MENTAL HEALTH CAPACITY LEGISLATION COMMITTEE
09.00AM – 09th May 2017
CORPORATE MEETING ROOM, HEADQUARTERS
UNIVERSITY HOSPITAL OF WALES

CARING FOR PEOPLE
KEEPING PEOPLE WELL

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

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Tuesday, 9 May 2017 at 09.00am
Corporate Meeting Room, Headquarters, UHW

AGENDA

PATIENT STORY – Mental Capacity Act		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Mental Health and Capacity Legislation meeting held on 29 November 2016	*Chair*
5	Action Log Review	*Chair*
6	Any Other Urgent Business Agreed with the Chair	*Chair*
MENTAL CAPACITY ACT		
7	Clinical Board Presentations: • Clinical Diagnostics and Therapeutics • Mental Health	*Oral*
8	Deprivation of Liberty Safeguard Monitoring Report	*Medical Director*
9	Mental Capacity Act Monitoring Report	*Medical Director*
MENTAL HEALTH ACT		
10	a) SBAR b) Mental Health Act Exception Report Oct-Dec c) Mental Health Act Exception Report Jan- Mar 17	*Medical Director*
11	Section 117 Compliance	*Medical Director*
12	a) Section 136 Partnership Arrangements	*Chief*

	b) Concordant Delivery Plan	*Operating Officer*
13	Health Inspectorate Wales – Mental Health Act Annual Report	*Medical Director*
14	Health Inspectorate Wales – Inspection Reports	*Oral Chief Operating Officer*
15	Review of Smoking Exemption	*Medical Director*
16	Hospital Manager's Power of Discharge sub Committee Annual Report	*Medical Director*
17	Mental Health Act Benchmarking Report	*Medical Director*
MENTAL HEALTH MEASURE		
18	Mental Health Measure Monitoring Report	*Medical Director*
COMMITTEE GOVERNANCE		
19	Committee Work Plan	*Board Secretary*
PART 2:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE** **Papers are available on the Health Board website**	
20	Hospital Managers Power of Discharge sub-Committee Minutes	*Chair, PoD sub-Committee*
21	Review of the Meeting	*Oral Chair*
22	To note the date, time and venue of the next meeting:- • **10.00am on Tuesday, 3 October 2017 Board Room Headquarters UHW**	

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UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 10.00 AM ON TUESDAY 29 NOVEMBER 2016
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Prof Marcus Longley	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Martyn Waygood	Independent Member and MHCLC Vice Chair
Margaret McLaughlin	Independent Member – Third Sector
Eileen Brandreth	Independent Member – Information, Communication and Technology

In attendance:

Dr Catrin Simpson	MCA Champion, Community Child Health
Dr Grace Kelly	MCA Champion, Dentistry Board
Dr Graham Shortland	Medical Director
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Jane Hancock (part)	Service User Representative
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Kay Jeynes	Director of Nursing, PCIC
Steve Curry	Acting Chief Operating Officer
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative

Apologies

Alice Casey	Chief Operating Officer (Lead Executive)
Dr Annie Proctor	Clinical Board Director, Mental Health
Jayne Tottle	Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Richard Evans	Clinical Board Director, Medicine
Andy Cole	Operational Manager, Mental Health, Vale of Glamorgan Social Services
Steve Lewis	Director, Advocacy Support Cymru
John Owen	Chair, Hospital Managers Power of Discharge Sub-Committee

Secretariat: Helen Bricknell

MHCLC 16/061 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/062 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/063 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

MHCLC 16/064 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 10 MAY 2016

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record following the comment from Ian Wile to be agreed - **COMPLETE**

MHCLC 16/065 ACTION LOG REVIEW

The Committee **RECEIVED** and **NOTED** the Action Log. The following points were highlighted:

1. **MHCLC 15/065 Issues Related to Learning Disabilities** – The Chair commented that this action is COMPLETE
2. **MHCLC 16/046 MCA Clinical Board Reports** – Has been picked up in Performance Reviews – COMPLETE
3. **MHCLC 16/052 Transfer to Hafan y Coed** – The logistical problems surrounding tobacco on Hafan Y Coed -to bring back at later date
4. **MHCLC 16/026 &16/043 Internal Audit Report (DoLS)** – To bring back
5. **MHCLC 16/027 DoLS Monitoring Report –** Brought to November meeting – COMPLETE
6. **MHCLC 16/050 MHA Exception Report** – To bring back when all data gathered around

MHCLC 16/066 ANY OTHER URGENT BUSINESS

There was no other urgent business.

MHCLC 16/067 PATIENT STORY – MENTAL HEALTH MEASURE

There was no Patient Story.

MHCLC 16/068 MENTAL CAPACITY ACT CLINICAL BOARD PRESENTATIONS

1. **Community Child Health**

Dr Catrin Simpson presented the position in Community Child Health as the Mental Capacity Act (MCA) Champion. She advised that ongoing training was provided to staff and the target is to reach 80% of Community Child Health staff trained by January 2018. The E Leaning module will be rolled out to staff who are unavailable to attend MCA training.

The monthly Quality and Safety meetings report on all usage of the MCA, no audit has been undertaken from the Community Child Health Directorate, but will be looked at being performed within the next year with the Audit Lead, however it has been reported of no clinical incidents in Child Health.

Issues have been raised around the use of the Independent Mental Capacity Act Advisory Services (IMCA) and 16-17 year olds and the input needed when there is no identified carer to support in the Best Interest decision making, training will address the awareness of this.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

Action – Professor Marcus Longley

ACTION: To monitor the training of the MCA module and the implementation within the Board – Dr Sian Moynihan/Dr C Simpson

2. **Dentistry**

Dr Grace Kelly, Mental Capacity Act Champion presented a challenging infrastructure for the Clinical Board and how the Mental Capacity Act and Best Interest Decisions are used. The majority of Best Interest decisions are carried out in Oral surgery and special care dentistry in relation to sedation and General Anesthesia. No Mental Capacity Act Audits undertaken will be planned.

Dental Clinical Directors have the responsibility for staff training and identifying the level of training. Not all staff will apply their training knowledge

of the MCA in undertaking Mental Capacity Assessments. There have been no clinical incidents or issues reported for the Dental Clinical Board.

In summary:

- To increase the Mental Capacity Act training within the Clinical Board and to monitor by profession who is being trained and who is using the MCA within the workplace.
- How frequently training is required
- Identify the working knowledge of MCA within staff
- Audit the knowledge and implications of the MCA
- Incident reporting around MCA and MCA reporting issues to report to monthly Quality and Safety meetings.

A case study of a patient with Learning Disabilities and ASD with limited cooperation for an exam was discussed and explained. The patient initially in a foster care setting but currently in an adult placement (paid)
The Multidisciplinary Teams, Professional Bodies (Consultant, SpR Dentistry, Social Worker, Foster family, IMCA
Referral to IMCA services required as foster family is paid carer, treatment needed is deemed “serious medical treatment”
Capacity Assessment/ Best Interest Decision carried out

The chair opened up to questions and comments

All doctors can revalidate through MARS, whilst Dentists have to revalidate through the appraisal system. Training and development needs to be strengthened through the Clinical Boards and Organisation on maturing the learning systems for the MCA and moving forward.
Discussions around Mental Capacity Act are carried out with patients but recorded on personal folders only as discussions not assessments.
Within the Dentistry Clinical Board many know of the MCA but it is the implementation that needs to strengthen.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

Action – Professor Marcus Longley

MHCLC 16/069 MENTAL CAPACITY ACT (MCA) UPDATED CAMHS REPORT

Dr Jenny Hunt presented the updated report with the limited assurance on reporting the legislative measures for children and young people. As Deprivation of Liberty differs in those age groups of under 16’s, 16-17 year

olds and those children “looked after”. Children under 16 can be deemed competent for consenting but if they choose not to and it is against their best interests then a court order can be obtained to decide what is within their best interest.

Due to the complexities of Mental Capacity Act and Deprivation of Liberty it was agreed that Dr Hunt, Ian Wile and Sunni Webb will collate figures to assure on how the Mental Health Act assessments within Cardiff and Vale University Health Board are undertaken on under 18 year olds are carried out and reported.

The Committee **NOTED** the report.

Action: Ian Wile/ Sunni Webb/ Dr J Hunt to collate more figures around the use of MCA

MHCLC 16/070 ISSUES RELATED TO LEARNING DISABILITIES

The Director of Nursing for PCIC presented the report outlining what constitutes a deprivation of liberty within a community learning disability setting and Article 5 of the European Convention on Human Rights.

The Chair opened up to comments:

- It was noted that there is a delay with the DoLS applications being completed in hospital setting within Cardiff and Vale and the Vale Council, the risks involved and the lack of funding for section 12 payments.
- Additional Best Interest resources have been depleted and awaiting for further funding on DoLS assessments.
- Primary care for patients in Care Homes and death under a DoLS, the implications surrounding this
- The funds needed to clear 1200-1300 DoLS assessments and decisions needed at high level meeting.

In summary the financial costs to clear the backlog need to be addressed and alternative ways for section 12 monies to be used in line with Best Interest Assessors, this deems to be problematic and must be re addressed. The risk registers should reflect these governance issues.

The Committee **NOTED** the written report

Action: Ensure Risk Registers are completed to reflect the risks – Kay Jeynes

MHCLC 16/071 UPDATED DoLS REPORT

The Committee received and noted the report from the Operations Manager the Chair opened up to questions and discussions.

The Best Interest Assessments are currently a year behind due to lack of funding and not meeting the timescales, however for urgent referrals these are being adhered to.

- Dr Jenny Hunt has pointed out whether that “police cells” are being used as a place of safety.
- There will be All Wales benchmarking in May 2017
- Positive comments regarding the use of Advocacy Support Cymru

MHCLC 16/072 MENTAL HEALTH ACT ACTIVITY REPORT

The Director of Operations, Mental Health, Mr Ian Wile presented the report and advised there were no exceptions to the report.

Mr Wile was also discussing data collection at an all Wales level where 5 of the 7 Health Boards were represented. The definition for invalid detentions and details for a core data set were agreed in order to benchmark performance. It was also possible that the data set could include the use of advocacy support. Directors of Primary Care were supporting this work.

It was agreed that Cardiff and Vale Health Board would collect data and compare with other Health Boards across Wales around the numbers on invalid detentions and use of Section 5. The information can be put forward and discussed at the Vice Chairs meeting with these comparisons from the Health Boards in Wales.

The Committee **NOTED** the report

MHCLC 16/073 MENTAL HEALTH MEASURE (all ages)

The Director of Operations, Mental Health, Mr Ian Wile gave an oral update on the quantity of referrals, twice as many within the Adult Mental Health services and not being able to reach the Tier 1 targets for 28 days. The Health Board are meeting the set targets and have commenced the re-modeling around GP Surgeries. Compliance has reached over 90% in November, with Parts 2, 3 and 4 of the Measure reaching 100% within the last quarter. The Director of Operations has stated that there have been mild to moderate problems surrounding Mental Health problems.

The Chair opened up to questions and discussion:

- Dr Jenny Hunt spoke about the referrals being somewhat 9 weeks on the waiting lists and they have significantly reduced to 6 weeks wait. There have been no clinical incidents or high risks to report. Low numbers of 16-17 year olds have been assessed by the Adults team, safeguarding measures have been adhered to under this legislation.
- Independent member, Mrs Eileen Brandreth remarked how impressed she is presently, with the Health Board and secondary Mental Health services, the third sector for out of hours are encouraging direct referrals and the promotion of "Well Being Clinics" thus allowing the steering of these groups to run effectively.

The Committee **NOTED** the report.

MHCLC 16/074 SERVICE CHANGES – IMPACT ON LEGISLATION

The Director of Operations had nothing further to add to the report. The Mental Health Act Services Manager explained that there will be Benchmarking workshops in January. The Code of Practice has 6 new chapters and updates for staff and Hospital Managers will be available if required to contact the Mental Health Act Manager.

Mental Capacity Act will be rolled out as part of Mandatory Training, starting in March 2017.

The Committee **NOTED** the update.

MHCLC 16/075 MENTAL HEALTH ACT 1983: CODE OF PRACTICE FOR WALES

The Mental Health Act Manager, Ms Sunni Webb advised that there are six new chapters to the Code of Practice and updates on the Guiding Principles. If anyone would like training or further guidance on the Code of Practice then please contact the Mental Health Act Manager. There are slides on the Intranet for internal staff.

The Committee **NOTED** the oral update

MHCLC 16/076 GOVERNANCE REMIT AND FREQUENCY

The Committee had no further questions or comments and the report was **NOTED.**

PART 2 REPORTS FOR INFORMATION

MHCLC 16/077 HOSPITAL MANAGERS POWER OF DISCHARGE SUBCOMMITTEE MINUTES

The Director of Operations, Mental Health, Mr Ian Wile reported that there were no incidents to report.

The Committee had no further questions or comments and the report was **NOTED.**

MHCLC 16/078 REVIEW OF THE MEETING

The Chair mentioned that "All Wales Benchmarking" will be brought back in 2017 for further discussion

MHCLC 16/079 DATE OF NEXT MEETING

The next meeting would be held at 10am on Tuesday 9 May 2017 in the Corporate Meeting Room, Headquarters, University Hospital of Wales (UHW).

ACTION LOG FOLLOWING MHCLC NOVEMBER 2016

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
MHCLC 16.028	10.05.16	Section 136 Partnership Arrangements	Check figures for the under 18s, CAMHS absconders and children cared for on an adult ward	I Wile	Data was hard to obtain. It was believed that no children had been affected – this will be double checked. Update to be received at **May 2017** meeting
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Seek ideas from volunteers and the Third Sector to enable patients to purchase cigarettes.	I Wile	Update to be received at **May 2017** meeting
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Bring the benefits realization report for Welsh Government to Committee after the first year.	I Wile	**October 2017**
MHCLC 16/050	9.8.16	MHA Exception Report	Ask the Police to provide details of BME within the Section 136 figures.	I Wile	**October 2017**
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
MHCLC 16/046	9.8.16	MCA Clinical Board Reports	Include Clinical Board compliance with the Mental Capacity Act and training within the performance management framework.	S Curry	**COMPLETE** to stay on log for monitoring purposes.

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Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team

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

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

- **Coordination of DoLS assessments as requested by Managing Authorities by undertaking the following assessments:**
  - Age - 18 and over
  - Mental Illness- Is medically diagnosed with a mental disorder
  - Mental Capacity - Lacks capacity for the decision to be accommodated in the hospital or care home
  - No refusals - there is no Advanced Decision previously made to refuse treatment or care, or conflict relating to this such as LPA or Deputy
  - Eligibility - This determines whether the person meets the requirements for detention under the Mental Health Act 1983;
  - Best Interests - The person needs to be deprived of liberty for reasons of health, safety and best interests.
- **Supervision and workload management of over 40 Best Interest Assessors;**
- **Advice and support to health and social care teams across the sector in relation to MCA/DoLS issues;**
- **Training for care homes and all inpatient sites across the hospitals of Cardiff and the Vale of Glamorgan areas.**

The DoLS team is based in the Vale of Glamorgan and consists of:

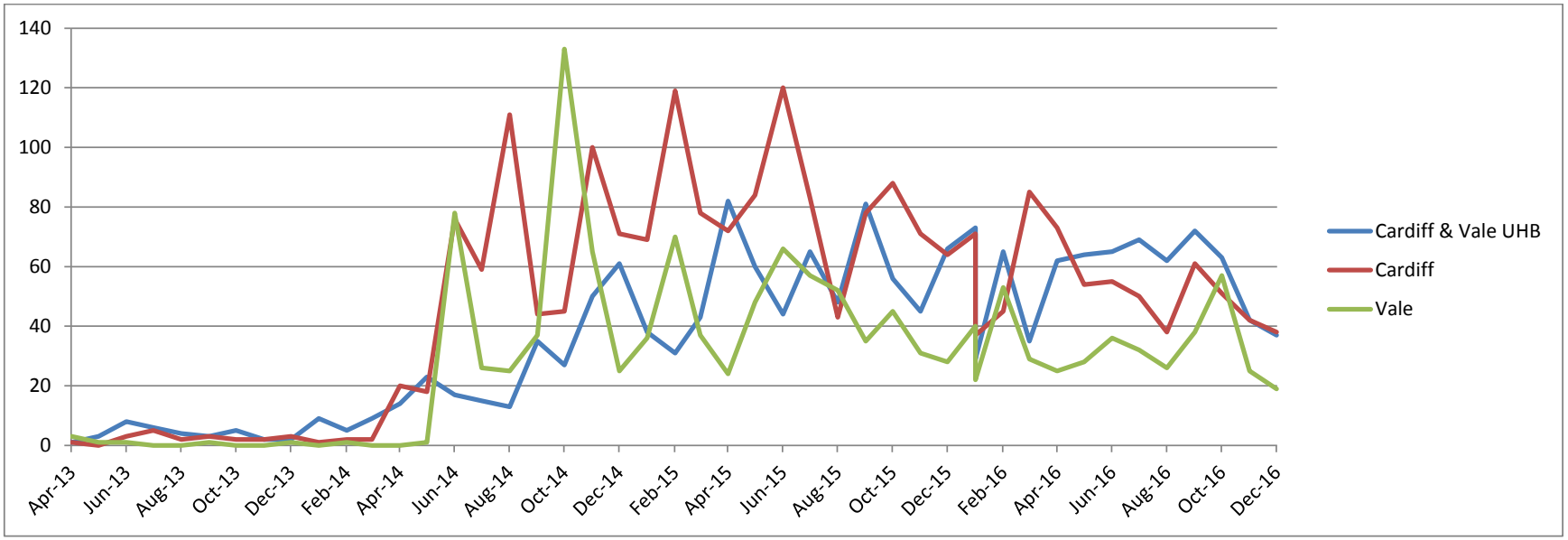
- 1 full time administrator (currently undertaking SW degree)
- 1 full time DOLS/MCA Coordinator (Band 7)
- 2.5 full time Best Interest Assessors

- 2.0 full time Best Interest Assessors (Cardiff Council funded)
- 1.0 full time Best Interest Assessor (Vale of Glamorgan funded)

- 15 rota'd Best Interest Assessors (Reducing number)

Referral rate…

The effects of the revised definition of Deprivation of Liberty following the Cheshire West Ruling continue to impact on the number of requests for Standard and Urgent Authorisations as described in the graph below. It is noticeable that in the three years post Cheshire West, the number of referrals has remained relatively stable which enables more reliable workforce planning.



The table below shows the number of DoLS referrals per Supervisory Body over the last 4 years. There appears to be a slight reduction in the number of referrals allowing the team to make some reductions in the delay between referral and assessment.

REFERRALS	2013/14	% of referrals	2014/15	% of referrals	2015/16	% of Referrals	2016/17 (end Jan)	% of Referrals
Cardiff Council	32	34.4%	866	49.1%	778	39.4%	626	48%
Vale Council	6	6.4%	489	27.7%	534	27%	264	21%
C&V UHB	55	59.1%	406	23%	661	33.5%	339	31%
Total	93	100%	1761	100%	1973	100%	1229	100%

Best Interest Assessments

The Welsh Government Expert Group have estimated by talking to each Supervisory Body that each DoLS Assessment takes on average one whole working day when taking into account the coordination, interview, consultation and administration for each assessment. The Cardiff and Vale DoLS Team averages 1.5 assessments per BIA, per working day.

ASSESSMENTS t	Completed Assessments 2014/15	% completed Assessments 2014/15	Completed Assessments 2015/16	% Completed Assessments (2015/16)	Completed Assessments (to Jan 2017)	% completed assessments (2016/17)	Outstanding Assessments
Cardiff Council	298	34.4%	305	32.4%	922	37%	548
Vale Council	169	19.5%	216	22.9%%	464	18%	296
C&V UHB	397	45.9%	419	44.5%%	1089	44%	74

It should be noted that the DoLS Team is not able to meet the statutory timescales (21 day) for Standard Authorisation Requests. We are currently one year behind timescale, but this is slowly reducing. The team is able to meet statutory timescales for Urgent Authorisation Requests which primarily are made from hospital wards, although care homes are making Urgent Authorisations requests in increasing numbers.

DoLS Authorisations

The Authorisation of completed DoLS assessments is an essential and important part of safeguarding vulnerable people. The Code is clear that the Authorisation must be undertaken by a senior manager independent of the provision of the care. The number of Authorisations required challenges already busy senior managers and had led to a number of outstanding Authorisations which adds to the risk of challenge for unlawful care and shortens Authorisation timescales and negates the effect of conditions.

AUTHORISATIONS	Outstanding Authorisations on 20th March 2017
Cardiff Council	76
Vale Council	4
C&V UHB	14

Law Commission Review into DoLS

The Law Commission published its review into the Deprivation of Liberty Safeguards and a draft Bill recommending a repeal of DoLS and the implementation of a new scheme. The proposed new scheme, called **Liberty Protection Safeguards (LPS)**, focuses on placing human rights protections (Art 5 & 8) at the beginning of the care planning process and includes people in their own home, supported living or shared lives schemes, and 16 and 17 year olds. In this way, people will not have to wait for an 'authorisation' of their care after the event, but will have their human rights protected before a deprivation occurs.

The proposal introduces the role of **'independent reviewer'**, who must not be involved in the person's care but must consider if the new care plan is 'proportionate and necessary' based on a mental capacity and medical assessment.

In cases where a person is objecting or the care plan is for the protection of others, the case will need to be referred to an **Approved Mental Capacity Professional** to further scrutinise the care plan for approval. There is no requirement for secondary Authorisation from the Responsible Body.

The Cardiff and Vale DoLS Partnership Board will need to consider the local implementation of the new scheme as the Bill is passed as an Act within the next few years, but in the meantime the existing DoLS remains in place.

Section 12 Doctors

Currently each and every DoLS Assessment requires a mental health and eligibility assessment by a Section 12 (MHA83) medical examiner at a cost of £182. The cost per Supervisory Body is indicated in the table.

The LPS scheme, although requires a medical assessment, the independent reviewer is able to make use of existing medical assessments rather than commissioning a stand-alone assessment. This represents a significant saving over the resource heavy DoLS process.

Use of Section 12 Doctors	Total number of occasions Sec 12 doctor used (2016/17)	Total Cost (£)
Cardiff Council	415	£75,910
Vale Council	162	£29,585
C&V UHB	644	£117,597

Partnership Agreement

Further to a recent Vale of Glamorgan internal Audit, a formal partnership agreement has been proposed, utilising Vale of Glamorgan template setting out the following:

- Function of Partnership Board
- Confirmation of Vale of Glamorgan as lead provider
- Confirmation of Funding agreement
- Resolution of complaints
- Quality Assurance
- Information Sharing Protocol

Cardiff and Vale Partnership Funding

FUNDING	Current Funding Equation	Current Funding Outturn	Actual Funding %	% of Referrals	Funding based on Referrals	% Completed Assessments (end Jan)	Funding Based on Comp Ass
Cardiff Council	40.74% (+2BIA)	£109,429 (+1BIA)	44.3%	48%	£118,479	37%	£91,327
Vale Council	14.65% (+1BIA)	£60,829	24.5%	21%	£51,834	18%	£44,429
C&V UHB	44.61%	£76,708	13.0%	31%	£76,517	44%	£108,606
	100%	£246,832	100%	100%	£246.515	100%	£246,515

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

Law Commission Review

- Local implementation of the proposed Liberty Protection Safeguards in due course.

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider
- Information Sharing Protocol

Andrew Cole
Operational Manager
Vale of Glamorgan Council
March 2017

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INVALID MENTAL HEALTH ACT DETENTIONS	
Name of Meeting : MHCLC	**Date of Meeting :** 09 May 2017

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

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mental Health Clinical Board Director of Operations

The Board is asked to:

- **AGREE**

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SITUATION

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 supervised community treatment is only as the Act allows.

There are no exceptions for this period from the main Mental Health Act Monitoring Report.

BACKGROUND

The number of patients detained without authority increased between October and December, further to identifying the majority of the errors were due to the

AMHP and the LSSA taking action to rectify this; these errors have reduced back to zero during the period January – March 2017:

Period	Number of incidents
October – December 2015	6
January – March 2016	5
April – June 2016	2
July – September 2016	0
October – December 2016	4
January – March 2017	0

ASSESSMENT AND ASSURANCE

Reasons for detention without authority:

No	Analysis	Action Taken at the Time
1	**General Medicine, UHL** MHA assessment carried out on general ward, application made for section 2, MHA. Assessment completed out of MHA Office hours. AMHP did complete receipt but gave incorrect information to nursing staff resulting in section papers not being received until the following morning. Patient detained without authority for 13 hours.	Section papers received by MHA Administrator to ensure patient detained in accordance with the Act. Ward Manager and doctor in charge of patients care notified of incident. Incident escalated to Operational Manager, LSSA who has spoken to the AMHP and reminded all AMHP's of the detention process. Due to the patients lack of capacity the nearest relative was informed.
2	**Adult Mental Health, UHL** MHA assessment carried out on mental health ward, Hafan Y Coed. Application made for section 3. Nursing staff followed the correct procedure and handed papers to the Shift Coordinator. Shift Coordinator did not receive the papers using the statutory form before depositing them in the MHA mailbox. Patient detained without authority for 11 hours.	Section papers received by MHA Administrator to ensure patient detained in accordance with the Act. Incident escalated to Senior Nurse Manager to ensure Shift Coordinators are aware of the procedure. MHA Manager met with the Shift Coordinator to explain the procedure and provided relevant information and guidance. Receipt of Applications for detention under the Mental Health Act Policy disseminated among Shift Coordinators and made available on the internet and

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		Mental Health Act Intranet page. Patient informed of incident.
3	**General Medicine, UHW** MHA assessment carried out on general ward, application made for section 2, MHA. AMHP did not complete receipt or follow the procedure to ensure that the section papers were received on behalf of the Hospital Managers. Patient detained without authority for 22 hours.	Section papers received by MHA Administrator to ensure patient detained in accordance with the Act. Ward Manager and Directorate Manager notified of incident. Incident escalated to Operational Manager, LSSA who has spoken to the AMHP and reminded all AMHP's of the detention process. Patient informed of incident.
4	**Adult Mental Health, UHL** 135 warrant obtained to remove mentally disordered person to place of safety. Warrant executed, person admitted to mental health ward. AMHP made a concurrent application for emergency admission for assessment under s4. Inappropriate use of the MHA, patient already detained under s135 therefore s4 invalid. The patient was not detained without authority on this occasion as the power to detain remained under s135.	MHA Administrator liaised with the ward to ensure the patient was aware of their legal status. MHA assessment arranged, patient subsequently detained under s2. Operational Manager, LSSA notified of incident and discussions took place with AMHP to ensure correct understanding of the procedure in relation to s135. Patient informed of incident.

