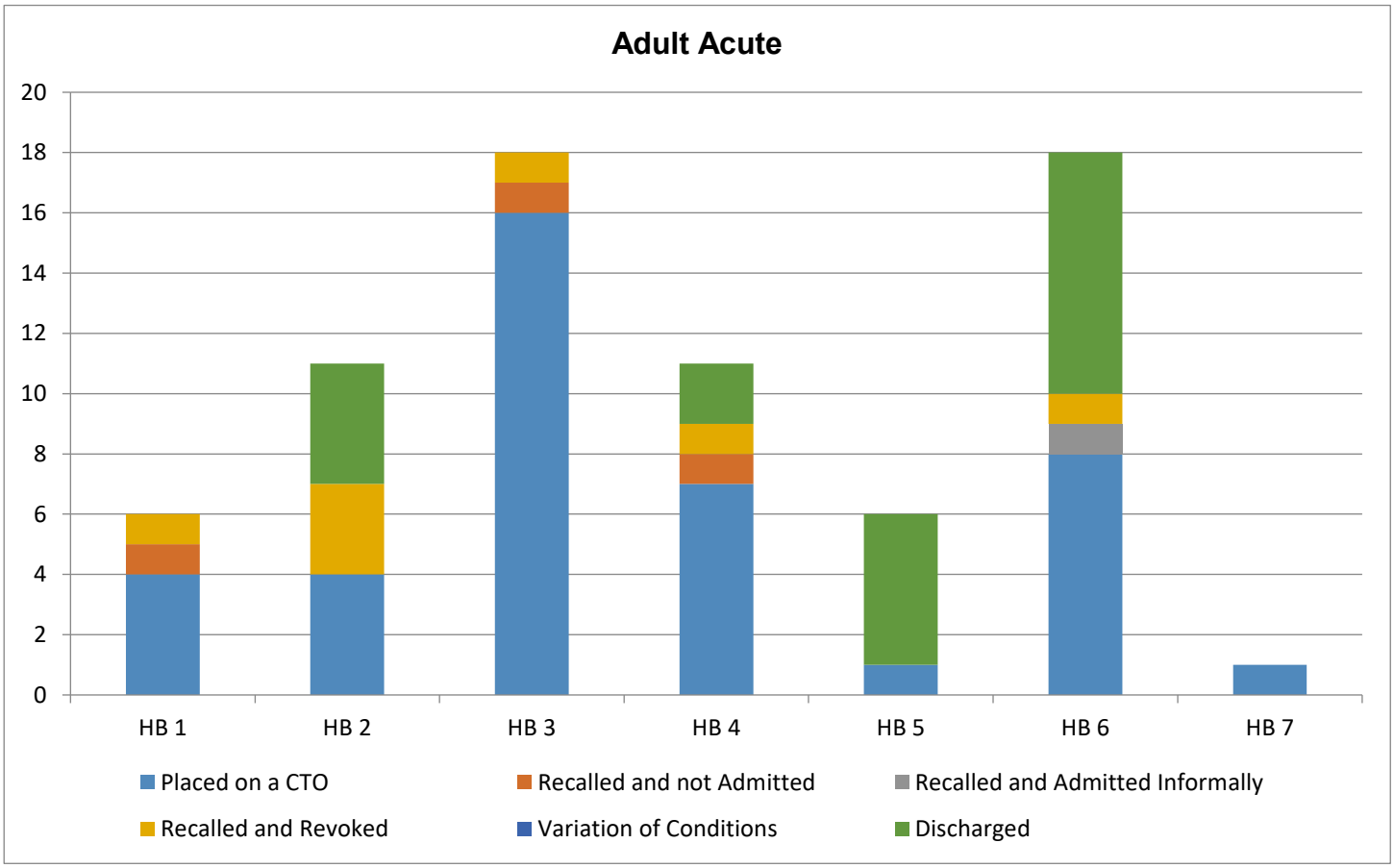


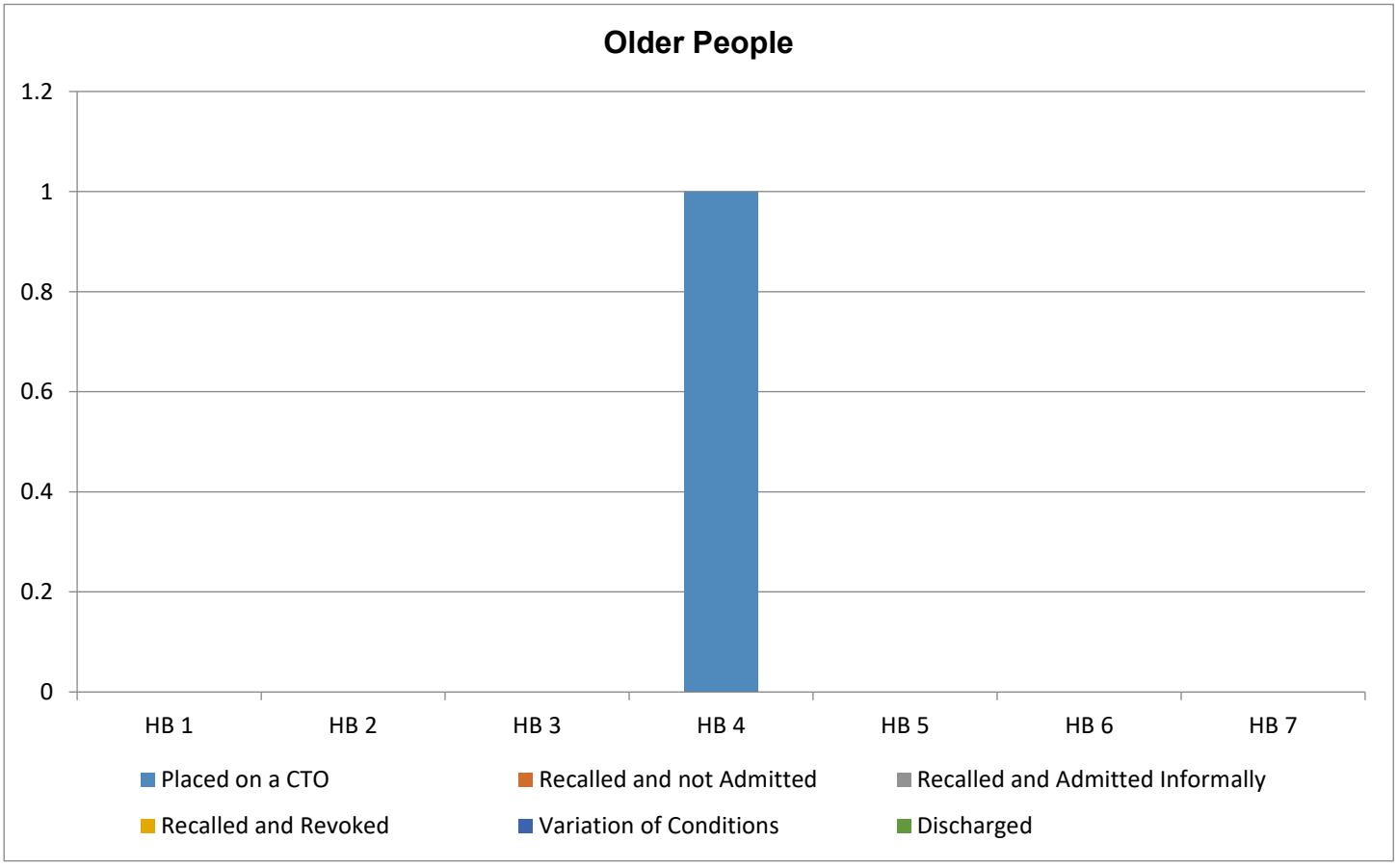
Community Treatment Order

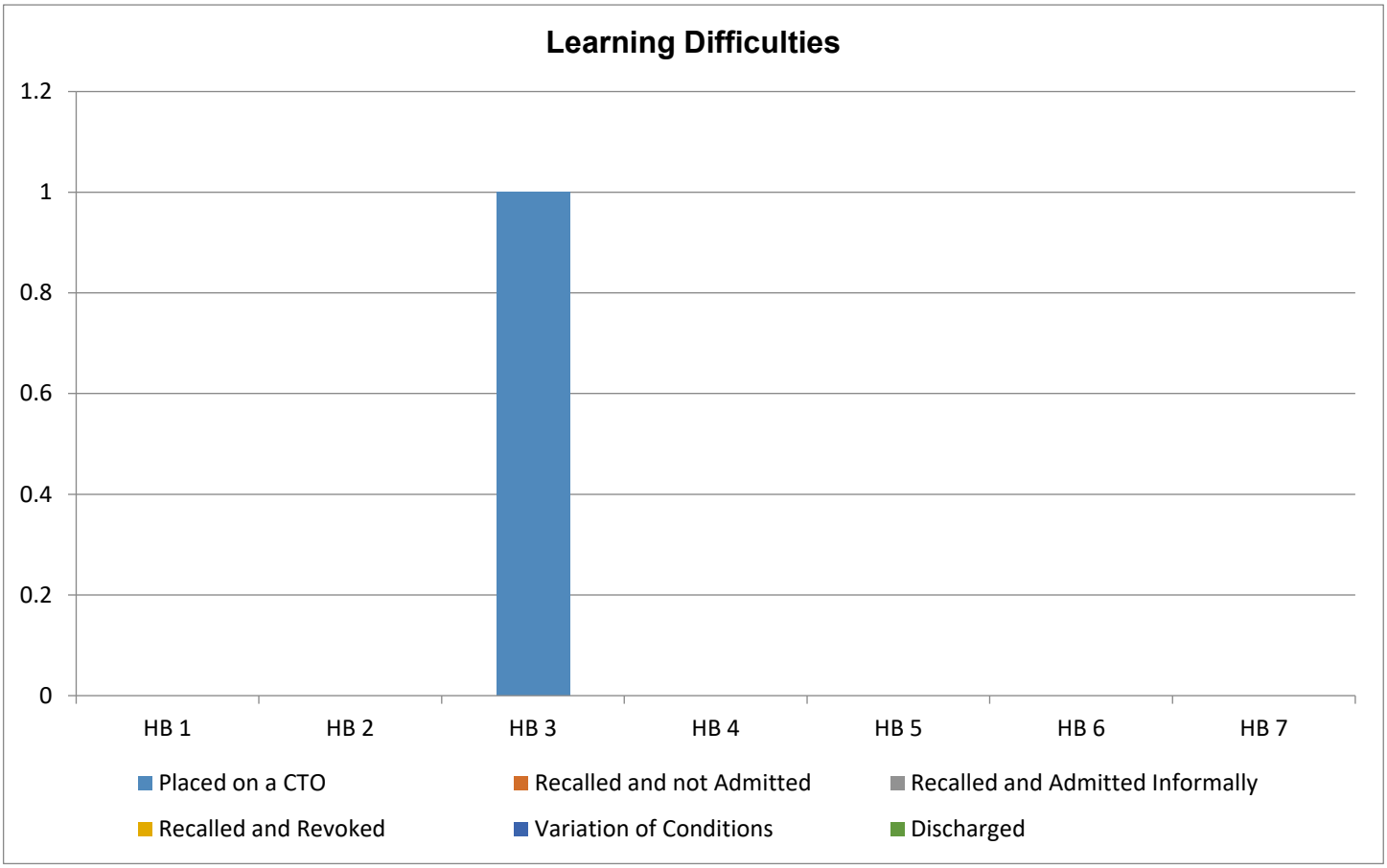
During the period a total of 43 patients were made subject to a Community Treatment Order across Wales.





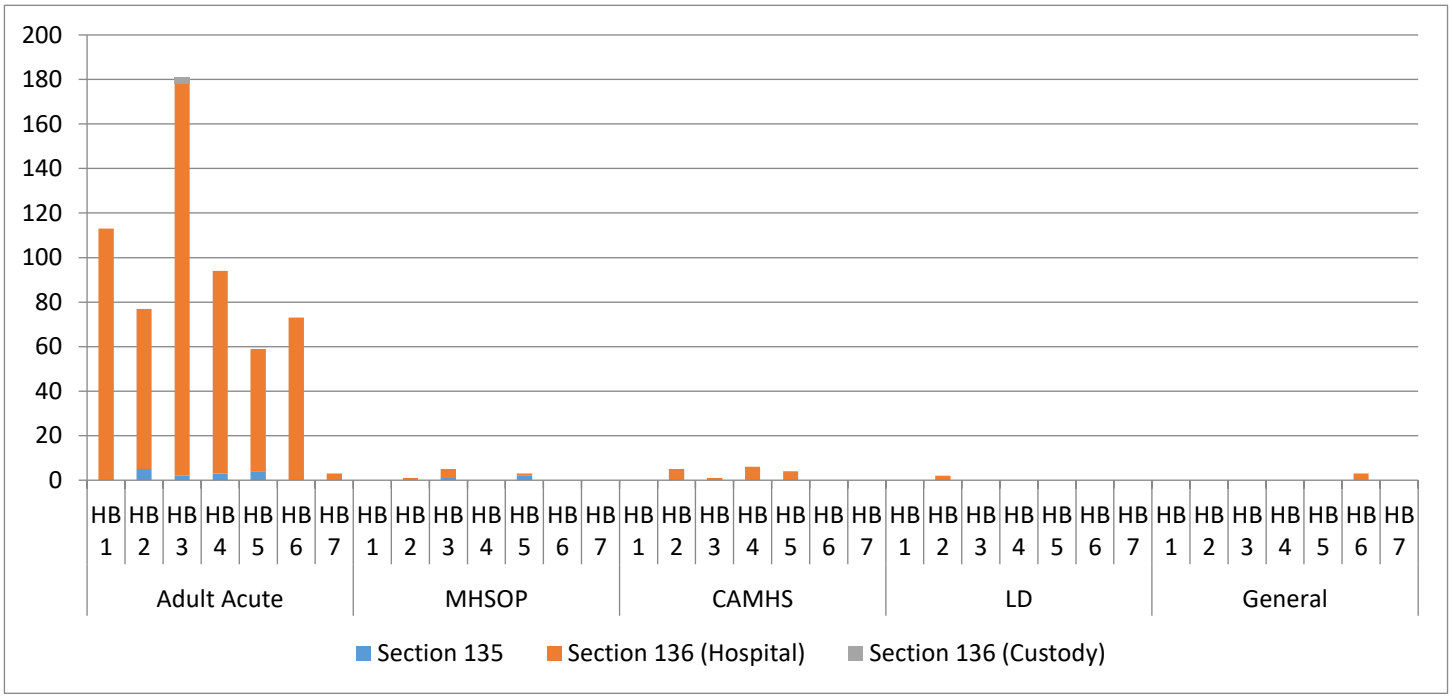

Adult Acute
20
18
16
14
12
10
8
6
4
2
0
HB 1
HB 2
HB 3
HB 4
HB 5
HB 6
HB 7
Placed on a CTO
Recalled and not Admitted
Recalled and Admitted Informally
Recalled and Revoked
Variation of Conditions
Discharged

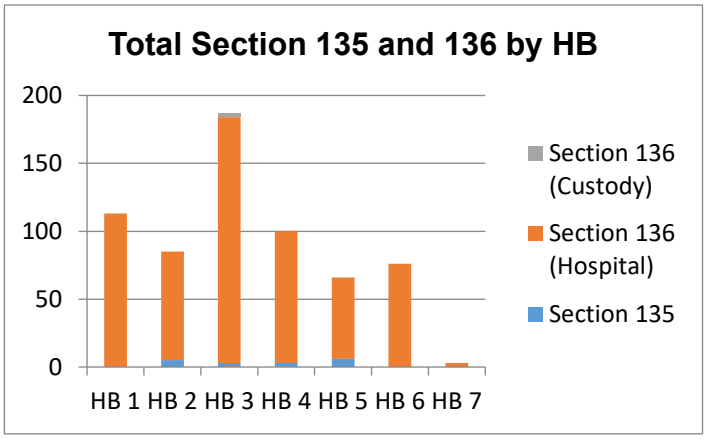

Older People
1.2
1
0.8
0.6
0.4
0.2
0
HB 1
HB 2
HB 3
HB 4
HB 5
HB 6
HB 7
Placed on a CTO
Recalled and not Admitted
Recalled and Admitted Informally
Recalled and Revoked
Variation of Conditions
Discharged

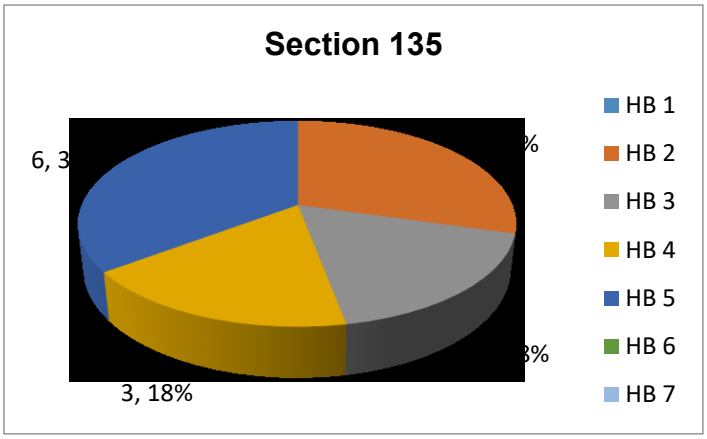

Learning Difficulties
1.2
1
0.8
0.6
0.4
0.2
0
HB 1
HB 2
HB 3
HB 4
HB 5
HB 6
HB 7
Placed on a CTO
Recalled and not Admitted
Recalled and Admitted Informally
Recalled and Revoked
Variation of Conditions
Discharged

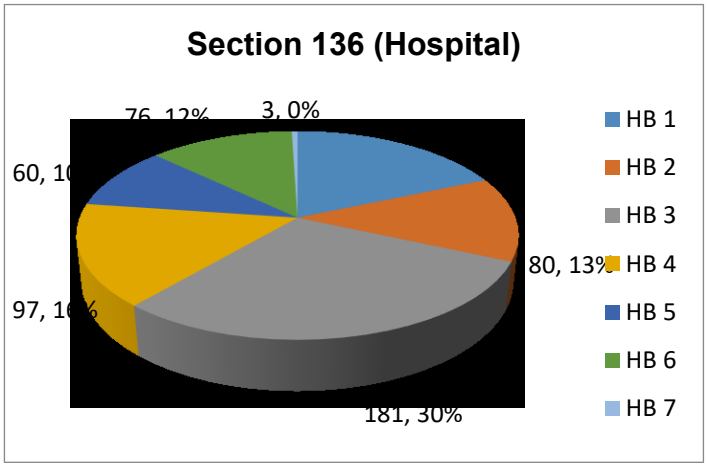
Section 135 & 136

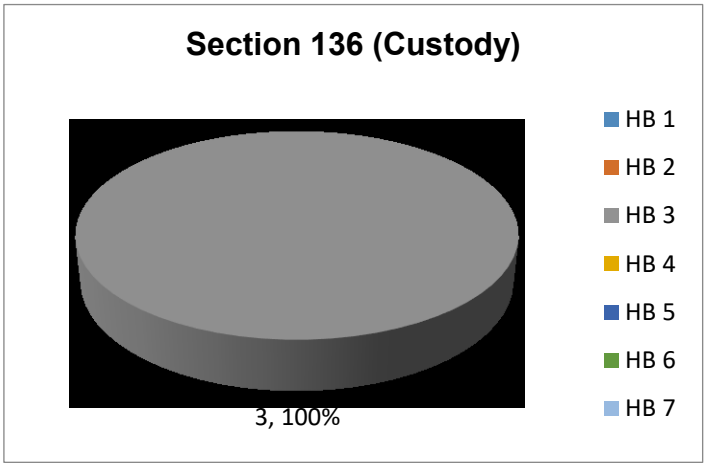
The charts below provide data on how section 135/136 is used across Wales broken down into specialities, HB's and total activity.





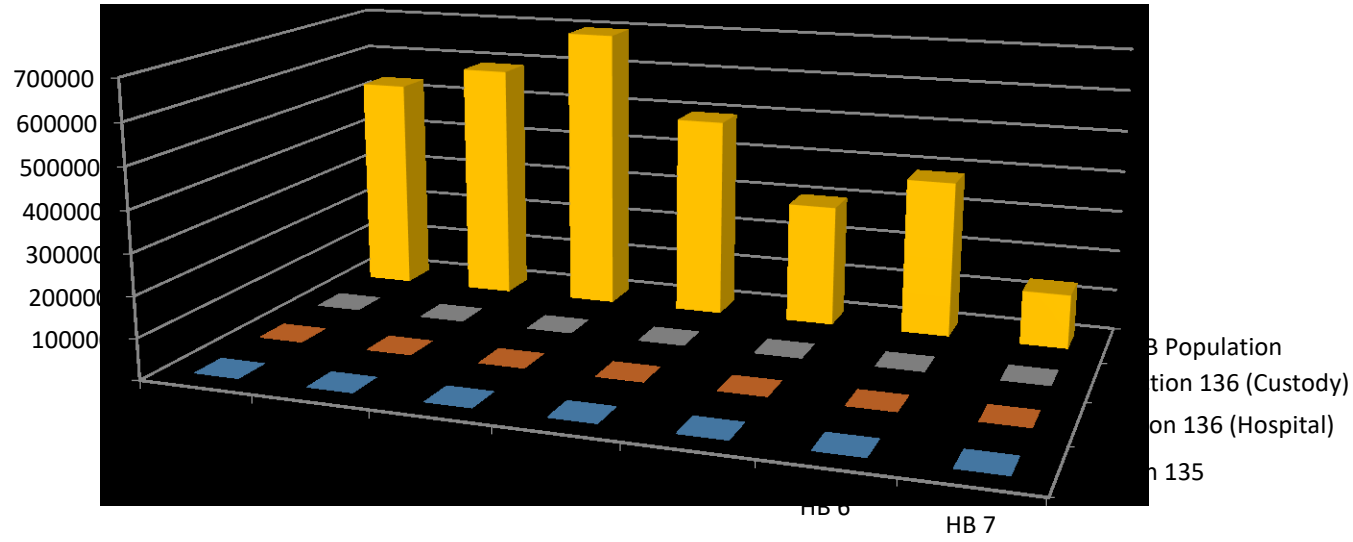






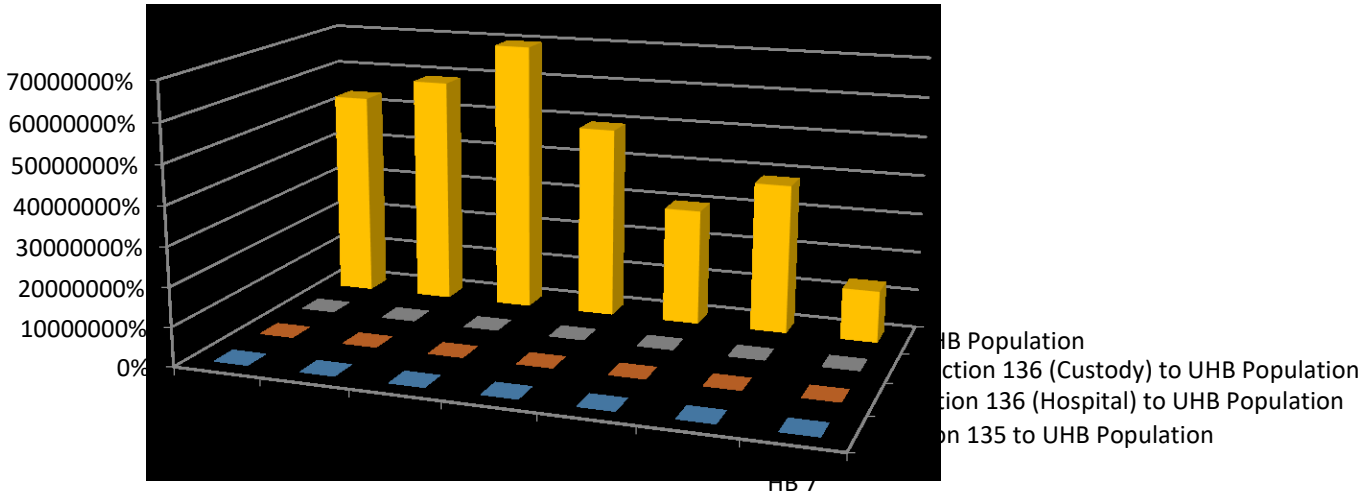
Section 135 and 136 Compared to Health Board Population

Section 135 and 136 Compared to Health Board Population (Numbers)



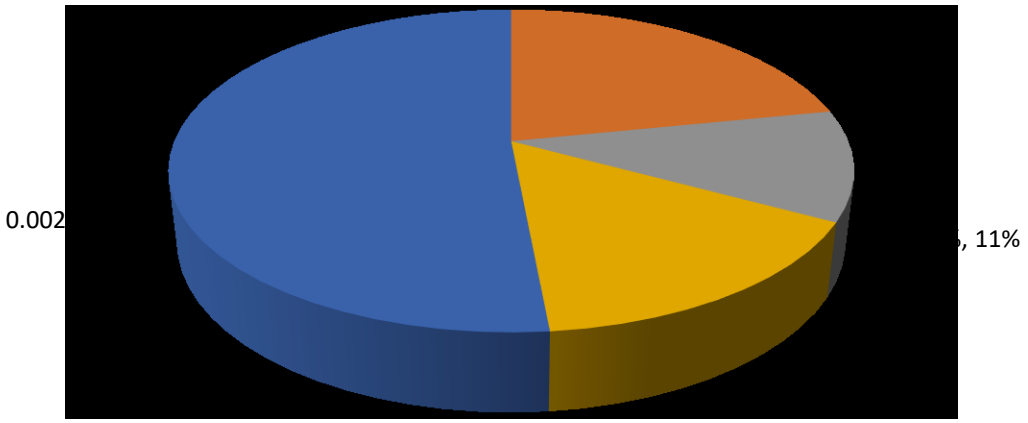
	HB 1	HB 2	HB 3	HB 4	HB 5	HB 6	HB 7
Section 135	0	5	3	3	6	0	0
Section 136 (Hospital)	113	80	181	97	60	76	3
Section 136 (Custody)	0	0	3	0	0	0	0
HB Population	531858	587743	696284	493446	299080	384239	132515