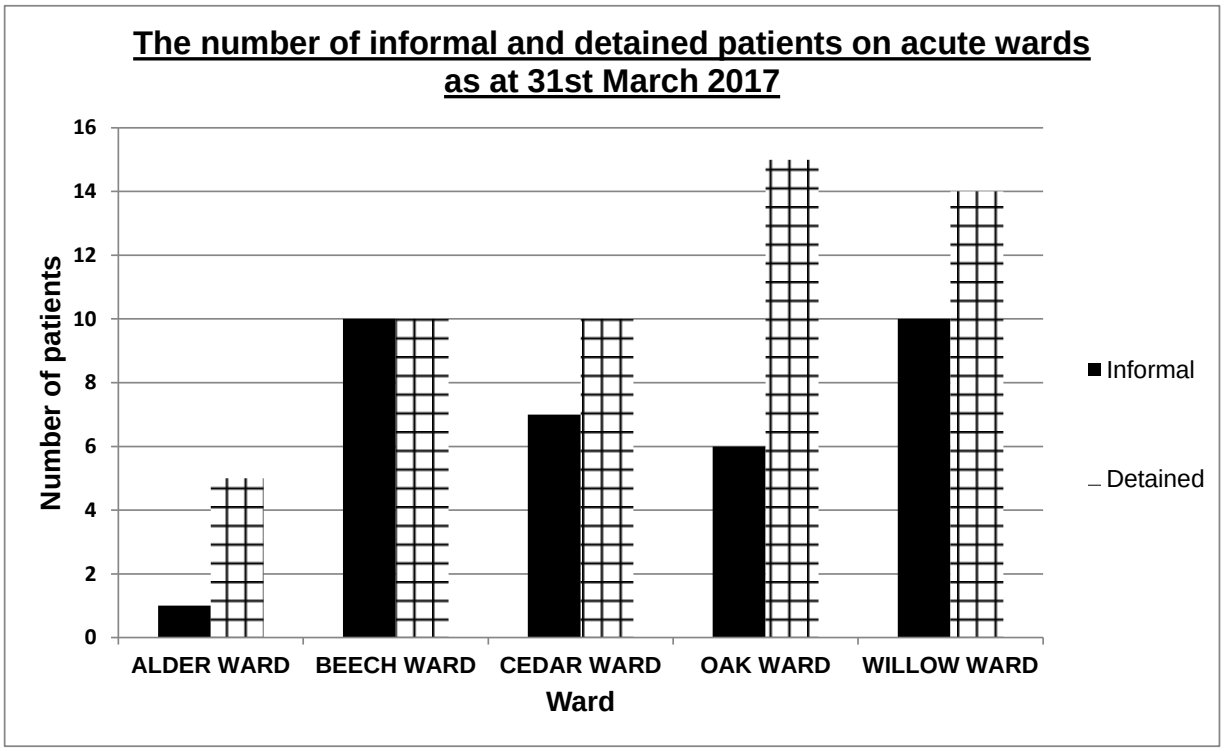
Report to the

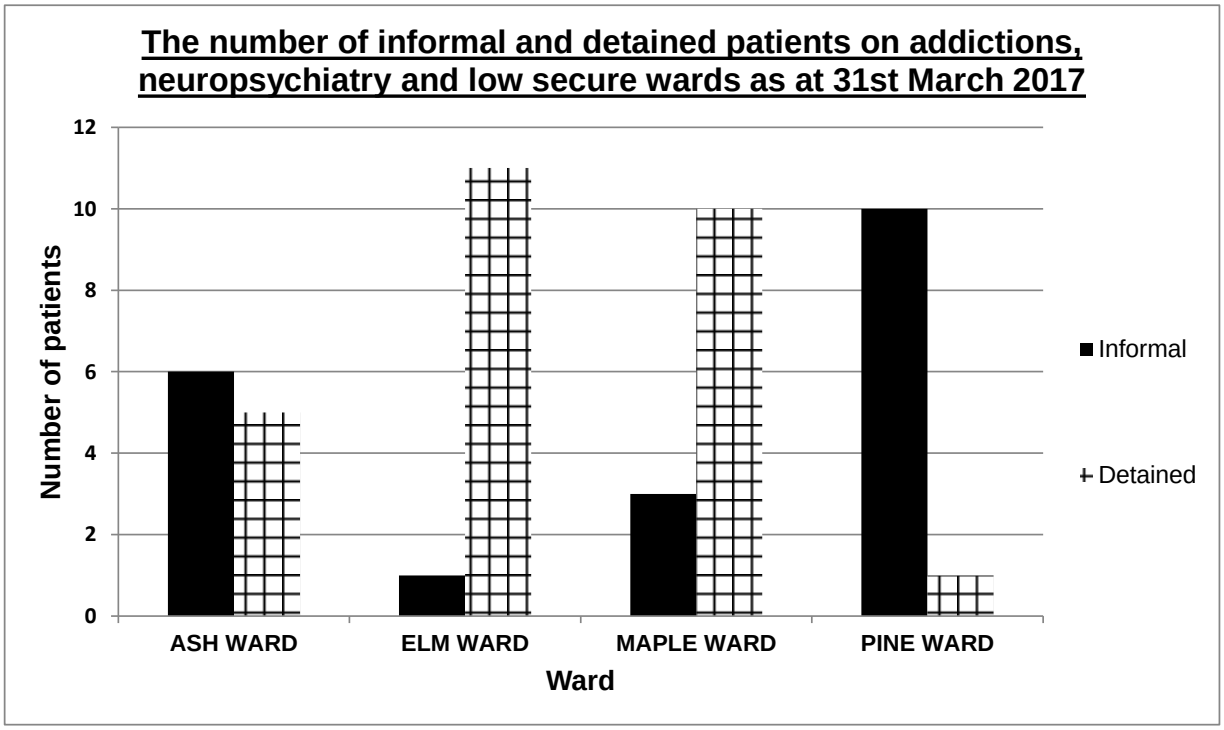
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

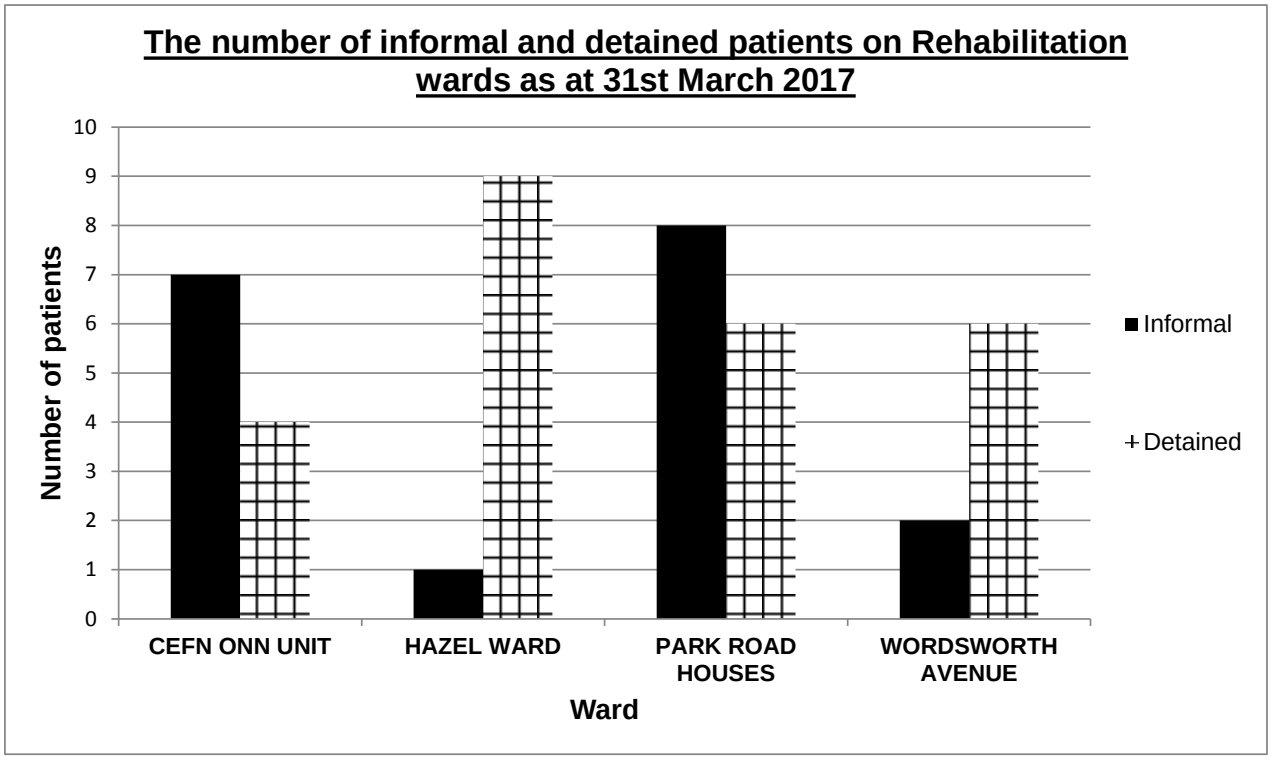
January- March 2017

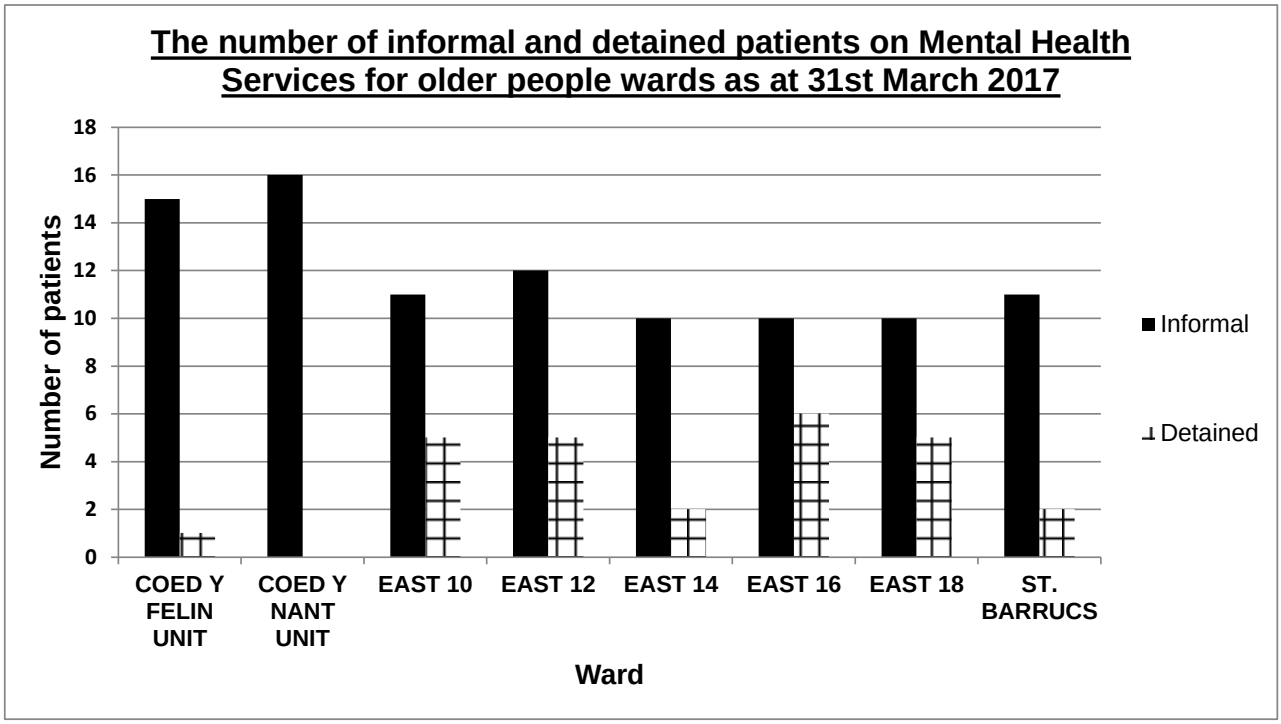
10.1


The number of informal and detained patients on acute wards as at 31st March 2017
Number of patients
16
14
12
10
8
6
4
2
0
ALDER WARD
BEECH WARD
CEDAR WARD
OAK WARD
WILLOW WARD
Ward
Informal
Detained


The number of informal and detained patients on addictions, neuropsychiatry and low secure wards as at 31st March 2017
Number of patients
12
10
8
6
4
2
0
ASH WARD
ELM WARD
MAPLE WARD
PINE WARD
Ward
Informal
Detained

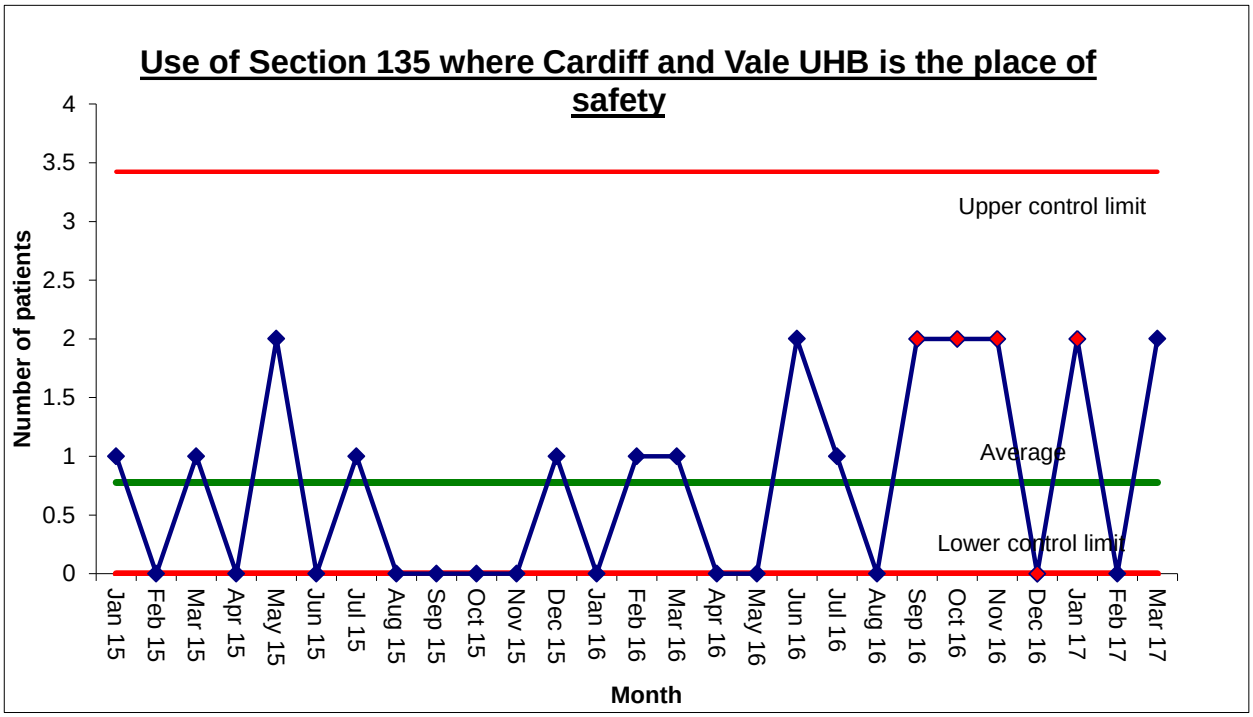
10.1


The number of informal and detained patients on Rehabilitation wards as at 31st March 2017
Number of patients
0
1
2
3
4
5
6
7
8
9
10
CEFN ONN UNIT
HAZEL WARD
PARK ROAD HOUSES
WORDSWORTH AVENUE
Ward
Informal
Detained


The number of informal and detained patients on Mental Health Services for older people wards as at 31st March 2017
Number of patients
0
2
4
6
8
10
12
14
16
18
COED Y FELIN UNIT
COED Y NANT UNIT
EAST 10
EAST 12
EAST 14
EAST 16
EAST 18
ST. BARRUCS
Ward
Informal
Detained

10.1

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

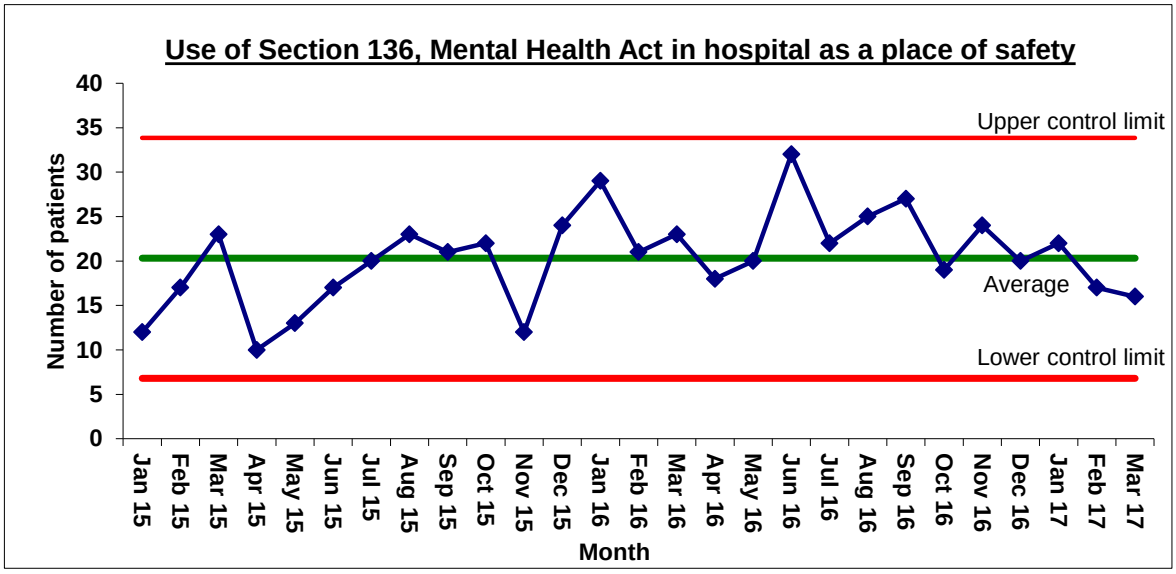


10.1

During the period January- March 2017 section 135(1) powers were executed on four occasions:-

- Two patients were subsequently placed on Section 2
- Two patients were subsequently placed on Section 3

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



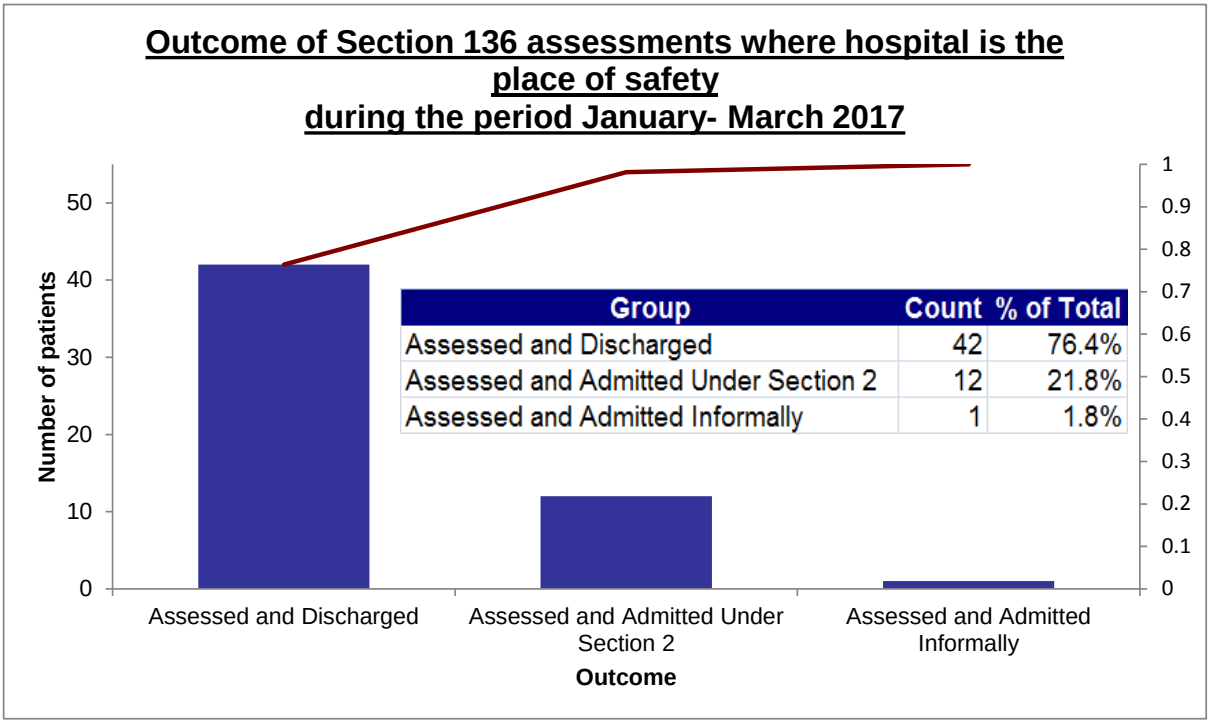
In the period January- March 2017, a total of 55 assessments were initiated by Section 136 powers where the MHA assessment took place in a hospital as the place of safety.

CAMHS

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

- Two discharged to community services
- Two discharged with no mental disorder
- One admitted and detained under section 2

10.1



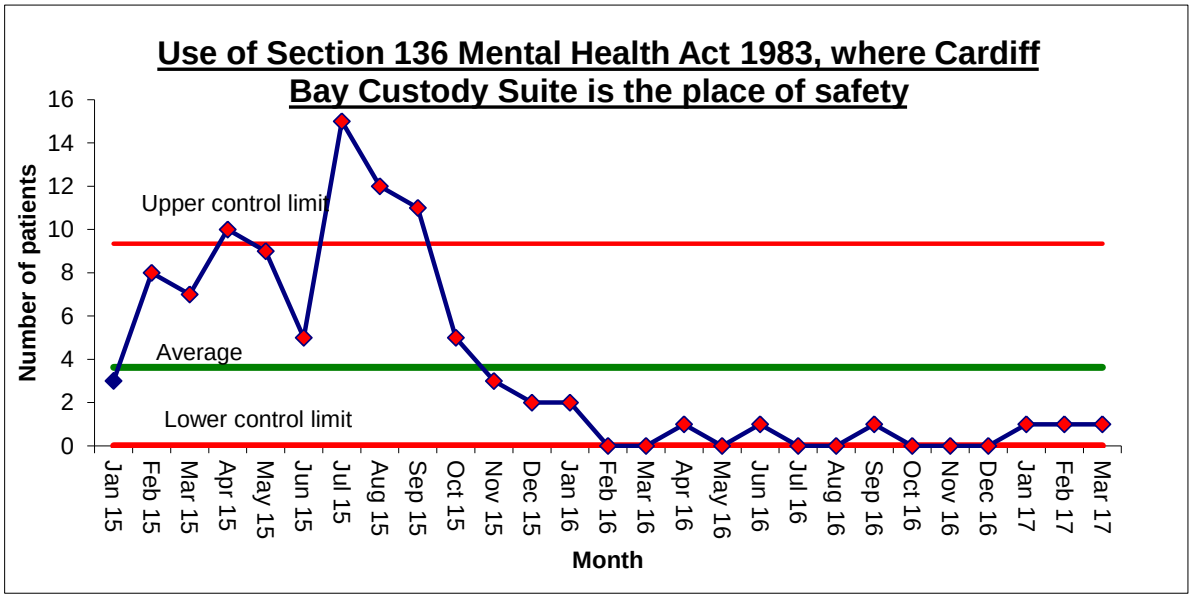
Group	Count	% of Total
Assessed and Discharged	42	76.4%
Assessed and Admitted Under Section 2	12	21.8%
Assessed and Admitted Informally	1	1.8%

The pareto chart highlights that 76.4% of individuals assessed under 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.

10.1

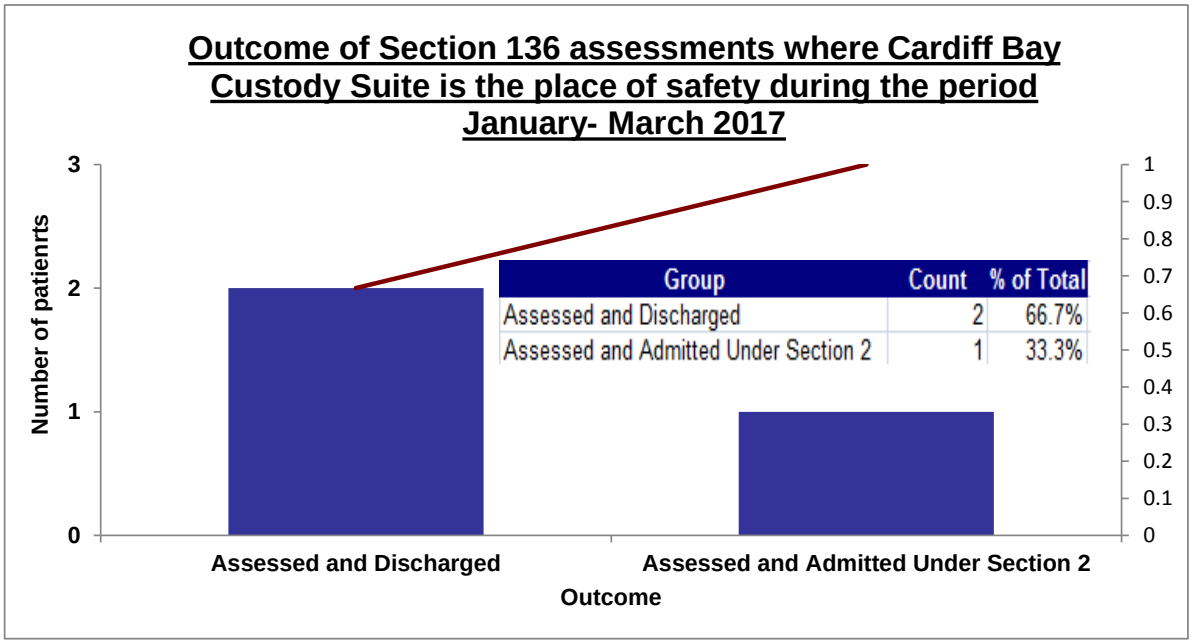
Section 136 – Mentally disordered persons found in public places
Mental Health Act assessments undertaken within the police station

This chart is based on information provided by the Police for January- March 2017



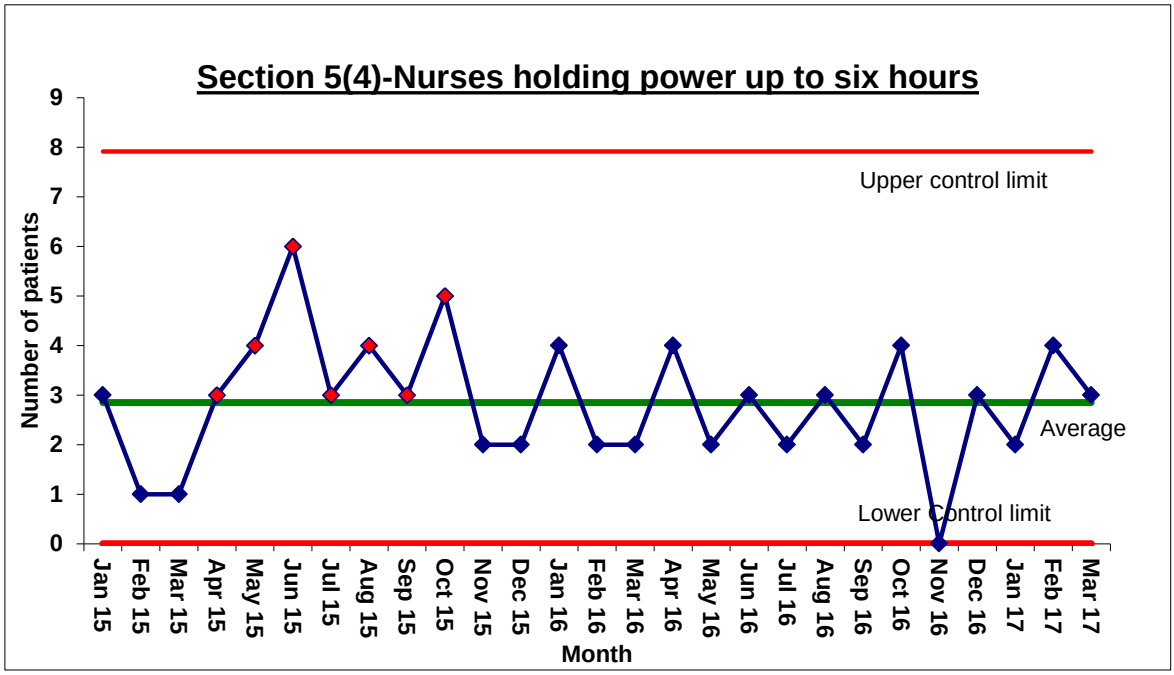
During the period January- March a total of 3 assessments were initiated by Section136 powers where MHA assessments took place in Cardiff Bay Custody Suite due to the unmanageable risk of violence.

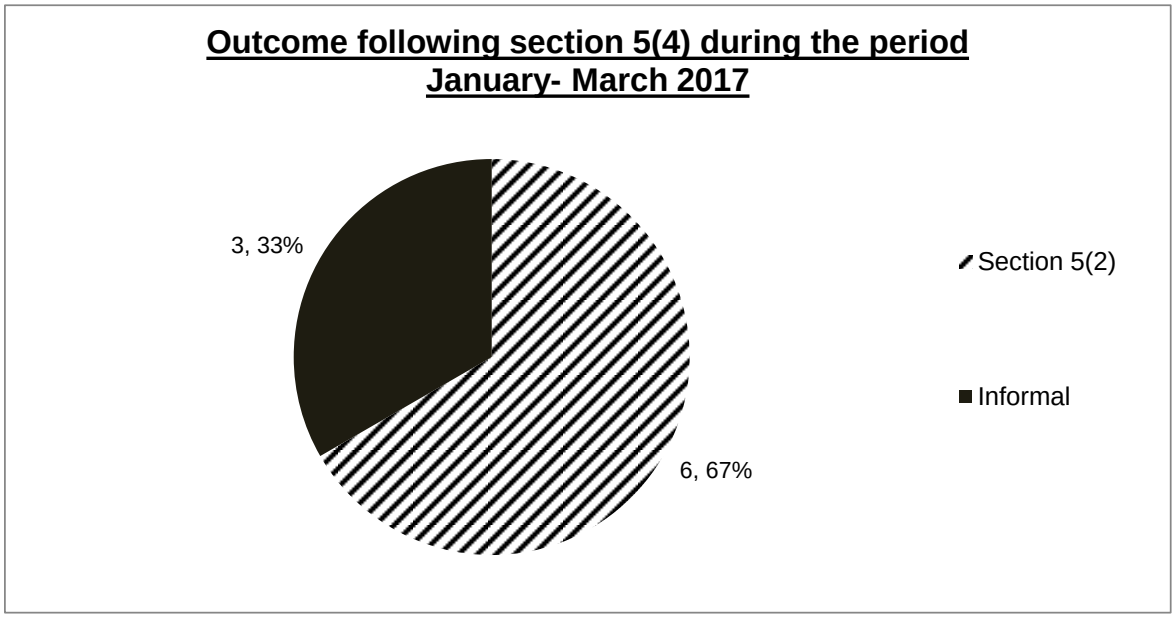
10.1



The pareto chart highlights that one individual was assessed under 136 and 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.

Section 5(4) Nurses' Holding Power



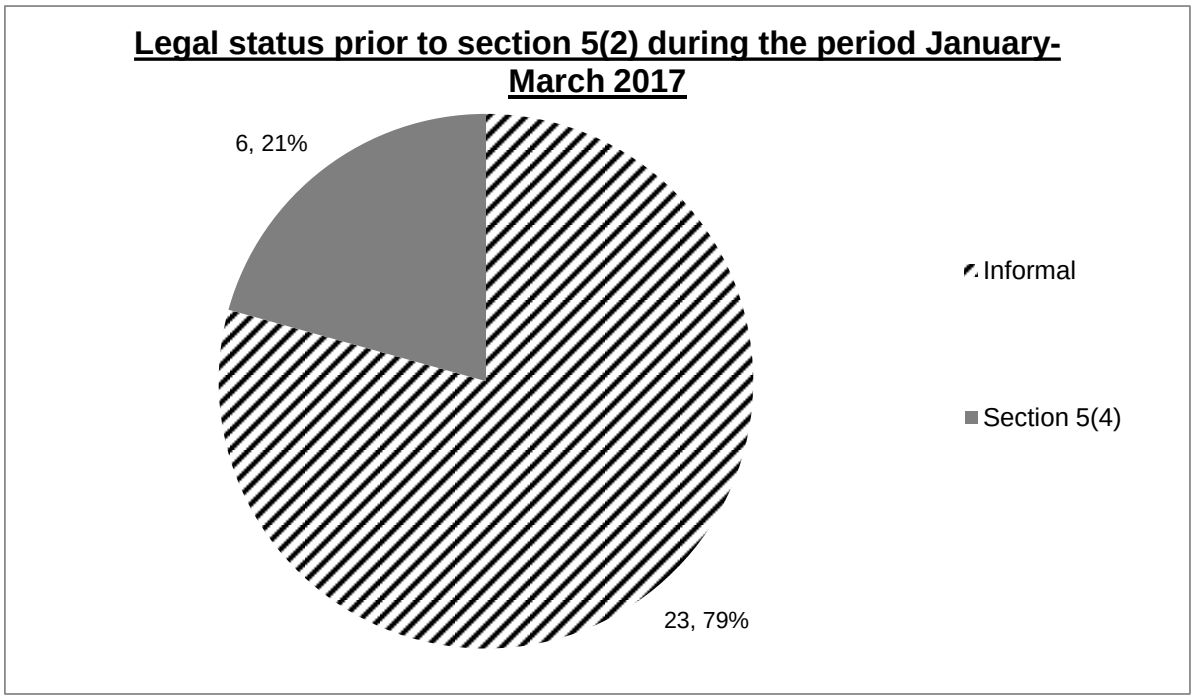


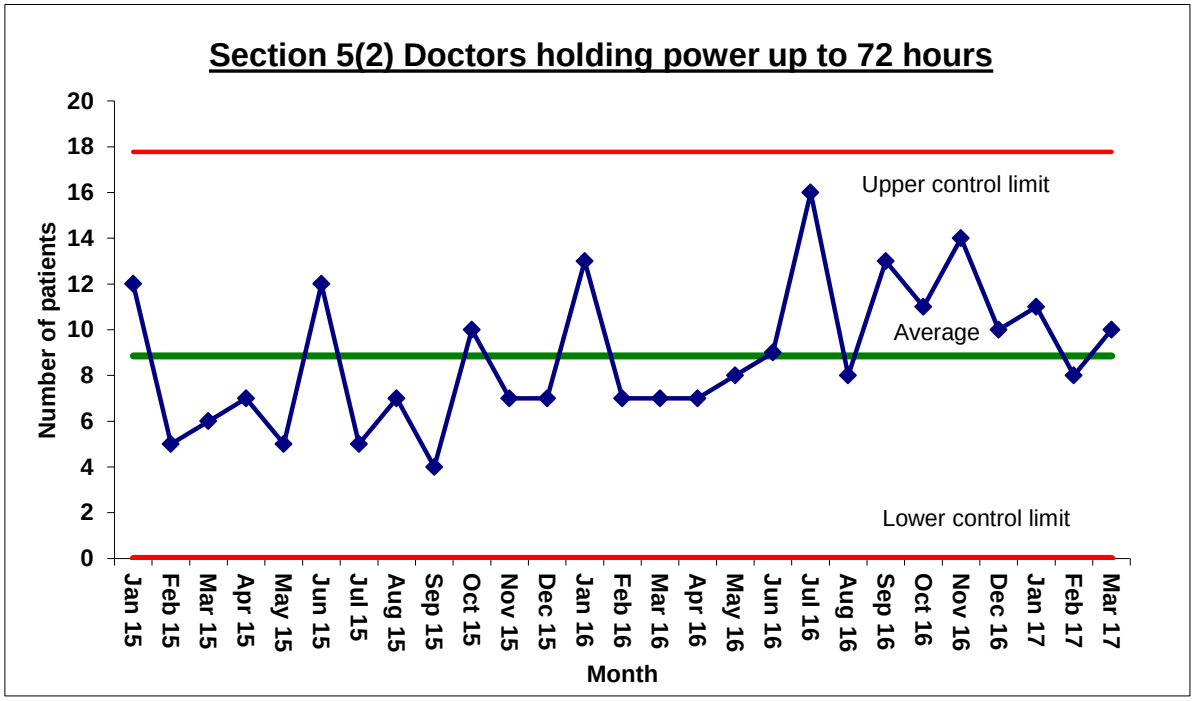
10.1

CAMHS

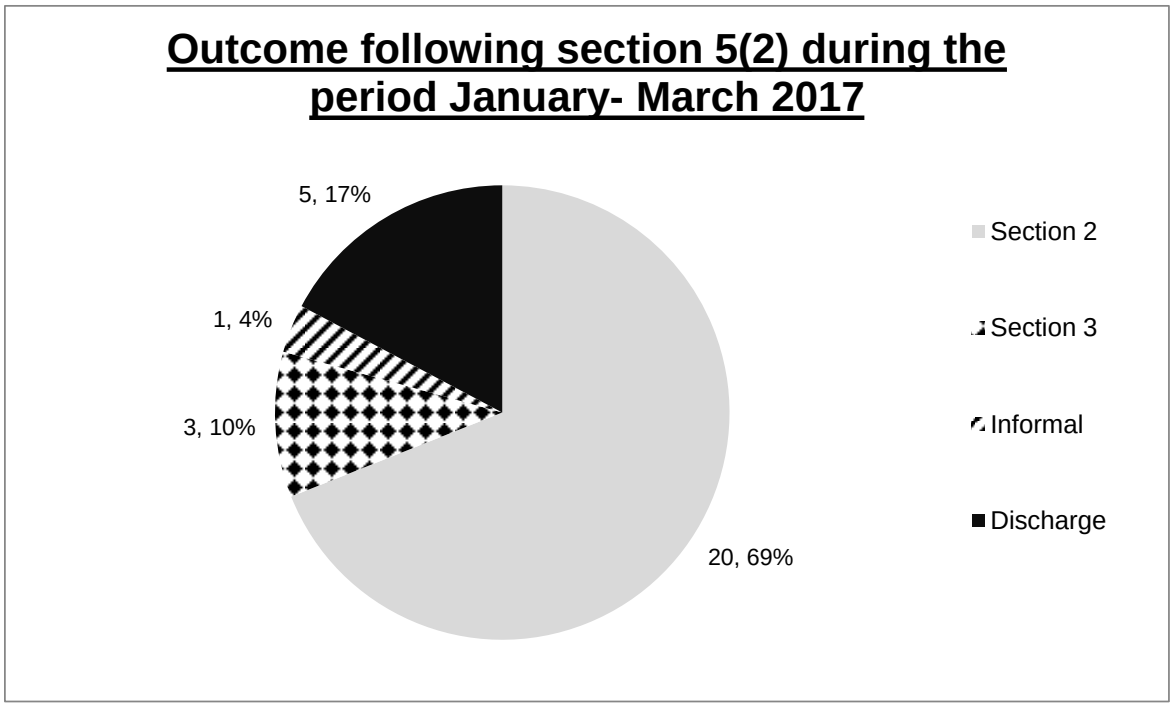
Two of these assessments were carried out on patients under the age of 18. Both were subsequently held under section 5(2).

Section 5(2) Doctors' Holding Power





10.1

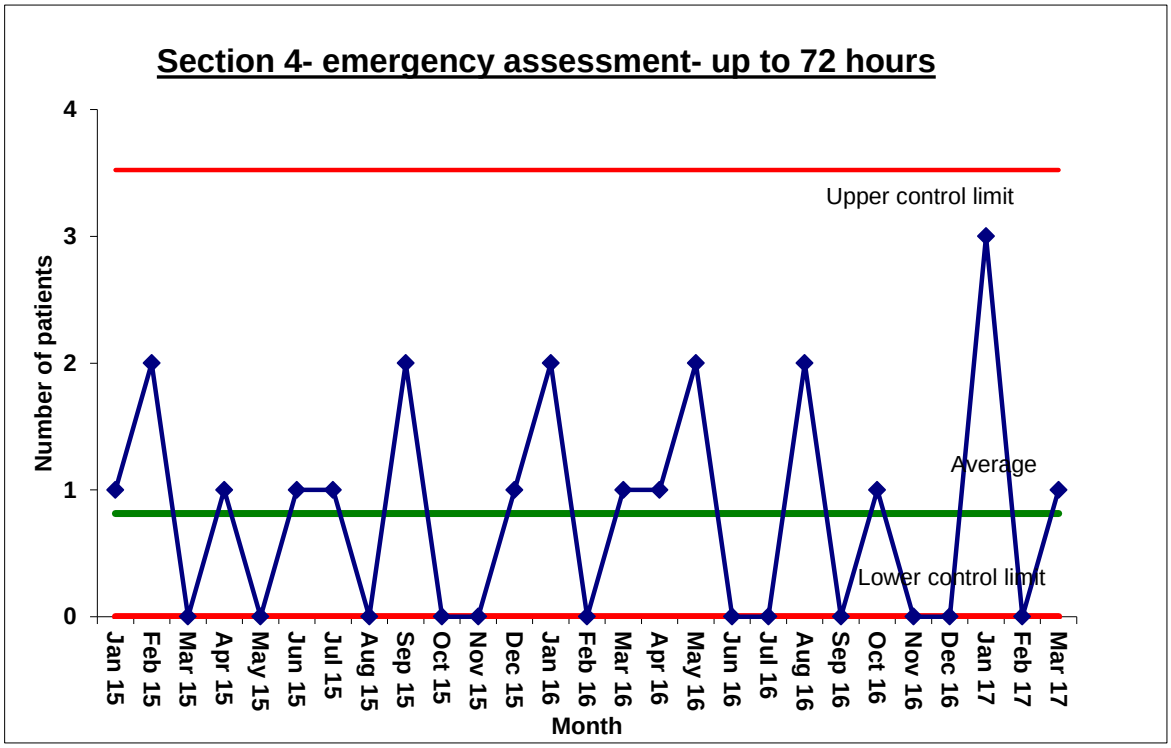


CAMHS

Two of these assessments were carried out on patients under the age of 18. Both were subsequently discharged home.

10.1

Section 4 – admission for Assessment in Cases of Emergency

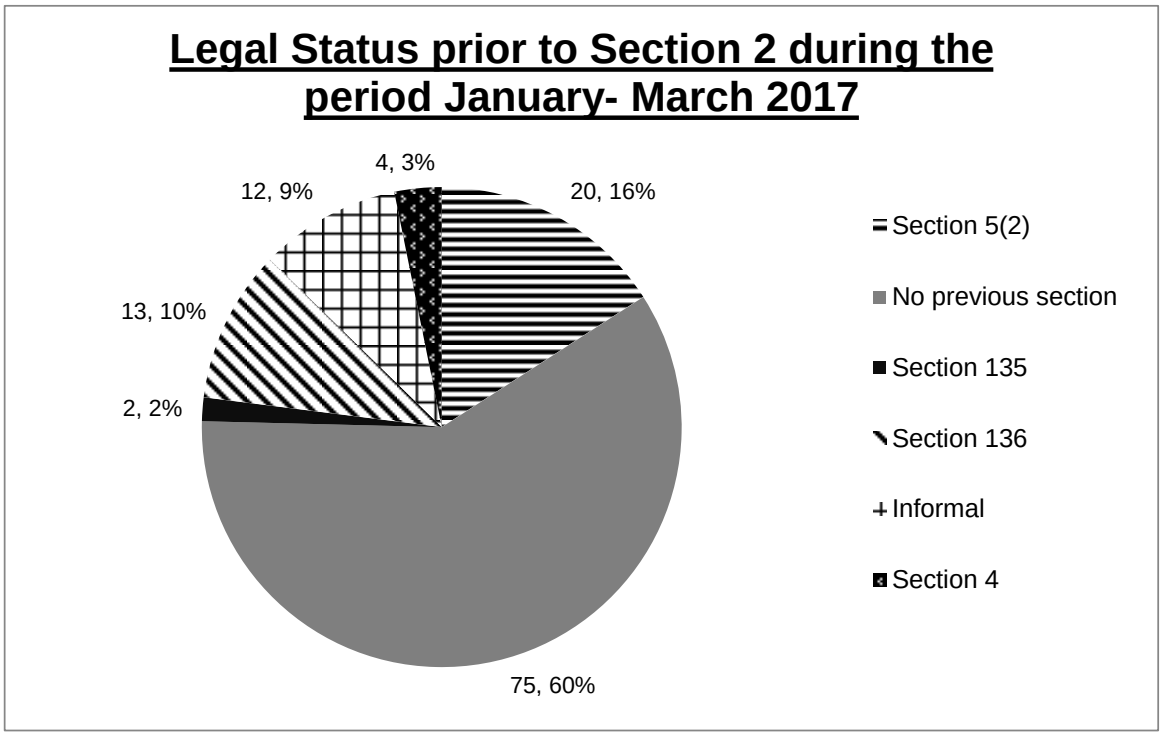


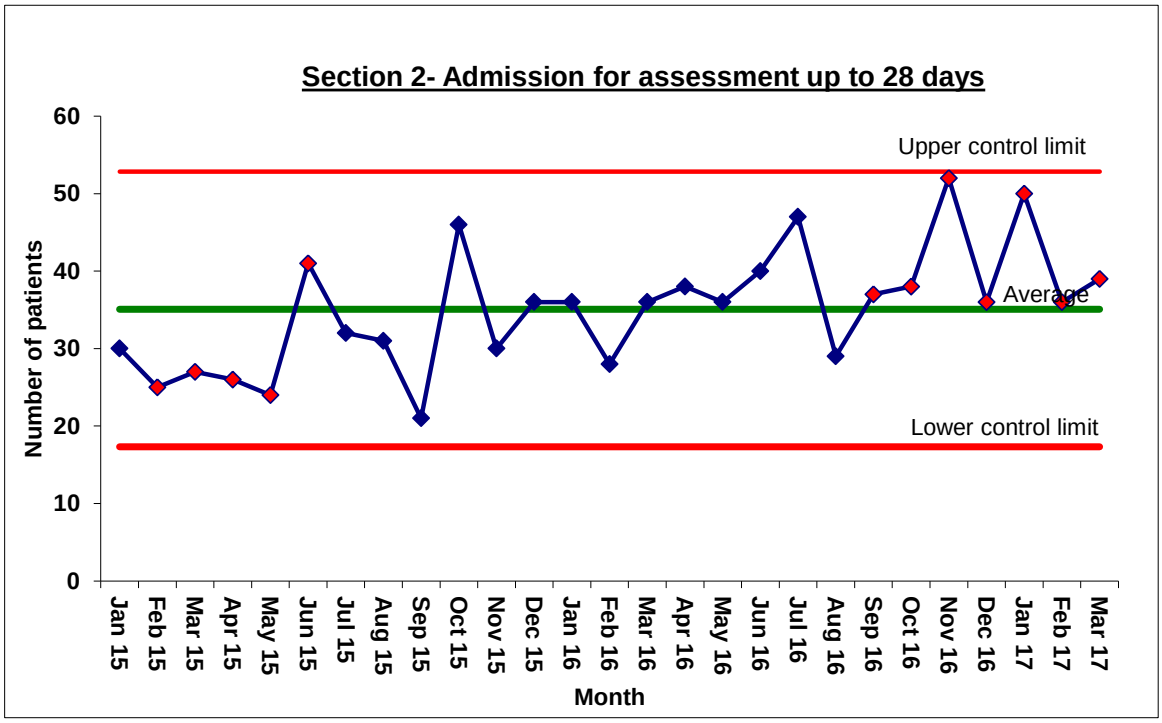
10.1

Section 4 was used on four occasions and subsequently converted to Section 2 during the period January- March for the following reasons:

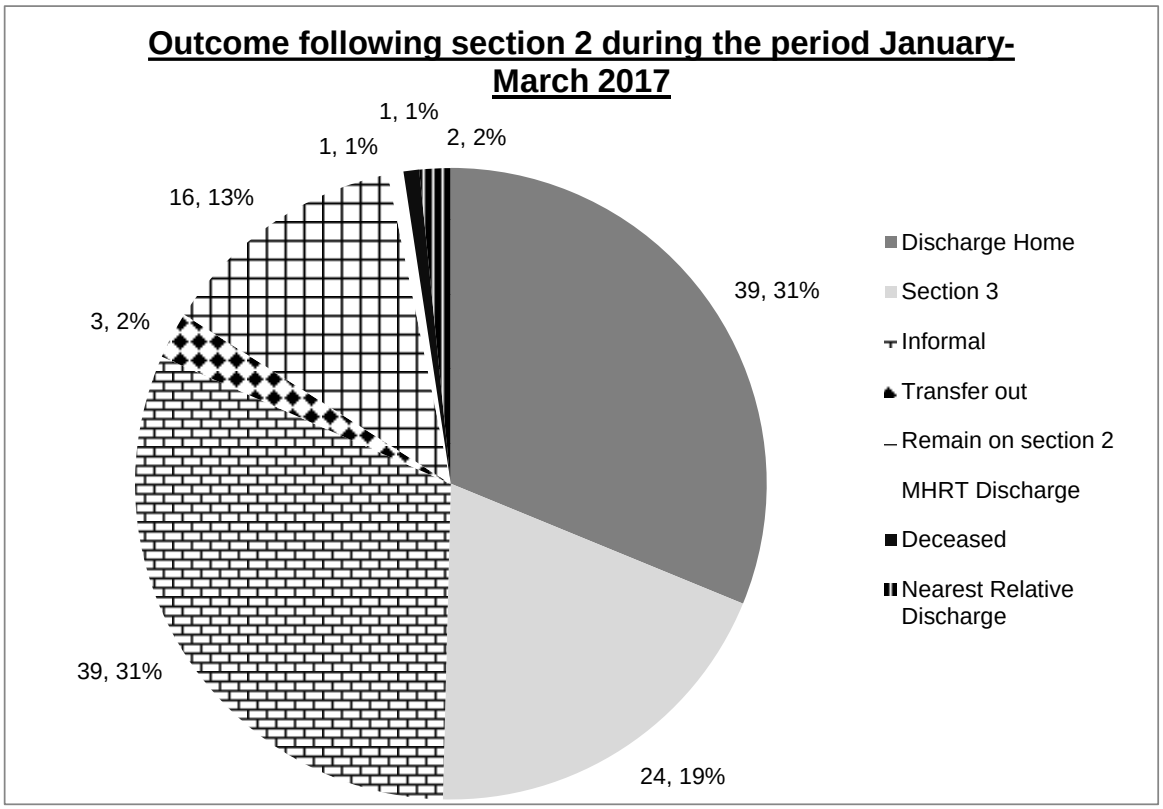
- Potential immediate risk to themselves and others. No section 12 Doctor available.

Section 2 – Admission for Assessment





10.1

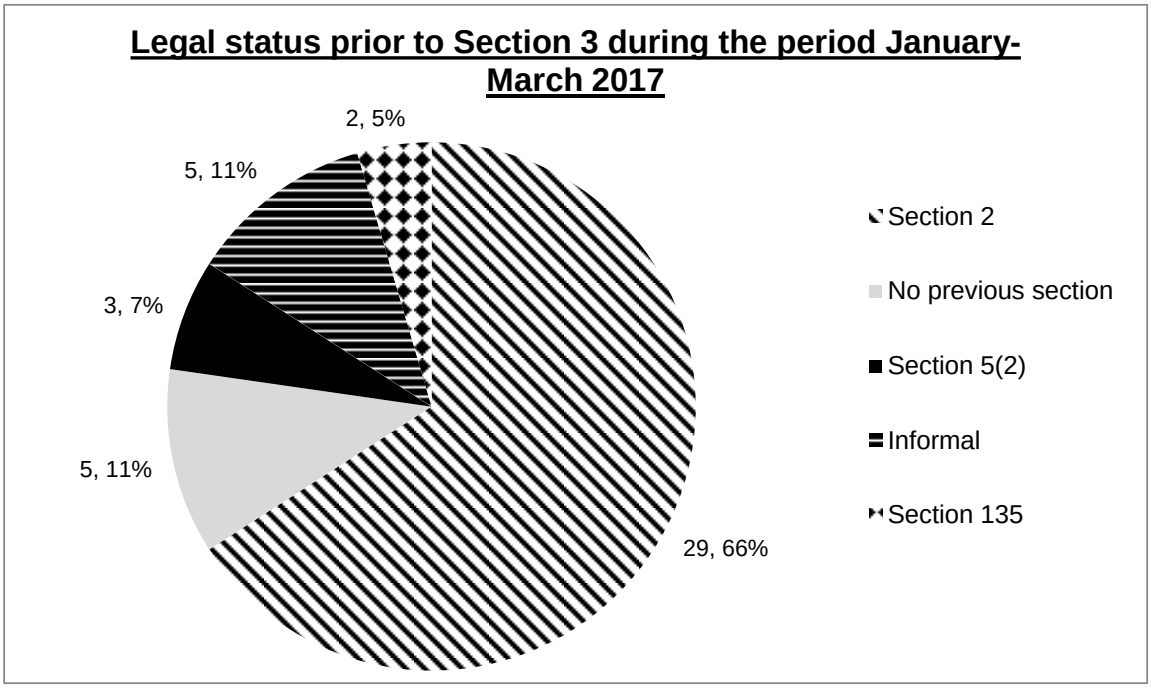


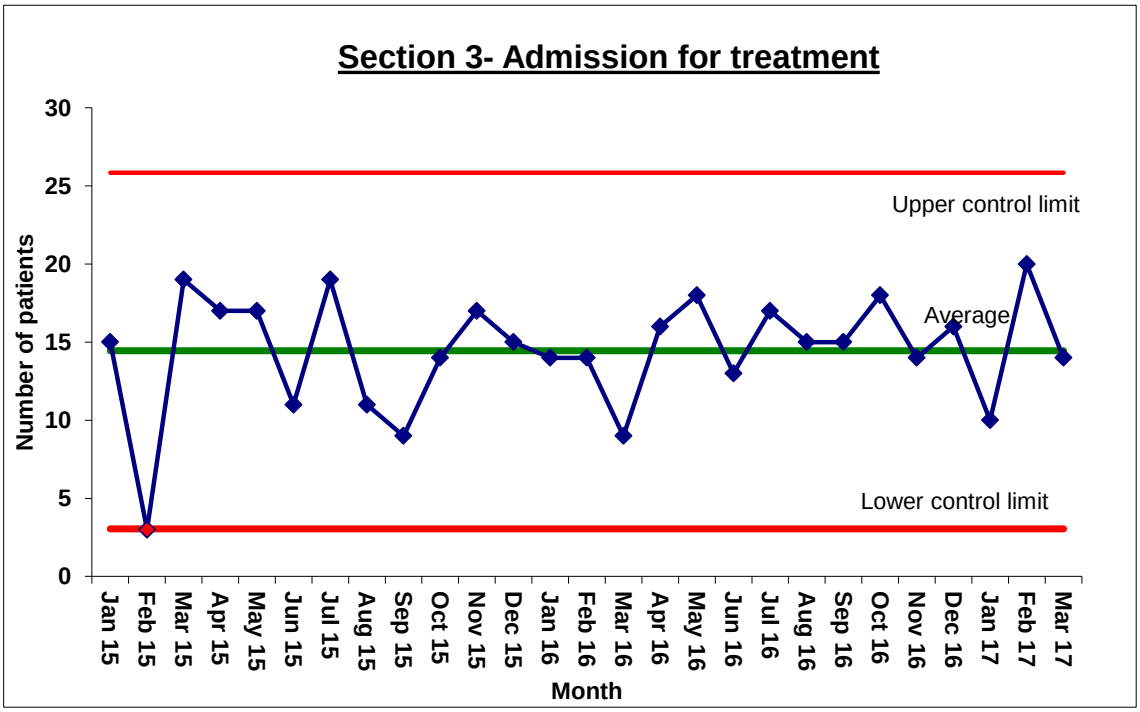
CAMHS

10.1

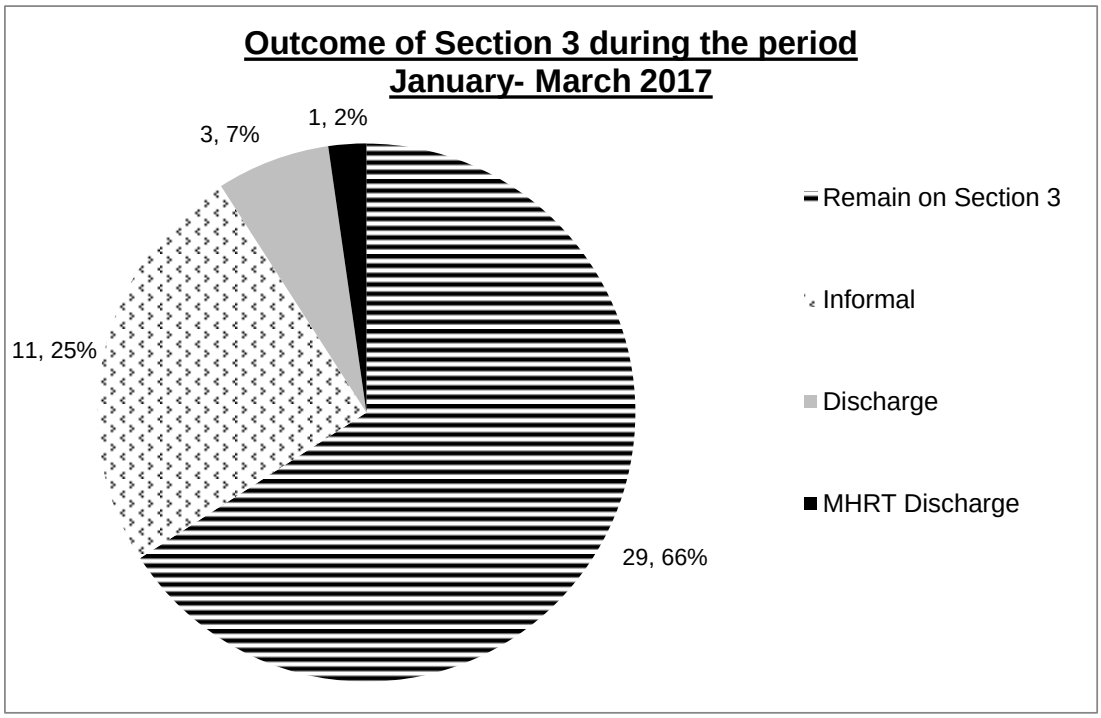
One of these assessments was carried out on a patient under the age of 18 years old. The patient was transferred to a CAMHS unit as soon as a bed became available.