Section 135 and 136 Compared to Health Board Population (Percentage)

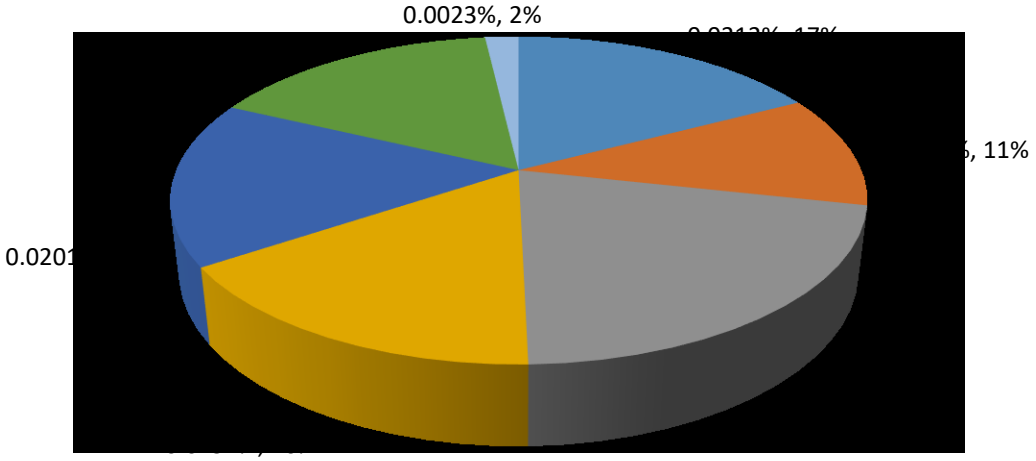


	HB 1	HB 2	HB 3	HB 4	HB 5	HB 6	HB 7
Section 135 to UHB Population	0.0000%	0.0009%	0.0004%	0.0006%	0.0020%	0.0000%	0.0000%
Section 136 (Hospital) to UHB Population	0.0212%	0.0136%	0.0260%	0.0197%	0.0201%	0.0198%	0.0023%
Section 136 (Custody) to UHB Population	0.0000%	0.0000%	0.0004%	0.0000%	0.0000%	0.0000%	0.0000%
HB Population	531858	587743	696284	493446	299080	384239	132515

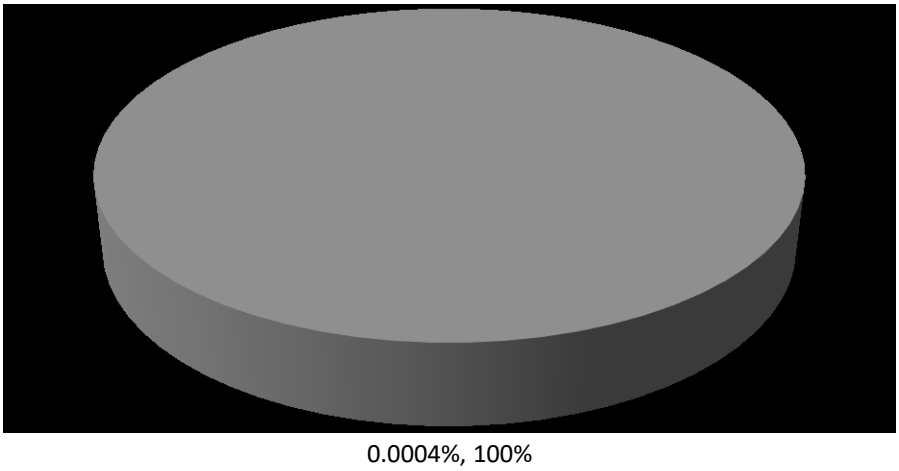
Section 135 to UHB Population



Section 136 (Hospital) to UHB Population

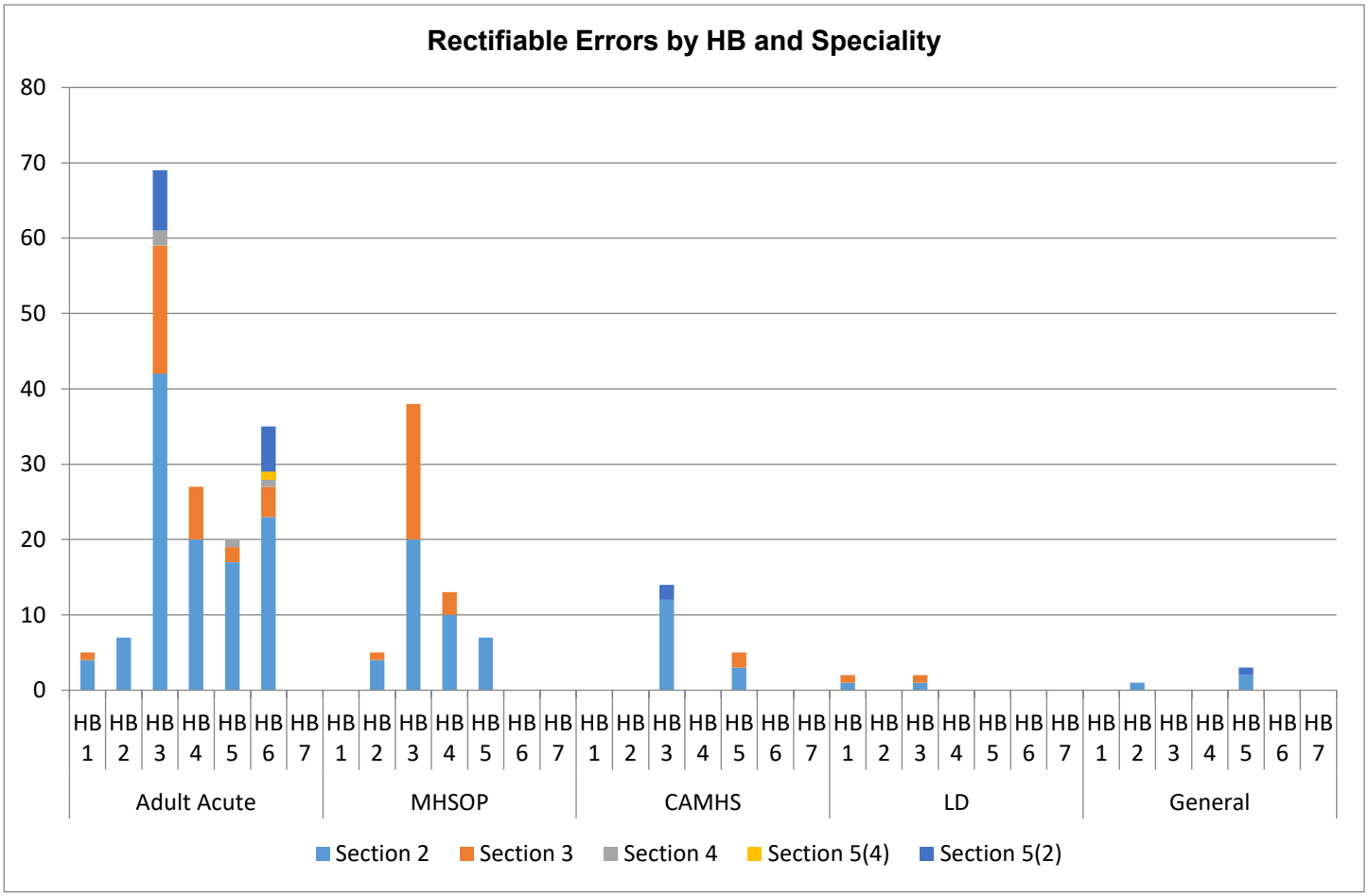


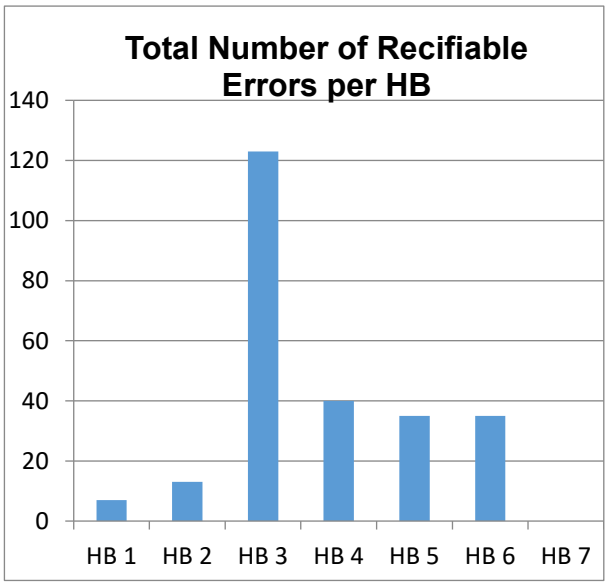
Section 136 (Custody) to UHB Population

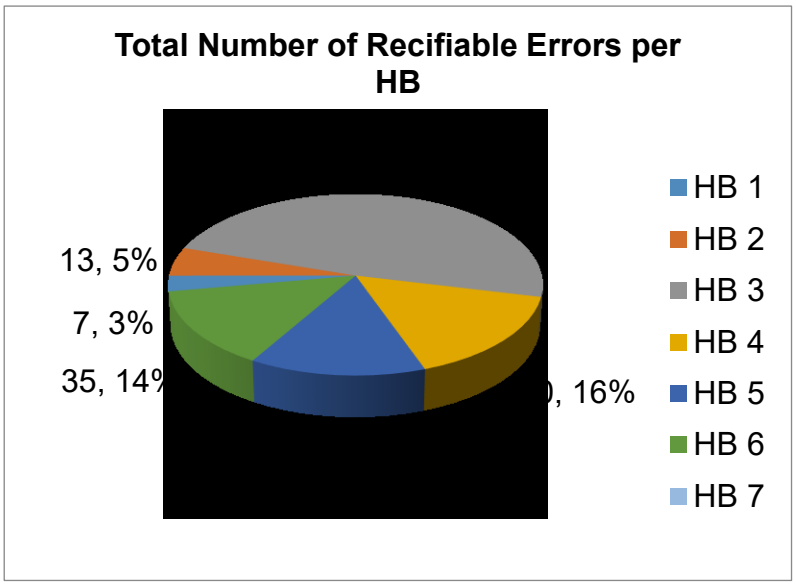


Rectifiable Errors

Rectifiable errors by HB and speciality.

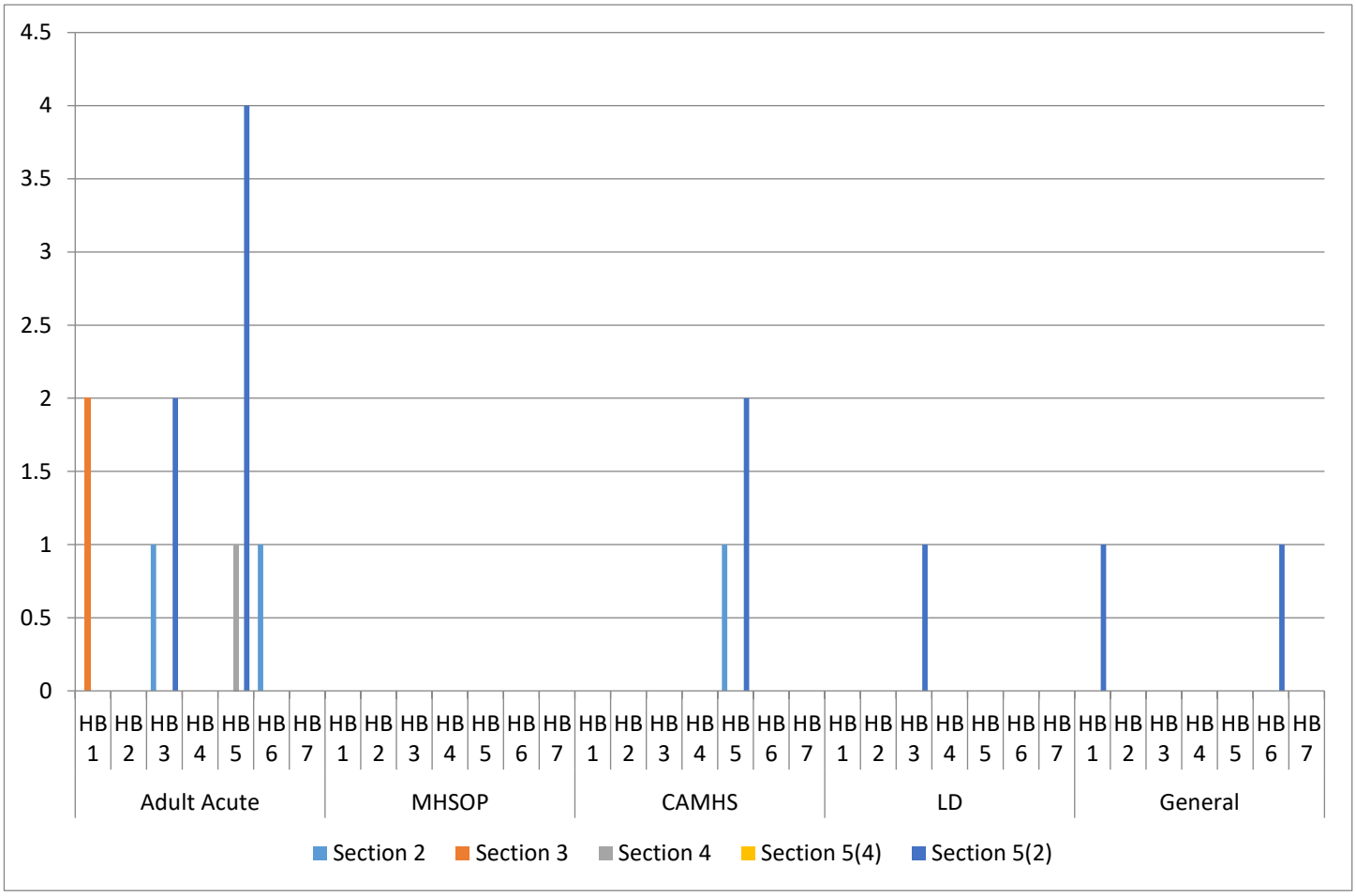


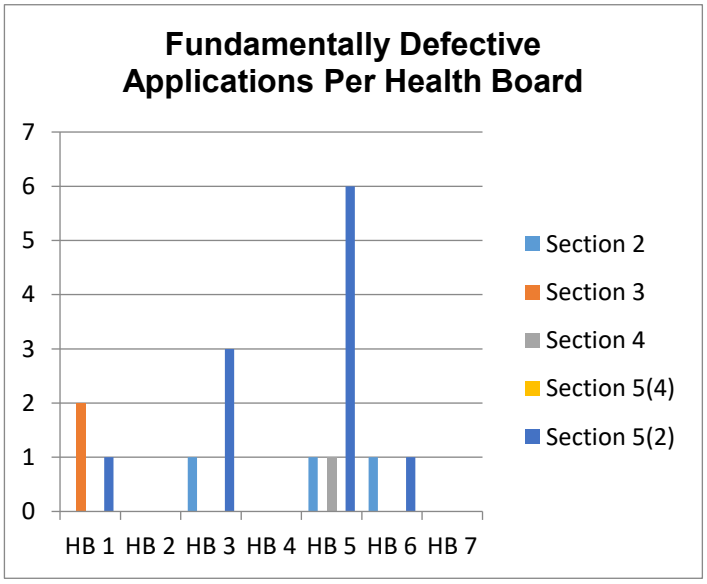


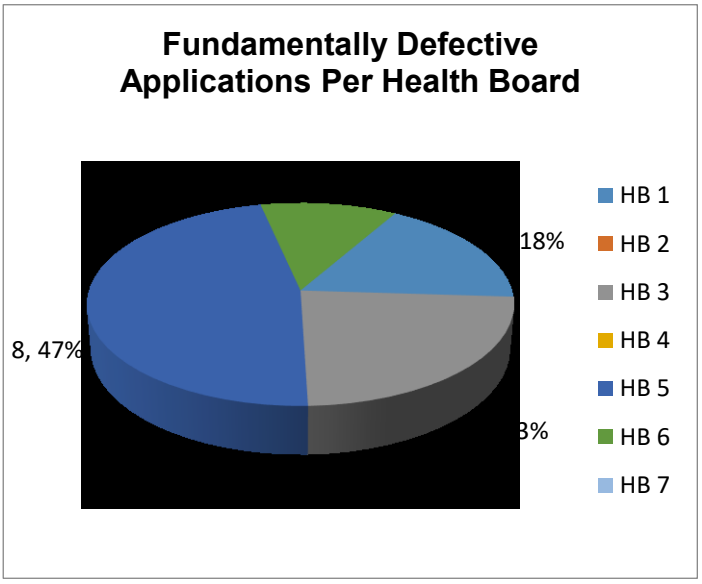


Fundamentally Defective

Number of fundamentally defective applications by speciality and HB.

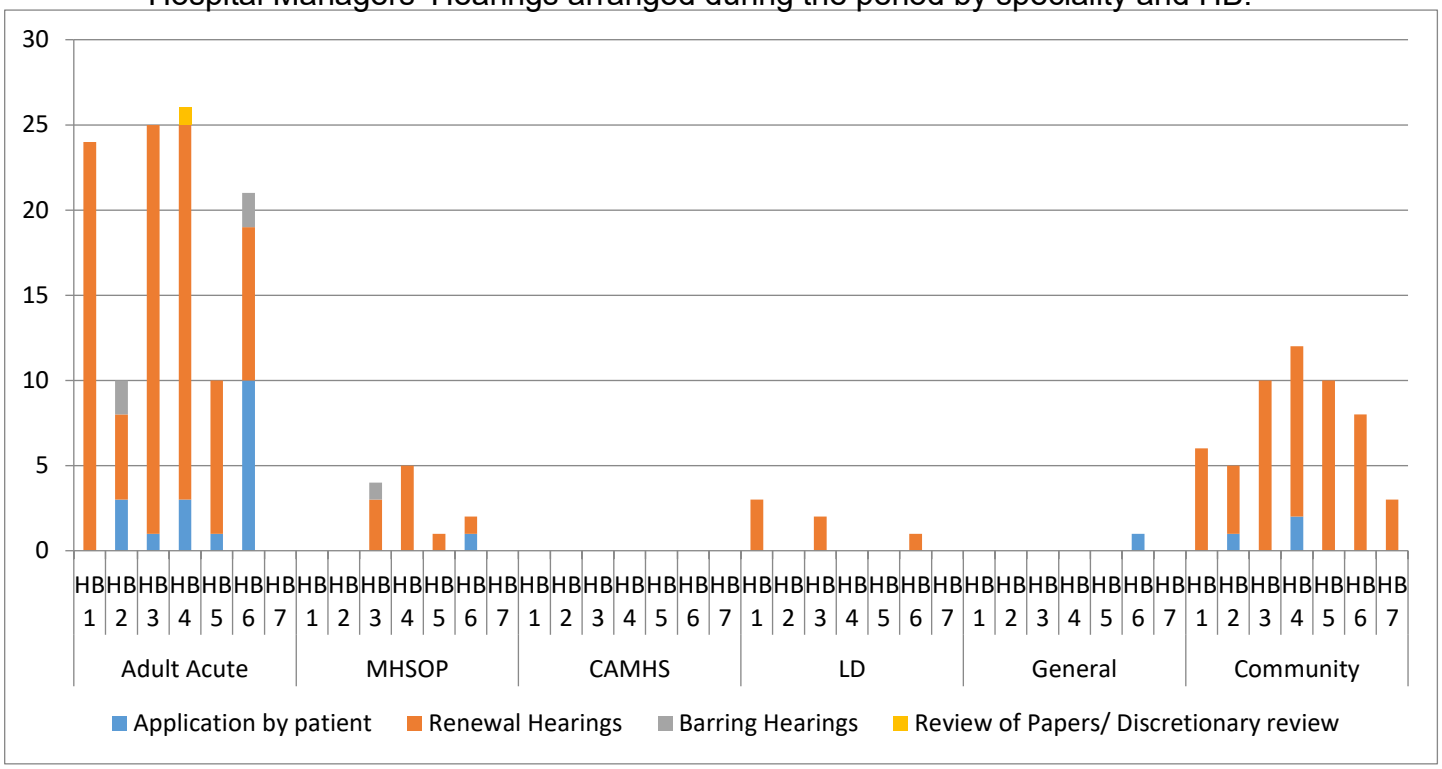


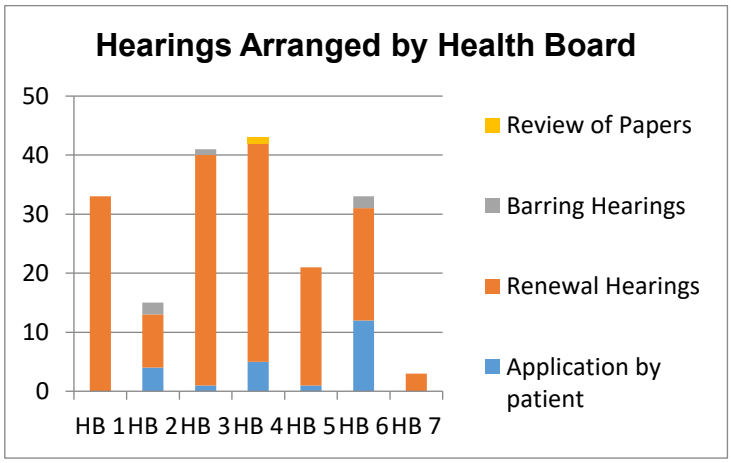


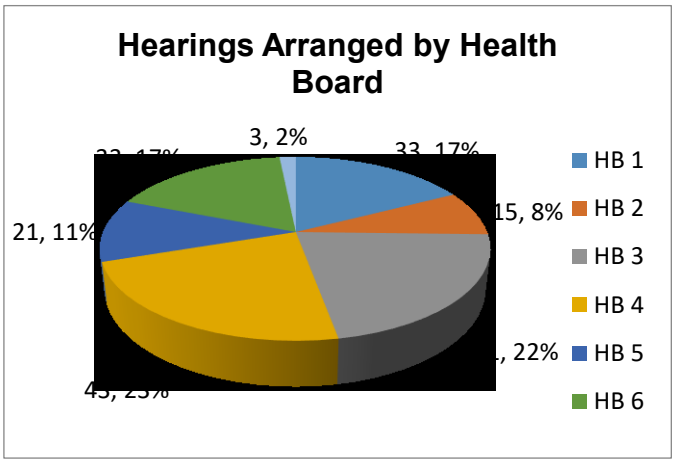


Hospital Managers Activity

Hospital Managers' Hearings arranged during the period by speciality and HB.