Section 3 – Admission for Treatment





10.1

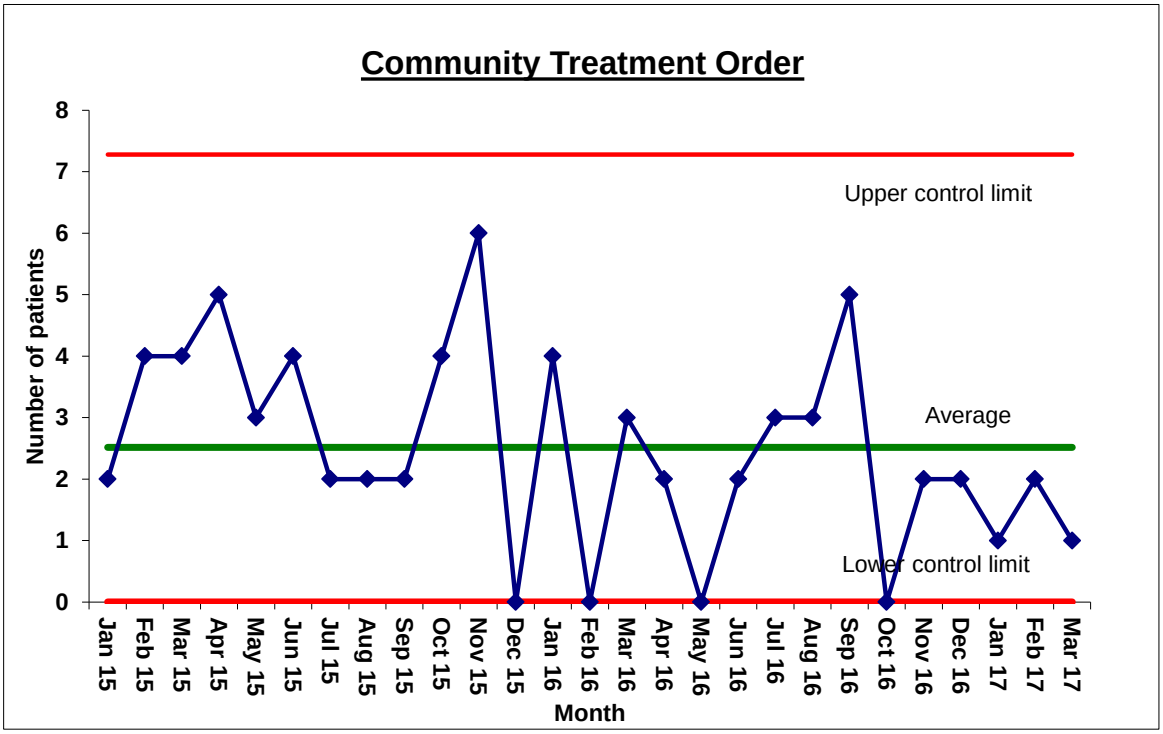

Outcome of Section 3 during the period January- March 2017
1, 2%
3, 7%
11, 25%
29, 66%
Remain on Section 3
Informal
Discharge
MHRT Discharge

10.1

Community Treatment Order

During the period January- March 2017, four patients were discharged to Community Treatment orders.

As at 31st March 2017, 37 patients were subject to a Community Treatment Order (CTO).



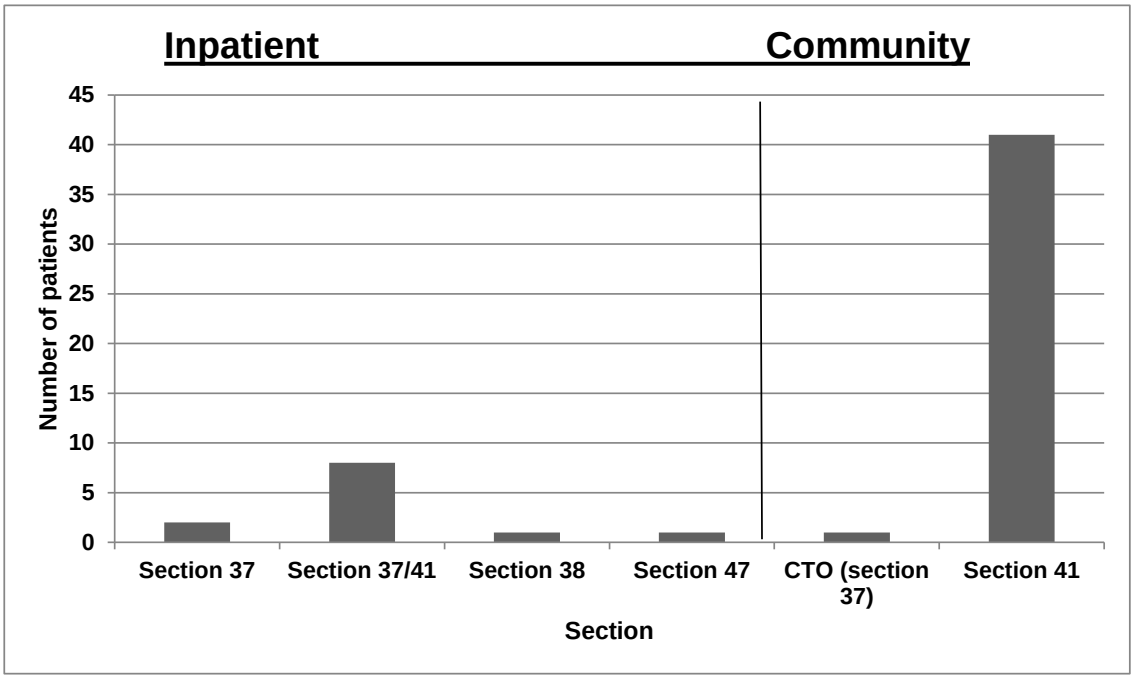
10.1

Recall of a community patient under section 17E

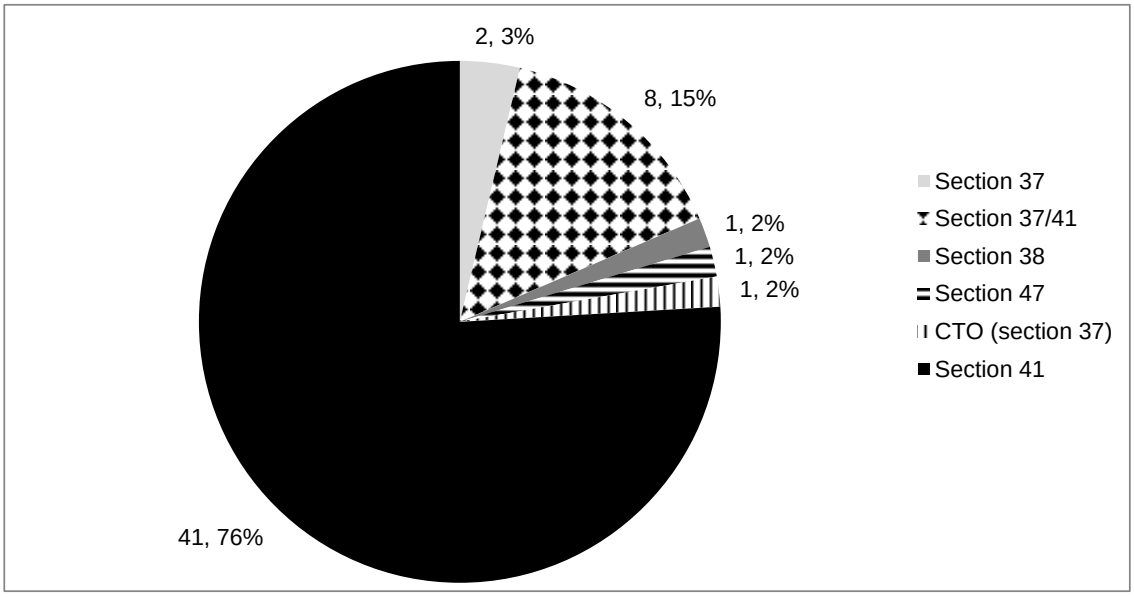
During the period January- March 2017, the power of recall was used on five occasions, all five patients were recalled to hospital and were subsequently revoked.

Part 3 of the Mental Health Act 1983

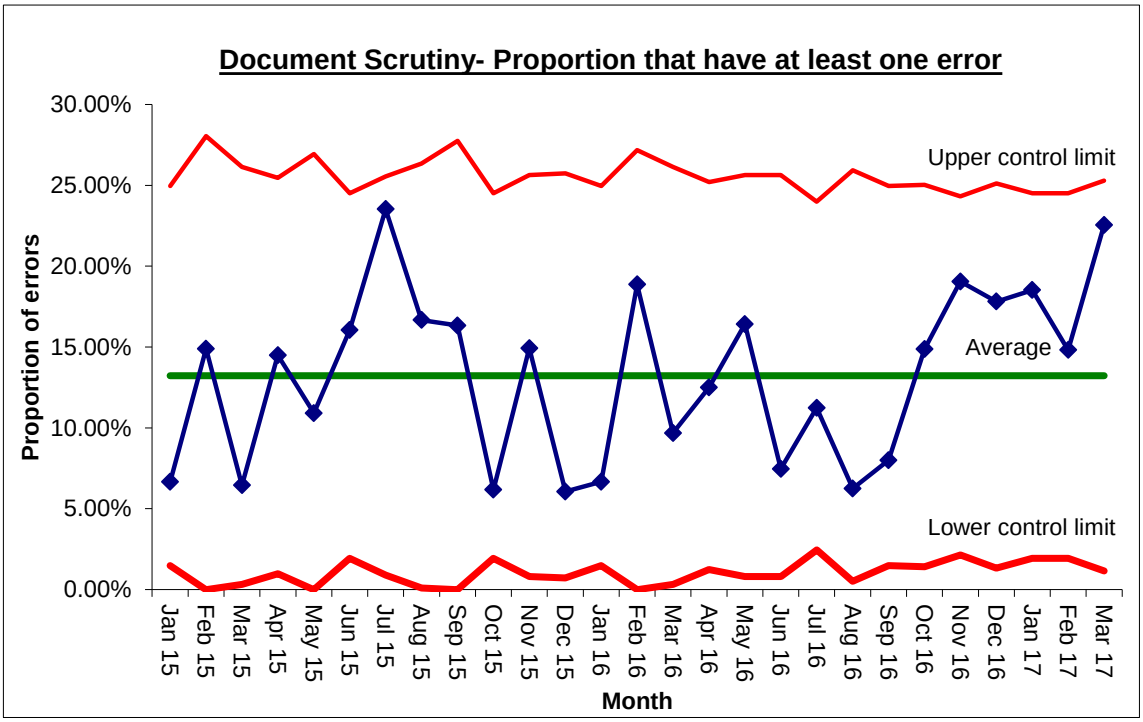
The number of Part 3 patients detained in Cardiff and the Vale University Health Board Hospitals or subject to Supervised Community Treatment/Conditional Discharge in the community as at March 31st 2017



10.1

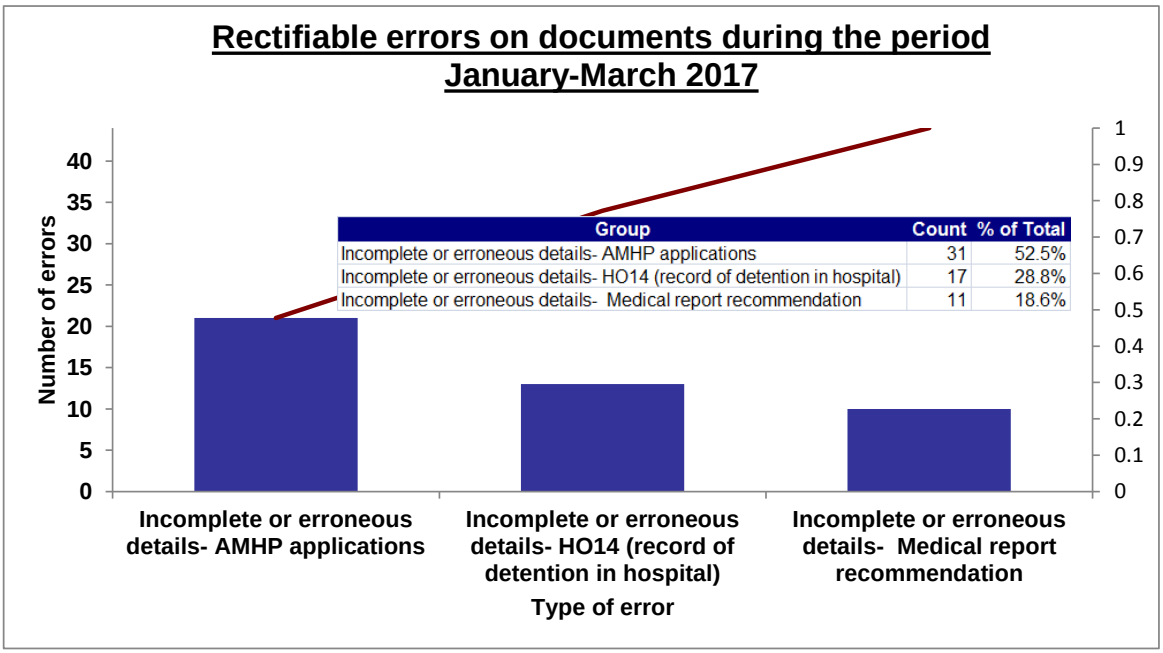


Scrutiny of documents during the period

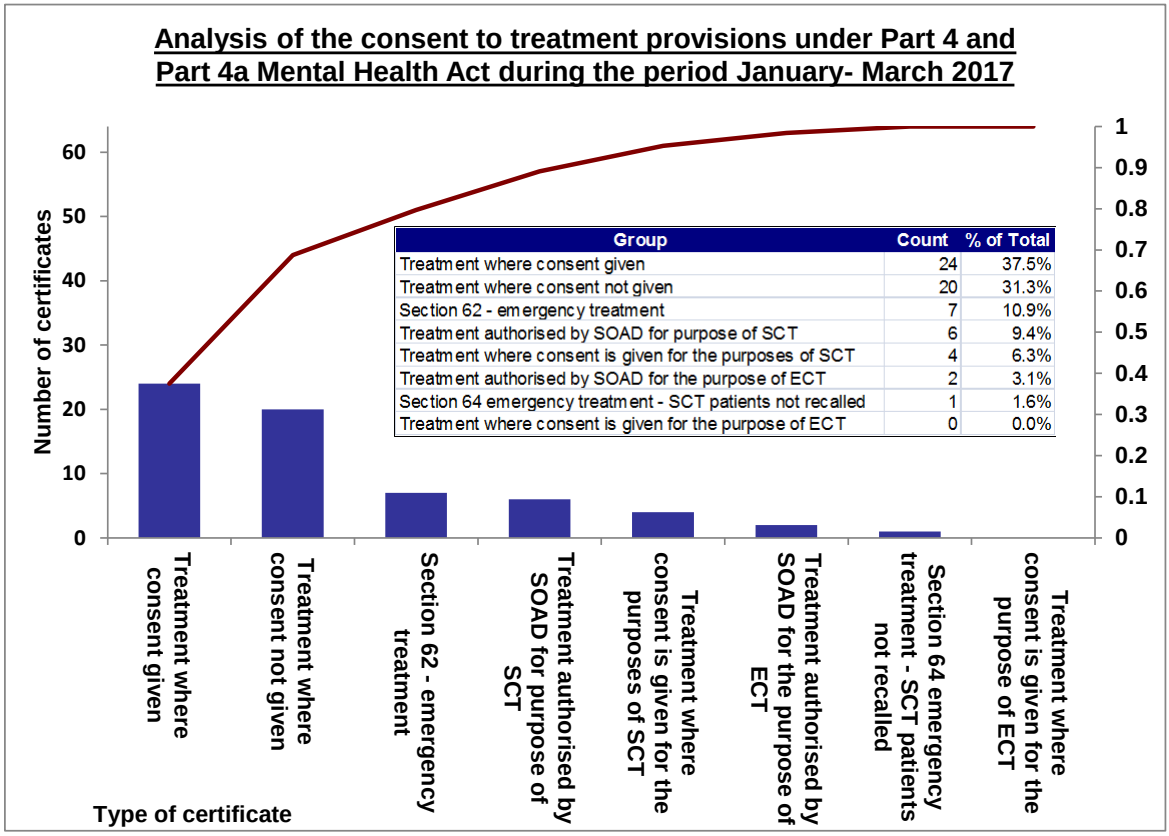


The chart above is a different type of control chart (P chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have narrower limit.

10.1



Consent to Treatment



Group	Count	% of Total
Treatment where consent given	24	37.5%
Treatment where consent not given	20	31.3%
Section 62 - emergency treatment	7	10.9%
Treatment authorised by SOAD for purpose of SCT	6	9.4%
Treatment where consent is given for the purposes of SCT	4	6.3%
Treatment authorised by SOAD for the purpose of ECT	2	3.1%
Section 64 emergency treatment - SCT patients not recalled	1	1.6%
Treatment where consent is given for the purpose of ECT	0	0.0%

10.1

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.

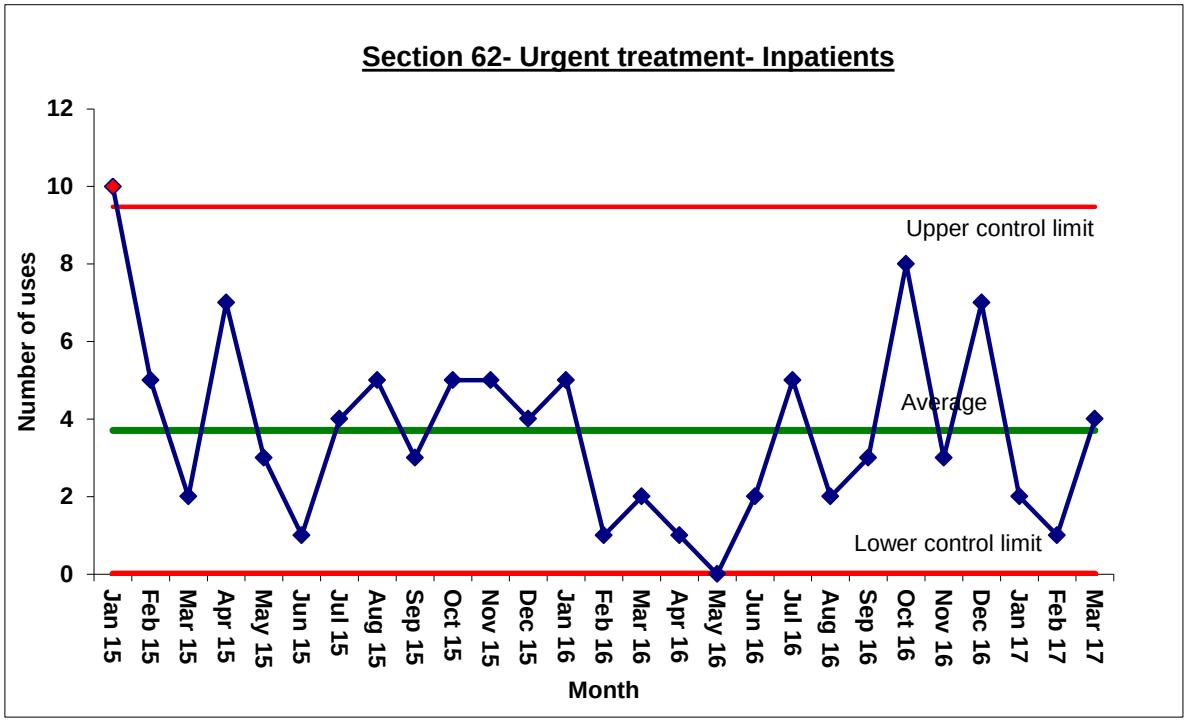
Urgent treatment is defined as treatment that is:

- 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.

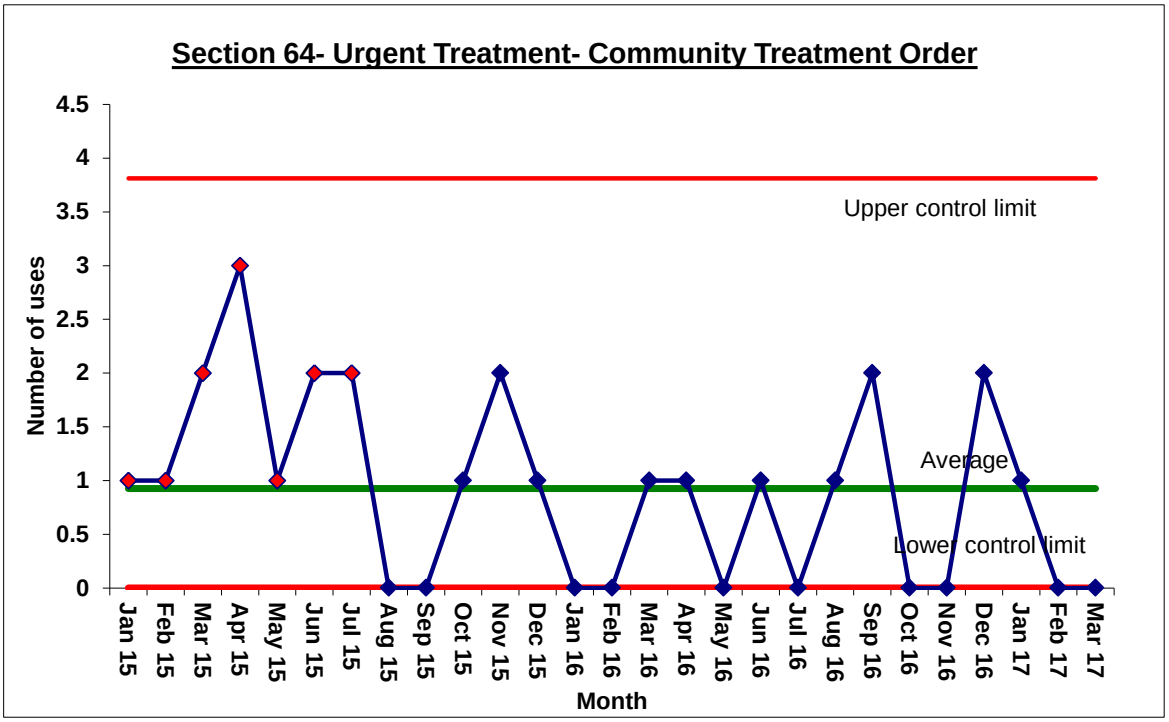
Urgent treatment can be used in any of the following instances:

- 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 seven occasions for the following reasons:

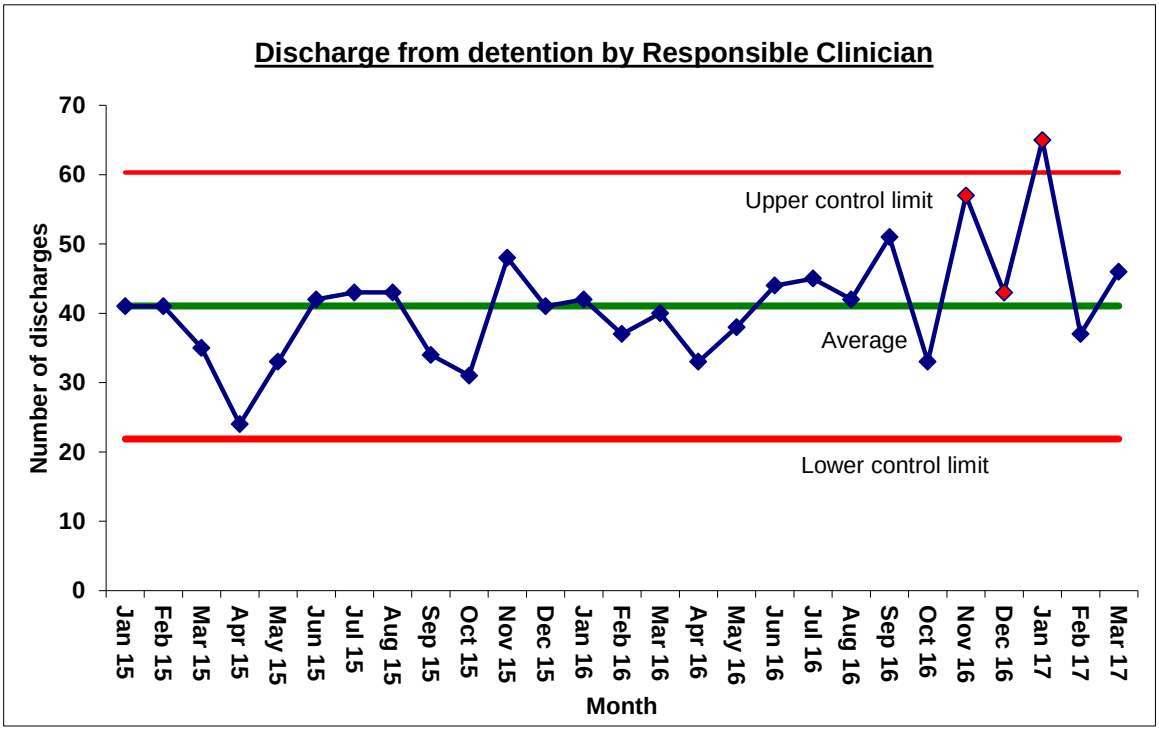
- Three month rule x 4
- Change of medication x 2
- Awaiting consent following revoke of CTO x 1

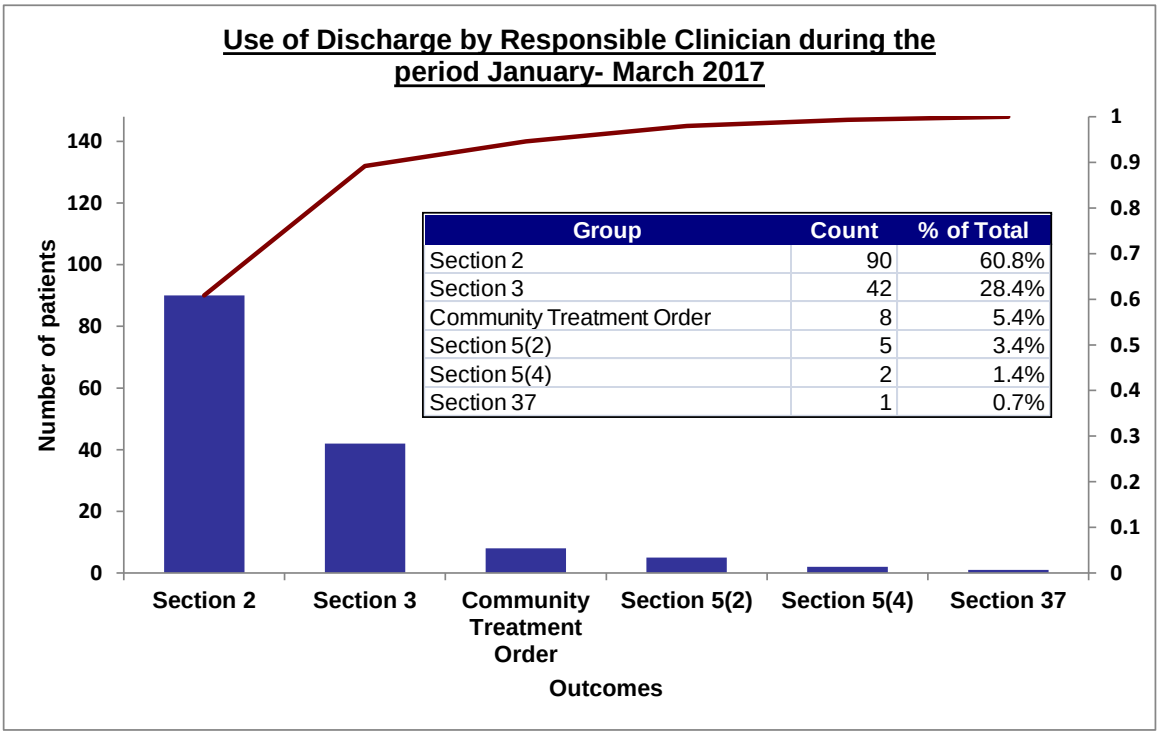


The above chart highlights that section 64 was used on one occasion during the period pending Part 4a certificate being provided by the SOAD.