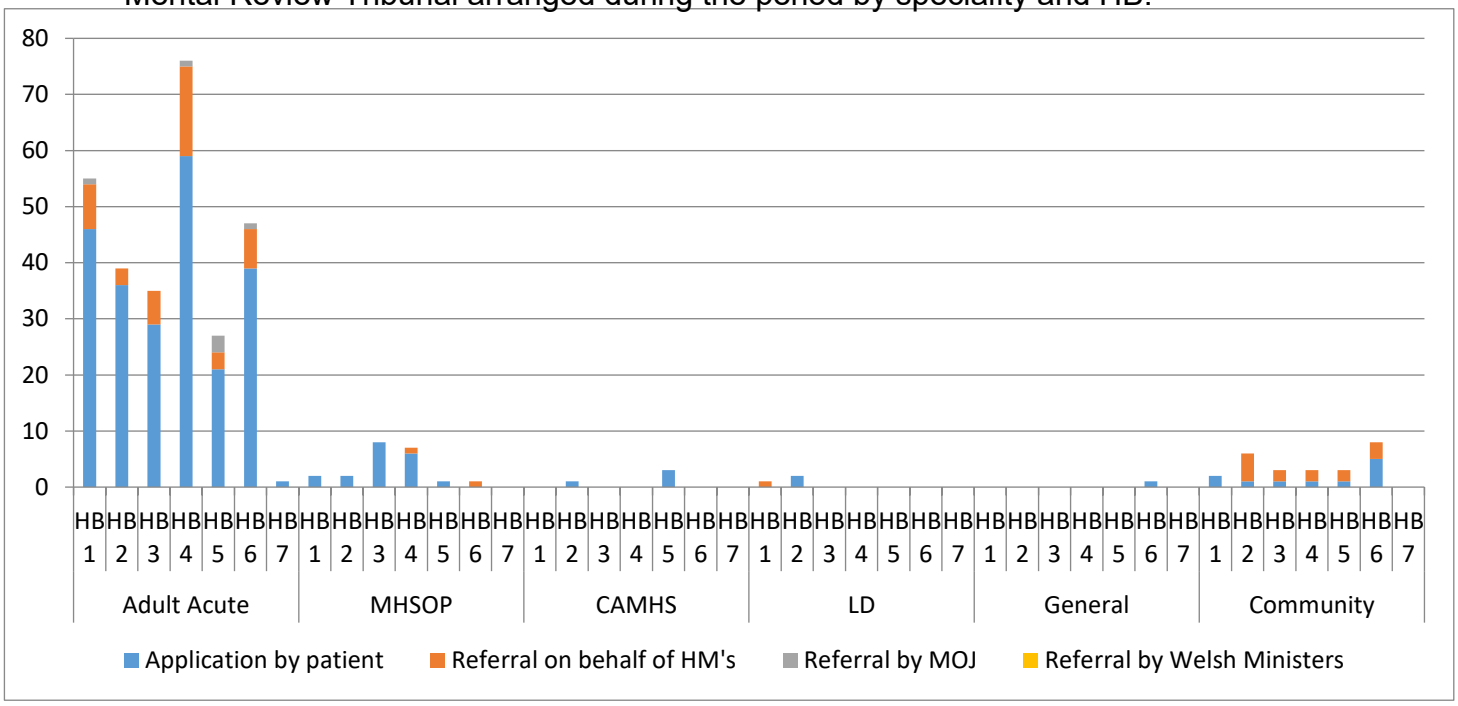


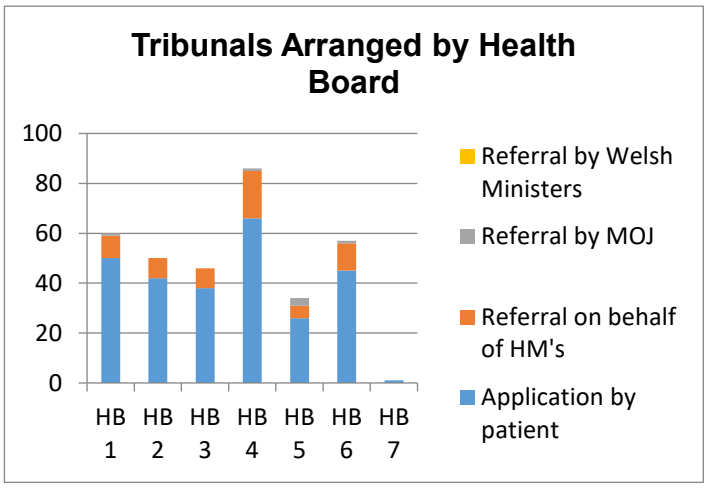


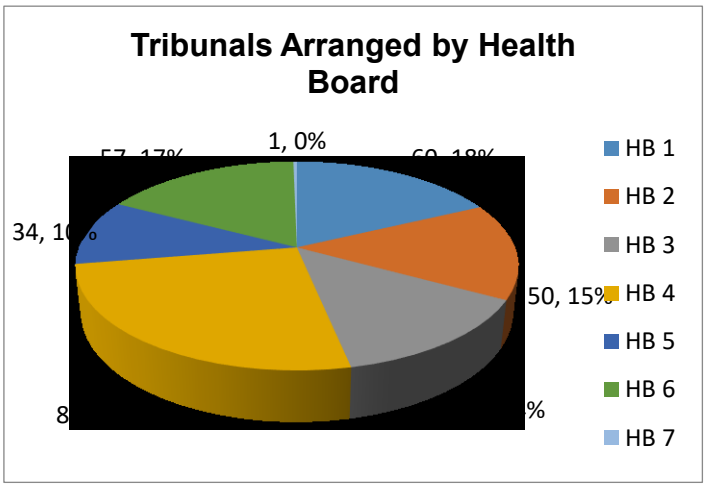


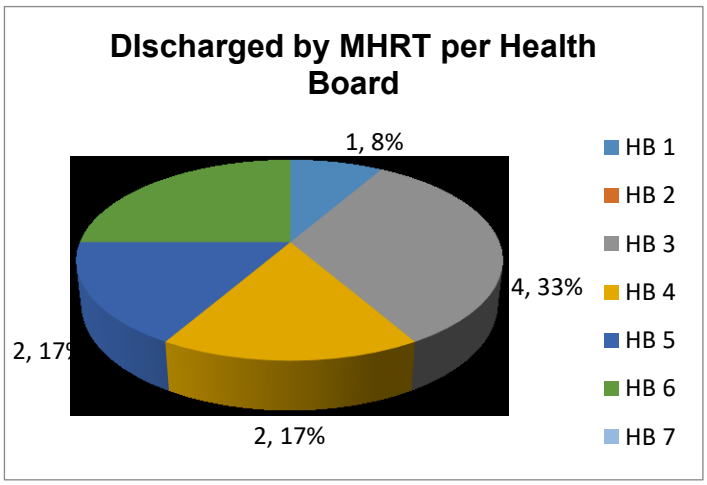
MHRT Activity

Mental Review Tribunal arranged during the period by speciality and HB.









REPORT TITLE:	**Mental Health Measure**								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	**12th February 2019**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Steve Curry – Chief Operating Officer								
REPORT AUTHOR (TITLE):	Ian Wile – Director of Operations, Mental Health								

PURPOSE OF REPORT:

To provide assurance to the committee on the four parts of the mental health measure

REPORT:

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.

BACKGROUND

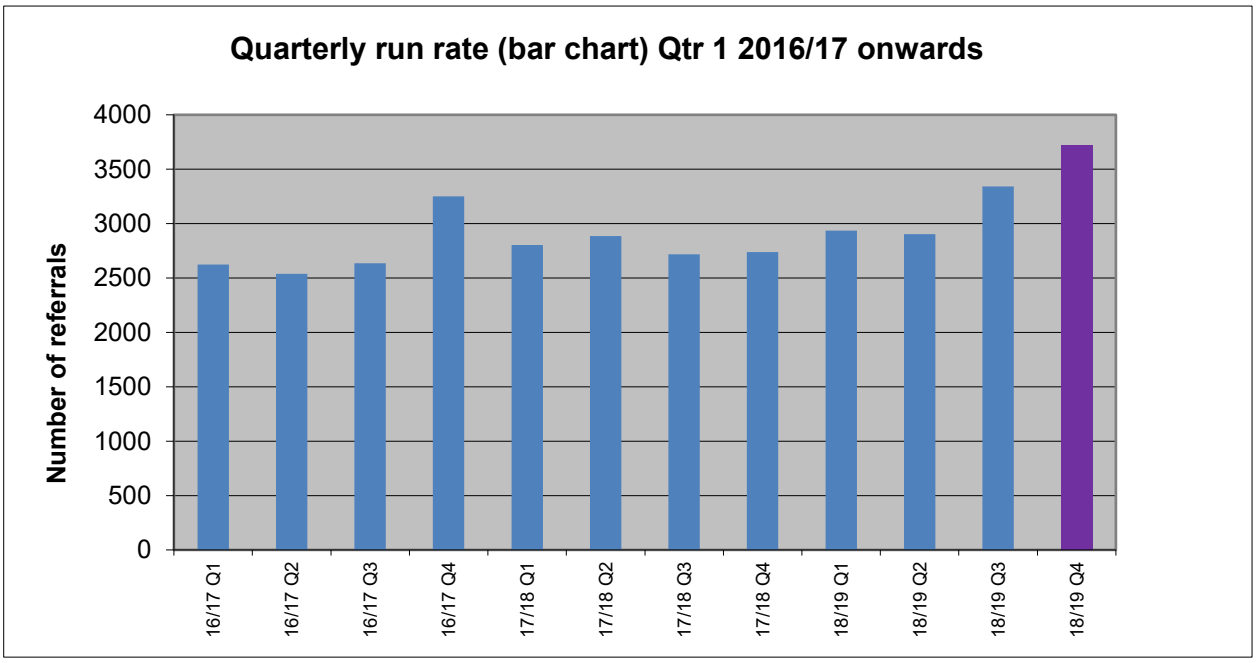
The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure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

ASSESSMENT AND ASSURANCE

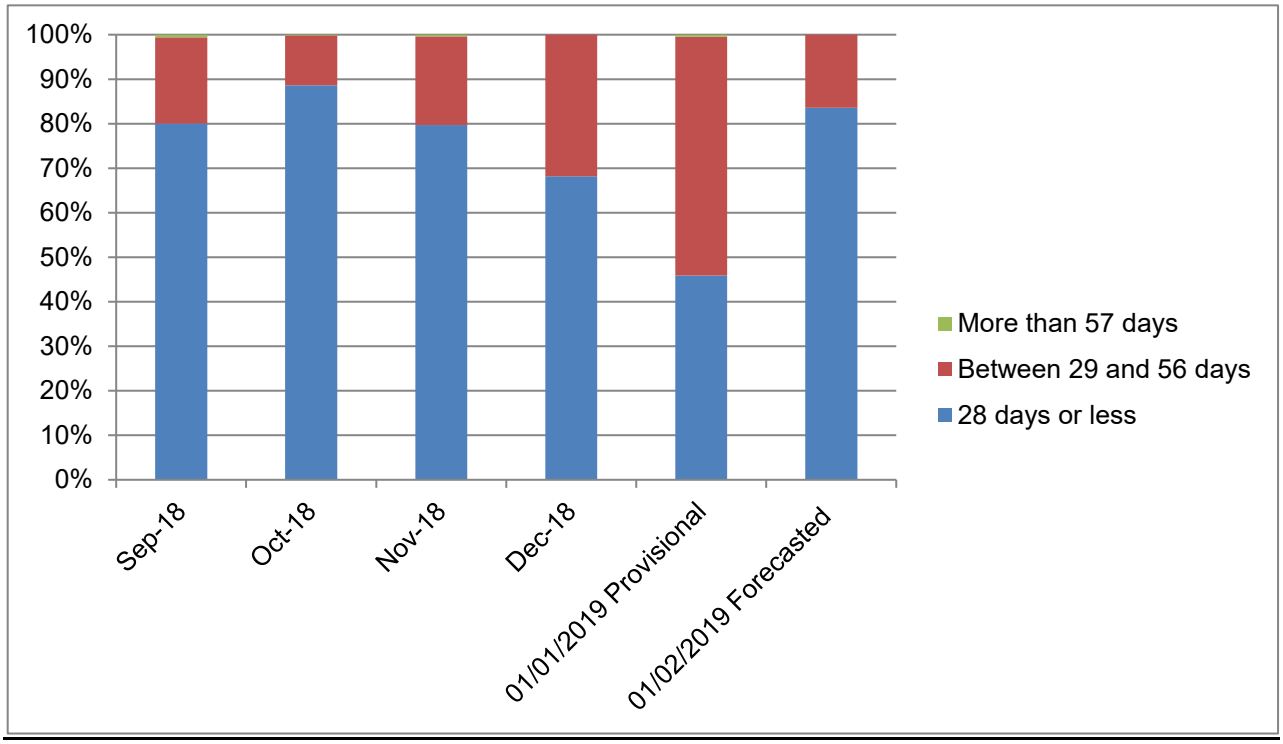
For Parts 1, 2 & 3 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

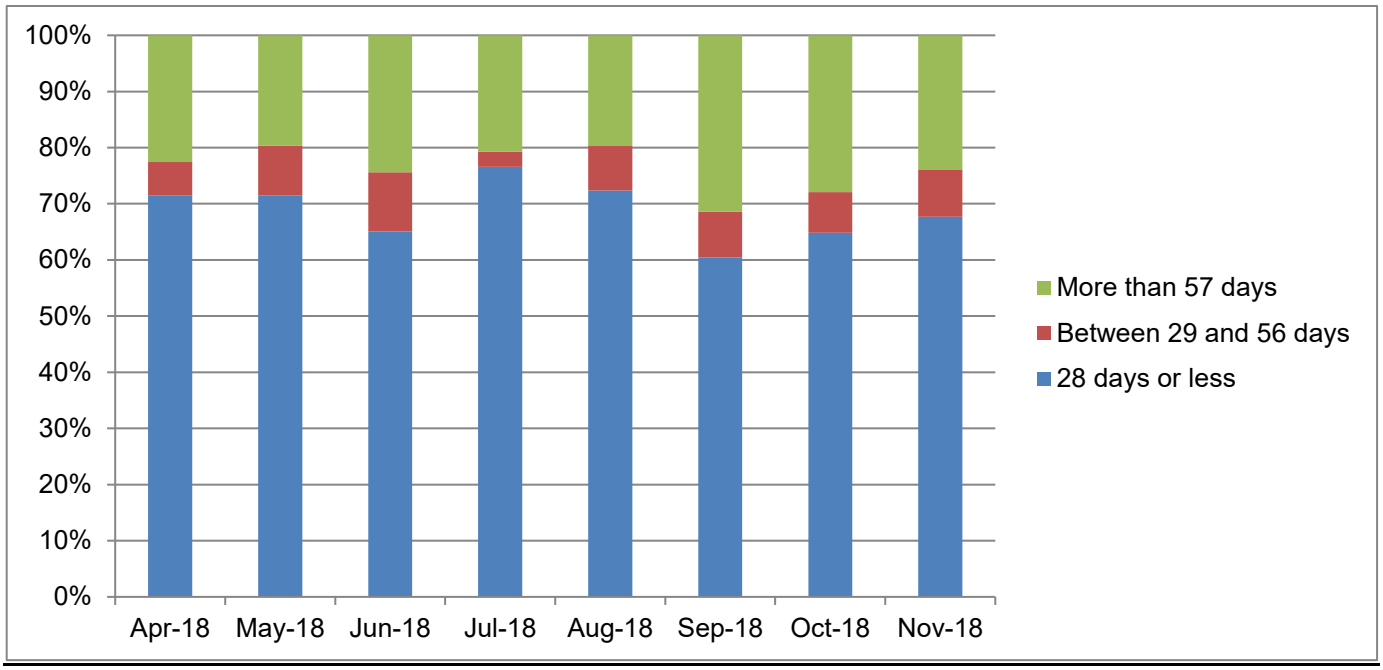
Following a period of relative uniformity in monthly referrals (monthly average of 970 approx.) PMHSS experienced a marked spike in referrals in October ’18 (1,350 approx.), monthly referral rates appear to have generally increased. Bar chart below shows the Quarterly referral run rate for PMHSS with confirmed data in blue and estimated data in purple. Estimated data is based on previous average month-on-month changes in referral rates for the previous three years.



For the reporting period PMHSS had maintained compliance with the Tier 1 target of assessing 80% of patients within 28 days of referral but the aforementioned spike in referrals in October ’18 has detrimentally effected the performance notably in December ’18 (an as yet to be confirmed performance of 68%) and January (forecasted report of approx. 50%) but with assessment bookings so far made for February implying compliance in that month.



In the same period, PMHSS has generally reported below the Tier 1 compliance target for treatment, i.e., of those assessed by PMHSS who were then offered a PMHSS intervention, 80% should start that intervention within 28 days. This is partly due to increased demand but equally, having reviewed the process mapping used to pull reporting data, it has been noted to not have been accessing the entire pool of reporting data and thus we have been effectively under-reporting to this target. This is in the process of being rectified and once completed the UHB is confident compliance will be reached.

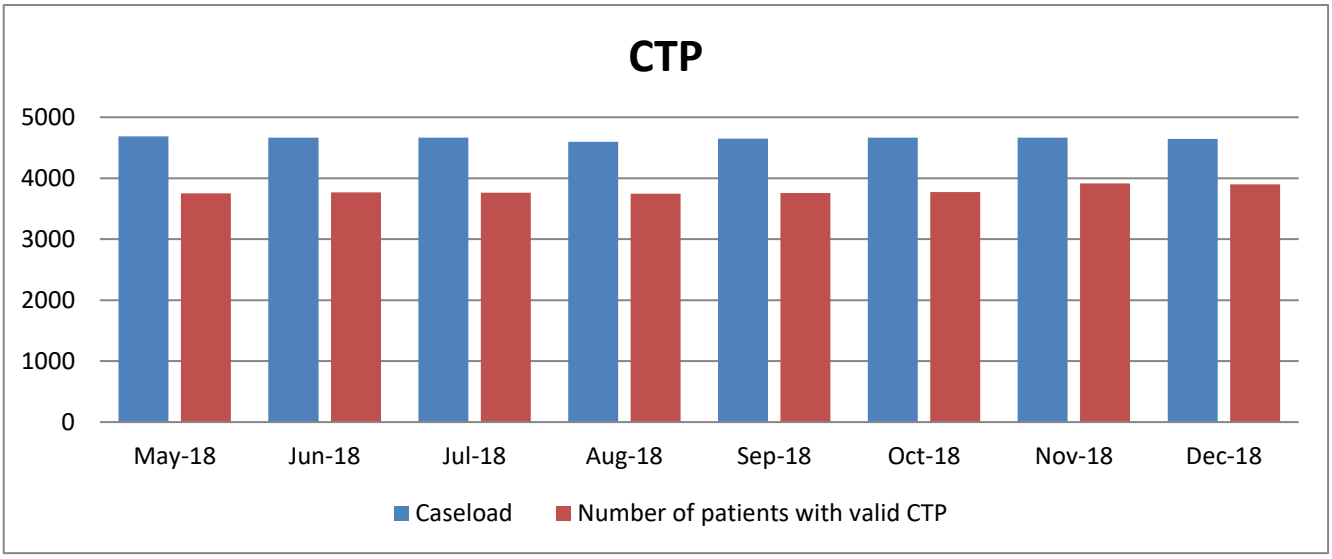


Part 2 – Care and Treatment Planning Within Secondary Mental Health Services

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:

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total number of patients in receipt of secondary MH services in C&V	4686	4666	4666	4599	4649	4663	4666	4646

90% of Service users have a valid CTP	3750 80.0%	3770 80.8%	3764 80.7 %	3749 81.5%	3755 80.8%	3773 80.9%	3912 83.8 %	3899 83.9%



Performance Issues

The impact on compliance remains low due to 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.

The clinical board will have discussions around the Service User cohorts recommended to be outside 'relevant' status for a CTP. This will be based on discussions with consultant colleagues, the code of practice for part 2 of the measure and local experience/knowledge. In support of this, where Service Users are re-designated as having primary care needs, there will be appropriate information given to the GP to ensure those shared care responsibilities are met. For Service Users subject to 117 aftercare, the appropriate process will be followed to discharge from secondary care services.

The Community Transformation pilot in the Vale to review the use of the 'care aims' model to inform outcome based care planning and to look at the feasibility of reallocating these patients.

During he Community Transformation pilot in the Vale Our service has seen a realignment of teams over the last 12 months with a new locality model implemented within the Vale. When West Vale Community Mental Health Team merged with C&V, they were never included in the PARIS report system parameters.

PARIS has now modified the report which included all merged teams within the parameters of

the report.

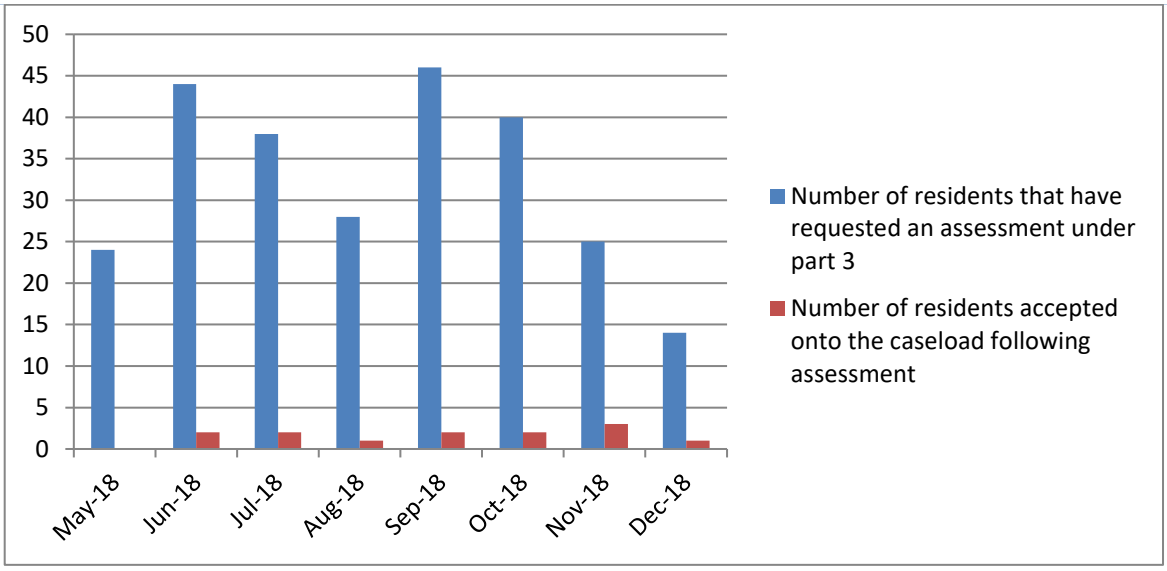
This has captured a total of 245 patients from the West Vale/Vale Locality who weren't originally captured under the merger. These have been added to the total number of patient resident in the UHB in receipt of secondary Mental Health Services as of 31st March 2018. Although some cleansing needs completing for the returns between April 2018 and November 2018

Cardiff and Vale UHB are still having problems with the Vale of Glamorgan council being unable to provide their CTP data and this is reflected in the data for older persons mental health service remaining the same for over a year. There have been reporting issues with data relating to WCCIS since their patients have been merged onto that system. We are hoping for an update within the next few weeks.

Part 3
Right to request an assessment by self –referral

Service user's who have previously received secondary mental health services and have been discharged have a right to self refer for an assessment of their mental health for up to three years following discharge.

	May-18	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**
Number of People assessed following request	24	44	38	28	46	40	25	14
Number of residents accepted onto the caseload following assessment	0	2	2	1	2	2	3	1



All part three requests and outcomes are scrutinized prior to reporting. It has previously been reported that there was a high rate of DNA for self referral assessments but attendance has remained at 100% attendance over the last 42 months.

Following part 3 requests there is a requirement to issue an outcome of assessment report within ten working days. The target set out by Welsh Government for this is 100%.

Part 4 – Advocacy

100% Compliance

		Jun-18	Sep-18	Dec-18
Number of new qualifying patients accepted into IMHA services during the quarter: **[quarterly count]**	Compulsory patients	93	116	121
	Informal/voluntary patients	25	31	19
	Total number of new qualifying patients accepted into IMHA services during the quarter	118	147	140

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time	x	10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar | Respectful / Dangos parch | Trust and integrity / Ymddiriedaeth ac uniondeb | Personal responsibility / Cyfrifoldeb personol

REPORT TITLE:	**Mental Health Measure Compliance and Quality – Part 2 Care and Treatment Plans (CTPs)**								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	12th February 2019	
STATUS:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**	**x**	
LEAD EXECUTIVE:	Chief Operating Officer								
REPORT AUTHOR (TITLE):	Director of Operations Mental Health Clinical Board								

PURPOSE OF REPORT:

The four parts of the mental health measure are tier 1 targets and impact on the quality and safety of care in mental health. The report is to specifically recognise the shortfallin compliance against Part 2 mental health measure in C&V (the legalright for all relevant service users to have a Careand Treatment Plan – CTP) as well as recognise the local and national concerns and improvement efforts against the quality of care and treatment planning.

REPORT:

SITUATION

Cardiff and Vale Mental Health Services have been reporting a breach in Compliance for Part 2 of the Mental Health Measure for a number of months of circa 5% and has seen little improvement. The compliance target is 90%.

During the same period, the MHCB received a National Delivery Unit All Wales report on the quality and use of Care and Treatment plans under Part 2 of the Mental Health Measure. 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 for both elements of Part 2, 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 90% tier 1 target for the Welsh Government. The Part 2 Regulations prescribe the form and content of the CTP.