10.1

Section 23 – Discharge

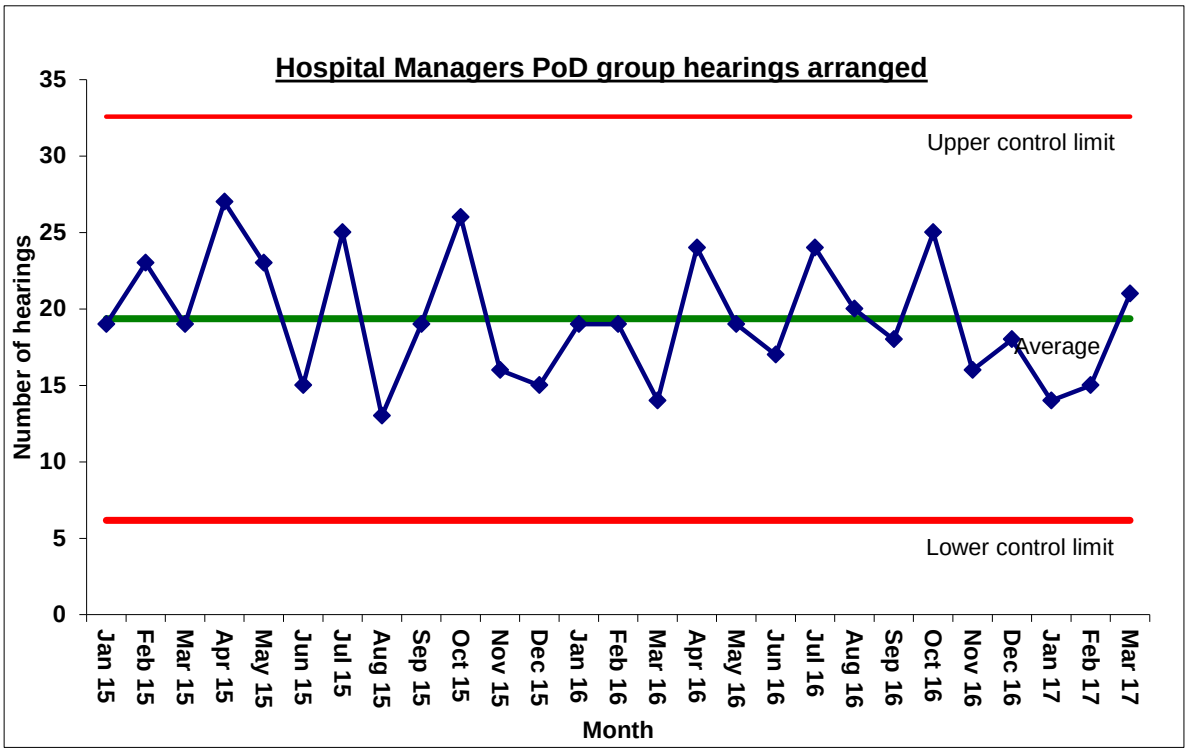


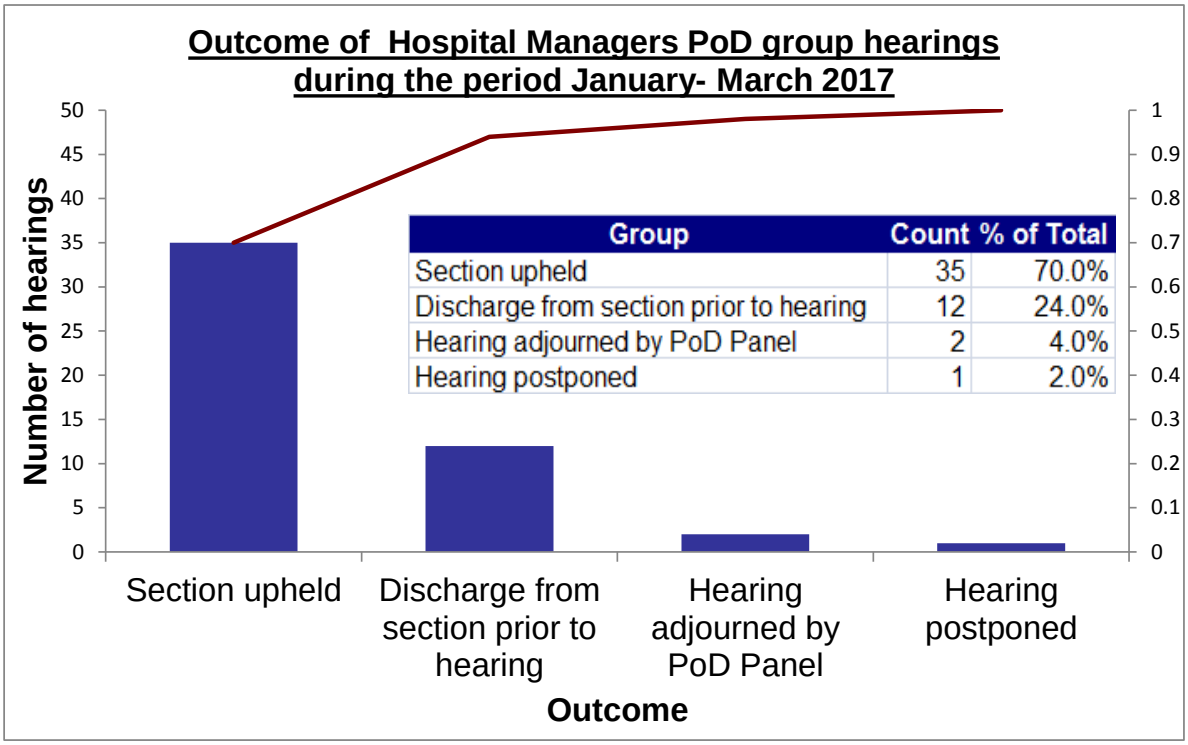


Group	Count	% of Total
Section 2	90	60.8%
Section 3	42	28.4%
Community Treatment Order	8	5.4%
Section 5(2)	5	3.4%
Section 5(4)	2	1.4%
Section 37	1	0.7%

10.1

Hospital Managers – Power of Discharge





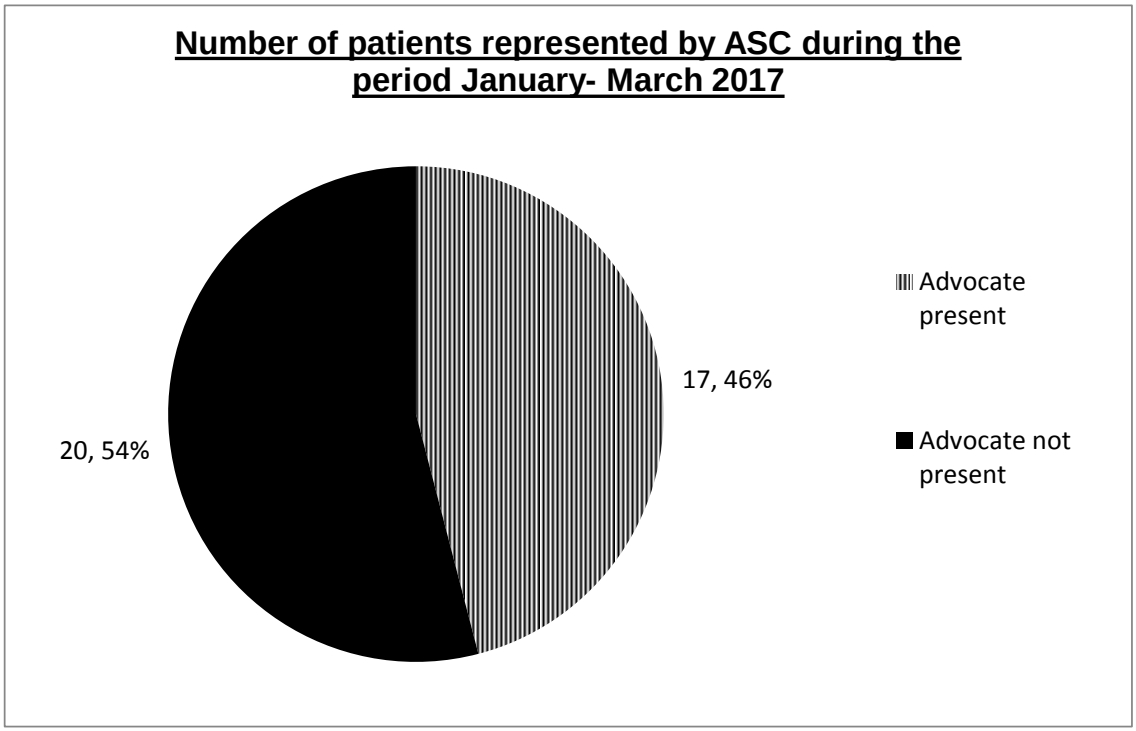
10.1

One hearing was postponed for the following reason:

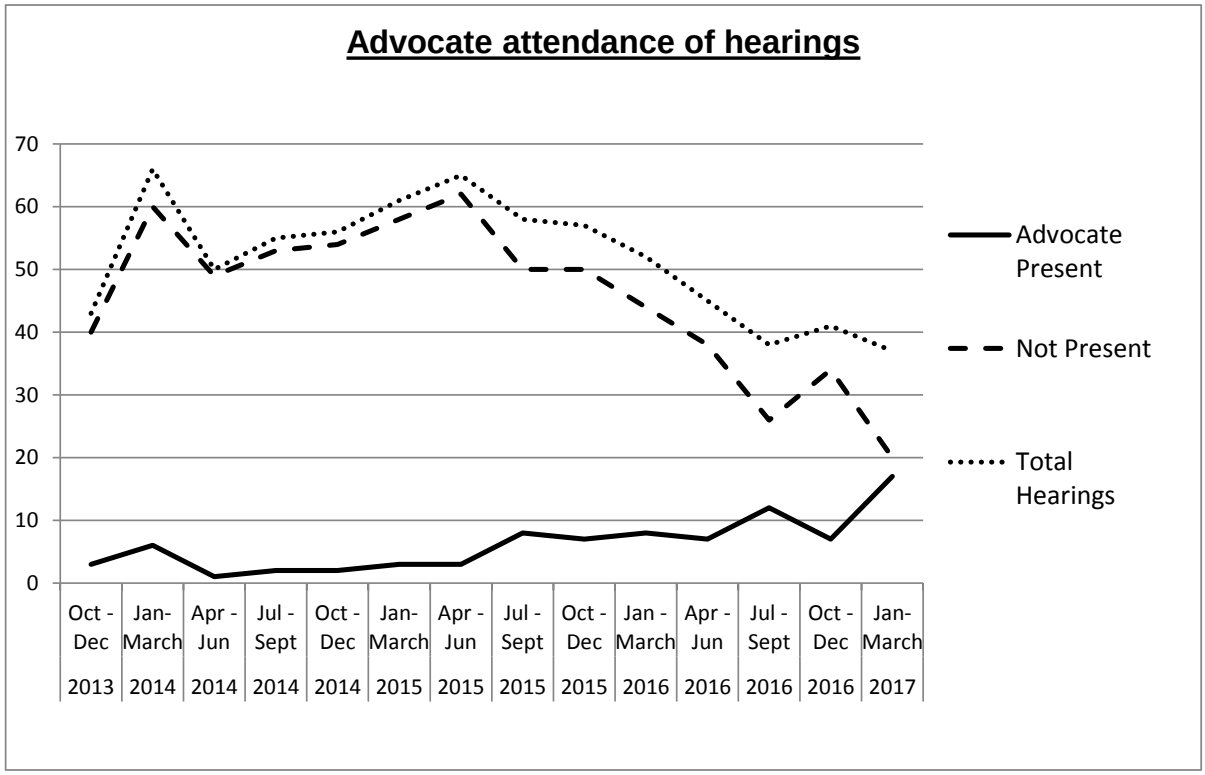
- Patient requested advocacy support at short notice.

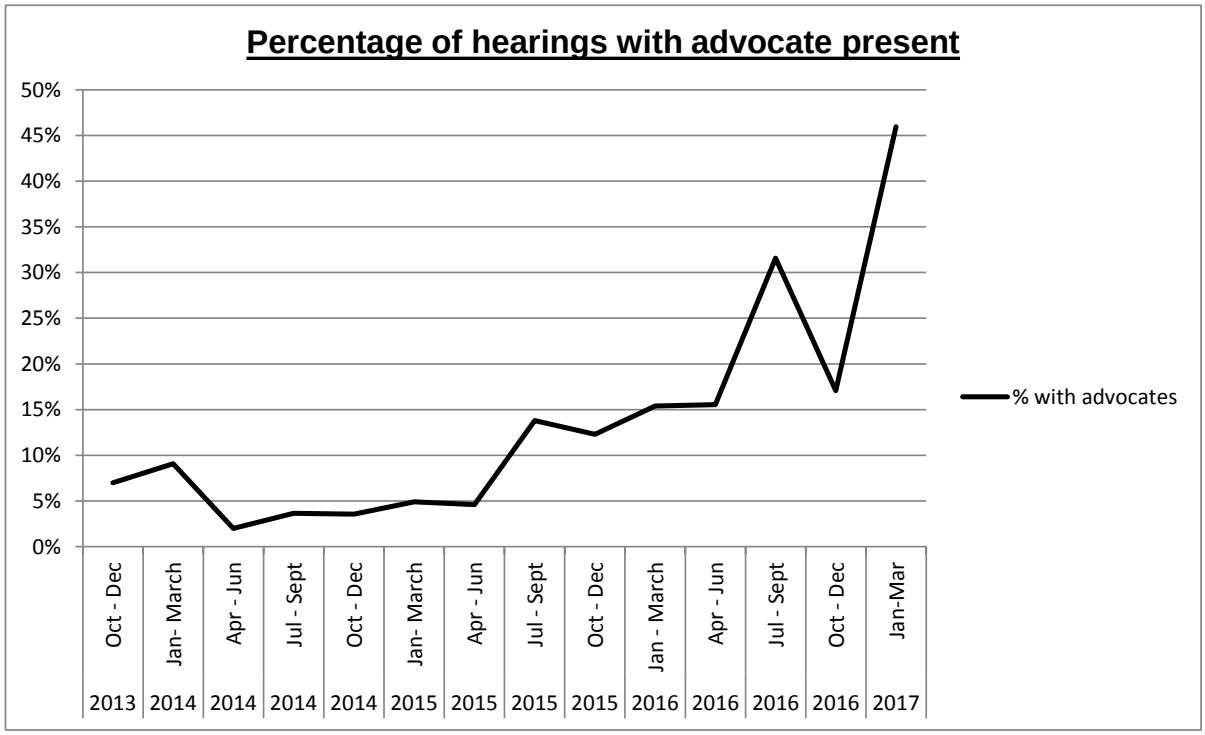
Two hearings were adjourned for the following reasons:

- For appropriate professionals to attend.



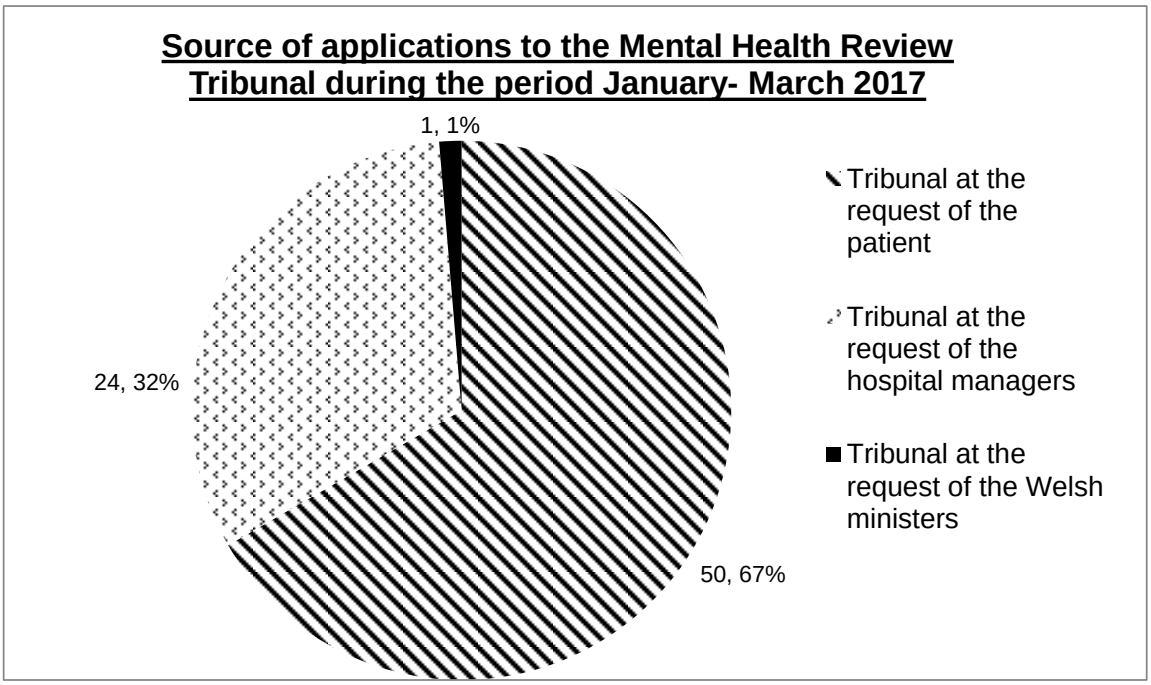
10.1


Advocate attendance of hearings
70
60
50
40
30
20
10
0
Oct - Dec 2013
Jan-March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan-March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
Jan-March 2017
Advocate Present
Not Present
Total Hearings

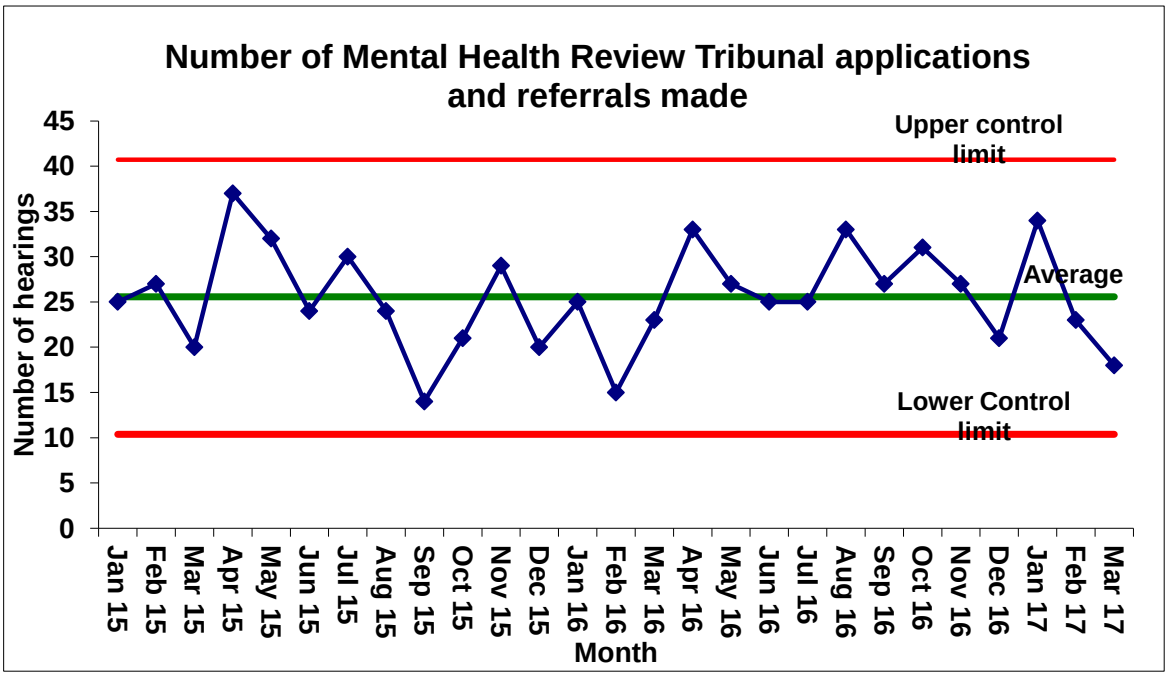

Percentage of hearings with advocate present
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Oct - Dec 2013
Jan- March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan- March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
Jan-Mar 2017
% with advocates

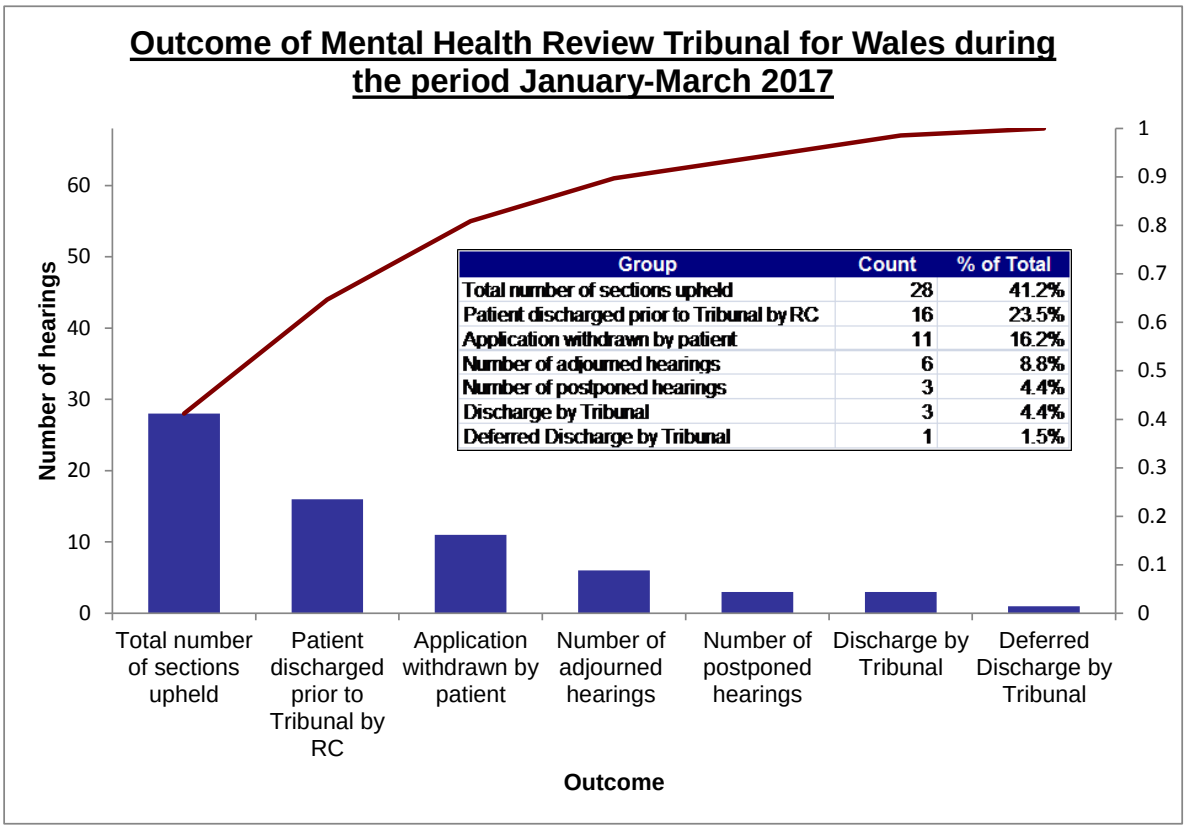
10.1

Mental Health Review Tribunal (MHRT) for Wales



10.1





Three hearings were postponed during the period for the following reasons:

- MHRT unable to fill panel
- At the request of the solicitor as patients primary nurse not available
- Covering RC not able to attend- date set by previous RC.

10.1

Six hearings were adjourned for the following reasons:

- Patient too unwell to attend
- To await further information on funding issues and referrals x 3
- Patient declined support of solicitor at the hearing and wanted to represent themselves.
- For prelim examination and RC to assess the patient prior to evidence being given.

Summary of other Mental Health Act Activity which took place during the period January- March 2017

Exclusion of visitors

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

Section 19 transfers to and from Cardiff and Vale UHB

Two patients detained under Part 2 of the Mental Health Act were transferred back to their locality health board from Cardiff and Vale UHB to a hospital under a different set of Managers.

One patient was transferred to a CAMHS facility.

One patient detained under Part 2 of the Mental Health Act was transferred back to Cardiff and Vale UHB as their locality health board from a hospital under a different set of Managers.

Death of detained patients

During the period there has been one death of a detained patient and one death of a patient subject to Community Treatment reported to HIW.

Section 117

Section 117 continues to be monitored by the MHA Department. As at 31st March 2017 Cardiff and Vale UHB maintain responsibility for 1636 patients eligible to section 117 after care.

10.1

During this period Cardiff and Vale UHB updated the 117 register to include a further 33 and discharged 21.

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	Written authorisation on a prescribed form for the

Treatment Order (CTO)	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.