The Code of Practice to Part 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 although there remains work to be done in determining 'relevant status' and how C&V MHCB has interpreted this. However, limited 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 understanding and commitment	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 directors and Third sector leads iii. To consider 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…- to be included in the agenda of the steering group for discussion	Feedback Completed by Dave Semmens – October 2018 Implementation Group established and chaired by Director of Operations – Complete Reporting to the Mental Health Legislation Committee
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.	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. 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.	Commenced by Dr Neil Jones CD adult service – Paper due in January 2019
Phase 2 – Intervention & Evaluation		
3. The Health Board and partner agencies should ensure that the formulation	i. Review the simplicity of documentation related to risk assessment and risk management and refine where necessary (layers of	Pilot commenced in the Vale for adult MH services by Community Transformation Manager – Evaluation due by

of risk and the management of an individual's safety is clearly evidenced, including detailed and wherever possible, personalised crisis planning	documentation have developed with the various iterations related to the use of CPA, UA and now CTP) and change/reduce where necessary ii. Deliver Risk Assessment & WARRN training in sequence with CTP training to 75% of staff in next 2 years (90% of registered nurses within that) iii. Audit compliance every 4 months and feed-back to MHCB Q&S Committee and report into the MHLC Formally	March 31st 2019 Cycle of training, audit tools and methods agreed – WARRN training commenced and refreshed CTP training to commence in January 2019
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.	i. Establish an education and training sub group and package which includes a guide to CTP use and development and the following characteristics: a. Its use as a Therapeutic tool b. Link with service user outcome measures c. MDT and Multi-agency delivery d. Focuses on a Pilot site to be determined 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	Complete and to include in refreshed training. Pilot commenced in the vale locality using 'care aims' to support clinicians to review their contribution to the care and treatment planning process to service users and work with SUs to define outcomes based on this. For evaluation in 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.	i. See training notes in no. 4 above ii. Continue to circulate lists of clients with 117 after-care responsibility to the integrated managers for use with MDT reviews iii. For Community service leads to develop a process of reminding case managers of review times which could include a PARIS flagging process. iv. Develop a comprehensive caseload supervision process to regularly support practitioners with caseload management and standards of clinical practice records including CTPs. v. Undertake CTP audit using the Delivery Unit tool on a sample of at	Complete and ongoing Method complete and implementation ongoing Complete and ongoing Re-commence in January 2019

	least 50 service users per quarter and report back performance to MHCB Q&S committee and the Mental Health Legislation Committee.	
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.	Process being piloted in Vale community locality – for evaluation in March 2019
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. iii. Mental Health and Innovation funding secured to enhance the treatment of service users with dual diagnosis using the COMPASS model	Complete – post holder in place and improvement method agreed Funding secured – recruitment to commence January 2019

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect	X	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	X
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	X	Long term	X	Integration	X	Collaboration		Involvement	X	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Minutes of the Mental Health Legislation and Governance Group held at 14:00 on 24 January 2019 in Meeting Room 2, Mental Health Act Office, Hafan Y Coed, Llandough Hospital

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Sunni Webb	Mental Health Act Manager
Peter Thomas	South Wales Police
Simon McDonald	Mental Health Act Administration Manager
Simon Amphlett	Senior Nurse – Crisis and Liaison Services
Dr Munawar Al-Mudhaffar	Consultant in Emergency Medicine
Dr Michael Ivenso	Clinical Director for MHSOP
Dr Adeline Cutinha	Deputy Clinical Director for MHSOP
Dr Deni Mohan	SPR MHSOP
Jeff Champney-Smith	Chair Power of Discharge Group
Linda Woodley	Operational Manager Vale of Glamorgan
Alex Allegretto	Independent Mental Health Advocacy Manager
Ceri Lovell	Team Leader – CAMHS Crisis Liaison Team
Adele Watkins	Paediatrics Representative

Apologies

Dr Mary Lawrence	Approved Clinician Representative
Julia Barrell	Mental Capacity Act Manager
Myfanwy Moran	Operational Manager Cardiff
Gareth John	Consultant Social Worker – DoLS/AMHP
Mark Warren	Interim Nurse Lead – Adult Mental Health
Will Adams	Team Leader – North Cardiff Crisis Team

1 **Welcome and Introductions**

The chair welcomed members and those in attendance especially those from outside of the Mental Health Clinical Board and external agencies.

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 reported a recent situation which raised a number of issues in relation to who would obtain the Section 135(2) warrant.

The MHA Coordinator has been working on a draft procedure but is unable to complete this because it has not been agreed who should be contacted to coordinate this process when these situations arise. On this occasion after being escalated to the Senior Team it was agreed that the patients Care Coordinator would obtain the warrant. However a decision needs to be made on who should be responsible for coordinating this process and identifying a suitable member of staff to obtain warrants in future to avoid unnecessary delay.

It was decided that this issue could not be resolved at this meeting and it was agreed that further discussion is required with the Mental Health Clinical Board Director of Operations and the Clinical Board Nurse Mental Health.

The group agreed that there will be some training implications once a decision is made.

ACTION – Chair to discuss with the Mental Health Clinical Board Director of Operations and Clinical Board Nurse, Mental Health

Section 136 in A+E

The South Wales Police representative explained that their position on the time of arrival is whenever somebody subject to 136 arrives at any hospital premises and that 16.46 has been redacted from the Mental health Act 1983, Code of Practice for Wales, Revised 2016 by Welsh Government. The Mental Health Act Manager confirmed that legal advice has been sought and Cardiff and Vale UHB's position is that the time of arrival is when the person arrives at the designated place of safety, which is the Emergency Assessment Suite, Hafan Y Coed. Only in exceptional circumstances can A+E be used as a designated POS when it is deemed suitable by health staff (the Doctor carrying out the mental health assessment or the Crisis Team). The Paediatrics representative asked if the rules are the same for under 18 year old people detained under 136. Both the South Wales Police representative and the Mental Health Act Manager confirmed this was the case.

The Mental Health Act Manager stated that they are awaiting the position on this matter from Welsh Government and that legal advice given is clear that a statutory code cannot be amended by an email.

Conveyance

A discussion took place about conveyance. The Operational Manager Vale of Glamorgan stated that the lack of ambulance transport for these people is a

very serious issue. Valuable resources are being used unnecessarily for many hours which is having a negative impact on social workers. Most difficulties occur further to an assessment where AMHP's are using their own cars, asking for staff from wards and various other improvised methods to arrange patient transport. It was confirmed that the Mental Health Clinical Board Director of Operations is preparing a paper for the Executive Board which provides an analysis of 2018 incidents where social workers have had to wait and is trying to develop an options paper to resolve this issue.

There is an issue around transferring patients between the Llanfair Unit and Hafan Y Coed/Llandough Hospital. Ambulances have been refused and on occasion taxis have been used. This onsight issue is to be taken up with in the above paper.

Extended Section 17 Leave

The Chair of the Power of Discharge group raised an apparent decrease in the use of Community Treatment Orders and wondered whether there had been an increase in the use of extended section 17 leave. The Clinical Director for MHSOP confirmed that he was not aware of any such deliberate change that could cause this.

The Senior Nurse for Crisis and Liaison Services stated that this could cause budget issues, as CTO would belong to Community Treatment Teams whilst Section 17 leave is the responsibility of Inpatients.

The Independent Mental Health Advocacy Manager stated that feedback from patients is that they generally prefer CTO to Section 17 leave as it feels less restrictive.

The Chair of the meeting requested that this be taken to the Consultants Meeting and that long term section 17 leave to be monitored in the mental health Act Activity Report.

ACTION – To be discussed within the Consultants Meeting

6 **Feedback on Operational Issues and Incidents**

Advocacy

The Independent Mental Health Advocacy Manager informed the group that he believed that Advocacy is working extremely well. There are very good relationships between themselves, the wards, and the MHA Office. Referrals have increased and advocacy attendance of Hearings has increased as a result.

The Chair of the Power of Discharge Group confirmed that Advocacy attendance at Hearings had increased hugely to the benefit of the patients.

AMHP Burnout

The Operational Manager Vale of Glamorgan raised an issue of AMHP burnout due to increased workloads. This is being exacerbated by late requests for mental health act assessments, sometimes only hours before the current section is due to expire and requested that Responsible Clinicians provide as much notice as possible in an attempt to alleviate this situation.

Unless it's an emergency assessment it would be helpful if the AMHP Manager is notified of potential assessments at least 3 to 5 days in advance if possible.

ACTION – To be fedback to consultants via the Consultant Meeting

Lack of facilities

The Chair, PoD Group brought raised an issue around the lack of ward based activities for patients and stated that the PoD Group have seen an increase of patients who have been granted escorted Section 17 leave to aid their recovery, but have been unable to take the leave. It is reported that this is usually due to staff shortages.

ACTION – Chair to raise at the Adult Directorate Quality and Safety Committee

136 Electronic Form

The Mental Health Act Administration Manager informed the group that the Police are planning on moving to an electronic form for Section 136. This will be emailed to the UHB when bringing a patient in under Section 136. The concern with that is a potential delay in UHB staff being able read the circumstances of the report. As part of this there are plans for a Section 136 case note on Paris so the UHB can also remove the requirement of a paper form.

ACTION – The Mental Health Act Administration Manager to take this forward

Section 136 Poster for Accident and Emergency

The poster designed for Accident and Emergency in relation to section 136 has been developed and agreed its content for circulation.

ACTION – MHA Manager to circulate

The Recording of AWOL Patients

The Mental Health Act Manager informed the group that there is an issue where the Mental Health Act Office is not being informed when patients are AWOL. Without this information calculations cannot be made to ascertain the timeframe in which a patient can be returned to hospital. The health staff in attendance agreed to take this issue back to their areas.

ACTION – MHA Manager to remind Senior Nurse Managers to ensure that all nursing staff report an AWOL patient to the MHA department

Police CPN Pilot

The South Wales Police representative informed the meeting that they had commenced their trial where a CPN would be based in their Operations Room in order to assist Officers in the field. This trial started on 09/01/2019 and already the number of people who the Police would have brought for a mental health assessment under section 136 has decreased by 50%. The group agreed that this was a fantastic achievement.

7 **Feedback from other meetings**

AMHP Forum

The Operational Manager Vale of Glamorgan informed the group that some AMHPs have felt like they are being excluded from discussions where patients are being considered for Section 3. It was made clear that AMHPs should not be excluded from these discussions as they are an integral part of the process.

ACTION – The Clinical Director, MHSOP, Deputy Clinical Director, MHSOP and the Approved Clinician Representative to take this back to the Consultants via the Consultant Meeting

Consultants Meeting

The Deputy Clinical Director for MHSOP stated that Consultants have felt a clear pressure from AMHPs for a patient's initial section to be Section 2 rather than Section 3. These patients have been well known to services and they believe that Section 3 would be the most appropriate section.

ACTION – The Operational Manager Vale of Glamorgan to investigate and report back in the next meeting.

The Clinical Director, MHSOP raised an issue in relation to AMHP managers insisting that the Duty Consultant on call participates in mental health assessments and explained whilst they should be the first point of call, they are not always available to carry out the assessment. In these instances he felt that a section 12 doctor should be obtained as this is no different to the Duty Consultant conducting the assessment when they do not have any previous acquaintance with the patient.

ACTION – The Operational Manager Vale of Glamorgan to investigate and report back in the next meeting.

8 **Power of Discharge Group**

Care and Treatment Plans

The Chair of the PoD Group stated that Care and Treatment Plans are a constant concern and continue to be out of date, inaccurate and have issues with them being cut and pasted badly from previous reports. The Chair, MHLGG reported that this issue has been raised in the Adult Directorate Quality and Safety Committee and will take further advice from the Mental Health Clinical Board Director of Operations re: project work on care planning.

Action – Clinical members to take back to their areas

Not for Disclosure

The Chair of the PoD Group explained that the patient should be provided with copies of the reports as soon as they are available, unless (in the light of any recommendation made by their authors) managers' discharge panel are of the opinion that disclosing the information would be likely to cause serious harm to the physical or mental health of the patient or any other individual.

Such information should be provided in a separate document, clearly headed "Not for Disclosure". The reasons why must be set out for consideration by panel members and the document must be signed and dated by the author.

There are no formal rules of procedure specifically applicable to a managers' hearing. The Code of Practice does, however, give some guidance. It is also appropriate to consider the provisions of the Mental Health Review Tribunal Rules insofar as they could be regarded as setting a standard to be followed in relation to a managers' hearing.

The test of being "likely to cause serious harm" is a fairly high standard and means that in most cases there could be no objection to disclosure of the reports. Accordingly, managers should consider whether there is anything in the reports which, if disclosed to the patient, would adversely affect the health or welfare of the patient or another. If so, it would be reasonable to withhold that material.

Interpreter Issue

The Group were informed of recent situation where an interpreter was requested by the ward for a managers hearing. However they were booked to attend at the time of the hearing allowing no time to meet with the patient beforehand. This resulted in the hearing being postponed because the patient had not had the opportunity to go through all the reports. It was agreed that an interpreter should be requested by the ward in the days prior to the hearing to go through the reports and allow the patient to digest and understand the information contained, and again prior to the actual meeting to allow the patient to have some time to prepare with the interpreter.

Action – Mental Health Act Manager to remind Senior Nurse Managers to ensure that nursing staff allow sufficient time when interpretation services are required

Accuracy of Information in Reports

The Chair of the PoD Group stated that there have been several occasions where factual information contained in reports has been disputed by the patient. All report authors should verify information before inclusion from a source other than any previous reports, as this has resulted in propagation of inaccuracies that can have detrimental effects on the patient.

9 **External Reviews**

HIW Inspection Report

Operational Manager Vale of Glamorgan is awaiting the report from HIW, although draft feedback has been positive overall

10 **Interface MHA/MCA/DoLS**

Although absent from this meeting, the Mental Capacity Act Manager requested that the attendees were informed that there has been occasions where a Mental Capacity Act assessments had been requested in an emergency, when the request could have been made several weeks in advance. The Mental Capacity Act Manager will bring more detail to the next meeting.

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 – This is on hold until the return of the Adult Clinical Director

12 **MHA Activity October – December 2018**

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.

Action – Approved Clinician Representative to provide feedback

13 **Any other business**

Statutory Consultees

The Clinical Director for MHSOP informed the group that there had been several issues identifying Statutory Consultees who would then be available for the SOAD. He has arranged to meet with the relevant staff in Therapies to see if a potential way forward would be to name the team, rather than the individual. That team would then provide the name of the consultee.

Action – The Clinical Director for MHSOP to feedback at the next meeting

14 **Next Meeting**

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

18 April 2019

18 July 2019

17 October 2019

REPORT TITLE:	**APPROVAL OF PATIENT INFORMATION TO DETAINED/COMMUNITY PATIENTS, MENTAL HEALTH ACT 1983 POLICY AND PROCEDURE**									
MEETING:	**Mental Health and Capacity Legislation Committee**						**MEETING DATE:**	**12 February 2019**		
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**	**x**	**For Information**			**x**
LEAD EXECUTIVE:	**Chief Operating Officer**									
REPORT AUTHOR (TITLE):	**Mental Health Act Manager, sunni.webb@wales.nhs.uk**									

PURPOSE OF REPORT:

SITUATION:
It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

This policy and procedure sets out the requirements for provision when providing information to detained or community patients under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of detained patients/community patients**.**

REPORT:

BACKGROUND, ASSESSMENT AND ASSURANCE:
This is a new policy to ensure statutory requirements under the Mental Health Act 1983 are met.

This Policy and Procedure provides clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Wide consultation has taken place to ensure that the Policy meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 02 October 2018 and 30 October 2018;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality, Safety and Experience Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document Patient Information to Detained/Community patients, Mental Health Act 1983 Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Patient Rights Information to Detained/Community Patients under , Mental Health Act, 1983 Policy

Policy Statement

Section 132/132A of the Mental Health Act 1983 (the Act) places a responsibility upon the hospital managers to take practicable steps to ensure that all detained patients and those subject to Community Treatment Orders (CTO) are given information about their rights regularly. Section 130D places a responsibility upon the responsible person to ensure that qualifying patients are given information about Independent mental Health Advocates. Section 133 places a duty on the hospital managers to inform the nearest relative of a detained patient that the patient is about to be discharged from detention (including being discharged subject to a community treatment order) or discharged from a community treatment order (other than a discharge ordered by the patient's nearest relative). The policy aims to standardise practices and processes of providing information and clarify and provide guidance to staff responsible for delivering the information.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when giving information to detained patients and community patients.

Staff will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are delivering this information .

Those with responsibility for the care and treatment of patients must be fully aware of the diverse needs of the patient and the most effective way to communicate with each individual, their family, carers and relevant others. It is important that the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained. Staff have a duty to check that the information they have communicated has been understood.

Policy Commitment

We will set out the requirements for provision of giving information to detained/community patients under section 132,132A, 130D and 133 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to those with responsibility for the care and treatment of patients.

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Supporting Procedures and Written Control Documents

This Policy and the Information to Detained /Community Patients (Patient's Rights) under Mental Health Act, 1983 Procedure describe the following with regard to the duties of hospital managers:

- The purpose of giving information to detained /community patients.
- The process for delivering information to detained/community patients.
- The duties of staff to inform patients subject to the MHA of their legal position.

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patients subject to a Community treatment Order.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Head of Operations

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

Equality & Health Impact Assessment for

INFORMATION TO DETAINED/COMMUNITY PATIENTS (PATIENTS RIGHTS) UNDER, MENTAL HEALTH ACT 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	**Information to Detained Patients and Community Patients (Patient's Rights) under, Mental Health Act, 1983 Policy**
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when giving information to detained/ community patients. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Staff should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are delivering this information.

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health)

		Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.

		Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff

		relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental

		Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are

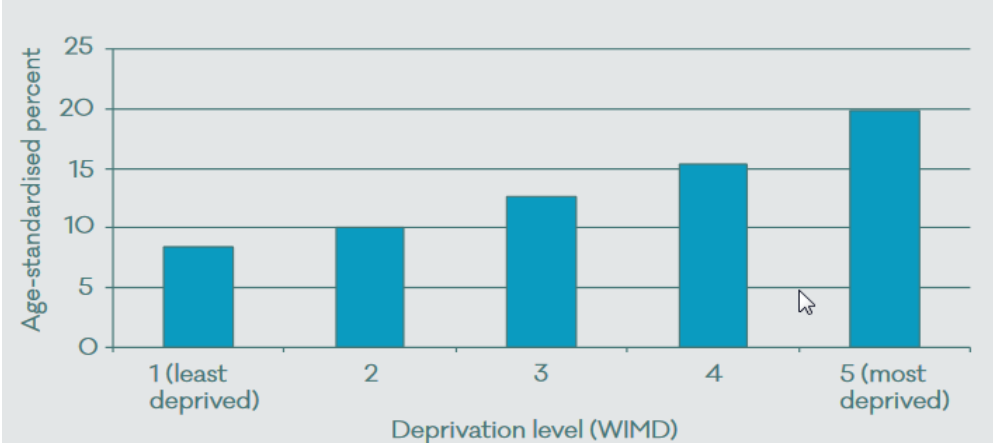
		also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with

		assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder),

		voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. **Gay and Bisexual Men’s Health Survey -** With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men’s sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers.

		The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.

		The impact of mental ill health on employment rates A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with

		employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004). **People according to where they live**  Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth. There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from

		illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty.

		Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

		Homeless Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

		It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

		26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.

		These risk factors may be present in any protected group. Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital stay, improved medication adherence or patients' quality of life, and have queried whether community treatment orders are an effective alternative to standard care. Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale'. **Ethical Considerations** Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions, community treatment orders will commonly be imposed on people who have capacity. Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns) **Examples of patient experience** Participants perceived both positive and negative impacts of CTOs. The positives included affirmation of experiences with the mental health system; improved rapport with the case management and clinical team,

		increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it. (Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system – Magnus Mfoafo-McCarthy International Journal of Equity in Health Sept 2014) Findings of **NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) (DoH 2011) -** The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO. A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

		(A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales" Simon Lawton Smith for the Kings Fund Sept 2005) Community treatment orders are designed to ensure patients live in their home or supported accommodation. The power of recall under section 17E is used when a patient is not compliant with their conditions or becomes mentally unwell. They are used for patients who have frequent repeated admissions to hospital.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities rather than the direct care and treatment of patients, although decisions made have an impact on the clinical pathways of patients. The Information to Detained Patients and Community Patients (Patient's Rights) under, Mental Health Act, 1983 covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- http://www.rdash.nhs.uk/wp-content/uploads/2014/04/S-132-Providing-Legal-Rights-v11-EIA2.pdf

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine t an earlier review is required.	N/A	N/A	N/A Whilst it is the hospital managers who have responsibilities under the Act for the provision of information to patients, carers and others, in practice it would usually be more appropriate for professionals working with the patient to provide them with the information. However in order to fulfil their statutory duties, hospital managers should have policies in place to ensure that regular checks are made to confirm the required information has been given to each patient and understood by them.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Patient Rights Information to Detained/ Community Patients Mental Health Act, 1983 Procedure

Introduction and Aim

This document supports the Information to Detained/Community Patients (Patient's Rights) under Section 132, 132A & 130D, Mental Health Act, 1983
Policy.

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To standardise practices and processes of providing information and clarify and provide guidance to staff responsible for delivering information.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This procedure describe the following with regard to information to detained patients and community patients (patient's rights)

- The purpose of giving information to detained/community patients
- The process for providing information to detained/community patients
- The duties of staff responsible for delivering the information

Staff must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they giving information to detained/community patients. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patients subject to a Community treatment Order.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Community Treatment Order Policy Community Treatment Order Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure Section 5(2), Doctors' Holding Power Policy Section 5(2), Doctors' Holding Power Procedure Section 5(4), Nurses' Holding Power Policy Section 5(4), Nurses' Holding Power Procedure Mental Health Review Tribunal Procedure and Guidance
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Mental Health Clinical Board Head of Operations*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*Date of Committee or Group Approval*	*TBA*	*New document*

Glossary of terms

Term	Definition
The Act	The Mental Health Act 1983 (as amended, including by the Mental Health Act 2007, the Health and Social Care Act 2012 and the Care Act 2014).
Nearest Relative	The NR is the person who is informed (unless the patient objects) or consulted with about the patient becoming subject to the provisions of the Act, which includes the right to order discharge of the patient and to object to some provisions of the Act.
Responsible Clinician	The Responsible Clinician is the approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a Community Treatment Order (CTO) can only be taken by the responsible clinician.
Mental Health Review Tribunal	An independent judicial body. Its main purpose is to review the cases of detained, conditionally discharged, and CTO patients under the Act and to direct the discharge of any patients where it thinks it appropriate. The Tribunal provides a significant safeguard for patients who have had their liberty curtailed under the Act.

Keywords	Mental Health Act, Patients Rights, Section 132, Section 132A, Section 130D, Section 133

CONTENTS

1. Introduction

Section 132 of the Mental Health Act 1983 (the Act) places a responsibility upon the hospital managers to take practicable steps to ensure that all detained patients are given information about their rights upon admission. Section 132A places a responsibility upon the hospital managers to take practicable steps to ensure that Community Treatment Order (CTO) patients are given information about their rights. Section 130D places a responsibility on the responsible person to ensure that qualifying patients are given information about Independent Mental Health Advocates (IMHAs). Section 133 places a responsibility upon the hospital manages to inform NR of a patients discharge from detention including being discharged from a CTO.

Although the Act does not impose any duties to give information to informal patients they should be given an explanation of their legal position and rights. It is important that they are aware that should they wish to leave the hospital they are advised to discuss this with their Doctor along with the nurse in charge of the ward, so that appropriate arrangements can be made for their safe discharge.

It must also be remembered that explaining patient rights to them is not a one-off event but needs to be ongoing throughout their detention as a person's level of understanding can fluctuate. This policy must be read in conjunction with MHA Code of Practice for Wales, Chapter 4 (MHA COP).

2. Policy Statement

This policy has been developed to guide staff on the execution of their duties to inform patients subject to the Act of their rights and legal position. The policy is also applicable to their NR.

3. Scope

The contents of this policy apply to all clinical staff working within the Health Board who are involved in the care and treatment of patients detained under the Act and those in the community involved in the care of patients subject to Community Treatment Orders.

4. Aim

The aim of this policy is to:

- Standardise practices and processes of providing information
- Clarify and provide guidance to staff responsible for delivering the information
- Provide a framework to staff on the information that should be given to detained patients and their NR
- Identify who should deliver this information and the expected frequency of the delivery of information.

5. Objectives

Practitioners should have due regard to the MHA COP generally and specifically to the guiding principles when they are providing information to patients and their NR.

There is a statutory duty to inform patients detained under specific sections of their right of access to an Independent Mental Health Advocate (IMHA). IMHA's are available for all patients receiving treatment for their mental disorder and can be invaluable in assisting the patient to understand the questions and information that is being presented to them and in helping patients communicate their views to staff, an IMHA should not be used as an interpreter, translator or as providers of general communication support other than in exceptional circumstances. If this is a requirement the reasons must be recorded within the patient health records. (Chapter 6 MHA COP)

6. PROCEDURE/IMPLEMENTATION

6.1 Availability of Information

For all patients, relevant information should be given to them as soon as is practicable, following:

- Admission to Hospital;
- Commencement of a period of detention under the Act;
- Detention under another section of the Act
- Renewal of any period of detention or extension of CTO

The information must be given both verbally and in writing, and detained patients must be given a copy of the statutory information leaflet which is provided by Welsh Government. Copies of any available information should also be displayed on the ward notice boards/leaflet racks.

6.2 Information to Informal Patients

Though section 132 is specific to detained patients, information regarding their legal rights and treatment should also be provided on an ongoing basis to informal patients. Information on advocacy services should also be made available to them. They should also be made aware of the fact that if they wish to leave hospital but it is felt that they need remain for a period of assessment and/or treatment, they could be assessed for possible detention under the Act. Where discussions take place staff should ensure this is documented.

6.3 Information to Detained Patients

Any detained patient must be informed as soon as possible both verbally and in writing of the following:

- Of the provisions of the Act under which they are being detained or subject to CTO and the effect of those provisions;

- Of the rights (if any) of their NR to discharge them (and what can happen if their Responsible Clinician does not agree with that decision);
- For community patients, of the effect of the CTO, including the conditions which they are required to keep and the circumstances in which their Responsible Clinician may recall them to hospital; and
- That help is available to them from an IMHA, and how to obtain that help;
- The reasons for their detention or CTO;
- The maximum length of the current period of detention or CTO;
- That their detention or CTO may be extended at any time if it is no longer required or the criteria for it are no longer met;
- That they will not automatically be discharged when the current period of detention or CTO ends;
- That their detention or CTO will not automatically be renewed or extended when the current period of detention or CTO ends;
- The reasons for a CTO being revoked;
- Their rights of appeal to both the Hospital Managers and the Mental Health Review Tribunal (MHRT). Appropriate details of address/telephone numbers should also be given along with guidance on how to make an application and a list of solicitors;
- That if they are detained on a treatment order (including a CTO) should it be extended for a further 6-month period and they do not appeal to the MHRT in the first period of detention, then the Health Board will automatically refer their case;
- That they have the right of legal representation at the MHRT and are given a list of solicitors who are specifically trained in mental health law;
- The nature and likely effects of any treatment which is planned;
- The role and powers of the Healthcare Inspectorate Wales (HIW) and how to make a complaint to them. The address and telephone number should also be supplied;
- Their right to receive or send correspondence and whether there are any constraints on this;
- The procedure for making a formal complaint to the Health Board;
- The patient's financial entitlements whilst in hospital and how to secure them;
- Details of the Visiting Policy for the unit and in particular any restrictions around the visiting of children;
- After care entitlement under section 117 (if applicable) and the implications of this.