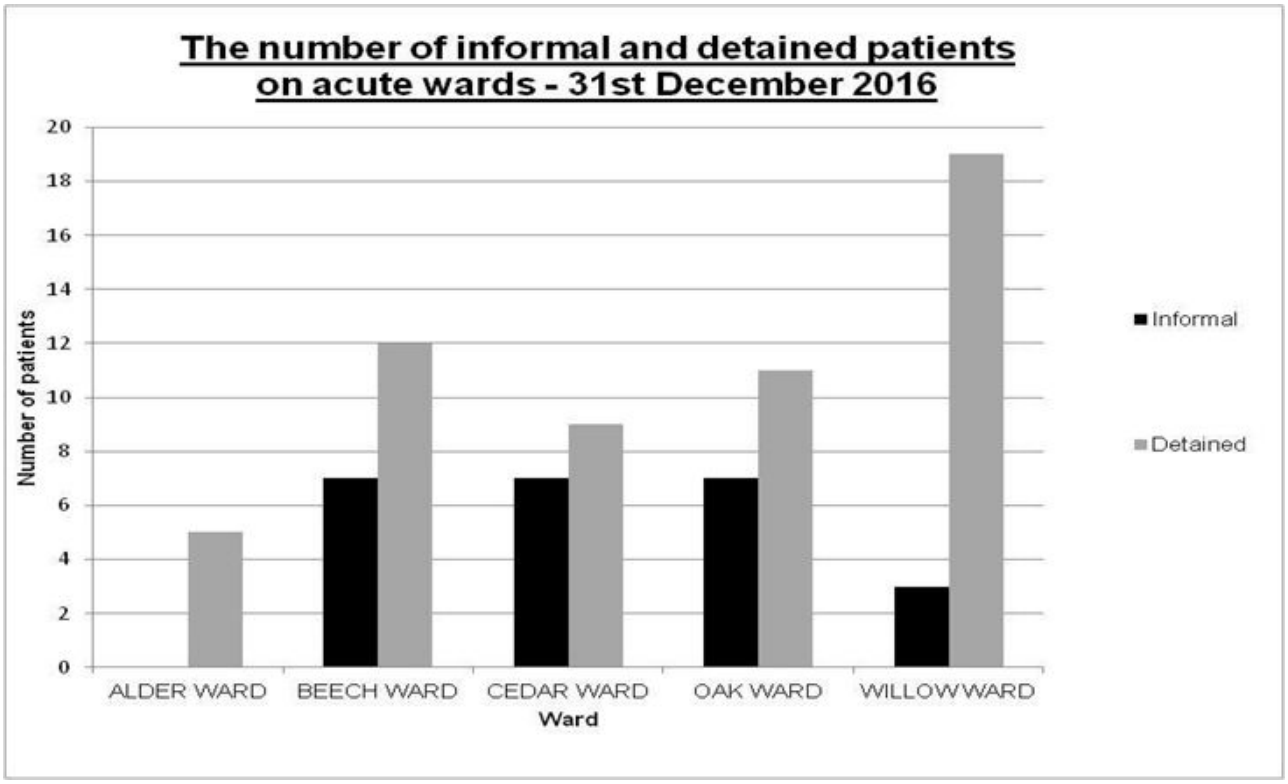
Report to the

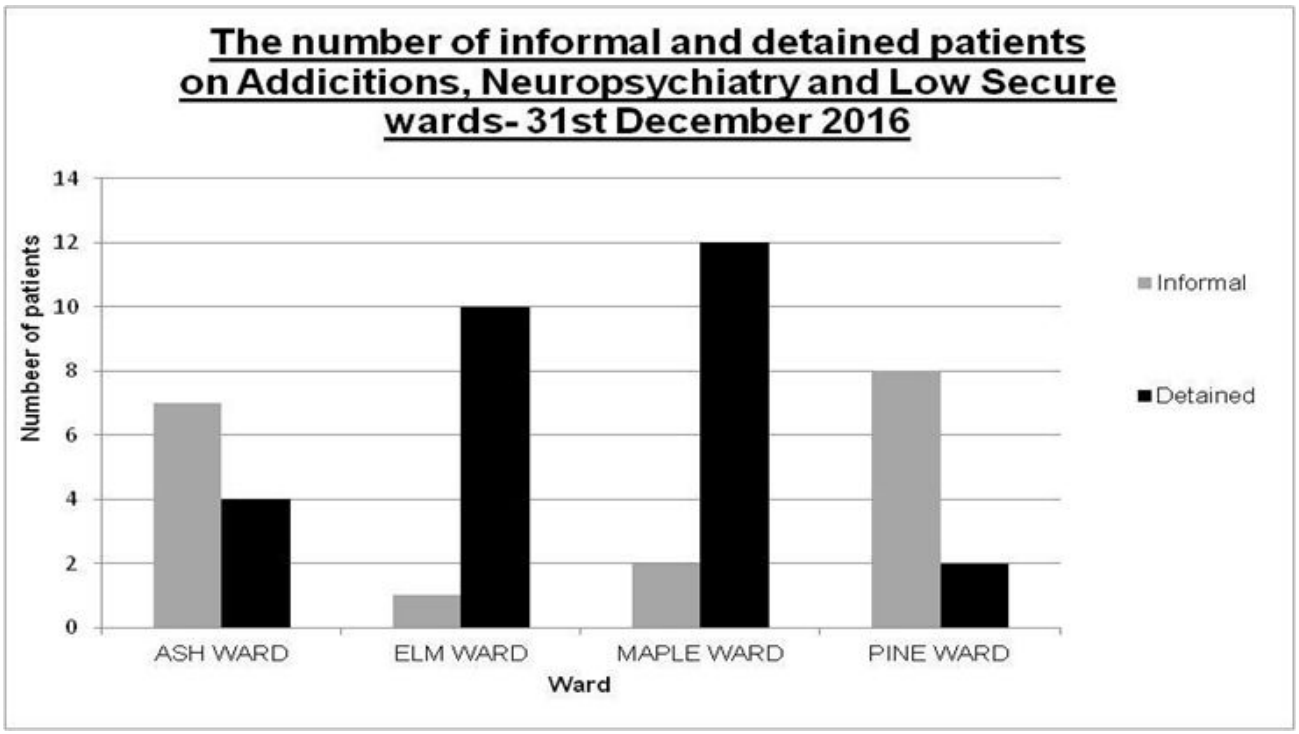
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

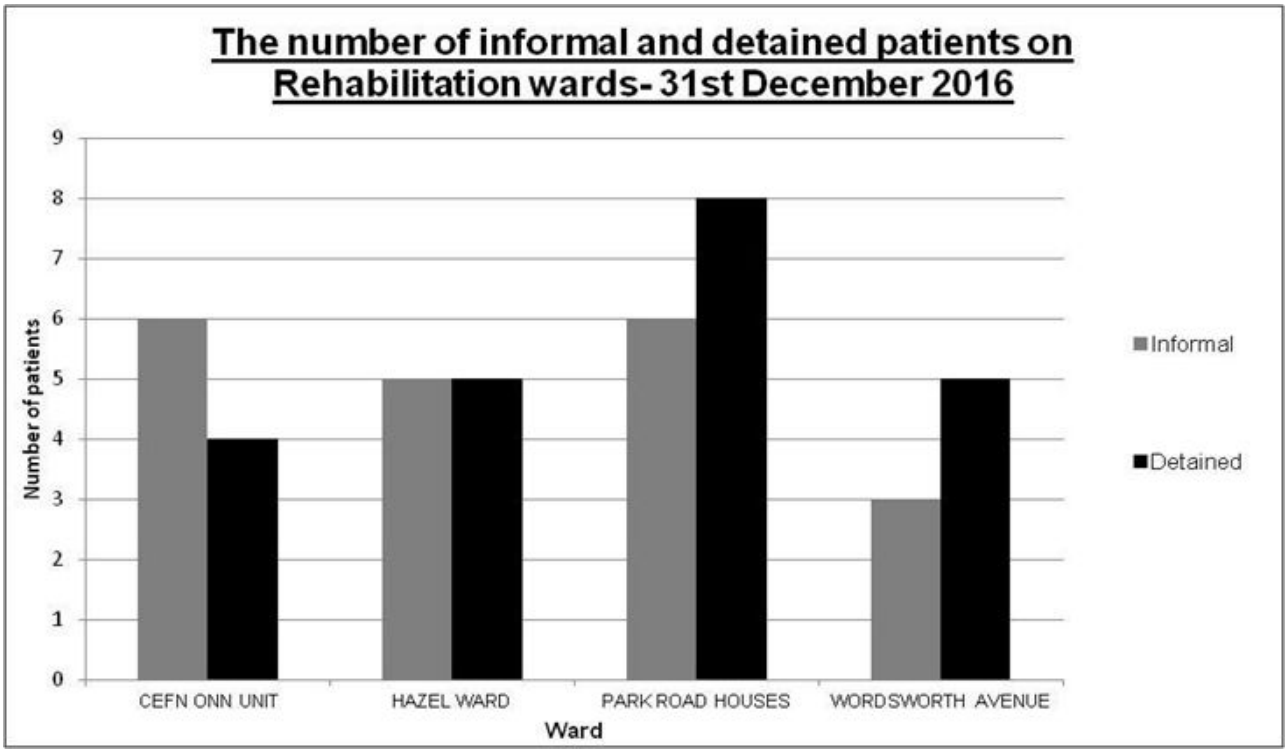
October- December 2016

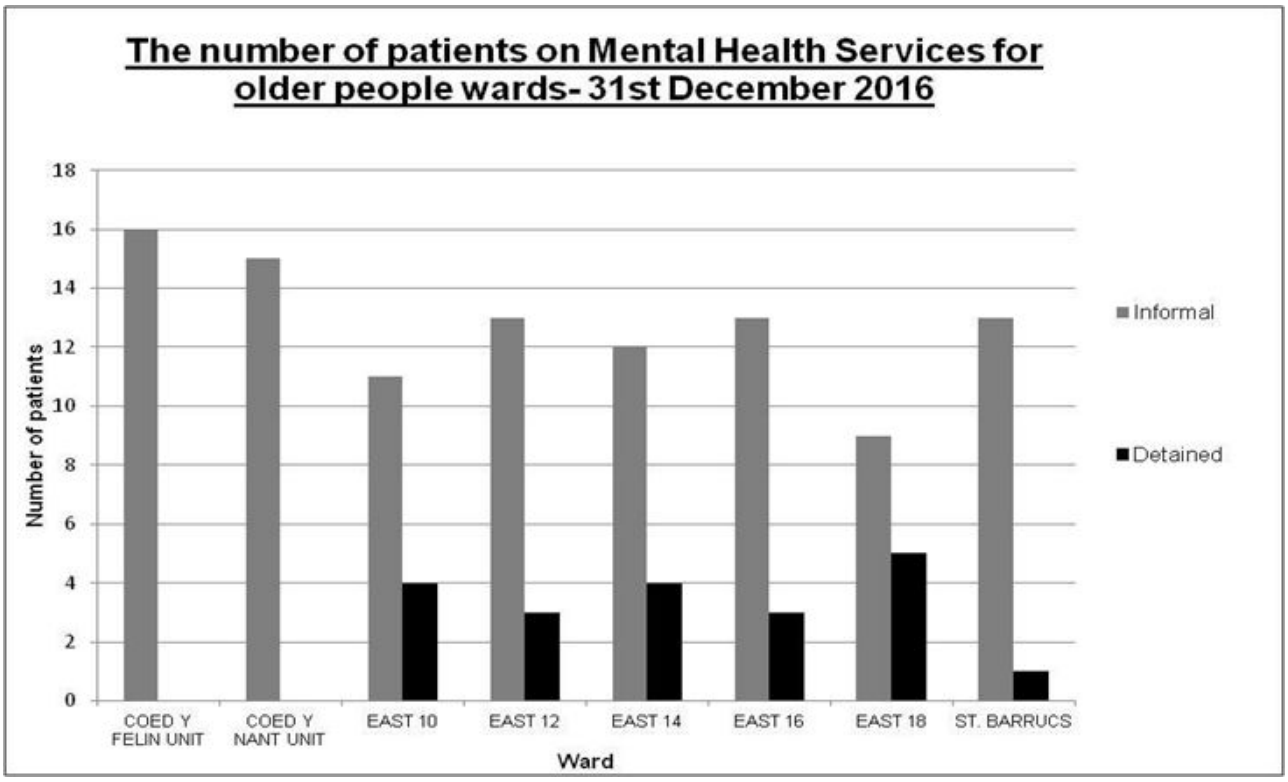
10.2


The number of informal and detained patients on acute wards - 31st December 2016
Number of patients
20
18
16
14
12
10
8
6
4
2
0
ALDER WARD
BEECH WARD
CEDAR WARD
OAK WARD
WILLOW WARD
Ward
Informal
Detained


The number of informal and detained patients on Addicitions, Neuropsychiatry and Low Secure wards- 31st December 2016
Numbeer of patients
14
12
10
8
6
4
2
0
ASH WARD
ELM WARD
MAPLE WARD
PINE WARD
Ward
Informal
Detained

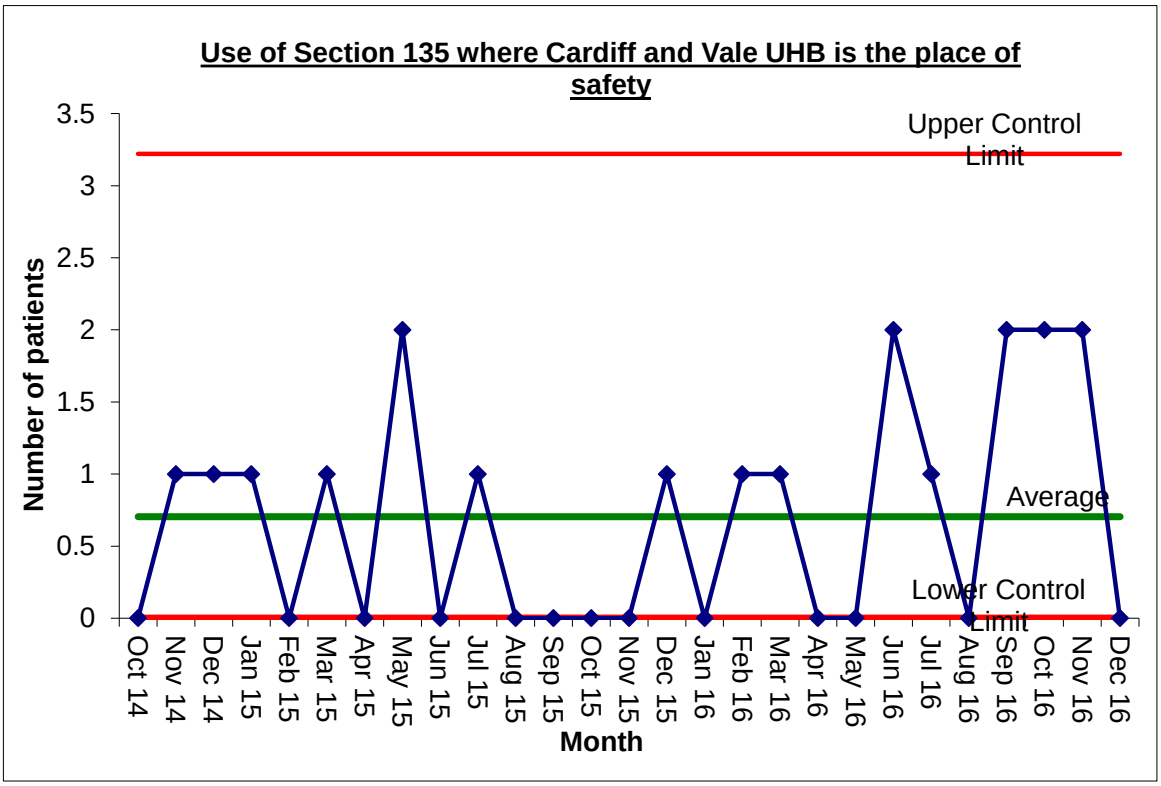
10.2


The number of informal and detained patients on Rehabilitation wards- 31st December 2016
Number of patients
0
1
2
3
4
5
6
7
8
9
CEFN ONN UNIT
HAZEL WARD
PARK ROAD HOUSES
WORDSWORTH AVENUE
Ward
Informal
Detained


The number of patients on Mental Health Services for older people wards- 31st December 2016
Number of patients
0
2
4
6
8
10
12
14
16
18
COED Y FELIN UNIT
COED Y NANT UNIT
EAST 10
EAST 12
EAST 14
EAST 16
EAST 18
ST. BARRUCS
Ward
Informal
Detained

10.2

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

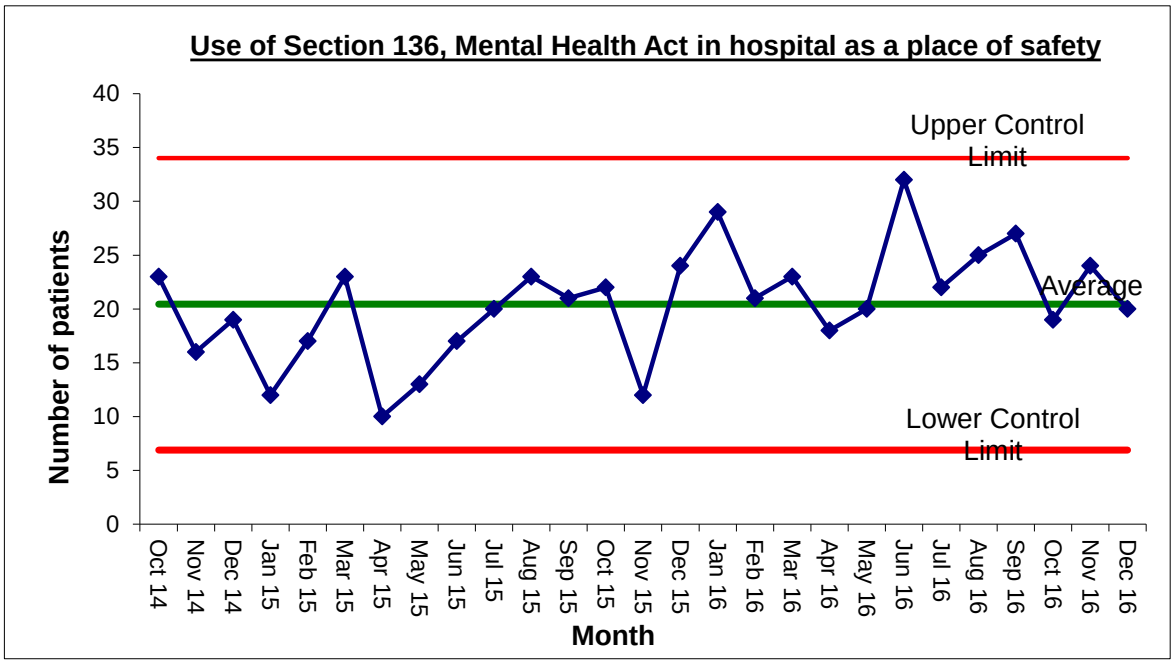


10.2

During the period October- December section 135(1) powers were executed on four occasions:-

- All four patients were subsequently placed on Section 2.

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

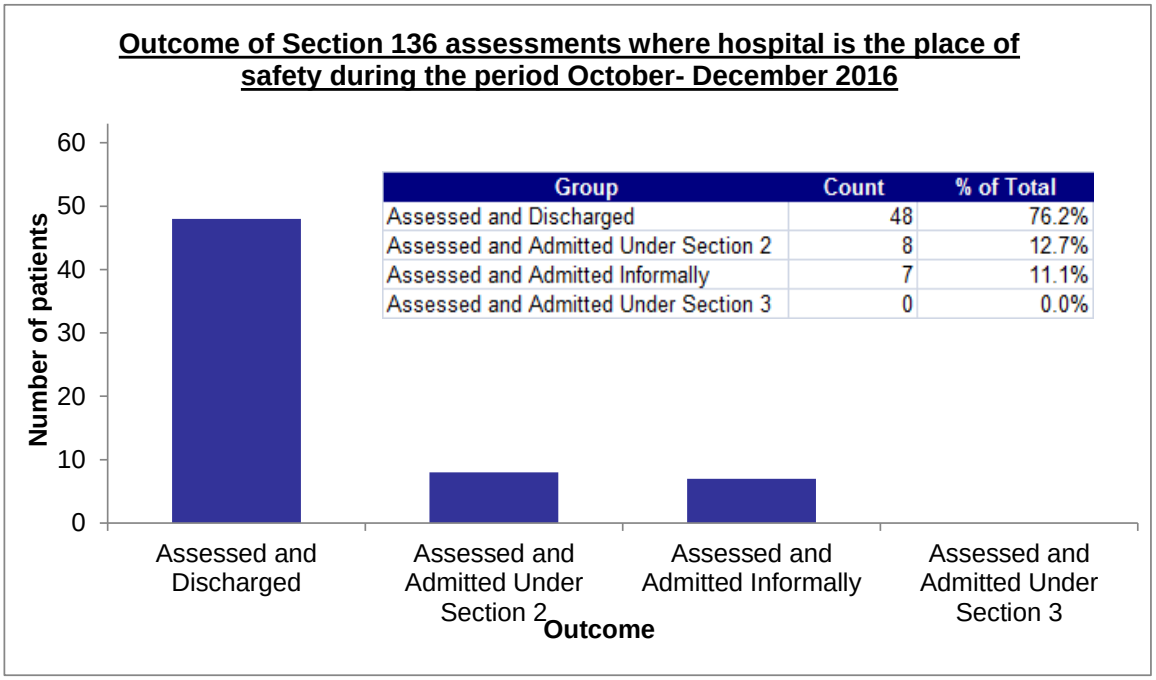


In the period October- December 2016, a total of 63 assessments were initiated by Section 136 powers where the MHA assessment took place in a hospital as the place of safety. **Three of these assessments were carried out on children under 18.**

10.2

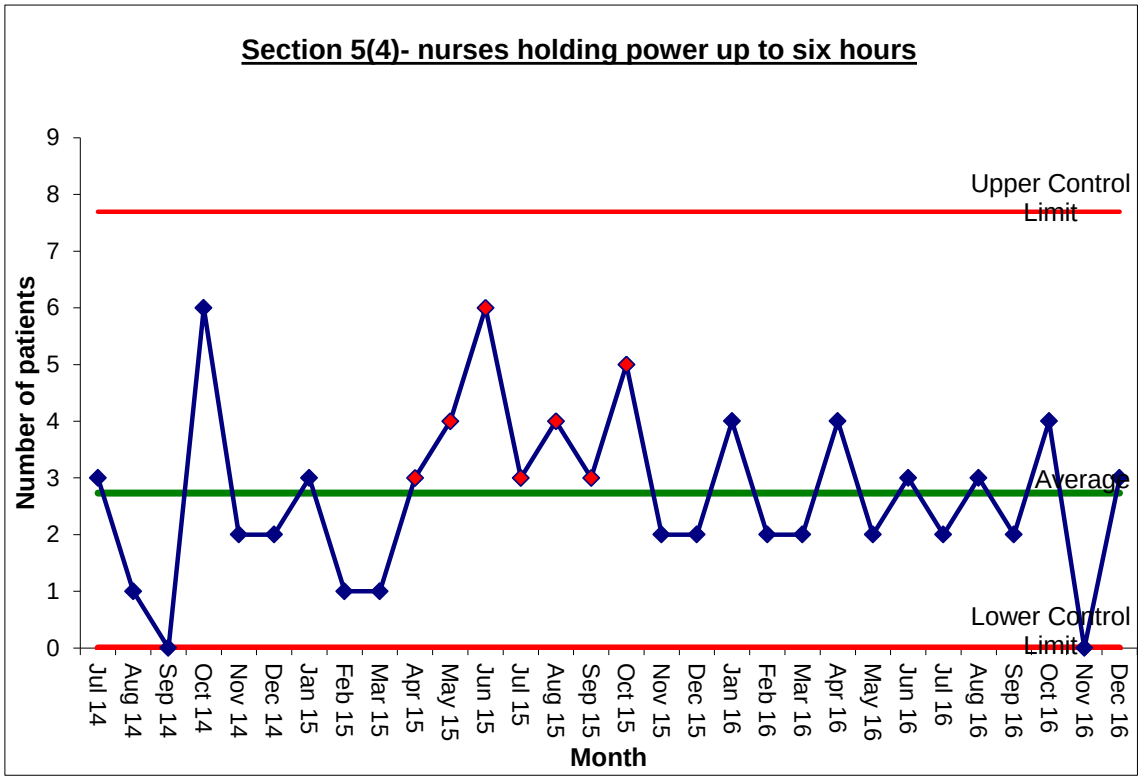
The pareto chart highlights that 76.2% of individuals assessed under 136 were not admitted to hospital.

Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.



Group	Count	% of Total
Assessed and Discharged	48	76.2%
Assessed and Admitted Under Section 2	8	12.7%
Assessed and Admitted Informally	7	11.1%
Assessed and Admitted Under Section 3	0	0.0%

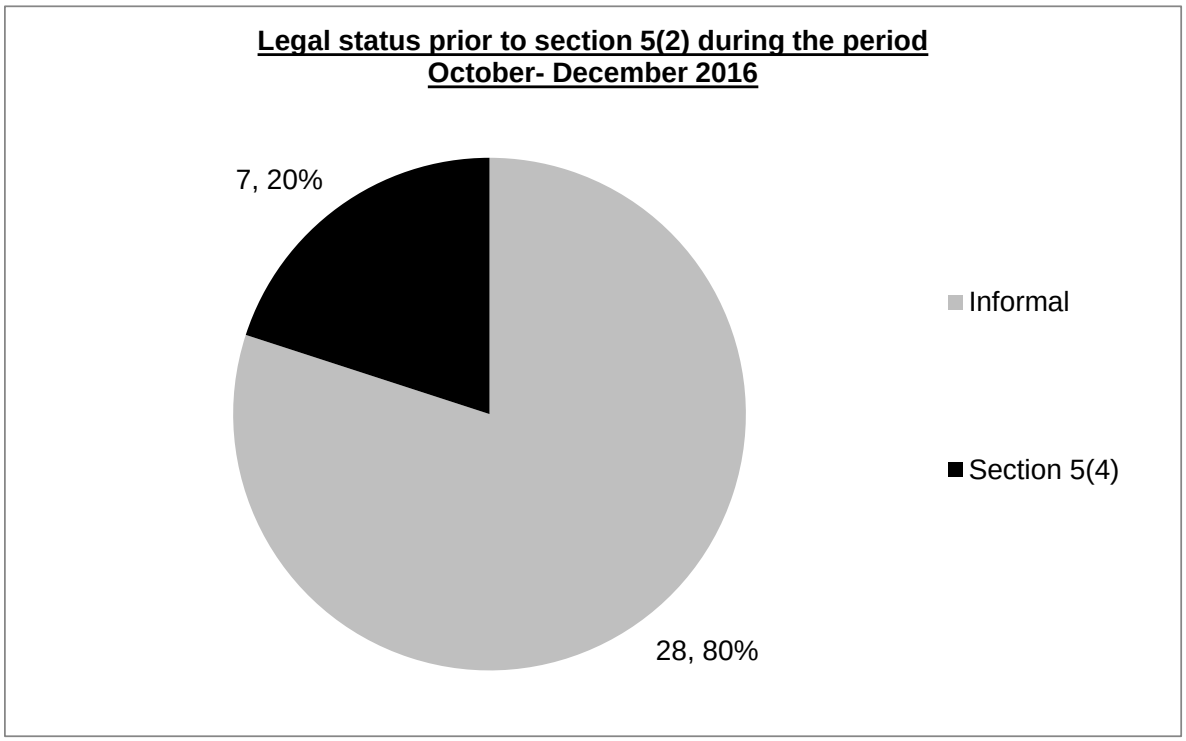
Section 5(4) Nurses' Holding Power

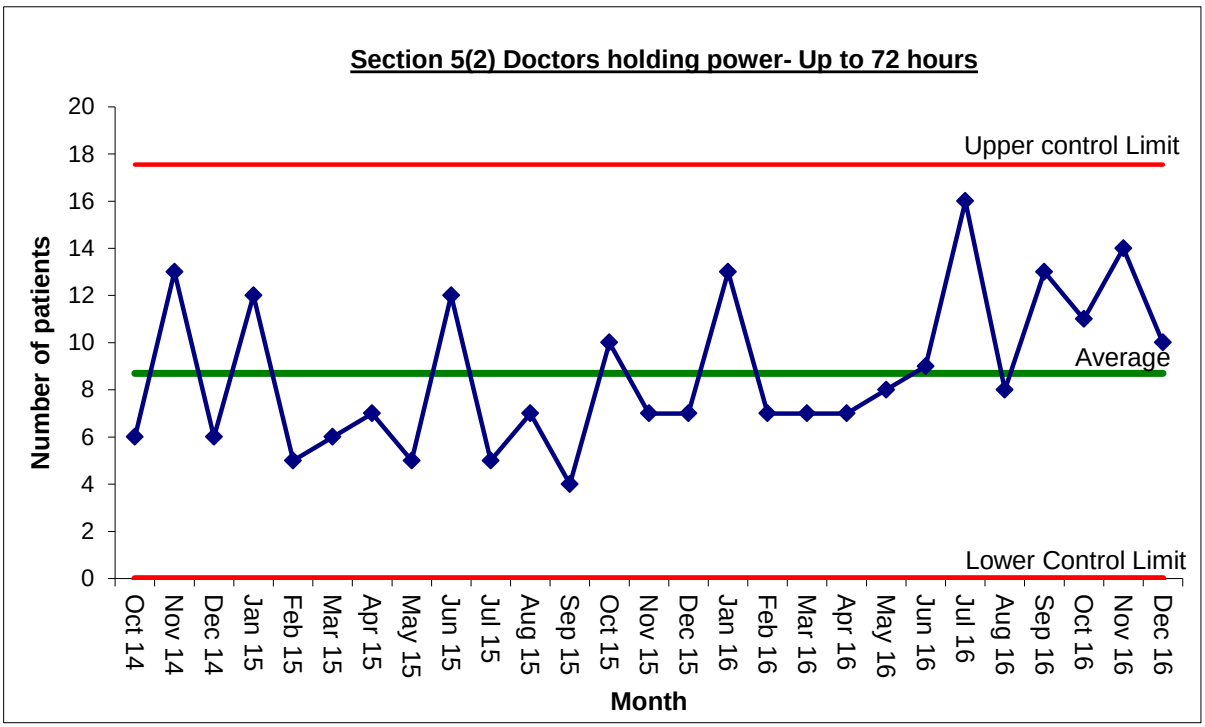


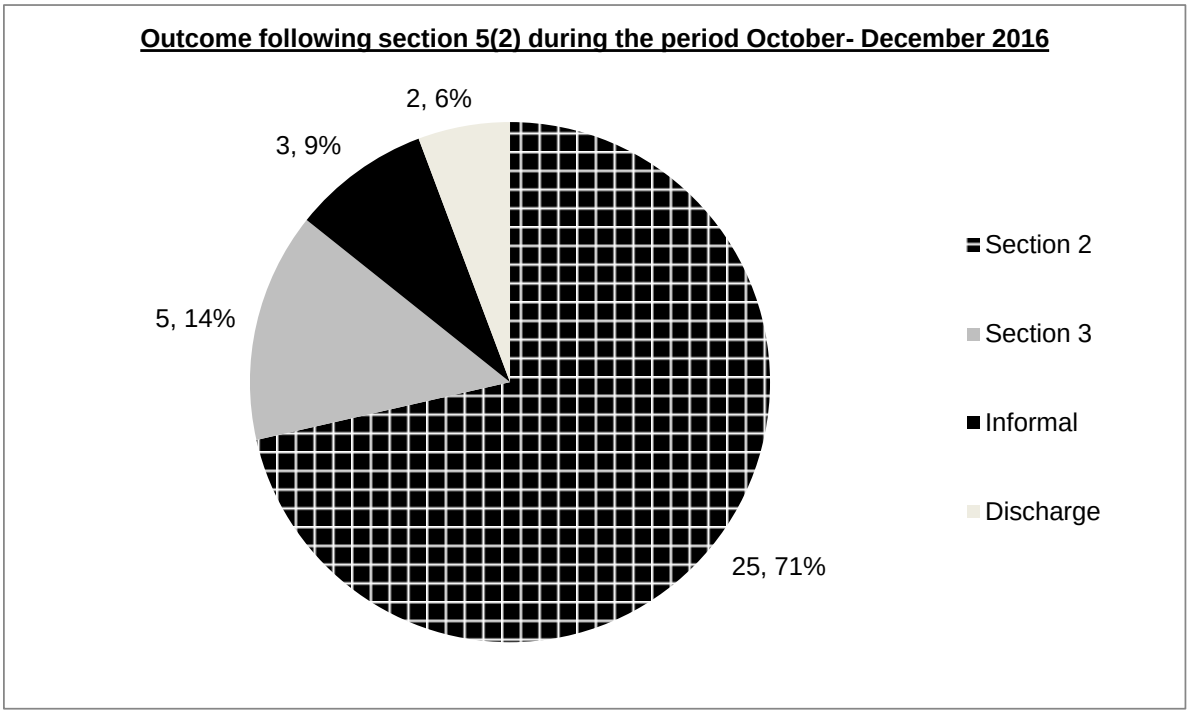
10.2

During the period October- December 2016 Section 5(4) was used on seven occasions, all of which were subsequently held under Section 5(2).