6.4 Information to Conditionally Discharged Patients following recall to hospital

Where a conditionally discharged patient is to be recalled to hospital, a brief verbal explanation of the Secretary of State's reasons for recall must be

provided to the patient at the time of recall unless there are exceptional reasons why this is not possible eg; the patient is violent or too distressed. The Secretary of State's warrant will detail the reasons. The patient should also receive a full explanation of the reasons for his or her recall within 72 hours after admission, and both written and oral explanations should be provided. Conditionally discharged patients recalled to hospital, should be told that their cases will be referred automatically to the Mental Health Review Tribunal.

6.5 Information on Consent to Treatment
All patients, regardless of their legal status, must be informed of:

- The nature, purpose and likely effects of any treatment which is planned;
- The circumstances (if any) in which they can be treated without their consent and the circumstances in which they have the right to refuse treatment;
- The role of the second opinion appointed doctors (SOADs) and the circumstances in which they may be involved; and
- (Where relevant) the rules on electro-convulsive therapy (ECT) and medication administered as part of ECT.

6.6 Information on access to the independent advocacy services
Access to independent advocacy services, is available in all areas of the Heath Board and all patients, regardless of their legal status, should be given information about the independent mental health advocacy service (IMHA), and how to access it.

Where independent advocacy services are available the inpatient wards will display on their patient information boards the days and times as to when the advocates will be on the unit.

6.7 Information on Rights to Vote
The Representation of the People Act 2000 makes it clear that in most circumstances, detained patients can still exercise their right to vote in general or other elections. To allow patients to exercise this right the Health Board should give information to them about their voting rights.

6.8 Information about the role of the Healthcare Inspectorate Wales (HIW)
All patients, regardless of their legal status, should be given information about:

- The role of HIW;
- When HIW is next due to visit the service;
- Their rights to meet with HIW during a visit; and
- Their rights to make a complaint to HIW.

6.9 Information to the nearest relative of detained patients

On admission or as soon as practical thereafter, the patient should be made aware of the fact that their NR, within the meaning of the Act, will be supplied with a copy of the written information of their rights, unless the patient objects.

Staff should also ascertain if the patient has an advance statement in place giving details of any other person they wish to be notified of their detention under the Act. If there is, the Mental Health Act Department is to be notified so that arrangements can be made for the necessary information to be sent.

A copy of the letter sent by the Mental Health Act Department to the patient's NR will be held in the patient's health records. If the patient does not wish their NR to be informed of their detention this is to be recorded on the appropriate record of patient's rights form at the earliest convenience.

6.10 Explaining and Understanding Patient Rights

The explaining of a patient's rights is an ongoing process throughout their stay in hospital or period of detention on a CTO and should be done both verbally and in writing.

It should be done in a suitable manner, at a suitable time, taking into account the patient's mental state and capacity to retain information. Staff should not rush through the process but give it their full attention, spending as much time as necessary with the patient in a private area free from interruption allowing time for questions to be asked. Carers and advocates should be involved where the patient wishes or if the patient lacks capacity to understand.

Consideration also needs to be given to the fact that there are some patients who have difficulties relating to their capacity to understand or the ability to retain the information given to them for any length of time. Whilst these patients are detained under the Act, the MHA COP advocates good practice in relation to detained patients who lack capacity or have fluctuating capacity. In these situations staff need to comply with the principles of the Mental Capacity Act (2005) and take all reasonable steps to provide information in a suitable format, i.e. easy word version large print version or pictorially in order to facilitate capacity to understand if at all possible. Staff need to be aware that they may have to explain their rights to such individuals on more than one occasion in the first instance and on a more frequent and ongoing basis.

The Welsh Assembly Government has produced a series of Mental Health Act patient information leaflets. These are designed to assist hospitals to meet their legal obligations under the Act to provide written information to patients subject to detention and other compulsory measures under the Act; they can be accessed via the Mental Health Act page on the Health Boards intranet site.

Once an explanation of their legal rights has been given to the patient staff must take steps to ascertain their level of understanding. If it is identified that a patient lacks the capacity to understand even after all attempts to assist them have been undertaken, their lack of capacity should be documented in their patients records. However, staff need to be aware that in the majority of cases any lack of capacity will not be permanent and in view of this staff must continue in their attempts to facilitate the patients understanding.

6.11 Communication with patients

Section 132 places a duty on the Health Board to take all reasonable steps to facilitate the patient's understanding of their legal rights. If the patient is not fluent in English or Welsh or has a learning or sensory impairment, arrangements must be made for the explanation of their rights to be delivered in a manner which is appropriate to their needs.

Everything possible should be done to overcome barriers to effective communication. Being able to communicate in the patients' usual language is essential to ensuring that those providing services can undertake an accurate assessment and deliver ongoing care and treatment. The Health Board should ensure people with specialist expertise e.g. in sign language or Makaton, are available as required. Staff should be aware of who to contact to ensure individuals' communication needs can be met.

Where interpretation is needed, every effort should be made to identify an interpreter who is suitable to the needs and circumstances of the patient. Arrangements are in place for staff to have access to these outside normal working hours

However, in respect of this policy interpreters should:

- Fully understand the terminology and conduct of a mental health interview;
- Have knowledge of the patient's cultural and religious values;
- Be able to interpret the law; and
- Be of a gender which accords with the patient's wishes.

NB: It is not desirable that relatives or friends be asked to act as interpreters and this should only be done in exceptional circumstances and at the express wish of the patient.

MHA patient information leaflets are available from the Mental Health Act Department in languages other than English and Welsh, and arrangements can be made for them to be provided in Braille and audio format.

6.12 Explanation of legal rights to a child/young person

For a child:

A child aged under 16 and anyone under this age who is admitted should have their legal rights under section 132 explained to them in the presence of their parent(s) (or others with parental responsibility) who will also be given a copy of the appropriate rights form.

For a young person:
A young person is a person aged 16–17 and the usual procedure with regard to reading a person their legal rights under this procedure should apply.

However, consideration should be given to completing this in the presence of their parent(s), if the patient agrees.

6.13 Confidentiality and sharing information in relation to a child/young person:
As with adults, children and young people have a right to confidentiality. Where children are competent, and young people have the capacity to make decisions about the use and disclosure of information they have provided in confidence, their views should be respected. (Chapter 19 MHA COP).

However, as with adults, in certain circumstances confidential information may be disclosed without the child or young person's consent, e.g. if there is reasonable cause to believe that the child or young person is suffering, or is at risk of suffering, significant harm.

The same principles of confidentiality apply if a child who is competent or a young person who has capacity to make a decision regarding the information does not wish their parent (or others with parental responsibility) to be involved in decision making about their care and treatment. Their decision should be respected unless the disclosure can be justified, e.g. if there is cause to suspect that the child or young person is suffering or is likely to suffer serious harm. Practitioners should encourage the child or young person to involve their parents (unless it is considered to do so would not be in the best interests of the child or young person). They should also be proactive in discussing with the child or young person the consequences of their parents not being involved.

Where a child or young person does not wish their parents to be involved, every effort should be made to understand the child or young person's reasons with a view to establishing whether the child or young person's concerns can be addressed.

6.14 Recording the reading of rights to a patient
An entry is to be made in the patient's health records to the effect that an oral and written explanation has been given with an indication of the patient's level of comprehension;

A patients rights form is to be completed and forwarded to the Mental Health Act Department indicating if the patient had the capacity to understand their legal rights or not;

If the patient did not understand, all further attempts will be recorded onto the patients rights form. Once a patient initially lacking capacity has understood their rights, a further patient's rights form will be completed and forwarded to the Mental Health Act Department. Staff will then continue to record on the patients rights form the on-going explanation to the patient of their legal rights.

If at the time of admission the patient is clearly lacking the capacity to understand all or any of the oral and written information regarding their detention, this is to be recorded along with a date for when it will be repeated.

If a patient continues to lack the capacity to understand all or any of the verbal and written information regarding this detention a record of this should be made within the patient's health records.

The reading of rights should be undertaken to reflect the individual needs of the patient but it is recommended that, as a minimum, staff should adhere to the guidance as detailed below:

Section	**Initial Frequency**	**Ongoing Frequency**	**Who by**
Section 2	As soon as practicable after the patients detention begins, then twice weekly for the first two weeks of detention	Weekly for the remaining period of detention	Named nurse or other nominated clinical staff
Section 3	At the time of the section being applied then once a week for the first month of detention	Monthly for the remaining period of detention	Named nurse, Care Coordinator or other nominated clinical Staff.
Section 37	At the time of the section being applied then once a week for the first month of detention	Monthly for the remaining period of detention	Named nurse, Care Coordinator or other nominated clinical staff
Community Treatment Order	At the time of the section being applied then once a week for the first month of detention.	To reflect the individual needs of the patient	Care Coordinator or other nominated clinical staff

The patient MUST also have their legal rights explained to them if their period of detention is renewed. This is to be recorded on a patient's rights form, which should then be forwarded to the Mental Health Act Department.

These minimum requirements do not prevent a member of the clinical team from using their professional judgement to decide how frequently individual patients legal rights have to be explained to them.

For patients who have a good understanding of their rights, it may not be necessary to renew their rights at such frequent intervals.

For any subsequent explanation of legal rights under section 132, staff should document this on a patient's rights form.

6.15 Discharge from Detention

When the patient is discharged from detention or if the authority for detention expires, the section's end date/time and the patient's right to leave hospital should be made known to them.

Section 133 provides a duty for the Hospital Managers to inform the NR of discharge from detention including CTO patients and this is to be given at least seven days before the discharge if practicable. To facilitate this it will be necessary for the patients' Responsible Clinician to inform the MHA Department of the planned discharge.

The requirement to inform the NR does not apply if the patient requests that information is not sent. The NR may also request that information is not sent to them regarding their relative.

7. Responsibilities

The Mental Health and Capacity Legislation Committee is responsible for:

- Overseeing the implementation of the Act within the organisation;
- The review and issuing of all policies and procedures which relate to the Act;
- Monitoring the Health Boards compliance with the legal requirements of the Act;
- Undertaking audit work and agreeing action plans in relation to the Act;

7.1 Hospital Managers under the Act

Whilst the MHA 1983 uses the term "Hospital Managers", in NHS Foundation Trusts and Health Boards they are defined as the "Hospital Managers". They have certain statutory duties they must fulfil under the Act and some of these duties including the explaining of legal rights under section 132 can be delegated by the hospital managers but in delegating this responsibility they must be satisfied that:

- The correct information is given to the patient/NR (with the patient's consent);
- The information is given in a suitable manner and at a suitable time, and, in accordance with the law;
- The member of staff who is to give the information has received sufficient guidance and is aware of the key issues regarding the information to be given;
- A record is kept of the information given, including how, when and by whom it was given;
- A regular check is made that the information has been properly given to each detained patient and understood by him or her;
- There are processes in place to monitor the explanation to patients of their legal rights under section 132.

7.2 Independent Mental Health Advocates (IMHA)

The role of the IMHA is to help qualifying patients (those detained under the Act, conditionally discharged, subject to guardianship or a CTO understand the legal provision to which they are subject under the Act and the rights and safeguards to which they are entitled. This could include assistance in obtaining information about any of the following:

The provisions of the legislation under which she/he qualifies for an IMHA;

- Any conditions or restrictions she/he is subject to, for example; any arrangements made for section 17 leave;
- The medical treatment being given, proposed or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised.

7.3 Clinical Staff

In relation to this policy all clinical staff must be aware of and comply with the contents of this procedure by providing inpatients with information about:

- Any conditions or restrictions she/he is subject to, for example, any arrangements made for Section 17 leave;
- The medical treatment being given, proposed or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised;
- The rights of qualifying patients to the services of an IMHA and how to obtain one.

Clinical staff should also:

- Complete all the necessary documentation required;

7.4 Care Co-ordinators

Care Co-ordinators are responsible for ensuring patients who are on a CTO are provided with information about:

- Any conditions or restrictions she/he is subject to for example any specific requirements around residency;
- The medical treatment being given, proposed, or being discussed and the legal authority under which this would be given;
- The requirements that would apply in connection with the giving of the treatment;
- Their rights under the Act and how those rights can be exercised;
- The rights of qualifying patients to the services of an IMHA and how to obtain one.
- Care Co-ordinators should also complete all the necessary documentation required.

Depending on the place of residence of the patient, support workers within care homes can also undertake these functions

7.5 Non-registered clinical staff

Any non- registered staff working within clinical services must:

- Be aware of this procedure and its contents;
- Direct any patient who has a query about their legal rights to a member of registered staff unless they are competent to address any issues raised.

7.6 Mental Health Act Department

The Mental Health Act Department are responsible for:

- Providing clinical staff with copies of the appropriate patient information leaflets;
- Monitoring the initial and on-going explanation of their legal rights to detained patients, via the receipt of the patients rights forms;
- Co-ordinating requests by patients for an appeal to the Hospital Managers and/or the Mental Health Review Tribunal;
- Ensuring referrals are made to the IMHA service where necessary;
- Patient's rights forms are filed within the patient's legal correspondence file and a copy in the patient's case notes.
- Ensuring copies of correspondence to NR are filed within the patient's legal correspondence files (Section 133).

8. References

Jones R (2016) Mental Health Act Manual, nineteenth Edition, Sweet and Maxwell

Code of Practice for Wales (revised 2016) Welsh Government

Mental Health (Wales) Measure 2010

Mental Capacity Act Code of Practice

Human Rights Act
Data Protection Act

9. Appendices

Appendix 1 – Patients Rights Form

Mental Health Act 1983 – Section 132/132A
Information to Detained Patients

Patients Name:	
Nearest Relative:	
Current Section:	**Date of Section:**
Ward:	**Name of IMHA:**

I can confirm that I have fully explained the contents of the Patients Rights Leaflet to the patient, including reasons for their detention and the patients right to an Independent Mental Health Advocate (IMHA)

I have informed the patient how long their detention will last for, if and when they have a right of appeal against their detention to the Mental Health Review Tribunal Wales. The role of the Hospital Managers, the patients right to raise a concern and how to do so. The role of Health Care Inspectorate Wales has been explained. Information of Treatment has also been explained in full.

Please tick one of the following boxes:	
The patient has understood the information read and has been given a copy of the information leaflet.	☐
The patient is currently refusing to have their rights read. Further attempts will be made.	☐
The patient currently lacks capacity to understand their rights. Further attempts will be made.	☐
The patient has no capacity to understand information	☐

Name of Staff Member reading rights	
Patients preferred language?	
Has the information been given to the patient in their preferred language?	**YES/NO**
Does the patient agree to the Nearest Relative being given information?	**YES/NO**

Patients Signature:	**Date:**

Please return this form to the Mental Health Act Office, Hafan Y Coed, Llandough Hospital, Penlan Road, Penarth, CF64 2XX.

Fax Number : 02921 824740

REPORT TITLE:	**APPROVAL OF APPLICATION FOR ADMISSION TO HOSPITAL UNDER PART II OF THE MENTAL HEALTH ACT 1983 POLICY AND PROCEDURE**										
MEETING:	**Mental Health and Capacity Legislation Committee**							**MEETING DATE:**	**12 February 2019**		
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**	**x**	**For Information**				**x**
LEAD EXECUTIVE:	**Chief Operating Officer**										
REPORT AUTHOR (TITLE):	**Mental Health Act Manager, sunni.webb@wales.nhs.uk**										

PURPOSE OF REPORT:

SITUATION:
It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

This policy and procedure sets out the requirements for provision when making an application for admission under Part II of the Act (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of detained patients under Part II of the Act.

REPORT:

BACKGROUND, ASSESSMENT AND ASSURANCE:
This is a new policy to ensure statutory requirements under the Mental Health Act 1983 are met.

This Policy and Procedure provides clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Wide consultation has taken place to ensure that the Policy meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 02 October 2018 and 30 October 2018;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality, Safety and Experience Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document Application for Admission to Hospital under Part II of the Mental Health Act 1983 Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

Application for Admission to Hospital under Part II of the Mental Health Act, 1983 Policy

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Mental Health Act.

Part II of the Mental Health Act relates to the following:

Section 2 – Admission for assessment
Section 3 – Admission for treatment
Section 4 – Emergency admission to hospital

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering admission to hospital under Part II of the Mental health Act. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering admission to hospital under Part II of the Mental Health Act and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

To set out the requirements for provision of admission to hospital under Part II of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients subject to part II of the Mental Health Act**.**

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners (‘doctors’), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 (as amended by the MHA 2007).

Supporting Procedures and Written Control Documents

This Policy and the Application for Admission to Hospital under Part II of the Mental Health Act Procedure describe the following with regard to the use of part II of the Mental Health Act:

- The purpose of part II of the Mental Health Act
- The process for considering admission to hospital under part II of the Mental Health Act
- The duties of the practitioners and agencies involved in the management of patients subject to part II of the Mental Health Act

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

Equality & Health Impact Assessment for

APPLICATION FOR ADMISSION TO HOSPITAL UNDER PART II OF THE MENTAL HEALTH ACT, 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	APPLICATION FOR ADMISSION TO HOSPITAL UNDER PART II OF THE MENTAL HEALTH ACT, 1983 POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure professionals are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Mental Health Act 1983. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the admission to hospital under Part II of the Mental Health Act 1983. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health)

		Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.

		Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff

		relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental

		Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are

		also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors’ misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with

		assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder),

		voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind "Our Communities, Our Mental Health"). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey. With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have

		depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.

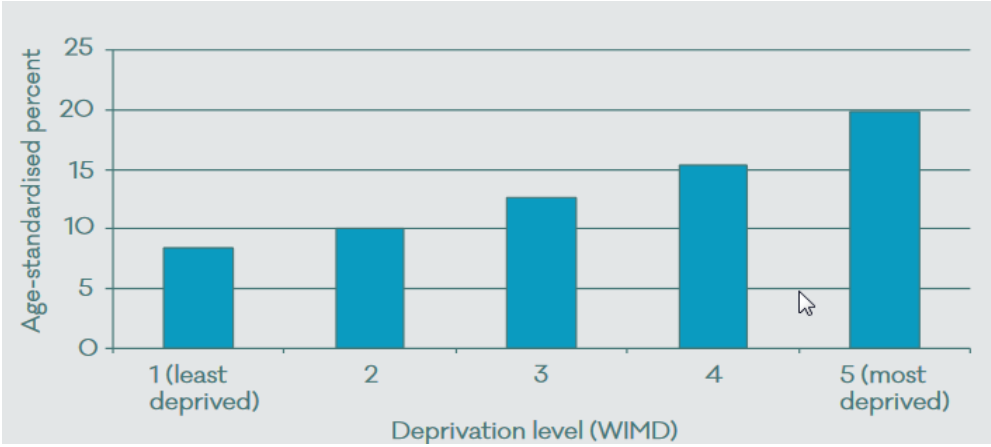
The impact of mental ill health on employment rates

A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).

Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in ‘elementary’ jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia,

premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include

		healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of

		poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

		Homeless Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

		It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

		26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.

		These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The Admission to Hospital under Part II of the Mental Health Act 1983 policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- http://www.cwp.nhs.uk/media/1707/mh3-admission-to-hospital-under-part-ii-of-the-mental-health-act-1983-and-mental-capacity-act-2005-deprivation-of-liberty-safeguards-issue-6.pdf

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A Hospital managers should monitor the use of admission under Part II of the Mental Health Act, including: • The use of section 4 and ensure second doctors are available to visit a patient within a reasonable time after being requested.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

Application for admission to hospital under Part II of the Mental Health Act, 1983 Procedure

Introduction and Aim

This document supports the Application for admission to hospital under Part II of the Mental Health act, 1983 Policy.

To ensure staff are aware of their individual and collective responsibilities when considering admission to hospital under Part II of the Mental Health Act.

To Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This Procedure describes the following with regard to admission to hospital under Part II of the Mental Health Act:

- The purpose of admission to hospital under Part II of the Mental Health Act
- The process for assessing the suitability for admission to hospital under Part II of the Mental Health Act
- The duties of the practitioners and agencies involved in the management of patients subject to admission to hospital under Part II of the Mental Health Act

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of a doctors' holding power. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative

	outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Policy Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure Receipt of Applications for Detention under the Mental Health Act Policy
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**

1	*Date of Committee or Group Approval*	*TBA*	*New document*

Glossary of terms

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
Mental Capacity Act (2005)	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Part 4, Mental Health Act	The part of the Act which deals mainly with the medical treatment for mental disorder of detained patients (including conditionally discharged and community treatment order patients who have been recalled to hospital). In particular, it sets out when they can and cannot be treated for the mental disorder without their consent
Section 2	Compulsory admission of a patient to hospital for assessment and for detention up to 28 days
Section 3	Compulsory admission to hospital for treatment and detention for up to six months
Section 4	An application for detention for assessment of mental disorder made with only one supporting medical recommendation in cases of urgent necessity. Also known as a section 4 application
Section 17 leave	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others

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1. INTRODUCTION

Part II of the Act deals with patients who are detained in hospital but have no criminal proceedings against them. These are referred to as civil sections.

This policy provides relevant professionals with guidance to facilitate compliance with the requirements in respect of admission to hospital under Part II of the Mental Health Act 1983.

Part II of the Mental Health Act relates to the following:

- Section 2 – Admission for assessment
- Section 3 – Admission for treatment
- Section 4 – Admission for assessment in cases of emergency
- Section 5 – Application in respect of patient already in hospital
- Section 6 – Effect of application for admission

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of patients subject to Part II of the Act in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

This procedure is applicable to all professionals within all Mental Health inpatient settings and general hospital settings.

4. MENTAL DISORDER

Mental disorder is defined in section 1 of the Mental Health Act as any disorder or disability of mind.

It is up to the relevant professionals involved to determine whether a person has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.

The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Act. Compulsory measures are only permitted where specific grounds about the potential consequences of the person's mental disorder are met. There are many forms of mental disorder which are unlikely ever to call for compulsory measures.

4.1 Dependence on alcohol or drugs

There are no grounds under the Act for detaining a person in hospital on the basis of alcohol or drug dependence alone. However, alcohol or drug dependence may be accompanied by, or associated with, a mental disorder which does fall within the Act's definition. Individuals with a dual diagnosis[1] should receive equitable care and treatment and support. If the criteria for detention are met, it is appropriate to detain people who are diagnosed with a mental disorder, even though they are also dependent on alcohol or drugs and/or if the mental disorder in question results from the person's alcohol or drug dependence.

Disorders or disabilities of the mind which are related to the use of alcohol or drugs e.g. withdrawal state with delirium or associated psychotic disorder, acute intoxication, or organic mental disorders associated with prolonged abuse of drugs or alcohol remain mental disorders for the purposes of the Act.

4.2 Learning disabilities

Learning disabilities are forms of mental disorder as defined in the Act. However someone with a learning disability and no other form of mental disorder may not be detained for treatment or made subject to guardianship or a Community Treatment Order under the Act unless their learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned. They can however be detained for assessment under section 2 of the Act.

4.3 Autistic spectrum disorders

It is possible for someone with an autistic spectrum disorder to meet the criteria for compulsory measures under the Act without having any other form of mental disorder, even if their autistic spectrum disorder is not associated with abnormally aggressive or seriously irresponsible behaviour.

4.4 Personality disorders

The Act does not distinguish between different forms of mental disorder and therefore applies to all types of personality disorders in exactly the same way as it applies to other mental disorders. Personality disorder must never be viewed as a diagnosis of exclusion.

5. NATURE OR DEGREE

Nature refers to the particular disorder from which the patient is suffering, its chronicity, its prognosis and the patient's previous response to receiving treatment for the disorder.

Degree refers to the current manifestation of the person's mental disorder.

6. APPROPRIATE MEDICAL TREATMENT

When a patient has been detained under a treatment section of the Act, there must be appropriate medical treatment available for their mental disorder. This is to ensure that nobody is detained unless they are actually to be offered treatment for their mental disorder.

Medical treatment for mental disorder means medical treatment for the purpose of alleviating or preventing a worsening of a mental disorder or one or more of its symptoms or manifestations.

Appropriate medical treatment does not have to involve medication or individual or group psychological therapy. In particular cases appropriate treatment consists solely of nursing and specialist day to day care under the clinical supervision of an approved clinician.

7. APPROPRIATE MEDICAL TREATMENT TEST

The appropriate medical treatment test requires a clinical judgment about whether an appropriate package of treatment for the mental disorder is available and accessible for the individual within the setting in which they are receiving that treatment. Where the appropriate medical treatment test forms part of the criteria for detention, the medical treatment in question is treatment for the mental disorder in the hospital in which the patient is to be detained. Where it is part of the criteria for CTO, it refers to the treatment for mental disorder that the person will be offered while on CTO.

8. SECTION 2 ADMISSION FOR ASSESSMENT

Detention under section 2 allows for assessment and treatment of people who have, or are believed to have a mental disorder for a maximum period of up to 28 days.

The person can be given treatment for mental disorder with or without their consent.

If the person absconds, they can be forcibly returned to hospital by any authorised member of hospital staff or by the police.

Criteria:

- The person is suffering from mental disorder ***and***
- It is of a nature or degree to warrant detention in hospital for assessment or assessment followed by treatment for at least a limited period ***and***
- The person ought to be detained in the interests of their own health ***or*** safety ***or*** with a view to the protection of others.

Section 2 pointers:

- An assessment as an inpatient is required in order to produce a treatment plan.
- A judgement is required on whether the patient will accept treatment on a voluntary/informal basis after admission.
- A judgement has to be made on whether a proposed treatment, which can only be administered to the patient under Part 4 of the Act, is likely to be effective.
- The condition of a patient who has already been assessed, and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and further assessment is required.
- The diagnosis and/or prognosis of a patient's condition is unclear.
- It has not been possible to undertake any other assessment in order to formulate a treatment plan.

Forms:

HO 1or HO2	Application by nearest relative ***or*** approved mental health professional (AMHP)
	and
HO3 or HO4	Joint (x1) or single medical recommendations (x2)
HO14	Record of detention in hospital

Not renewable:

If the patient is required to stay in hospital, this would be either as an informal patient or detained for treatment under section 3, **except** it can be extended when an approved mental heath professional (AMHP) wishes to make an application to further detain a patient under section 3 but the nearest relative objects to the making of the application. As the objection prevents the application being made, the AMHP can consider displacing the nearest relative under section 29 of the Mental health Act 1983 (MHA) by making an application to the County Court. If the application is lodged with the court, the section 2 can be extended under section 38 of the County Court Act 1984 whilst consideration is being given to displacing the nearest relative.

9. SECTION 3 ADMISSION FOR TREATMENT

Detention under section 3 allows for detention and treatment of a people in hospital for up to six months.

The person can be given treatment for mental disorder with or without their consent.

If the person absconds, they can be forcibly returned to hospital by any authorised member of hospital staff or by the police.

Criteria:

- The person is suffering from mental disorder ***and***
- It is of a nature or degree which makes it appropriate for them to receive medical treatment in hospital ***and***
- It is necessary for the health **or** safety of the person **or** for the protection of others that they receive that treatment ***and***
- Treatment cannot be provided unless they are detained ***and***
- Appropriate medical treatment is available for them

Learning disability – under the provisions of section 3 of the Act, learning disability is only considered to be a mental disorder if it is associated with ***abnormally aggressive or seriously irresponsible conduct*** on the part of the person concerned (this does **not** apply to section 2).

Section 3 pointers:

- The patient is considered to need compulsory admission for the treatment of mental disorder, which is already known to his or her clinical team, and has recently been assessed by that team.
- The patient is detained under section 2 and assessment indicates a need for compulsory treatment under the Act beyond the existing period of detention. In such circumstances an application for detention under section 3 should be made at the earliest opportunity and should not be delayed until the end of the existing period of detention.

Appropriate medical treatment must be available in all cases; the recommending doctors are required to state on the form that 'appropriate treatment' is available, including the name of one of more hospitals who can provide the treatment.

Forms:

HO 5 or HO6	Application by nearest relative ***or*** approved mental health professional (AMHP)
	and
HO7 or HO8	Joint (x1) or single medical recommendations (x2)
HO14	Record of detention in hospital

Renewable:

Initial detention is for a period of up to six months, renewable for a further six months and annually thereafter.

Before a patients detention expires, the Responsible Clinician must decide whether or

10. SECTION 4 ADMISSION FOR ASSESSMENT IN CASES OF EMERGENCY

Detention under section 4 allows for admission to hospital in an emergency for a maximum period of up to 72 hours. It may be applied when section 2 would be appropriate but the team are unable to obtain the two medical recommendations required and the patient needs urgent hospital admission.

Section 4 should only be used where the patient's urgent need for assessment outweighs the alternative of waiting for a medical examination by a second doctor. The section should never be used for medical or administrative convenience, for example because it is more convenient for the second doctor to examine the patient as an inpatient rather than in the community.

An emergency arises when those involved cannot safely manage the mental state or behaviour of the patient. To be satisfied that an emergency has arisen, there must be evidence of:

- An immediate and significant risk of mental or physical harm to the patient or others
- The immediate and significant danger of serious harm to property
- The need for the use of restrictive interventions on a patient

Criteria:

- The criteria for detention for assessment under section 2 are met
- The patients detention is required as a matter of urgent necessity; and
- Obtaining a second medical recommendation would cause undesirable delay

The AMHP making the application for detention under section 4 must have personally seen the patient within the previous 24 hours. The patient must be admitted within 24 hours of either the medical recommendation or the application being made.

Forms:

HO9 or HO10	Application by nearest relative ***or*** approved mental health professional (AMHP)

HO11 Medical recommendation for emergency admission

HO4 Required to convert to section 2

Not renewable:

This section may be converted to section 2 within the 72 hour period by the addition of one other medical recommendation. Upon conversion, the 28 day period begins from the date of the section 4.

As a matter of good practice, it should be noted that section 4 should only be used if there is serious intent for the patient to be placed on section 2. Arrangements for obtaining a second medical recommendation must be initiated immediately.

If the approved clinician in charge of the patient's treatment considers that section 3 is more appropriate, two fresh recommendations and a new application must be made within the 72 hour period. The treatment order would begin from the date of the application for section 3.

11. MEDICAL RECOMMENDATIONS

An application must be supported by written recommendations from two doctors who have personally examined the patient. Except for section 4 when only one medical recommendation is required.

Recommendations may be made separately by each doctor or as a joint recommendation signed by both.

A medical examination must involve:

- A direct personal examination of the patient and their mental state, and
- Consideration of all available relevant clinical information, including that in the possession of others, professional or non – professional
- If the risk of violence from the patient makes direct examination unsafe then an examination by observation can be undertaken, such circumstance must be fully documented.

Where practicable, at least one of the medical recommendations should be provided by a doctor who has previous acquaintance with the patient. Preferably, this should be a doctor who has personally treated the patient. It is sufficient for the doctor to have had some previous knowledge of the patient's

case. A patient's GP will usually have knowledge of the patient's physical health and family circumstances, which may be helpful in any assessment.

It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act. The Act requires that at least one of the doctors must be so approved.

Doctors must give reasons for the opinions stated in their recommendations. When giving a clinical description of the patient's mental disorder as part of these reasons, doctors should include a description of the patient's symptoms and behaviour, not merely a diagnostic classification.

Where patients are subject to the short-term effects of alcohol or drugs, whether prescribed or self administered, which make interviewing them difficult, the doctors should either wait until the effects have abated before interviewing the patient or arrange to return later. If it is not realistic to wait, because of the patient's disturbed behaviour and the urgency of the case, the assessment will also have to be based information the doctor can obtain from reliable sources. This will also apply if the patient is not willing to speak to the doctor. This should be made clear in the doctor's recommendation.

When making recommendations for detention under section 3, doctors are required to state that appropriate medical treatment is available for the patient. It is their responsibility to take the necessary steps to secure a hospital bed; it is not the responsibility of the applicant.

Except for emergency applications under section 4, these limits are:

- The date on which the applicant last saw the patient must be within the period of 14 days ending with the date of the application.
- The dates of the medical examinations of the patients by the two doctors who gave the recommendations (not the dates of the recommendations themselves) must be not more than 5 clear days apart.
- The dates of signatures of both medical recommendations must not exceed the date of the application.
- The patient's admission to hospital (or if the patient is already in hospital the reception of the documents by a person authorised by the hospital managers to receive them) must take place within 14 days beginning with the date of the later of the two medical examinations.

When an emergency application is made under section 4 it is accompanied in the first place by only one medical recommendation. The time limits, which apply to emergency applications, are:

- The time at which the applicant last saw the patient must be within the period of 24 hours ending with the time of the application

- The patient's admission to hospital must take place within the period of 24 hours starting with the time of the medical examination or with the time of the application whichever is earlier. An emergency application is founded on a medical recommendation therefore the date/time of application must be later than the date/time of the medical recommendation.
- The second medical recommendation must be received on behalf of the managers not more than 72 hours after the time of the patient's admission. The two medical recommendations must then comply with all the normal requirements except the requirement as to the time of the signature of the second recommendation.

12. APPLICATIONS UNDER THE ACT

An application for detention may only be made by an AMHP or the patients nearest relative. An AMHP is usually a more appropriate applicant that a patients nearest relative, given their professional training and knowledge of the legislation and local resources. This also removes the risk that an application by the nearest relative might have an adverse effect on their relationship with the patient.

An application must be supported by two medical recommendations, other than an emergency application, given in accordance with the Act. Doctors who are approached directly by a nearest relative about the possibility of an application being made should advise the nearest relative of their right to require a local authority to arrange for an AMHP to consider the patients case.

When AMHP's make an application for admission under section 2 , they must take such steps as are practicable to inform the nearest relative that the application is to be (or has been) made and of the nearest relatives power to discharge the patient. The AMHP should also inform the main carer (if a different person from the nearest relative) that an application has been made.

Before making an application for admission under section 3, AMHP's must consult the nearest relative, unless it's not reasonably practicable or would involve unreasonable delay. When coming to a decision to consult the nearest relative the applicant will need to give consideration to the patient's Article 5 and Article 8 rights.

The applicant must be satisfied that detention in hospital is the most appropriate way of providing the care and medical treatment that the patient needs, and that the criteria for that particular section is met. Consideration should be given to all the circumstances of the case, including:

- The benefit to the patient of the involvement of their nearest relative, including to protect the patients Article 5 rights
- The patient's wishes including taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of

their wishes they have made in advance. However, a patient's wishes will not solely determine whether it is reasonably practicable to consult the nearest relative

- Any detrimental effect that involving the nearest relative would have on the patient health and wellbeing
- Whether there is good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.

If the nearest relative is not consulted or informed, AMHP's should record their reasons. Consultation must not be avoided purely because it is thought that the nearest relative might object to the application.

If the nearest relative objects to an application being made for admission for treatment under section 3, the application cannot be made. If it is thought necessary to proceed with the application to ensure the patients safety or that of others and the patient continues to object, the AMHP will need to consider applying to the county court for the nearest relative's displacement under section 29 of the Act.

13. CONFLICT OF INTEREST

Conflicts of interest may arise which prevent an AMHP from making the application for a patients detention, and a doctor from making a recommendation supporting the application.

The potential conflict of interest may arise for a number of reasons. Those reasons are the existence of a professional, financial, business or personal relationship between that person and another assessor, or between that person and wither the patient or, where the application is to be made by the patients nearest relative.

<table>
<tr><th colspan="2">Assessor's have a potential conflict if any of the following apply:</th></tr>
<tr><td colspan="2">The Assessor has a financial interest in the outcome of the decision whether or not to give a recommendation or make the application</td></tr>
<tr><td>The Assessor employs</td><td rowspan="3">The patient, or

Either of the other assessors making the recommendations or application</td></tr>
<tr><td>The Assessor directs the work of</td></tr>
<tr><td>The Assessor is closely involved in the same business venture (which includes being a partner, director, other office-holder or major shareholder) as</td></tr>
<tr><td>The Assessor is the wife, ex-wife, husband, ex-husband, civil partner, ex-civil partner, mother, father, sister, brother, half-sister, half-brother, daughter, son, aunt, uncle, grandmother, grandfather, grandson, granddaughter, first cousin, nephew, niece, mother-in-law, father-in-law,</td><td>The patient, or

Either of the doctors making the recommendations on which the application is</td></tr>
</table>

daughter-in-law, son-in-law, sister-in-law, brother-in-law, grandmother-in-law, grandfather-in-law, granddaughter-in-law, grandson-in-law, (including adoptive and step-relationships) of	based The applicant (whether an AMHP or the nearest relative
The Assessor is living as if wife, husband or civil partner with	
The Assessors making the recommendations and application are members of the same team organised to work together for clinical purposes on a routine basis	
The Assessors and the patient are members of the same team organised to work together for clinical purposes on a routine basis	
Both doctors' are on the staff of an independent hospital to which the patient's admission is being considered	

An application which relied on a recommendation made by a doctor who had a potential conflict of interest would be invalid.

Among the effects of this are that:

- only one of the recommendations in support of an application for admission to an independent hospital may be made by a doctor on the staff of that hospital, and
- three professionals involved in an application may not all be in the same clinical team, as described above, nor may any of the professionals involved be in the same clinical team as the patient.

The latter rule about membership of the same clinical team does not apply if the AMHP or doctor concerned thinks that it is of urgent necessity that an application be made and a delay would involve serious risk to the health or safety of the patient or others. In other words, in urgent cases it is possible for all three professionals to be from the same clinical team, and for any or all of them to be from the same clinical team as the patient.

Note that 'in-law' relationships include relationships based on civil partnerships as well as marriage. They do not include relationships based on people living together as if they were married or in a civil partnership.

14. RECEIPT AND SCRUTINY OF DOCUMENTS

Once the application has been completed, the section papers must be delivered to the appropriate officer acting on behalf of the Hospital Managers.

The UHB has delegated the receipt of detention documents on behalf of the Hospital Managers to:

- Mental Health Act Manager
- Mental Health Act Administration Services Manager
- Mental Health Act Coordinator

- Mental Health Act Administrators
- Shift Co-ordinator

Officers responsible for receiving detention papers should accept them as soon as possible on a statutory form HO14 (sections 2, 3 and 4 – record of detention in hospital). An administrative scrutiny checklist for receiving detention papers should be used each time and attached to the detention papers.

During office hours (9.00am and 5:00pm) detention papers must be submitted to the Mental Health Act Office in Hafan Y Coed, UHL to enable the team to undertake receipt and scrutiny. Other sites must make contact with the Mental Health Act Office to inform them that they have detention papers to be received and make arrangements to fax the papers as a priority.

Outside of office hours between 5:00pm and 8.30pm the Shift Coordinator for the appropriate area i.e Hafan Y Coed, MHSOP or Rehab must be contacted via bleep or through the main switchboard in order to make arrangements to receive detention papers.

The Night Site Manager is the delegated officer between 8.30pm and 8.30am for the purpose of receipt of detention papers and can be contacted by bleep or the main switchboard.

The ward must keep a copy of the section papers in the patients file until the final version which has been processed by the Mental Health Act Office available.

For further information see Receipt of applications for detention under the Mental Health Act 1983 policy UHB 340:

http://www.cardiffandvaleuhb.wales.nhs.uk/opendoc/300573

15. OUTCOME OF DETENTION

The Responsible Clinician's power of discharge:

Section 23 of the Act allows responsible Clinicians to discharge Part 2 patients, by giving a discharge order in writing. As Responsible Clinicians have the power to discharge patients, they must keep under review the appropriateness of using that power. If, at any time a responsible clinician concludes that the criteria which would justify renewing a patient's detention are not met, they should exercise their power of discharge. They should not wait until the patients detention is due to expire.

Section 2:

- Discharge by Responsible Clinician ***Form HO17***

- Discharge by Mental Health Review Tribunal for Wales
- Discharge by Hospital Managers' hearing ***Form HO17***
- Discharge by the nearest relative

Section 3:

- Discharge by Responsible Clinician ***Form HO17***
- Discharge by Mental Health Review Tribunal for Wales
- Discharge by Hospital Managers' hearing ***Form HO17***
- Discharge by the nearest relative
- Placed onto a community treatment order ***Form CP1***

Section 4:

Discharge by Responsible Clinician ***Form HO17***

The nearest relatives power of discharge:

Section 23 of the Act allows the nearest relative to order a patients discharge from detention under section 2 or 3.

The nearest relative must give 72 hours notice in writing to the hospital. The nearest relatives order may be barred if within the 72 hour period, the responsible clinician provides a written report using form NR1stating that they consider the patient, if so discharged, ***would be likely to act in a manner dangerous to other persons or to himself***. This question focuses on the probability of dangerous acts, such as causing serious physical injury or lasting psychological harm, not merely on the patient's general need for safety and others general need for protection.

The barring report prevents the nearest relative from ordering discharge at any time in the six months following the date of the report.

If the patient were detained under section 2 the nearest relative cannot take the matter further.

If the patient were detained under section 3 then the nearest relative may, within 28 days of the barring report being issued, apply to the Mental Health Review Tribunal for Wales for the patients discharge instead.

The Hospital Managers must consider holding a review when the responsible clinician makes a report to them barring an order by nearest relative to discharge a patient.

When deciding whether to consider the case, hospital managers should take into account whether the Mental Health Review Tribunal for Wales has recently considered the patients case or is due to do so in the near future. If the decision is not to consider the case reasons why not should be documented.

16. MONITORING

It is essential that compliance with the legal requirements of the Act and the Mental Health Act Code of Practice for Wales, Revised 2016 are monitored.

Hospital managers should monitor the use of section 4 and ensure second doctors are available to visit a patient within a reasonable time after being requested. This will also be monitored by Healthcare Inspectorate Wales.

17. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the Mental Health Act Administration Team.

18. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

19. RESPONSIBILITIES

20.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

20.2 Chief Operating officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

20.3 Designated Individuals

This procedure applies to all of those who have defined responsibilities under the provisions of the Act.

20. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health

Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
Mental Health Act 1983, Code of Practice for Wales, Revised 2016 - https://gov.wales/docs/dhss/publications/160920mentalacten.pdf
Reference Guide to the Mental Health Act 1983 - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417412/Reference_Guide.pdf

REPORT TITLE:	**APPROVAL OF REVIEW OF DETENTION OR COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY AND PROCEDURE**									
MEETING:	**Mental Health and Capacity Legislation Committee**						**MEETING DATE:**	**12 February 2019**		
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**	**x**	**For Information**			**x**
LEAD EXECUTIVE:	**Chief Operating Officer**									
REPORT AUTHOR (TITLE):	**Mental Health Act Manager, sunni.webb@wales.nhs.uk**									

PURPOSE OF REPORT:

SITUATION:
It is essential that compliance with the legal requirements of the Mental Health Act 1983 and the Mental Health Act 1983 Code of Practice for Wales, Revised 2016 are monitored. Local Health Boards and Local Authorities should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed. A non exhaustive list of relevant policies required are detailed in the Mental Health Act 1983 Code of Practice for Wales, Revised 2016.

This policy and procedure sets out the requirements for provision when undertaking a review of detention or a community treatment order under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of detained patients/community patients.

REPORT:

BACKGROUND, ASSESSMENT AND ASSURANCE:
This is a new policy to ensure statutory requirements under the Mental Health Act 1983 are met.

This Policy and Procedure provides clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners ('doctors'), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Wide consultation has taken place to ensure that the Policy meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 02 October 2018 and 30 October 2018;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality, Safety and Experience Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager, the Principal Health Promotion Specialist

Where appropriate comments were taken on board and incorporated within the document.

The primary source for dissemination of this document Review of Detention or Community Treatment Order, Mental Health Act 1983 Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information

Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Yes / No / Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

Kind and caring / Caredig a gofalgar · Respectful / Dangos parch · Trust and integrity / Ymddiriedaeth ac uniondeb · Personal responsibility / Cyfrifoldeb personol

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:**

REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when carrying out a review of detention and Community Treatment Order (CTO) under the Mental Health Act 1983.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically when managing patients considered for renewal of detention or extension of community treatment. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering renewal of detention or extension of community treatment must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

We will set out the requirements for provision of review of detention and community treatment orders under the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patients subject to detention or CTO**.**

This does not apply to restricted patients without the consent of the Secretary of State for Justice

We will ensure statutory requirements under the Mental Health Act 1983 are met by providing clear direction and guidance which will be easily accessible on our internet/intranet sites to particular individuals including registered medical practitioners (‘doctors’), approved clinicians, managers and staff of hospitals in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

Supporting Procedures and Written Control Documents

This Policy and the Review of Detention and Community Treatment Order, Mental health Act 1983 Policy describe the following with regard to a review:

- The purpose of a review
- The process for assessing the suitability for the continued use of detention or community treatment
- The duties of the practitioners and agencies involved in the management of patients subject to detention and community treatment

Other supporting documents are:

- The Mental Health Act 1983 (as amended by the Mental Health Act 2007)
- Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008
- The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)
- The respective Codes of Practice of the above Acts of Parliament
- The Human Rights Act 1998 (and the European Convention on Human Rights)
- Domestic Violence, Crime and Victims Act, 2004

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts where patients are subject to Community Treatment Orders.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.

Policy Approved by	Pending - Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how this policy will be implemented	Mental Health and Capacity Legislation Committee
Accountable Executive or Clinical Board Director	Mental Health Clinical Board Director of Operations

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
1	Date approved by Board/Committee/Sub Committee dd/mm/yyyy	TBA *[To be inserted by the Gov. Dept]*	*New document*
2			

Equality & Health Impact Assessment for

REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure staff are aware of their individual and collective responsibilities when carrying out a review to consider renewal of detention or extension of community treatment. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they carrying out a review to consider renewal of detention or extension of community treatment. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[1] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[2].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016). Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with

[1] http://nww2.nphs.wales.nhs.uk:8080/PubHObservatoryProjDocs.nsf
[2] http://www.cardiffandvaleuhb.wales.nhs.uk/the-challenges-we-face

		an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, 1 an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health)

		Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, “Our Communities, Our Mental Health”) Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics.

		Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff

		relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental

		Health, in the UK, 20% of women are affected by mental health problems during the perinatal period.11 In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are

		also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, "Our Communities, Our Mental Health") The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with

		assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder),

		voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind "Our Communities, Our Mental Health"). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have

		depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration.

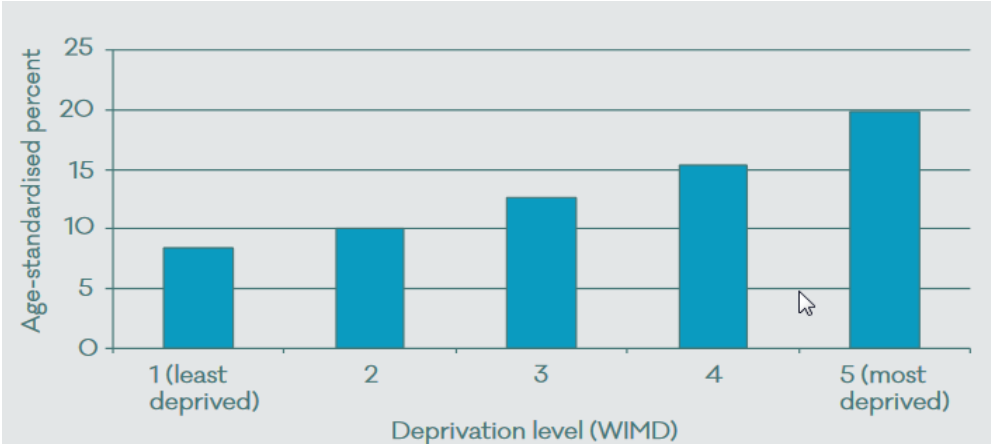
The impact of mental ill health on employment rates

A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002).

Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in ‘elementary’ jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia,

premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include

		healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of

		poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

		Homeless Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships.

		It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints.Stigma may also be attached tomental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

		26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality.

		These risk factors may be present in any protected group. Reviews of the international research literature have found many methodological limitations and no robust evidence about either the positive or negative effect of community treatment orders on key outcomes such as hospital readmissions, length of hospital stay, improved medication adherence or patients' quality of life, and have queried whether community treatment orders are an effective alternative to standard care. Although not opposing community treatment orders in principle, the Royal College of Psychiatrists has pointed out that 'studies from abroad do not show community treatment orders to be the panacea the Government makes them out to be. Indeed the evidence is equivocal as to whether they bestow any benefits on a wide scale'. **Ethical Considerations** Community treatment orders pit patient autonomy against professional paternalism, raising serious ethical concerns. The 2007 Act is risk-based, not capacity-based. Given that the majority of psychiatric in-patients have the capacity to make treatment decisions, community treatment orders will commonly be imposed on people who have capacity. Community treatment orders are not a good thing -Simon Lawton-Smith / John Dawson and Tom Burns) **Examples of patient experience** Participants perceived both positive and negative impacts of CTOs. The positives included affirmation of experiences with the mental health system; improved rapport with the case management and clinical team,

		increased medication compliance and feelings of empowerment. The negative feedback included feelings of being coerced and the stigma associated with it. (Community treatment orders and the experiences of ethnic minority individuals diagnosed with serious mental illness in the Canadian mental health system – Magnus Mfoafo-McCarthy International Journal of Equity in Health Sept 2014) Findings of **NO HEALTH WITHOUT MENTAL HEALTH: A cross-Government mental health outcomes strategy for people of all ages Analysis of the Impact on Equality (AIE) (DoH 2011) -** The Care Quality Commission (CQC) recently highlighted a number of human rights issues relating to the use of CTOs, including concern about appropriate usage, over-representation of black and minority ethnic (BME) groups among those issued with CTOs and a lack of consistent practice when involving patients in care decisions, such as the details of their CTO. A compulsory community-based treatment order requires a patient to comply with a set of conditions, such as taking their medication, while allowing them to live in the community, as a less restrictive alternative to hospital. These orders are particularly targeted at people who tend to have difficulty engaging with mental health services or taking their medication, leading to an exacerbation of their mental health problems, which can end up with a hospital admission. They are intended to increase compliance with medication and patient engagement with outpatient services, while reducing hospital admissions and lowering the risk of harm to themselves or others.

		(A Question of Numbers – Potential Impact of Community Based Treatment Orders in England and Wales" Simon Lawton Smith for the Kings Fund Sept 2005) Community treatment orders are designed to ensure patients live in their home or supported accommodation. The power of recall under section 17E is used when a patient is not compliant with their conditions or becomes mentally unwell. They are used for patients who have frequent repeated admissions to hospital.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to direct care and treatment of patients. The Review of detention and Community Treatment Policy covers mental health patients across community, outpatient and inpatient settings. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis. The functions are carried out on a day to day basis.