Section 5(2) Doctors' Holding Power

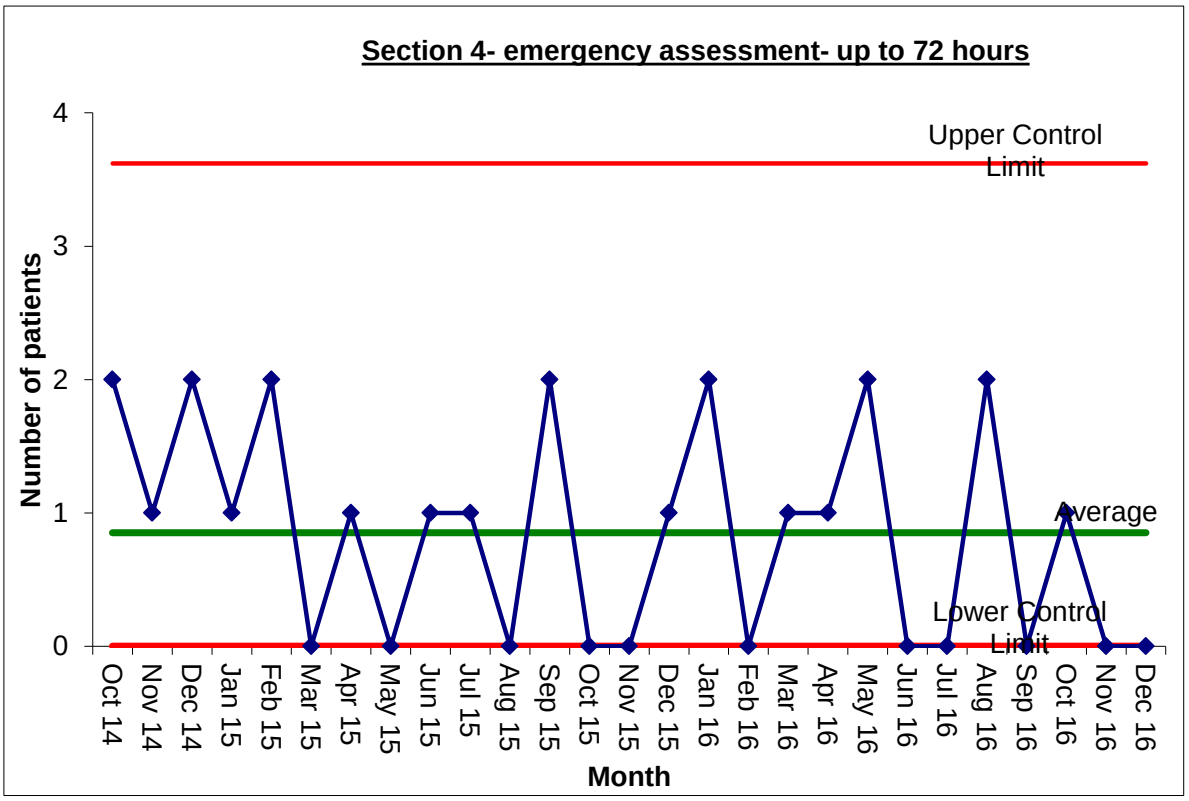





Outcome following section 5(2) during the period October- December 2016
2, 6%
3, 9%
5, 14%
25, 71%
Section 2
Section 3
Informal
Discharge

10.2

Section 4 – admission for Assessment in Cases of Emergency

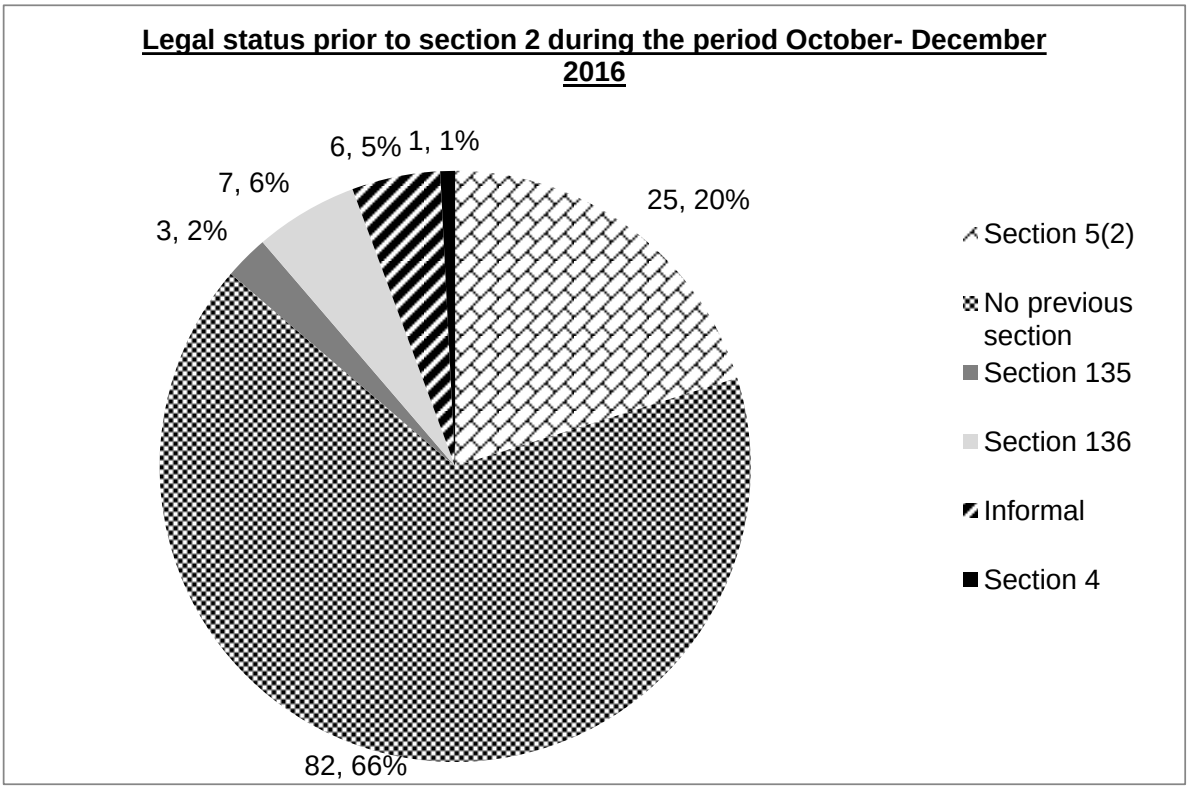


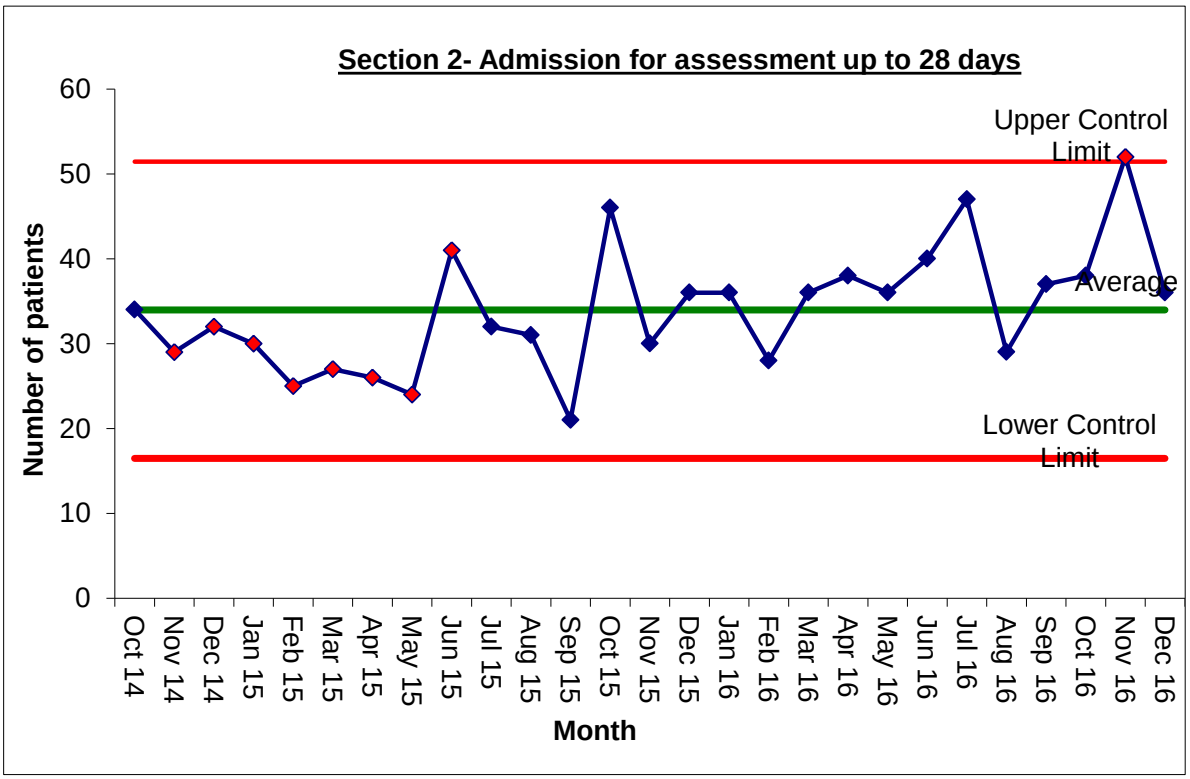
10.2

Section 4 was used on one occasion and subsequently converted to Section 2 during the period October- December 2016 for the following reason:

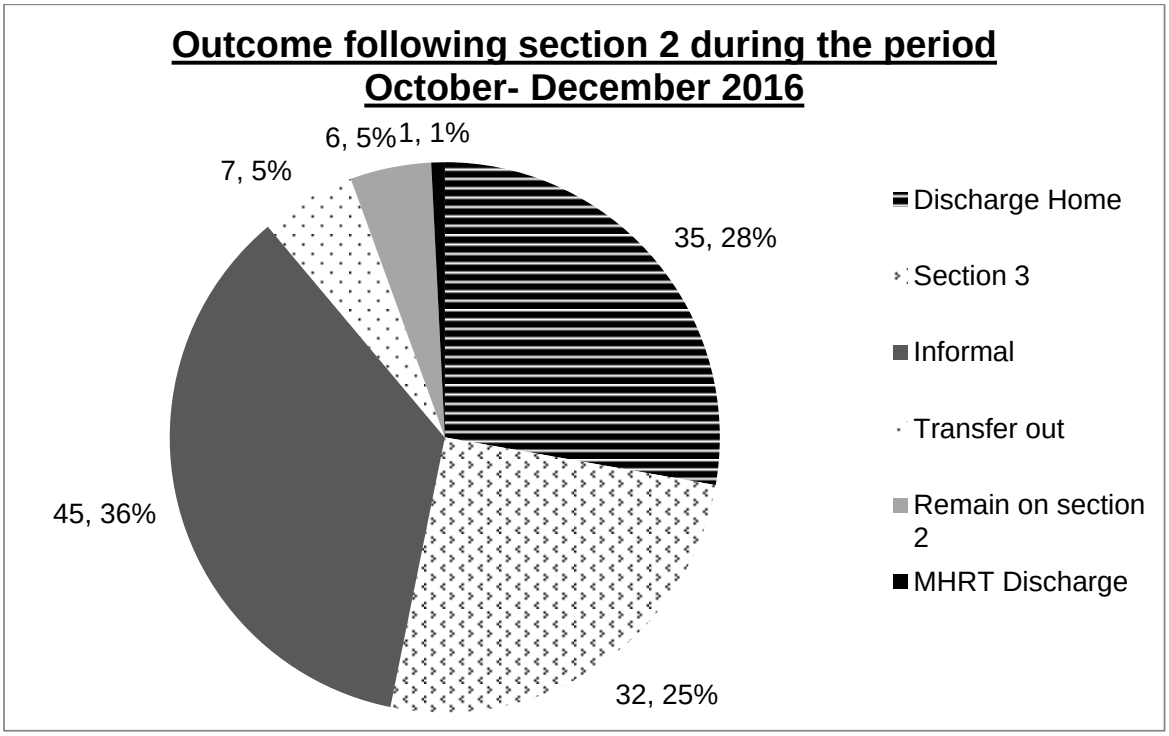
- Potential immediate risk to themselves and others. No section 12 Doctor available.

Section 2 – Admission for Assessment



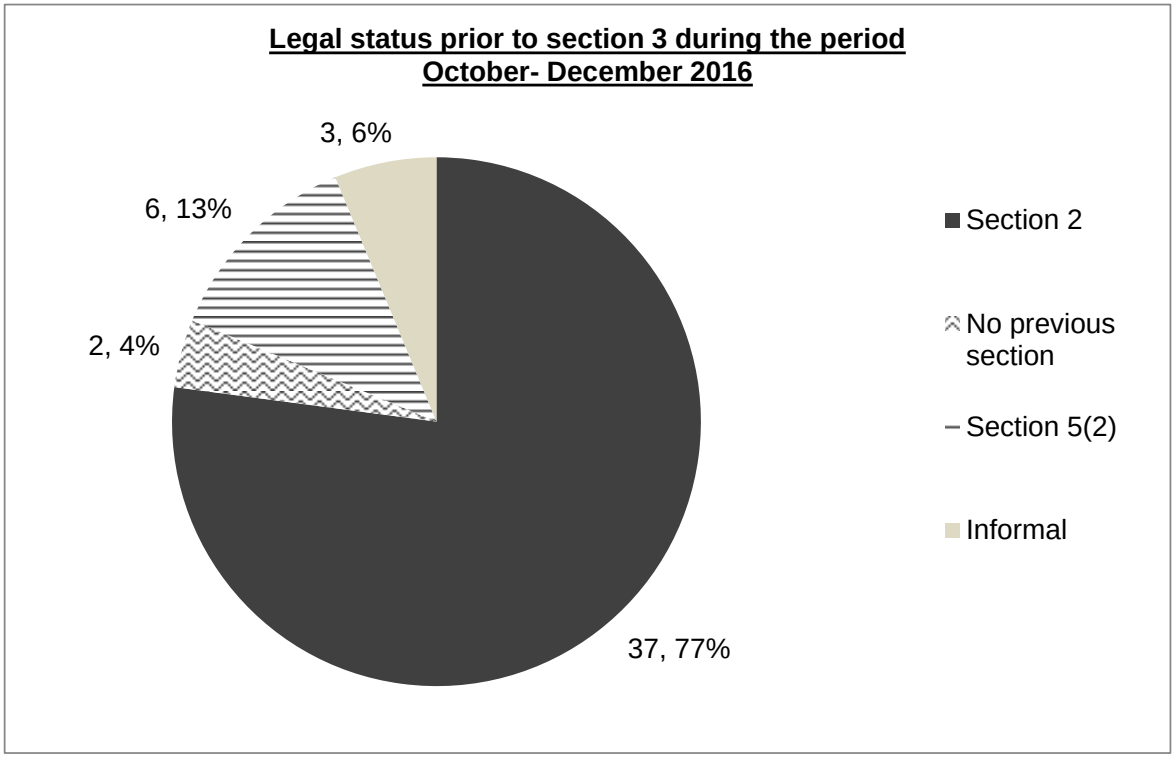


10.2

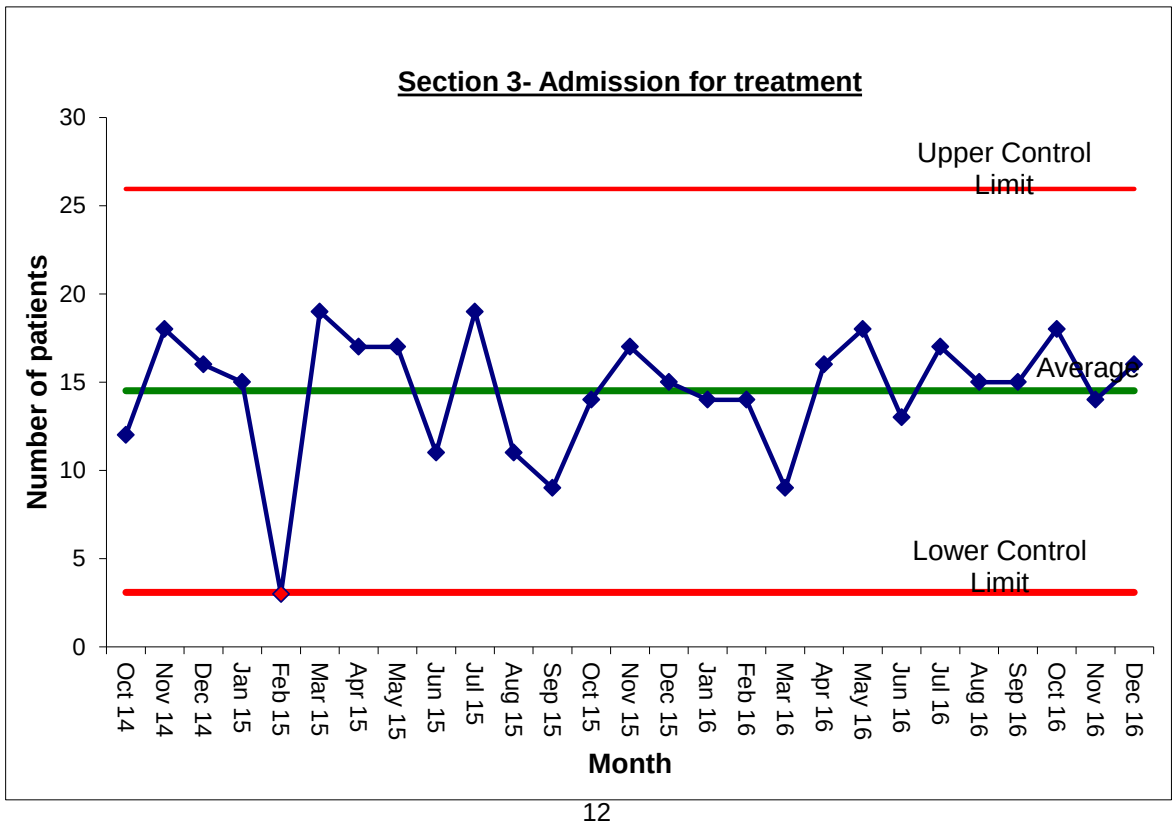

Outcome following section 2 during the period October- December 2016
6, 5%
1, 1%
7, 5%
35, 28%
45, 36%
32, 25%
Discharge Home
Section 3
Informal
Transfer out
Remain on section 2
MHRT Discharge

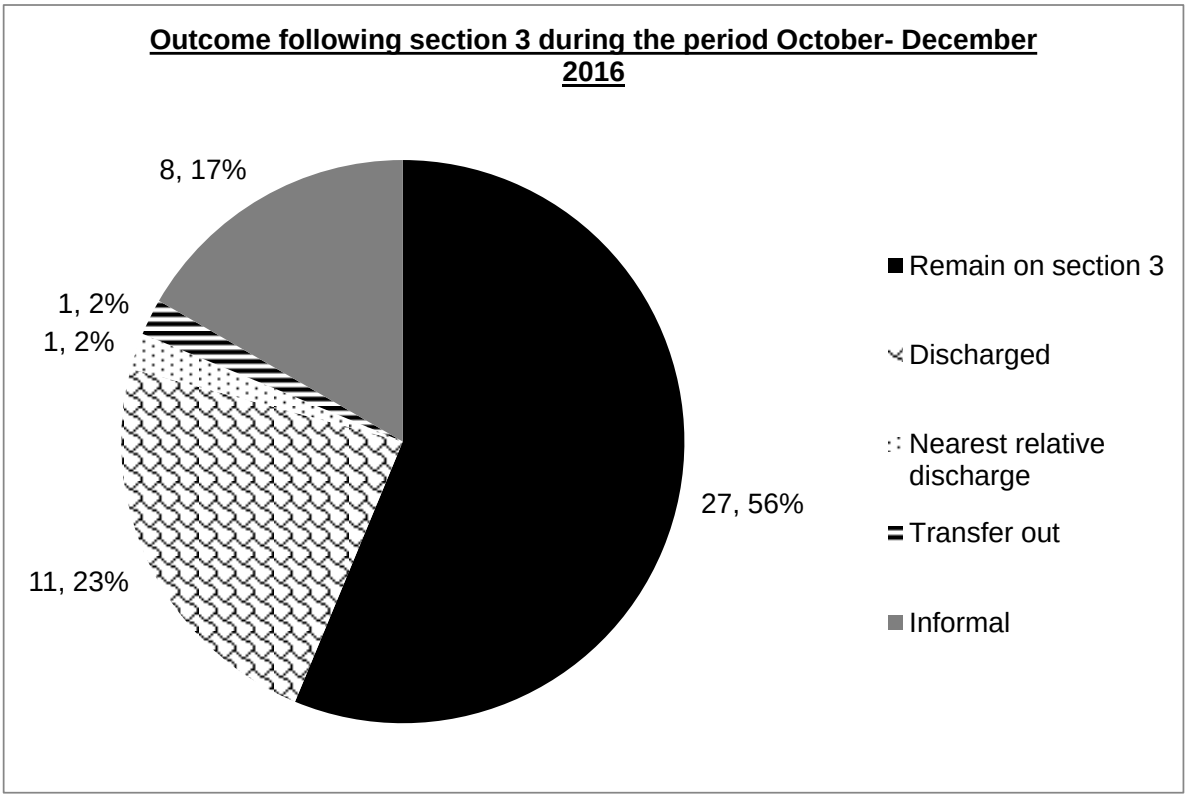
10.2

Section 3 – Admission for Treatment



10.2



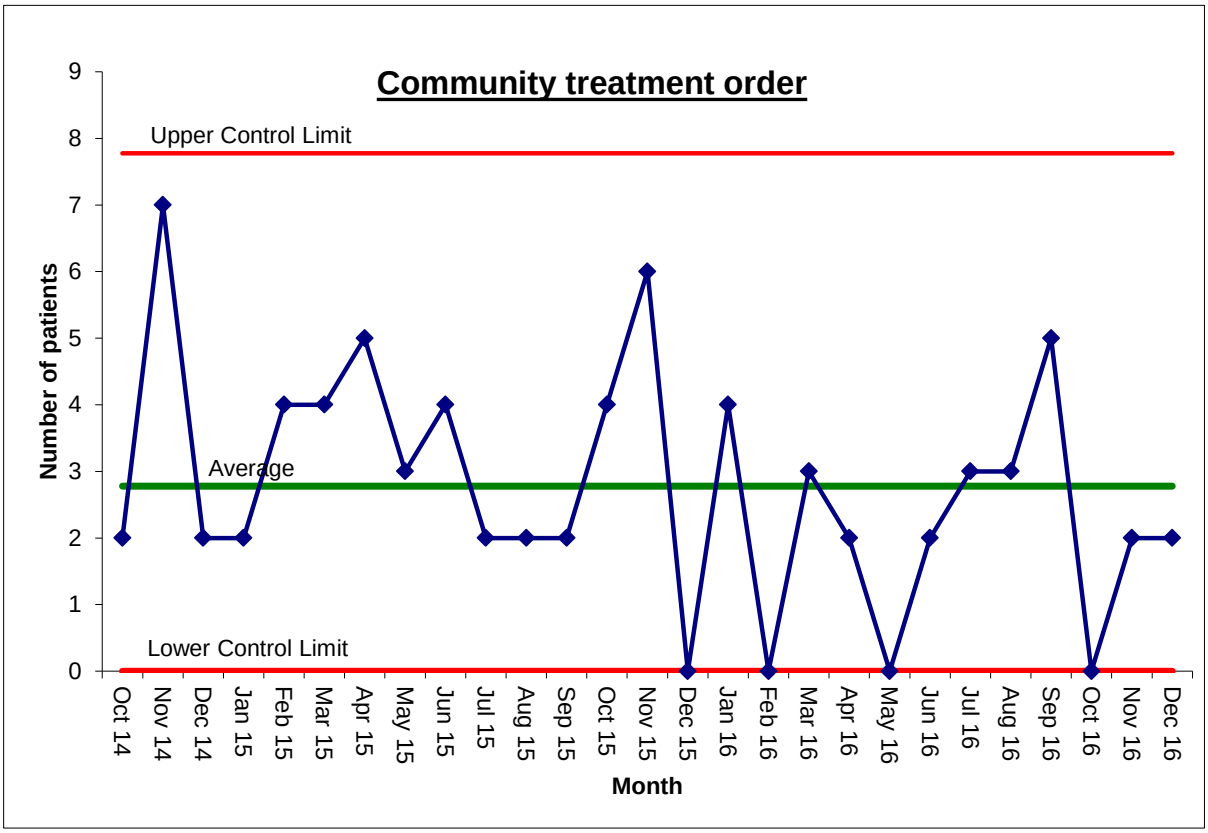

Outcome following section 3 during the period October- December 2016
8, 17%
1, 2%
1, 2%
27, 56%
11, 23%
Remain on section 3
Discharged
Nearest relative discharge
Transfer out
Informal

10.2

Community Treatment Order

During the period October- December 2016, four patients were discharged to Supervised Community Treatment (SCT).

As at 31st December 2016, 47 patients were subject to a Community Treatment Order (CTO).