6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	There is potential for a positive impact in that there is an awareness of this protected characteristic.	N/A	Under Policy Statement
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or impairment, mental health conditions, long-term medical conditions such as diabetes	Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments. There is potential for a positive impact in that there is an awareness of this protected	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	characteristic and staff have to take into account the diverse needs of the individual patient.	understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or	There is potential for a positive impact in that there is an awareness of this protected characteristic and staff have to take into account the diverse needs of the individual patient.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff*	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
who has completed a process to change his or her gender with or without going through any medical procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	We are aware of potential negative impact in terms of the LGBT+ communities and access to health care services as noted elsewhere within the EHIA.	*"It's Just Good Care – A guide for health staff caring for people who are trans*" is made available to staff.*	Under Policy Statement
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding. They are protected for 26 weeks after having a baby whether or not	No impact anticipated. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
they are on maternity leave.			
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	There is a potential for a negative impact as there is a lot of well documented evidence to suggest that. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an	Under Policy Statement A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		interpreter should be obtained.	
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	There is the potential for impact as suggested by the evidence above. However staff have to take into account the diverse needs of the individual patient. .		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures.
6.8 People who are attracted to other people of: • the opposite sex (heterosexual); • the same sex (lesbian or gay); • both sexes (bisexual)	We know from evidence that there are potential negative issues in terms of these protected characteristics. However staff have to take into account the diverse needs of the individual	N/A	N/A

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	patient.		
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	There is the potential for a negative impact. However staff have to take into account the diverse needs of the individual patient.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be	Under Policy Statement Staff are made aware of the translation and interpretation policy.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
		obtained.	
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	There is awareness that mental health problems have a greater impact on people's ability to work than any other group of disorders. However staff have to take into account the diverse needs of the individual patient. Disabled people with enduring mental health problems of all types are much less likely to be economically active than those with physical or sensory impairments.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access services and facilities	No impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	Staff will respect the rights and needs of carers alongside the person's right to confidentiality. A Review of the person's consent to share information with family members, carers and other services will take place during the inpatient stay.	A key duty is that the Doctor must be fully aware of the diverse needs of the patient when considering detention and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate.** Make reference to where the mitigation is included in the document, as appropriate
	No impact has been identified at this time in relation to the homeless, asylum seekers and prisoners, though it is recognised that there is sometimes poorer mental health issues due to their circumstances and that there consequences for their mental health. However staff have to take into account the diverse needs of the individual patient.	language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.	

7. HIA / How will the strategy, policy, plan, procedure and/or service impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	No Impact identified at this time, though it is recognised that there is poorer mental health in more deprived areas. However staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the harm caused by alcohol and /or	No impact identified at this time, though it is recognised that healthy lifestyles can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
non-prescribed drugs plus access to services that support disease prevention (e.g. immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales			
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working conditions	No impact identified at this time, though it is recognised that being employed can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient Wales	No impact identified at this time, though it is recognised that environmental issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	No impact identified at this time, though it is recognised that social and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.	N/A	Under Policy Statement
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of	No impact identified at this time, though it is recognised that macro-economic, environmental and sustainability factors social	N/A	Under Policy Statement

How will the strategy, policy, plan, procedure and/or service impact on:-	**Potential positive and/or negative impacts and any particular groups affected**	**Recommendations for improvement/ mitigation**	**Action taken by Clinical Board / Corporate Directorate** Make reference to where the mitigation is included in the document, as appropriate
government policies; gross domestic product; economic development; biological diversity; climate Well-being Goal – A globally responsible Wales	and community influences and related issues can have a positive impact on mental health and well-being. Staff have to take into account the diverse needs of the individual patient.		

Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. . **https://www.google.co.uk/search?q=Impact+of+community+treatment+orders+on+protected+groups&oq=Impact+of+community+treatment+orders+on+protected+groups&gs_l=psy-ab.12...1837221.1854919.0.1857397.59.38.1.0.0.0.531.5383.0j2j4j6j3j1.16.0....0...1.1.64.psy-ab..50.0.0.gB1dGnixrkY** CTOs are intended to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	To ensure that an interpreter/translation is requested immediately to avoid delay and ensure patients are provided with information in their preferred language in a timely manner.	All appropriate staff	As and When required/requested	Staff will be/are made aware of our Interpretation and Translation policy and its use with service users.
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	Not required	N/A	N/A	No action

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine t an earlier review is required.	N/A	N/A	N/A Following recall, the hospital managers are responsible for ensuring no patient is detained for longer than 72 hours unless the CTO is revoked. The relevant statutory form must be completed on the patients arrival at hospital. Arrangements should be put in place to ensure the patients length of stay following the time of detention after recall, as recorded on the form, is carefully monitored. The hospital managers should also ensure there are clear guidelines and procedures in place to cover any necessary transfers of responsibility between responsible clinicians in the community and in hospital and the procedure to be followed when a patient is receiving inpatient services from a private provider and a community treatment order is appropriate.

Reference Number: *TBA* **Version Number:** 1	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

REVIEW OF DETENTION AND COMMUNITY TREATMENT ORDER, MENTAL HEALTH ACT 1983 PROCEDURE

Introduction and Aim

This document supports the Review Detention and Community Treatment Order, Mental Health Act 1983 Policy.

To ensure staff are aware of their individual and collective responsibilities when reviewing detention and community treatment order's (CTO) under the Act.

To Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

To Ensure that statutory requirements under the Mental Health Act 1983 are met.

Objectives

This Procedure describes the following with regard to renewing detention and extending a community treatment order:

- The purpose of reviewing detention and CTO
- The process for reviewing detention CTO
- The duties of the practitioners and agencies involved in the management of reviewing detention and CTO

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are reviewing detention or CTO. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure applies to all of our staff in any inpatient or community setting where a person is liable to be detained or who is subject to a CTO and the Associate Mental Health Act Managers who have delegated responsibility from the Board.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Review of detention and Community Treatment Order Policy Community Treatment Order Policy Community Treatment Order Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Mental Health Clinical Board Director of Operations*
Author(s)	*Mental Health Act Manager*

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*Date of Committee or Group Approval*	*TBA*	*New document*

Glossary of terms

Term	Definition
AC	Approved Clinician – A mental health professional approved by the Welsh Ministers to act as an approved clinician for the purposes of the Act. In practice, Health Boards take these decisions on behalf of the Welsh Ministers
Community Treatment Order (CTO)	The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.
Approved Mental Health Professional (AMHP)	A professional with training in the use of the Act, approved by a local authority to carry out a number of functions under the Act.
RC	Responsible Clinician - The approved clinician with overall responsibility for the patient's case
IMHA	Independent Mental Health Advocate – An advocate independent of the team involved in patient care available to offer support to patients.
Mental Capacity Act (2005)	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth
Article 5 European Convention of Human Rights (ECHR)	Right to Liberty and Security of Person: *No one should be deprived of their liberty except for specific cases and in accordance with procedure prescribed by law e.g. after conviction, lawful arrest on suspicion of having committed an offence, lawful detention of person of unsound mind, to prevent the spread of infectious diseases. Everyone deprived of liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of detention shall be decided speedily by a court and release ordered if the detention is not lawful.*
MHRTfW	Mental Health Review Tribunal for Wales – A judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge
Section 3	Compulsory admission to hospital for treatment and detention for up to six months
Keywords	Section 20, Duration of authority Section 20A, Community treatment period

CONTENTS

1. INTRODUCTION

The Mental Health Act gives the Hospital Managers the power to renew detention and extend a CTO. This does not apply to restricted patients without the consent of the Secretary of State for Justice. This procedure is to ensure that the UHB meets its responsibilities in relation to renewing detention and extending a CTO.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the management of patients considered for renewal of detention or extension of community treatment. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales (Revised 2016).

It provides guidance on the role and responsibilities of the Responsible Clinician (RC) and the role of the patient's nearest relative. Due consideration should be given to the use of the option with the least possible restrictions.

3. SCOPE

This procedure applies to all staff working in Cardiff and Vale University Local Health Board whose role involves the care and treatment of patients / service users covered under the Mental Health Act and the Associate Mental Health Act Managers who have delegated responsibility from the Board.

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

4. DETENTION: RENEWAL, DISCHARGE OR CTO

Before a patient's detention or CTO expires, the RC must decide whether the patient's current period of detention should be renewed or CTO extended. The RC must examine the patient and decide within the two months leading up to the expiry of the patients detention or CTO whether the criteria for renewing detention under section 20 of the Act or section 20 A are met, or whether discharge is appropriate.

The RC should discuss their decision with the patient and must consult one or more other people who have been professionally concerned with the patient's medical treatment. The RC should also consult the wider multi-disciplinary team (MDT). Where appropriate, this should include the

nearest relative, the independent mental health advocate (IMHA) and/or other representative, patient's aftercare and any other key service providers.

5. EXAMINATION OF THE PATIENT

If a patient refuses to be examined or is assessed as being either too ill or too disturbed to be examined, the RC's examination of the patient could comprise of:

- Her observations of the patient
- A consideration of the patient's medical history and prognosis
- An evaluation of the patients current condition in a MDT case conference

The examination could take place on an out-patient basis if the patient is on section 17 leave.

A mandatory condition of a community treatment order is that a patient must make themselves available for examination under Section 20 A, as requested.

The patient's compliance with the conditions will be a key indicator of how a CTO is working in practice.

If the patient is not complying , the reasons for this should be properly investigated. Appropriate action will be needed, which may indicate a need to consider recall to hospital.

6. RENEWAL OF DETENTION

In order to renew detention, the patients RC must submit a report to the Hospital Managers confirming that the following conditions are satisfied:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and
- It is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and that it cannot be provide unless he continues to be detained; and
- Appropriate medical treatment is available to him

Where the RC is satisfied that the criteria for renewing the patient's detention are met, they must complete part 1 of the statutory renewal report (form HO15/HO16).

7. SECOND PROFESSIONAL

Before the RC can submit the statutory renewal of detention report, they are required to obtain the written agreement of another professional ('the second professional') that the criteria are met. Before examining a patient to decide whether to make a renewal report, the responsible clinician should identify and record who the second professional is to be. This second professional must be professionally concerned with the patient's treatment and must not belong to the same profession as the RC.

The involvement of a second professional is intended to provide an additional safeguard for patients by ensuring:

- Renewal is formally agreed by at least two suitably qualified and competent professionals who are familiar with the patients case
- Those two professionals are different disciplines, and so bring different complementary, professional perspectives to bear
- The two professionals are able to reach their own decisions independently of one another

The second professional should:

- Have sufficient experience and expertise to decide whether the patients continued detention is necessary and lawful
- Have been actively involved in the planning, management or delivery of the patients care and treatment
- Have had sufficient recent contact with the patient to be able to make an informed judgement about the patient's case.

Second professionals should satisfy themselves, they have sufficient information on which to make the decision or whether they need to meet separately with the patient. RC's should ensure the second professional is given enough notice to be able to interview or examine the patient if appropriate.

If the second professional is in agreement with the RC they must complete part 2 of the statutory renewal report (form HO15/HO16). The RC is now able to complete part 3 of the form and furnish to the hospital managers.

It is submitted that in the event of the second professional deciding that the grounds for renewal are not satisfied, the agreement of another second professional could be sought even if there are no "exceptional circumstances".

8. FURNISHING THE REPORT TO THE HOSPITAL MANAGERS

A report is furnished to the hospital managers when it is committed to the internal mailing system or alternatively handed to a member of staff authorised by the hospital managers to receive it (see Hospital Managers Scheme of Delegation Policy).

If the report is being furnished through the internal mailing system it must be either faxed to the Mental health Act Department (029 21824740) or scanned and emailed to the generic account (Mentalhealthact.Team.CAV@wales.nhs.uk) to enable the Mental Health Act Administrator to make the appropriate record.

The furnishing of the RC's report gives authority for continued detention/extension of CTO of the patient. If the authorised period of detention expires without there being a report duly furnished, any detention after the expiry date will plainly be unlawful and render the managers at risk of successful action.

9. EXTENDING A CTO

In order to extend a CTO, the patients RC must submit a report to the Hospital Managers confirming that the following conditions are satisfied:

- The patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- It is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- Subject to his continuing to be liable to recalled, such treatment can be provided without his being detained in hospital;
- It is necessary that the RC should continue to be able to exercise the power under section 17E(1) above to recall the patient to hospital; and
- Appropriate medical treatment is available for him

They must also consult with one or more other people who have been professional concerned with the patient's medical treatment.

Where the RC is satisfied that the criteria for extending the patient's CTO are met, they must complete part 1 of the statutory report (form CP3/CP4).

10. APPROVED MENTAL HEALTH PROFESSIONAL (AMHP)

Before the RC can submit the report they must obtain the written agreement of an AMHP. The RC should ensure the AMHP is given enough notice to be able to interview the patient if appropriate.

The AMHP does not have to be the same AMHP who originally agreed the patient should become a CTO patient. It may (but need not) be an AMHP who is already involved in the patient's care and treatment. It can be AMHP acting on behalf of any willing local authority. If no other local authority is willing, responsibility for ensuring that an AMHP considers the case should lie with the local authority which is responsible under section 117 for the patient's after-care.

If the AMHP is in agreement with the RC they must complete part 2 of the statutory report (form CP3/CP4). The RC is now able to complete part 3 of the form and furnish to the hospital managers (see 8 above furnishing the report to the hospital managers)

11. NOT HOLDING A REVIEW BEFORE DETENTION/CTO EXPIRES

If authority for detention is not renewed and the patient continues to be kept in circumstances which amount to a deprivation of liberty this will be a breach of the patients rights under Article 5 of the European Court of Human Rights (ECHR).

The RC should notify the hospital managers immediately by contacting the Mental Health Act Manager. The hospital managers should report the breach to Healthcare Inspectorate Wales (HIW) as a serious incident and the patient informed.

The patient must be informed and either immediately discharged or there must be lawful authority to continue to detain the patient, for example, in exercise of the holding powers in the Act. If necessary a new application for admission or assessment should then be made. The hospital managers should ensure a review is undertaken within one month to determine why this has happened and what actions have been taken to resolve this and to ensure that it won't happen again in the future.

12. RESPONSIBLE CLINICIANS POWER OF DISCHARGE

Section 23 of the Act allows RC's to discharge Part 2 patients, unrestricted Part 3 patients and all CTO patients by giving a discharge order in writing. As RC's have the power to discharge patients, they must keep under review the appropriateness of using that power. If, at any time, a RC concludes that the criteria which would justify renewing a patients detention or extending the patient's CTO are not met, they should exercise their power of discharge. They should not wait until the patient's detention or CTO is due to expire.

13. NEAREST RELATIVE'S POWER OF DISCHARGE

A patient detained for assessment or treatment under Part 2 of the Act may also be discharged by their nearest relative. The hospital managers should ensure the nearest relative is aware of the power and how to use it.

Before giving a discharge order, the nearest relative must give the hospital managers at least 72 hours notice in writing of their intention to discharge the patient.

The 72 hour period starts to run from the time when the notice is received by the authorised person on behalf of the Hospital Managers.

During that period the patient's RC can block the discharge by issuing a 'barring report' (form NR1) stating that, if discharged, the patient is likely to act in a manner dangerous to themselves or others.

The barring report should also detail the likelihood and nature of such dangerous acts, such as causing serious physical injury or lasting psychological harm and, not merely the patient's and others general need for safety and protection. If a RC wishes to block a patient's discharge by issuing a barring report, a copy should be given to the patient and to the nearest relative.

It will only be in the most exceptional circumstances that a copy would not be give, e.g. details in the report contain the patient's stated intention to harm the nearest relative.

The nearest relative's notice and discharge order must both be given in writing, but do not have to be in any specific form. Hospital managers should treat a discharge order given without prior notice as being both notice of intention to discharge the patients after 72 hours.

Once received on behalf of the hospital managers by the Mental Health Act Administrator or Shift Coordinator the discharge order is deemed as served and the 72 hour period begins.

The Mental Health Act Department will liaise with the RC to ensure the patient is examined within the 72 hours and a decision is made as to whether a barring notice will be issued by the RC.

If a barring order is issued the Mental Health Act Team will make arrangements for a hospital managers hearing to be held within two weeks of the barring order being issued.

14. DISCHARGE BY THE HOSPITAL MANAGERS AND THE MENTAL HEALTH REVIEW TRIBUNAL for WALES

Patients may also be discharged by the hospital managers or by the Mental Health Review Tribunal for Wales. See Power of Discharge Hospital Managers Hearing Protocol and the Mental Health Review Tribunal Procedure.

15. PROCEDURES FOR REVIEWING DETENTION OR A CTO

Hospital managers should ensure all relevant parties, nearest relatives and, if different, their carers are aware that patients have the right to seek discharge by the hospital managers. They also need to understand the distinction between this right and the right to apply to the Mental Health Review Tribunal for Wales.

Hospital managers:

- May undertake a review of whether or not a patient should be discharged at any time at their discretion
- Must undertake a review if the patient's RC submits a report to them under section 20 of the Act or renewing detention under section 20A, extending the CTO.
- Should consider holding a review when they receive request from the patient. Such a request may be supported by a carer, their independent mental health advocate (IMHA), independent mental capacity advocate, by their attorney or deputy.
- Must consider holding a review when the RC makes a report to them under section 25(1) barring an order by the nearest relative to discharge a patient.

In the last two cases, when deciding whether to consider the case, hospital managers should take into account whether the MHRT for Wales has recently considered the patient's case or is due to do so in the near future. The decision reached should be recorded in writing. If the decision is not to consider the case the reasons why not should be documented. This will be facilitated by the Mental Health Act Department.

In these cases, the patient, or the nearest relative, will be actively seeking discharge. Where the RC submits a report renewing detention or extending a CTO, the hospital managers must consider the renewal or extension even if the patient does not object to it.

A restricted patient is entitled to ask the hospital managers to consider whether they should conduct a review of his or her detention, although the hospital managers may not discharge the patient following any such review without the consent of the Secretary of State for Justice.

16. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the Mental Health Act Department.

17. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

18. RESPONSIBILITIES

18.1 Chief Executive

The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

18.2 Chief Operating officer

The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

18.3 Designated Individuals

This procedure applies to all professionals who have defined responsibilities under the provisions of the Act.

19. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

Report Title:	Self Assessment – Mental Health and Capacity Legislation Committee								
Meeting:	Mental Health and Capacity Legislation Committee						**Meeting Date:**	12.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Mental Health and Capacity Legislation Committee with the opportunity to discuss the attached self-assessment and associated process to be undertaken by the Director of Corporate Governance.

REPORT

BACKGROUND

It is good practice and good governance for the Committees of the Board to undertake an assessment of their effectiveness on an annual basis.

ASSESSMENT

Attached to the report is an effectiveness assessment to be undertaken by the Members and the Executive Lead of the Mental Health and Capacity Legislation Committee. The assessment will be sent out to Members to complete and then the results will be analysed by the Director of Corporate Governance. The results of the review and an action plan to improve will then be reported back to the next meeting of the Mental Health and Capacity Legislation Committee.

RECOMMENDATION

The Mental Health and Capacity Legislation Committee is asked to:

APPROVE that the attached effectiveness review is undertaken and results and action plan reported back to the next meeting of the Committee.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Mental Health and Capacity Legislation Committee – Self Evaluation 2019

Key to status (shown in Status column where applicable): 1=must do 2=should do 3=could do

Establishment, Composition, Organisation, Resources, Duties		Status	Strong	Adequate	Needs Improvement	Comments
1	The Mental Health and Capacity Legislation Committee terms of reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the committee and the full board.	1				
2	The board was active in its consideration of Mental Health and Capacity Legislation Committee composition	2				
3	The Mental Health and Capacity Legislation Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.					
4	The Mental Health and Capacity Legislation Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.	2				
5	Mental Health and Capacity Legislation Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the committee's responsibilities.	2				
6	Appropriate internal or external support and resources are available to the Mental Health and Capacity Legislation Committee and it has sufficient membership and authority to perform its role effectively.	1				
7	The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees	2				

Establishment, Composition, Organisation, Resources, Duties		Status	Yes	No	Comments
8	Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	2			
9	Are changes to the committee's current and future workload discussed and approved at Board level?	2			
10	Are committee members independent of the management team?	1			

Agenda Management and Oversight of Process		Status	Strong	Adequate	Needs Improvement	Comments
11	The Mental Health and Capacity Legislation committee's agenda-setting process is thorough and led by the Mental Health and Capacity Legislation committee chair.					

Agenda Management, Oversight of the Financial Reporting Process, Compliance with the Law and Regulations Governing the NHS and Internal Control		Status	Yes	No	Comments
12	Has the Committee established a plan for the conduct of its work across the year?	2			
13	Has the committee formally considered how its work integrates with wider performance management and standards compliance?	2			
14	Has the committee been briefed on its assurance responsibilities with regard to internal control and risk management, particularly with regard to the Annual Governance Statement and the Board Assurance Framework?	2			
15	Has the committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	2			
16	Does the Board ensure that Committee members have sufficient knowledge of the organisation to identify key risks and to challenge line management on critical and sensitive matters?	2			
17	Is the committee satisfied that the Board has been advised that assurance reporting is in place to encompass all the organisations responsibilities?	2			

Continuous Improvement		Status	Strong	Adequate	Needs Improvement	Comments
18	The Mental Health and Capacity Legislation committee's self-evaluation process is in place and effective	2				

Overall Evaluation		Status	Strong	Adequate	Needs Improvement	Comments
19	What is your overall assessment of the performance of the Mental Health and Capacity Legislation Committee?					

Additional Comments:

Name

Position

Report Title:	Draft Annual Report 2018/19 – Mental Health and Capacity Legislation Committee							
Meeting:	Mental Health and Capacity Legislation Committee					**Meeting Date:**	12.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**	
Lead Executive:	Director of Corporate Governance							
Report Author (Title):	Director of Corporate Governance							

SITUATION

The purpose of the report is to provide Members of the Mental Health and Capacity Legislation Committee with the opportunity to discuss the attached Annual Report prior to submission to the Board for approval.

REPORT

BACKGROUND

It is good practice and good governance for the Committees of the Board to produce an Annual Report from the Committee to demonstrate that it has undertaken the duties set out in its Terms of Reference and provide assurance to the Board that this is the case.

ASSESSMENT

The attached Annual Report 2018/19 of the Mental Health and Capacity Legislation Committee demonstrates that the Committee has undertaken the duties as set out in its Terms of Reference. The Committee has achieved an overall attendance rate of 89% and has met on three occassions.

RECOMMENDATION

The Mental Health and Capacity Legislation Committee is asked to:

REVIEW the draft Annual Report 2018/19 of the Mental Health and Capacity Legislation Committee.
RECOMMEND the Annual Report to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

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Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of Mental Health & Capacity Legislation Committee 2018/19

1.0 INTRODUCTION

In accordance with best practice and good governance, the Mental Health & Capacity Legislation Committee produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee consists of three Independent Members. In addition, the meetings are also attended by the Chief Operating Officer (Executive Lead for the Committee), the Director of Corporate Governance and other Officers who contribute to the work of the Committee. Time is allocated, at the end of each meeting, to review the effectiveness of the meeting.

3.0 MEETINGS AND ATTENDANCE

The Committee met three times during the period 1 April 2018 to 31 March 2019 in line with its Terms of Reference and has discharged its responsibilities by requesting reassurances from Trust Officers and colleagues. The Mental Health & Capacity Legislation Committee achieved an attendance rate of 89% during the period 1st April 2018 to 31st March 2019 as set out below:

	26/06/2018	23/10/2018	12/02/2010	**Attendance**
Eileen Brandreth	√	√	√	**100%**
Charles Janczewski	√	√	√	**100%**
Sara Moseley	X	√	√	**67%**
Total	**67%**	**100%**	**100%**	

4.0 TERMS OF REFERENCE

The Terms of Reference were reviewed and approved by the Committee on 12th February 2019 and were approved by the Board on 31st March 2019.

5.0 WORK UNDERTAKEN

During the financial year 2018/19 the Mental Health & Capacity Legislation Committee reviewed the following key items at its meetings:

- Deprivation of Liberty Safeguards Monitoring Report – June 2018, October 2018, February 2019.
- Mental Capacity Act Monitoring Report - June 2018, October 2018, February 2019.
- Mental Health Act Exception Report – June 2018, October 2018, February 2019

- Mental Health Act Inspection Report
- Mental Health Measure Monitoring Report – June 2018, October 2018, February 2019
- Mental Health Legislation Operational Group – June 2018, October 2018, February 2019
- Committee Work plan – June 2018
- Hospital Managers Power of Discharge Sub-Committee Minutes – June 2018, October 2018, February 2019
- Deprivation of Liberty Safeguards Monitoring Report – October 2018
- PCIC Presentation – June 2018
- Part 2 – Mental Health Measure – Care and Treatment Plans – October 2018,
- Psychological Therapies Referral to Treatment – 26 weeks Briefing – October 2018
- Hospital Managers Power of Discharge Annual Report – October 2018
- Approved controlled documents relevant to the Mental Health & Capacity Legislation Committee – June 2018, October 2018, February 2019
- Mental Health Benchmarking Report – February 2019
- RPC Legislative Implications – February 2019
- National Review of Mental Health Act – February 2019
- Hospital Managers Power of Discharge Terms of Reference – February 2019.

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Mental Health & Capacity Legislation Committee meetings by presenting a summary report (introduced from November 2018) of the key discussion items at the Mental Health & Capacity Legislation Committee. The report is presented by the Chair of Mental Health & Capacity Legislation Committee.

7.0 OPINION

The Committee is of the opinion that the draft Mental Health & Capacity Legislation Report 2018/19 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Charles Janczewski

Committee Chair

Report Title:	Terms of Reference – Mental Health and Capacity Legislation Committee								
Meeting:	Mental Health and Capacity Legislation Committee						**Meeting Date:**	12.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Mental Health and Capacity Legislation Committee with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

REPORT

BACKGROUND

The Terms of Reference for the Mental Health and Capacity Legislation Committee were last reviewed in March 2015.

ASSESSMENT

The Terms of Reference for the Mental Health and Capacity Legislation Committee have been reviewed by the Director of Corporate Governance. There are a limited number of changes to the document, these have been tracked and left in the draft so Committee Members can identify the changes that have been made.

RECOMMENDATION

The Mental Health and Capacity Legislation Committee is asked to:

APPROVE the changes to the Terms of Reference for the Mental Health and Capacity Legislation Committee and
RECOMMEND the changes to the Board for approval.

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	
4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

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Cardiff and Vale University Health Board

Mental Health & Capacity Legislation Committee

Terms of Reference

Approved XX

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Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

1. INTRODUCTION

1.1 The University Health Board's (UHB) Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (and the UHB Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health & Capacity Legislation Committee.** The detailed terms of reference and operating arrangements agreed by the Board in respect of this Committee are set out below.

1.3 The principal remit of this Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure).

Mental Health Act

1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

1.5 The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.

1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

Mental Health Measure

1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

1.10 The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

1.11 The MCA covers 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 caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS)

Thus the scope of MCA extends beyond those patients who have a mental disorder.

2. PURPOSE

2.1 The purpose of the Mental Health and Capacity Legislation Committee (the Committee) is to give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Act;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

The Committee will also advise the Board of any areas of concern in relation to compliance with the MHA, the Measure and MCA.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- consider and approve relevant policies and control documents in support of the operation of Mental Health and Capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- consider any other information, reports, etc that the Committee deems appropriate.

Authority

3.2 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference, concentrating on the governance systems in place and indicators of their effectiveness, particularly in the management of risk. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the UHB's procurement, budgetary and other requirements.

Sub Committees

3.4 In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a sub-committee, to be known as the Power of Discharge Sub-committee. Three or more members drawn from the Sub-Committee will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to SCT.

3.5 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

Retention of Board Responsibility

3.6 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Cardiff and Vale University Health Board, as well as the Power of Discharge Group.

4. MEMBERSHIP

Members

4.1 A minimum of four (4) members, comprising:

Chair	Vice Chair of the Board
Vice Chair	Chosen from amongst the Independent Members on the Committee
Members	A minimum of two other Independent Members of the Board The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers and partners are expected to be in attendance so that the Committee can obtain appropriate assurances on compliance with mental health and mental capacity legislation across its breadth of statutory responsibilities:

- Chief Operating Officer (Lead Executive)
- Director of Corporate Governance
- Medical Director

- Clinical Board Director Mental Health
- Clinical Board Nurse Mental Health
- Head of Operations and Delivery, Mental Health Clinical Board
- Clinical Board Director (or their nominated representative) – Medicine
- Clinical Board Director (or their nominated representative) – Primary, Community and Intermediate Care
- Local Authority Associate Board Member (Director of Social Services)
- Mental Health Act Manager
- Mental Capacity Act Manager
- Representative from Hospital Managers Power of Discharge Group
- Chief Executive – IMHA service provider
- Chief Executive – IMCA service provider

4.3. By invitation:

The Committee Chair may extend invitations to attend committee meetings to others from within or outside the organisation who the committee considers should attend, taking account of the matters under consideration.

Secretariat

4.4 The Director of Corporate Governance shall attend every meeting and the meeting will be serviced by a member of the Corporate Governance team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair (and, where appropriate, on the basis of advice from the UHB Remuneration and Terms of Service sub-committee).

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for Committee members as part of the UHB overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

Quorum

5.1 Two Independent Members, one of whom should be the committee Chair or Vice

Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than three times a year and otherwise as the Chair of the Committee deems necessary – consistent with the UHB annual plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw, to facilitate open and frank discussion of particular matters.

Format of agenda

5.4 The agenda for the meeting will be split into three parts comprising of:

- Mental Health Act 1983;
- Mental Health Measure (Wales) 2010;
- and Mental Capacity Act 2005.

The proportion of time to be spent at each meeting on the respective parts will be set out in the Committee meeting planner, alternating the focus during the cycle of meetings and according to need.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.

6.2 The Committee is directly accountable to the UHB for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information.

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee shall embed the UHB values, corporate standards, priorities and requirements, for example equality and human rights, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example the Board's Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, for example where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board shall oversee a process of regular and rigorous self assessment and evaluation of the Committee's performance and operation, including that of any sub-committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

9. REVIEW

9.1 These Terms of Reference shall be reviewed annually by the Committee with reference to the Board or sooner if required e.g. change in legislation.

Report Title:	Work Plan 2019/20 – Mental Health and Capacity Legislation Committee								
Meeting:	Mental Health and Capacity Legislation Committee						**Meeting Date:**	12.02.19	
Status:	**For Discussion**	x	**For Assurance**		**For Approval**	x	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	Director of Corporate Governance								

SITUATION

The purpose of the report is to provide Members of the Mental Health and Capacity Legislation Committee with the opportunity to review the Mental Health and Capacity Legislation Work Plan 2019/20 prior to presentation to the Board for approval

REPORT

BACKGROUND

The work plan for the Committee should be reviewed annually by the Committee prior to presentation to the Board to ensure that all areas within its Terms of Reference are covered within the plan.

ASSESSMENT

The work plan for the Mental Health and Capacity Legislation Committee 2019/20 has been based on the requirements set out within Mental Health and Capacity Legislation Committee Terms of Reference which assumes that the Committee meets four times a year

RECOMMENDATION

The Mental Health and Capacity Legislation Committee is asked to:

REVIEW the Work Plan 2019/20
APPROVE the Work Plan 2019/20
RECOMMEND approval to the Board of Directors

Shaping our Future Wellbeing Strategic Objectives			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	

4. Offer services that deliver the population health our citizens are entitled to expect		9. Reduce harm, waste and variation sustainably making best use of the resources available to us	
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered											
Sustainable Development Principles: Five ways of working	Prevention	x	Long term		Integration		Collaboration		Involvement		
Equality and Health Impact Assessment Completed:	Not Applicable										

Mental Health and Capacity Legislation Committee Work Plan 2019 - 20					
A -Approval D- discussion I - Information	**Exec Lead**	**12-Feb**	**4-Jun**	**22-Oct**	**1-Feb**
Agenda Item					
Mental Health Act					
MHA Monitoring Exception Report	SC	D	D	D	D
Section 17 Compliance	SC	D	D	D	D
Section 138 Partnership Arrangements	SC	D	D	D	D
Policies in support of operation of MHCL	SC	D	D	D	D
Hospital Managers Power of Discharge Sub Committee Minutes	SC	D	D	D	D
Mental Health Measure Act Monitoring					
Mental Health Measure Monitoring Report	SC	D	D	D	D
Care and Treatment Plans Update Report	SC	D	D	D	D
Mental Capacity Act					
MCA Monitoring Report	SC	D	D	D	D
DOLs Monitoring Report	SC	D	D	D	D
DOLs Audit	SC			D	
Inspection Reports					
HIW MHA Inspection Reports	SC	D	D	D	D
Public Service Ombudsman Wales Reports	SC	D	D	D	D
Annual Reports					
Hospital Managers Power of Discharge Sub Committee Annual Report	SC		D		
HIW MHA Annual Report	SC		D		
MHCL Committee Governance					
Annual Work Plan	NF	A			
Self assessment of effectiveness	NF	A	D		
Review Terms of Reference	NF	A			
Produce Committee Annual Report	NF	A			
Minutes of Audit Committee Meeting	NF	A	A	A	A
Action log of Audit Committee Meeting	NF	D	D	D	D

Attachment 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 30 OCTOBER 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 Teresa Goss	PoD member
Mr John Owen	PoD member
Mrs Patricia Hallett	PoD member
Mrs Wendy Hewitt-Sayer	PoD member
Mr Mike Lewis	PoD member
Mrs Sharon Dixon	PoD member
Dr John Copley	PoD member
Mr Peter Kelly	PoD member
Mr Rashpal Singh	PoD member
Mrs Mary Williams	PoD member
Mrs Carol Thomas	PoD member

In attendance:

Miss Sunni Webb	Mental Health Act Manager
Mr Simon McDonald	Mental Health Act Coordinator
Miss Bethan Ellis	Assistant Mental Health Act Administrator

Apologies:

Mr Huw Roberts	PoD member
Mrs Mair Rawle	PoD member
Mr Alan Parker	PoD member
Mrs Sarah Vetter	PoD member
Mr Simon Williams	PoD member
Mr Tony Summers	PoD member
Mrs Elaine Gorvett	PoD member

1 Welcome and Introductions

The Chair of the group introduced everyone to the meeting and welcomed Bethan Ellis, a new member of the MHA Team

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

Interpreters

A discussion took place around the use of interpreters in Hearings, specifically who decides if an interpreter is required and who arranges this. The consensus was that the clinical team make the decision if an interpreter is required, as they would know this already as they are treating the patient. It is also the clinical team's responsibility to arrange an interpreter. It was decided that if the panel feel that an interpreter is required and there isn't one present, then they should adjourn to re-convene when there is an interpreter present.

One of the members cited a recent adjourned Hearing where the patient's Nearest Relative would have required an interpreter if it had gone ahead. The decision was that if the panel feel the need for an interpreter, then they should adjourn to re-convene when there is an interpreter present.

Observations

There were concerns that there could be confidentiality issues for observing Hearings. The group were assured that the presence of an observer was checked with the patient and their representative prior to the Hearing. Assurance was also given that the information disclosed to the observer during the Hearing was a necessary part of the observation process.

The Chair explained that as every member is required to be observed, then due to the way panels are setup some Members may be observed multiple times as they could be sat with members who have not been observed previously. The group understood this.

The Chair explained that the results of the observations may be used in the Member's yearly appraisals.

4 Minutes of Meeting held on 24 July 2018

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

5 Matters Arising

DBS Checks

The Mental Health Act Manager confirmed the UHB policy is that the Members are required to have a DBS check every 3 years.

ACTION:- The Mental Health Act Administration Manager to devise a system to track this

Social Work attendance

The Mental Health Act Manager explained the changes the MHA office have made to the procedure to attempt to increase Social Worker attendance. The process now is to ask the relevant team for a date where both the Responsible Clinician and Social Worker are

available. This new process began earlier this month, it is too soon to tell if there is a positive effect.

Extended section 17 Leave

The Mental Health Act Manager explained that according the Coed of Practice for Wales 2016 then section 17 leave over seven days is to be regarded as extended leave. However for monitoring purposes the MHA Office will note any leave that is for a duration of over 28 days.

List of ward specialities

The group thanked the Mental Health Act Administration Manager for the list of ward specialities that had been provided to them.

Treatment of physical issues

The chair explained that this issue had been escalated to the Mental Health and Capacity Legislation Committee, where it has been referred to the Mental Health Legislation Governing Group.

CTO data

The group thanked the Mental Health Act Administration Manager for the CTO data that had been provided to them.

6 MHA Activity Monitoring report July - September 2018

PoD and MHRT Activity

The group read and accepted both reports

7 Concerns/compliments from the Power of Discharge Group hearings July - September 2018

One of the comments concerned a patient who had no Nearest Relative identified at the time of the Hearing, however the response from the clinical team was that the patients sister had now been appointed in that role. The group were told that this was because there were issues around identifying which of the patient's family members was a UK resident.

Another of the comments centred on a patients lack of leave entitlement and their frustrations of the lack of ward based activities. This led to a wider discussion about the range of ward based activities. The group as a whole expressed their concern about the general lack of ward based activities and the possible negative impact on the patients' well being that this could impact upon.

ACTION:- MHA Manager and PoD Group Chair to take the issue to the Mental Health Legislation Governing Group

Several of the managers reported that they did not believe that the patient understood the purpose of their Hearings. The Chair reminded everybody that one of the tasks on the checklist for the Hearing is to explain its purpose to the patient. The Mental Health Act

Manager took this opportunity to explain one of the future plans, an MHA open clinic. This is planned to be an open walk in clinic based in the MHA Offices where patients and their families can come for advice and explanations of subjects relating to the Mental Health Act.

There was a general concern that there is never any feedback/comments from the patients themselves. The Mental Health Act Manager stated that the MHA Team are looking into a comments/suggestions box that would be places in the vicinity of the Hearing rooms. Anybody would be able to leave feedback/comments.

8 Training

Decision Writing Workshop

The workshop to look at decision making/writing has been postponed. This is due to its proximity to the all Wales training day that will take place in the Angel Hotel in Cardiff on 28/11/2018.

Breakaway/SIMA Training

Breakaway/Strategies and Interventions for Managing Aggression (SIMA) online training has been assessed as unsuitable for the group by the Chair and the MHA Administration Manager. In its place a disclaimer form is being developed that each PoD Member who does not attend the training will be required to sign.

Other Disorders

A training session is due to be setup to explain the nature of less common disorders. Most patients who have a Managers Hearing have some form of psychotic disorder, but there are other disorders that can result in detention under the MHA. One of the Forensic Consultants believes that the number of patients suffering from these other disorders will be increasing within Cardiff and Vale UHB.

9 Any other business

Young people

One of the members has concerns about the treatment of young people with various conditions that are being kept in specialist units. One patient was cited who had been held in seclusion for over ten years. The member had found that there are 2,375 young people being held in these units in the UK. The group was asked if they would support a letter to the Care Quality Commission asking for a review of this. The group felt that they could not support this as they did not have enough information on the subject and if they did that could be seen as though the Cardiff and Vale Clinical Board were behind this view. The group gave the member their blessing but only as an individual, not as part of the group.

December Availability

The Mental Health Act Manager asked the group to let the MHA Office know their availability for Hearing in December, as this can be a difficult time of the year to setup Hearings due to the holidays.

UHW Car Parking

The Mental Health Act Administration Manager informed the group that they have special parking privileges at the UHW site. They can park on any level of the large multi-story car park for any length of time, but only if they are on official PoD duties.

10 Date of future meeting

To be held at 10.00hrs in the Seminar Room, First Floor, HYC, and UHL on 22/01/2019

Attachment 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10AM ON 22 JANUARY IN MEETING ROOM 2, MENTAL HEALTH ACT OFFICE AT HAFAN Y COED.

Present:

Mr Jeff Champney-Smith	Chair, PoD Group
Mrs Elizabeth Singer	Vice Chair, Pod Group
Mrs Teresa Goss	PoD member
Mr John Owen	PoD member
Mr Mike Lewis	PoD member
Mrs Sharon Dixon	PoD member
Dr John Copley	PoD member
Mr Peter Kelly	PoD member
Mrs Carol Thomas	PoD member
Mr Huw Roberts	PoD member
Mrs Mair Rawle	PoD member
Mr Alan Parker	PoD member
Mrs Sarah Vetter	PoD member
Mr Tony Summers	PoD member

In attendance:

Miss Sunni Webb	Mental Health Act Manager
Mr Simon McDonald	Mental Health Act Coordinator
Miss Bethan Ellis	Assistant Mental Health Act Administrator

Apologies:

Mrs Patricia Hallett	PoD member
Mrs Wendy Hewitt-Sayer	PoD member
Mr Rashpal Singh	PoD member
Mrs Mary Williams	PoD member
Mr Simon Williams	PoD member
Mrs Elaine Gorvett	PoD member

1 Welcome and Introductions

The Chair of the group welcomed everyone to the meeting.

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

Legal Updates

A discussion took place around recent legal judgements and the impact this may have on any hearing relating to a Community Treatment Order (CTO). The recent judgements determined that any conditions applied to a CTO cannot deprive a person of their liberty. The Chair of the group stated that should such a situation arise the panel should consider discharge after taking advice from the MHA Office.

The Mental Health Act Manager stated that if a panel had concerns in relation to a deprivation of liberty whilst reviewing a CTO case, then they should seek advice from the MHA Team. This may be a reason to adjourn.

Chair Responsibilities

A discussion took place around when the panel could adjourn a Hearing. It was stated that any decision to adjourn should be from a consultation with the whole panel, the MHA Team, and other attendees, if appropriate, before that decision should be made. A key factor in this decision is;-

"**Would adjourning allow the panel to gain further information essential to making the decision?**"

A hearing had to adjourn due to unsatisfactory arrangements being made for the interpreter. The ward had made arrangements for an interpreter to attend the hearing, however they had not arranged for an interpreter to go through the reports with the patient prior to the hearing. This resulted in an adjournment after the panel had allowed an hour for the interpreter to go through the reports, it was clear the interpreter would need significantly longer.

4 Minutes of Meeting held on 30 October 2018

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

5 Matters Arising

DBS Checks

The Mental Health Act Manager confirmed the UHB policy is that the Members are required to have a DBS check every 3 years. The MHA Coordinator will start referring the appropriate members in February 2019.

Social Work attendance

The attendance of Social Workers at Hearing is still causing some concern. The consensus of the group was that this was due to staffing pressures over the Christmas period. The Mental Health Act Administration Manager informed the group that a trial is already underway in select CMHT's where they receive a daily report that lists upcoming Hearings. When operational this would leave no room for the team not knowing about a Hearing, even if there were staffing issues. The Mental Health Act Administration Manager informed the

group that there will soon be an attendee to the AMHP forum by a member of the MHA Team.

Lack of patient activities

One of the members raised a concern of the lack of ward based activities available to patients. The Chair stated that this is one of the items he is going to take to the Mental Health Legislation and Governance Group (MHLGG).

ACTION – Chair, PoD to raise at the MHLGG

6 MHA Activity Monitoring report September - October 2018

PoD and MHRT Activity

The group read and accepted both reports.

It was noted that whilst the number of advocates in attendance was good, there is still a fair number where the advocate did not attend. Could this be the choice of the patient?

ACTION – The Mental Health Act Administration Manager to investigate the recording and reporting of this information.

The group discussed the high number of patients being discharged prior to a managers hearing or Tribunal and requested further information in relation to this.

ACTION – The Mental Health Act Administration Manager to produce figures around how close patients were discharged to their Hearing date (MHAM + MHRT) and the Section these patients were on.

7 Concerns/compliments from the Power of Discharge Group hearings July - September 2018

It was noted that there has been an increase in the number of doctors attending the hearing without prior knowledge of the patient. The Chair and the Mental Health Act Manager explained that there had been a high turnover of Locum Consultants recently.

The Chair re-iterated that if there is anything in the reports that any member does not understand, they are to ask the Mental Health Act Team for advice before the Hearing.

8 Training

Decision Writing Workshop

It was agreed that the workshop will be arranged between the end of March and beginning of April 2019.

ACTION – The Mental Health Act Manager to set a date and inform the group.

Breakaway/SIMA Training

The Mental Health Clinical Board Director of Operations has made a decision that a disclaimer is not adequate and that there should be some form of training, even if this is just breakaway or violence and aggression.
ACTION – Chair and/or The Mental Health Act Manager to discuss with the SIMA trainer.

Other Disorders

Further training less common disorders will be arranged in the future.

Risk

One of the members reminded the group that a past speaker, Mr Martin Harper, had previously offered to return to the group to explain Risk and its associated management. Mr Martin Harper has since changed job role.

ACTION – The Mental Health Act Manager to find out if Mr Martin Harper was still available to do this.

9 Any other business

Hearing Reports

One of the Members queried the process of sending the reports to panel members, including timescales. The Mental Health Act Manager confirmed that (except for short notice Hearings);-

- The reports are requested six weeks prior to the Hearing.
- The reports are expected two weeks prior to the Hearing.
- The reports will be sent to the panel members one week prior to the Hearing – unless they are late from the report author.
- The reports could be sent individually, or together depending upon when the MHA Team receive them.
- If there is anything further that the members would like, or think is missing, then they are to contact the MHA Team. For example the reports may make reference to some treatment being provided by a therapist, and the panel may feel a report from the therapist would play a part in the decision.

Inaccuracies within reports

One of the managers was on the panel for a Hearing where the reports contained inaccurate information about activities of the patient. The patient disputed these and when asked, the author found the information in previous reports that their report was based upon. What can be done in this situation? The Chair stated that it was up to the patient and/or their representative to challenge the factual content of the reports such as this. If any panel has this type of situation then they can address it in the Hearing with the author and/or record it in the comments.

Recording of adjournments

One of the managers requested space on the Hearing minutes to record the reasons for adjournment. The group discussed this and agreed that a separate area away from the comments would be beneficial.

ACTION – The Mental Health Act Manager to arrange for this to be carried out.

10 Date of future meeting

To be held at 10:00 hrs in the Seminar Room, First Floor, HYC, UHL on 16 April 2019

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

MENTAL HEALTH ACT HOSPITAL MANAGERS' POWER OF DISCHARGE GROUP

TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. Introduction

1.1 In line with Standing orders (3.3.1) and the UHB Scheme of Delegation, the Mental Health Capacity& Legislation Committee has established the Mental Health Act Hospital Managers' Power of Discharge Group to carry out specific aspects of Committee business on its behalf. The detailed terms of reference and operating arrangements in respect of this Sub Group are set out below.

2. Purpose

2.1 The purpose of the Mental Health Act Hospital Managers' Power of Discharge Group ("the Sub Committee") is to:-

- Consider all relevant issues for Mental Health Act Hospital Managers to undertake their role in accordance with UHB and legislative requirements
- Receive activity monitoring reports on the use of the Mental Health Act
- Ensure that Discharge panels are acting in a fair and reasonable manner and exercised lawfully
- Consider updates regarding recommendations made during panel hearings
- Discuss and agree training for Mental Health Act Hospital Managers
- Receive professional advice to support the discharge of the Mental Health Act Manager role
- Provide a forum for consideration of any matter impacting on the decision making for discharge of patients detained under the Mental Health Act
- Receive development/ discussion sessions to improve overall knowledge of services.

3. Delegated powers and authority

3.1 The Sub Committee will, in respect of its provision of advice to the Mental Health Capacity& Legislation Committee, comment specifically upon:

- Processes in place to support discharge panels
- Advise on issues arising from discharge panels and appeals of an unusual or contentious nature
- Discuss training requirements of Mental Health Act Hospital Managers
- Discuss any impact of legislative changes on role of Mental Health Act Hospital Managers
- Highlight any impact of service changes on ability to undertake Mental Health Act Manager role effectively.

3.2 To achieve this, the Mental Health Capacity& Legislation Committee shall support the Sub Committee to provide assurance that:

- Mental Health Act Hospital Managers are effectively equipped and trained to undertake their role
- The UHB provides appropriate support to ensure the Discharge Panels operate effectively
- That the Discharge Hearings are undertaken in a fair, reasonable and lawful manner
- The UHB is aware of the impact of any legislative or service changes impacting on the Discharge panels' considerations and recommendations.

Authority

3.3 The Sub Committee is authorised to request legal advice via the Mental Health Act Manager (within their respective delegated limits) without recourse to the Mental Health Capacity& Legislation Committee.

Access

3.4 The chair of the Sub Committee shall have reasonable access to the Chair of the Mental Health Capacity & Legislation Committee, Executive Directors and other relevant senior staff.

4. Membership

Members

4.1 Membership comprises of:

- Chair of Sub Committee
- Vice Chair of Sub Committee
- Vice Chair of UHB Board/ Nominated Independent Member
- Mental Health Act Hospital Managers

Attendees

4.2 The Mental Health Act Manager/ Sub Committee Chair may invite:

- Any other UHB officials; and/or
- Any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary Mental Health Act Manager.

5. Committee Meetings

Quorum

5.1 At least one third of members must be present to ensure the quorum of the Sub Committee, one of whom should be the Sub Committee Chair or Vice Chair.

Frequency of Meetings

Meetings shall be held no less than quarterly and otherwise as the Chair of the Sub Committee deems necessary- consistent with the annual plan of the Mental Health Act Hospital Managers' Power of Discharge Group Business.

6. Relationships and accountabilities with the Board and its committees/ groups

6.1 The Sub Committee is directly accountable to the Mental Health Capacity& Legislation Committee for its performance in exercising the functions set out in these terms of reference.

6.2 The Sub Committee shall embed the UHB corporate standards, priorities and requirements, e.g- equality and human rights through the conduct of its business.

7. Reporting and assurance arrangements

7.1 The Sub Committee shall:

- Produce a plan of training and development needs for Mental Health Act Hospital Managers for approval by the Mental Health Capacity& Legislation Committee. This is a set agenda item at PoD meetings and is ongoing throughout the year.
- Report quarterly to the Mental Health Capacity& Legislation Committee.
- Provide annual report for Mental Health Capacity& Legislation Committee. An annual appraisal/ Review will be undertaken for Mental Health Act Hospital Managers to highlight any area they need further support and to give assurance to the UHB that they are suitable to carry out their role appropriately.

8. Applicability of standing orders to Sub Committee Business

8.1 The requirements for the conduct of business as set out in the UHB's Standing Orders are equally applicable to the operation of the Sub Committee, except in the following areas:

- Quorum (as per Terms of Reference)

9. Review

9.1 These terms of reference and operating arrangements shall be reviewed bi-annually by the Mental Health Capacity& Legislation Committee with reference to the Board.