10.2

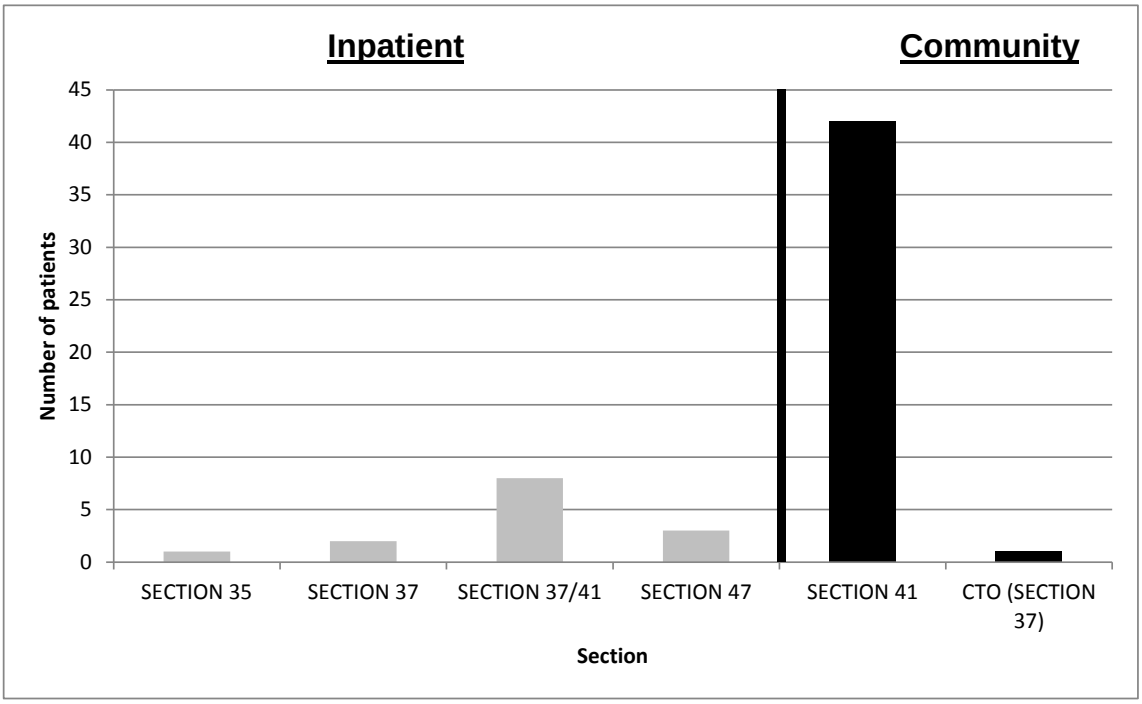
Recall of a community patient under section 17E

During the period October- December 2016, the power of recall was used on one occasion with the following outcome:

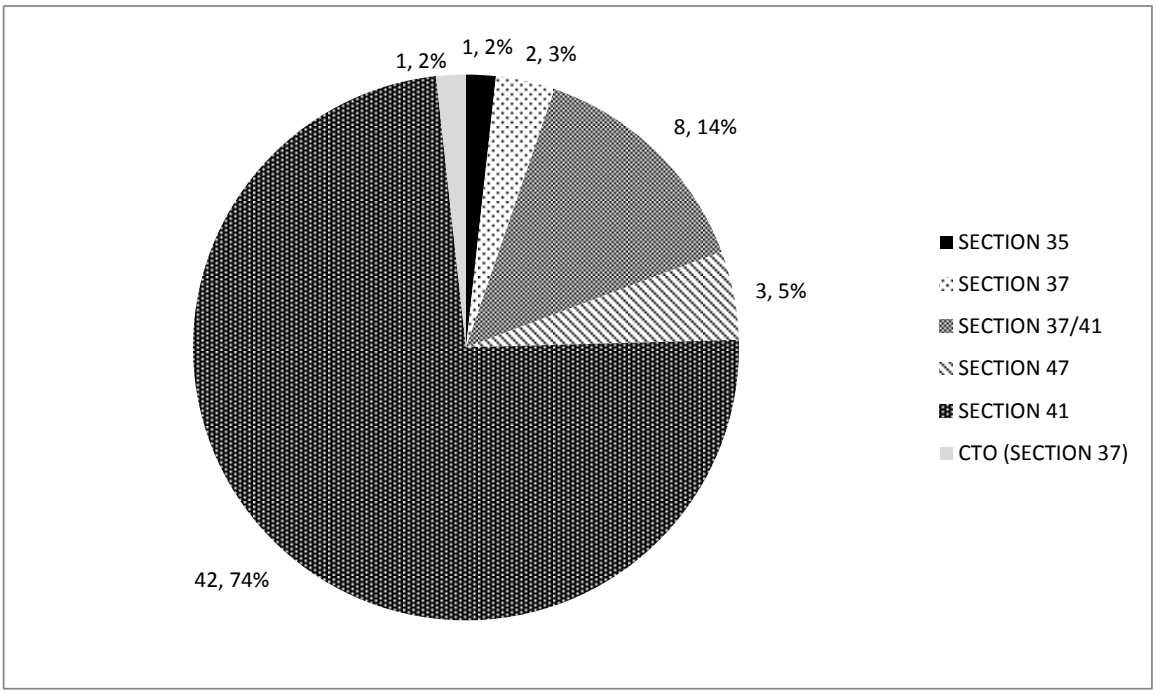
- One patient recalled to hospital and revoked.

Part 3 of the Mental Health Act 1983

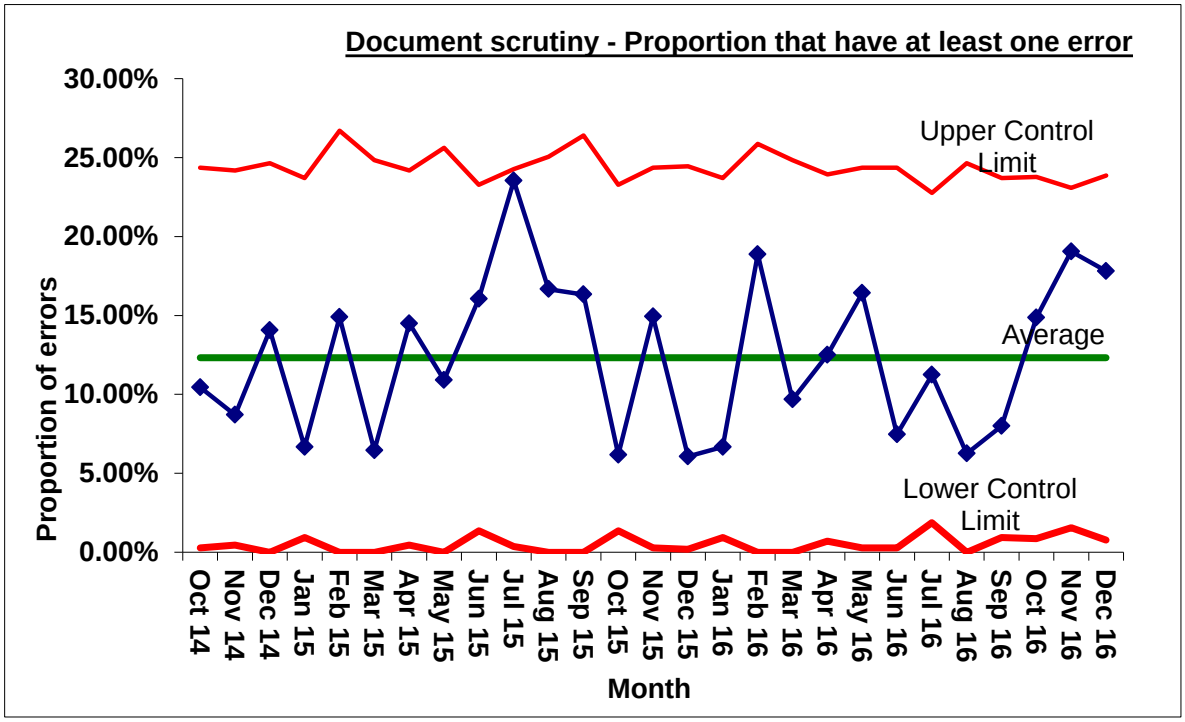
The number of Part 3 patients detained in Cardiff and the Vale University Health Board Hospitals or subject to Supervised Community Treatment/Conditional Discharge in the community as at December 31st 2016



10.2

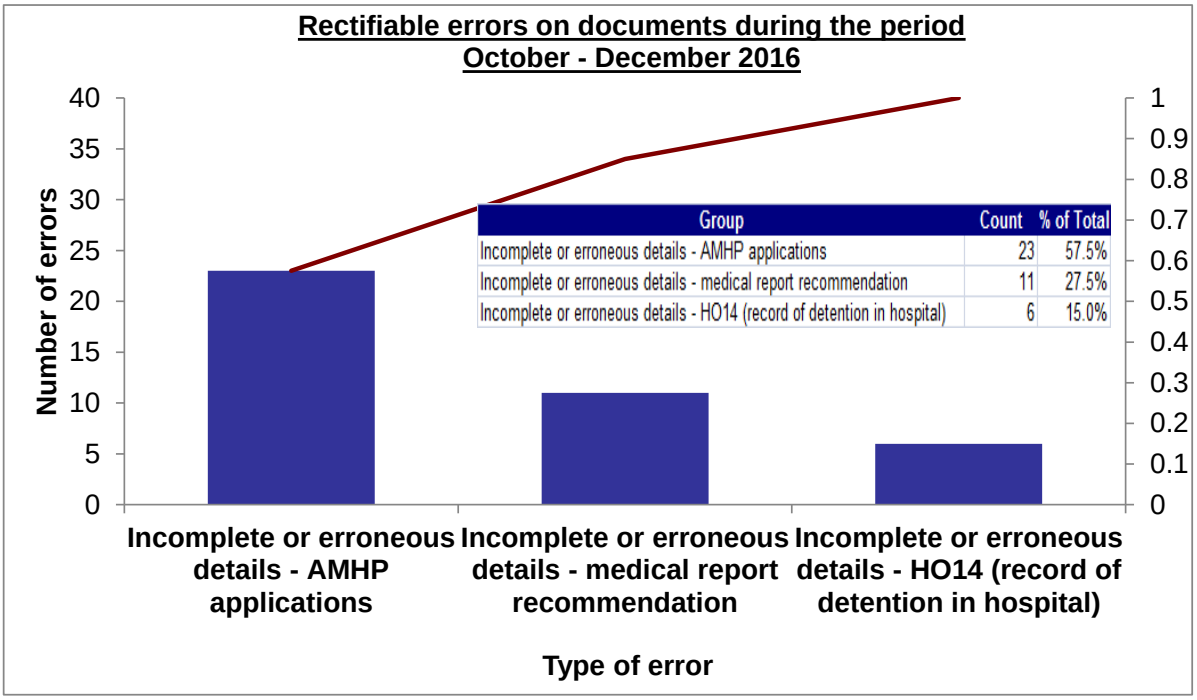


Scrutiny of documents during the period

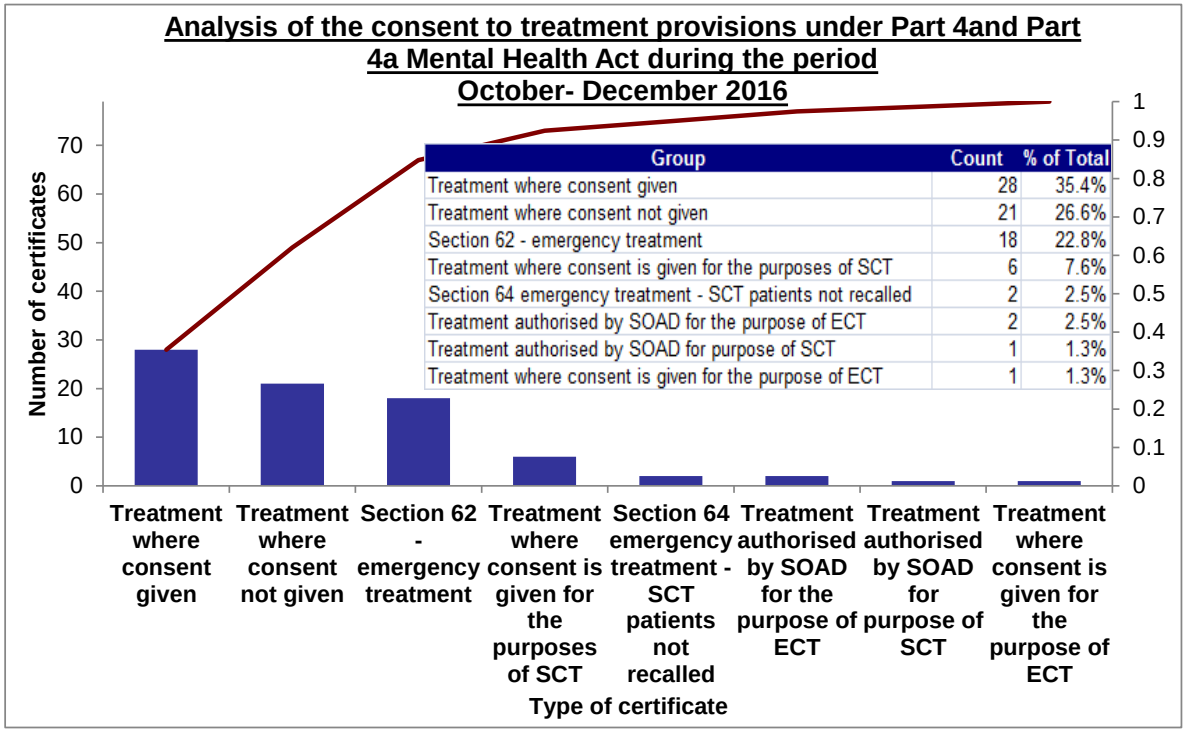


The chart above is a different type of control chart (P chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have narrower limit.

10.2



Consent to Treatment



Group	Count	% of Total
Treatment where consent given	28	35.4%
Treatment where consent not given	21	26.6%
Section 62 - emergency treatment	18	22.8%
Treatment where consent is given for the purposes of SCT	6	7.6%
Section 64 emergency treatment - SCT patients not recalled	2	2.5%
Treatment authorised by SOAD for the purpose of ECT	2	2.5%
Treatment authorised by SOAD for purpose of SCT	1	1.3%
Treatment where consent is given for the purpose of ECT	1	1.3%

Urgent treatment

10.2

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.

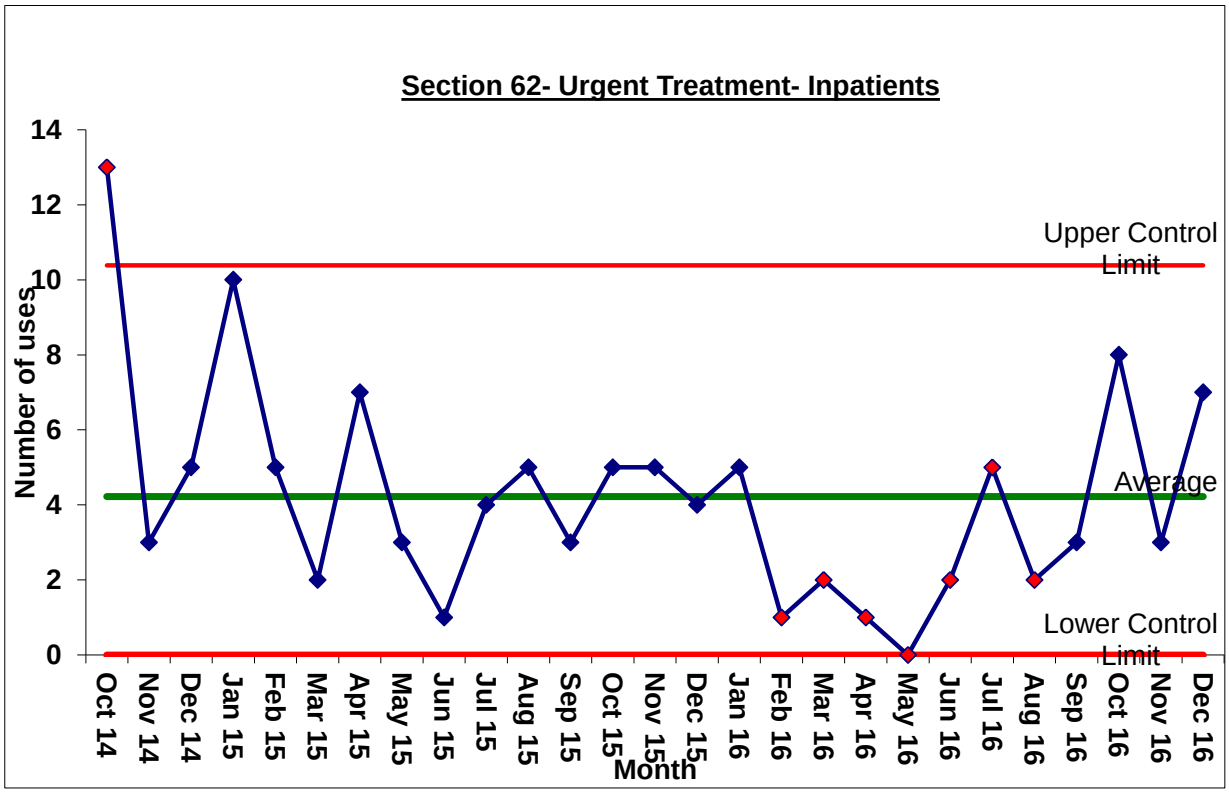
Urgent treatment is defined as treatment that is:

- 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:

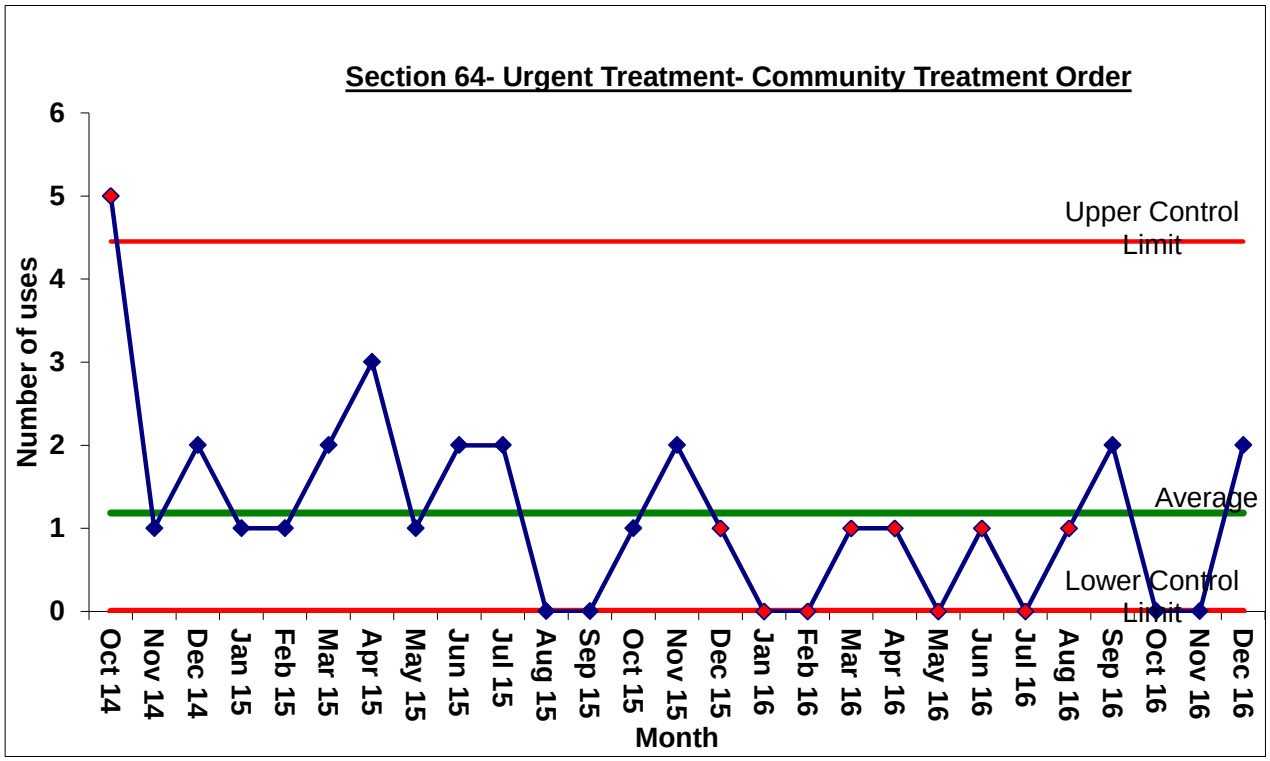
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been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



10.2

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

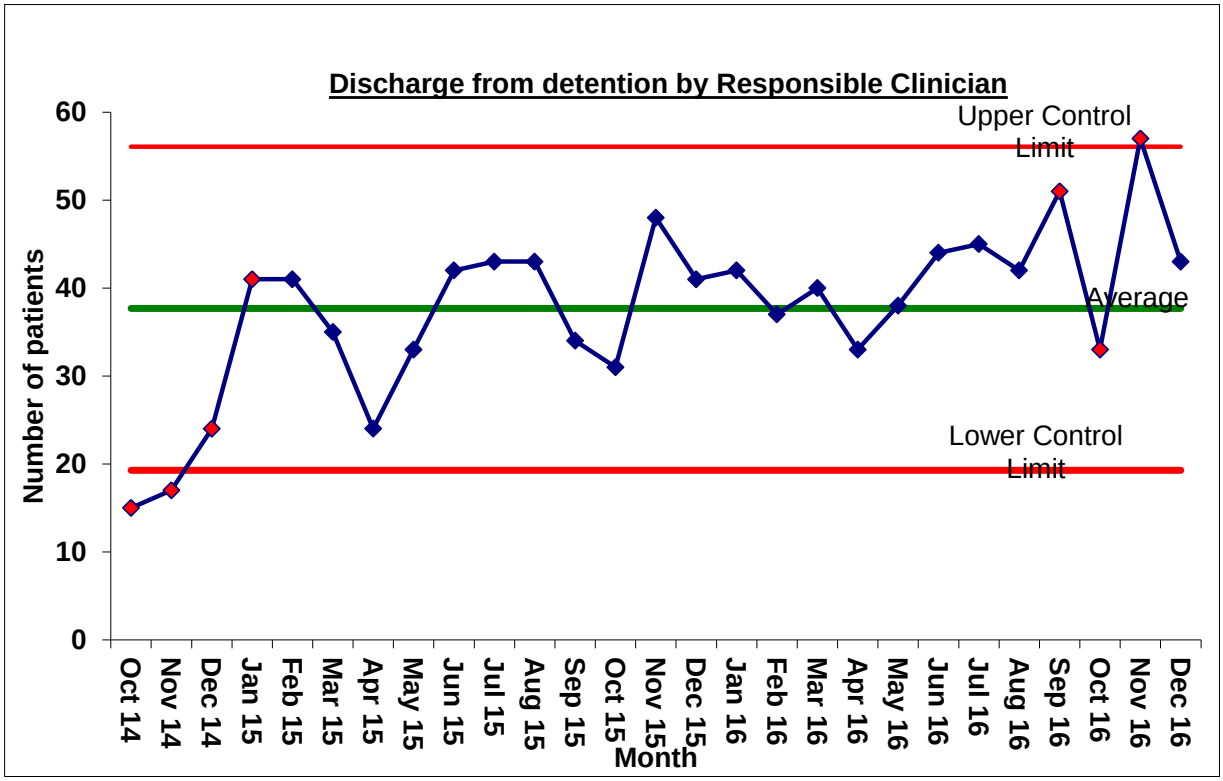
- Awaiting certification due to the three month consent to treatment rule - 8
- Emergency ECT treatment - 1
- Waiting certification for a change in medication - 3
- Patient withdrew consent - 1
- Lost capacity to consent - 3
- Awaiting certification due to revoke of CTO - 1
- Awaiting new certification following time limited CO3 - 1



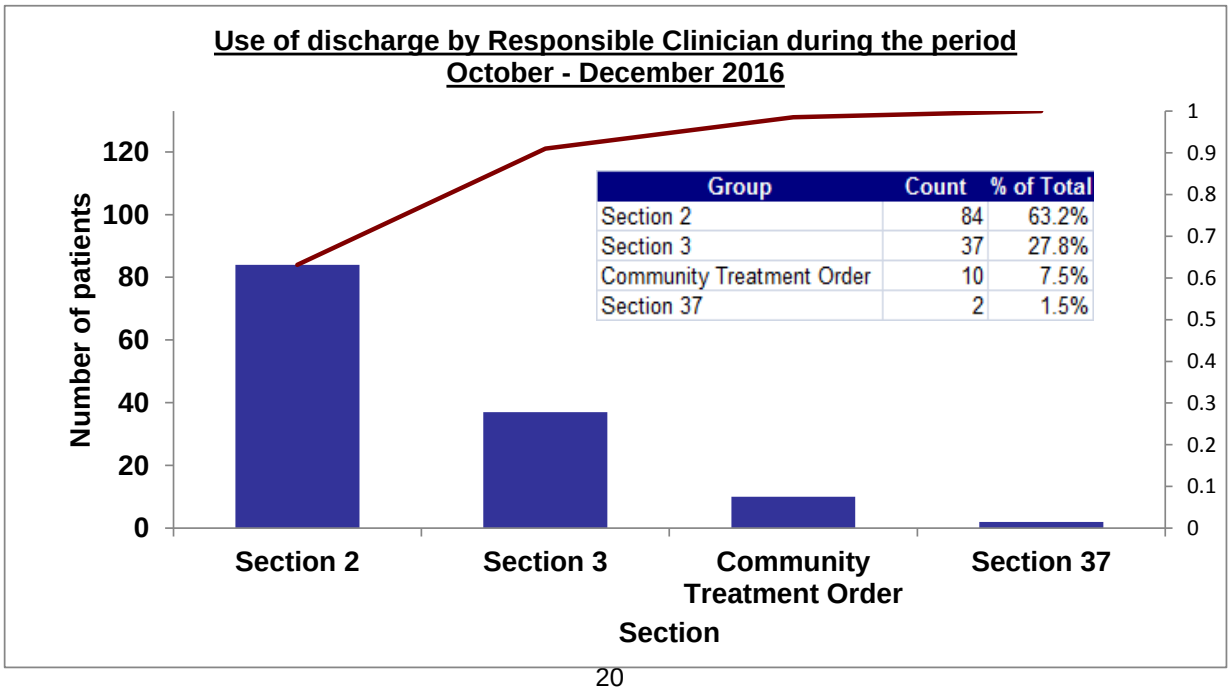
The above chart highlights that section 64 was used on two occasions during the period pending Part 4a certificate being provided by the SOAD.

10.2

Section 23 – Discharge

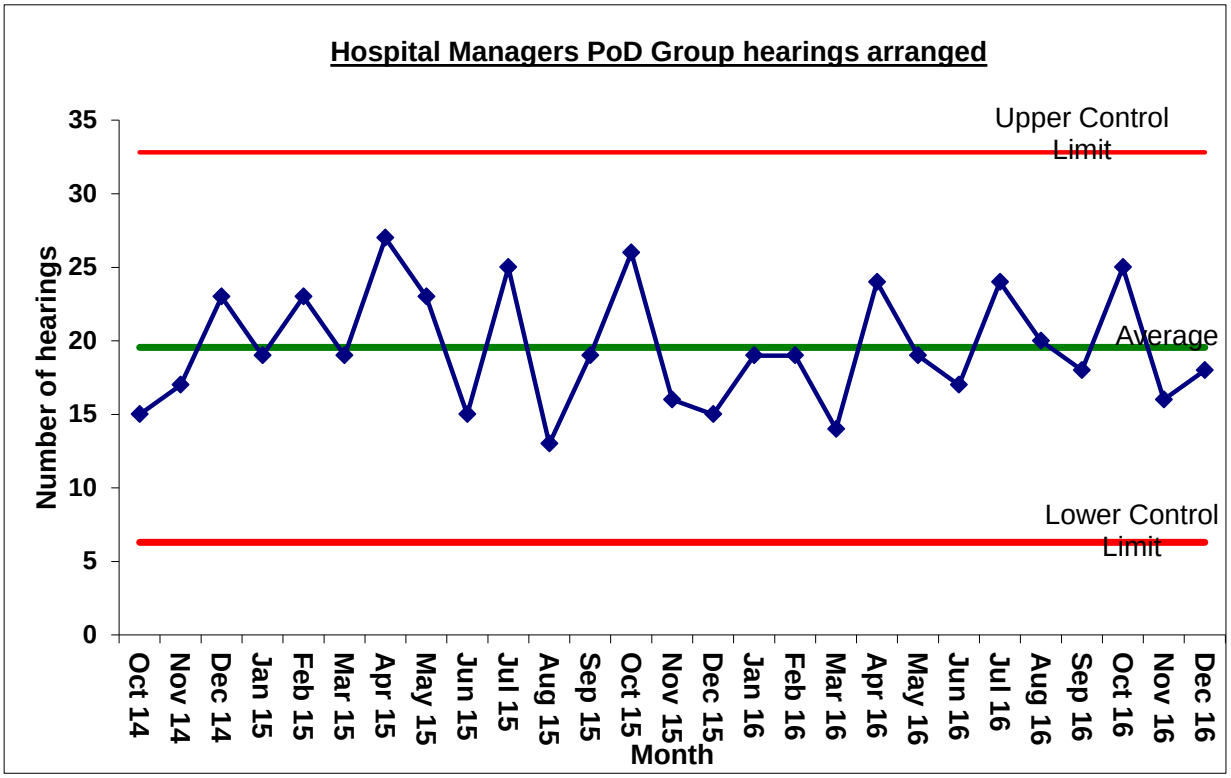


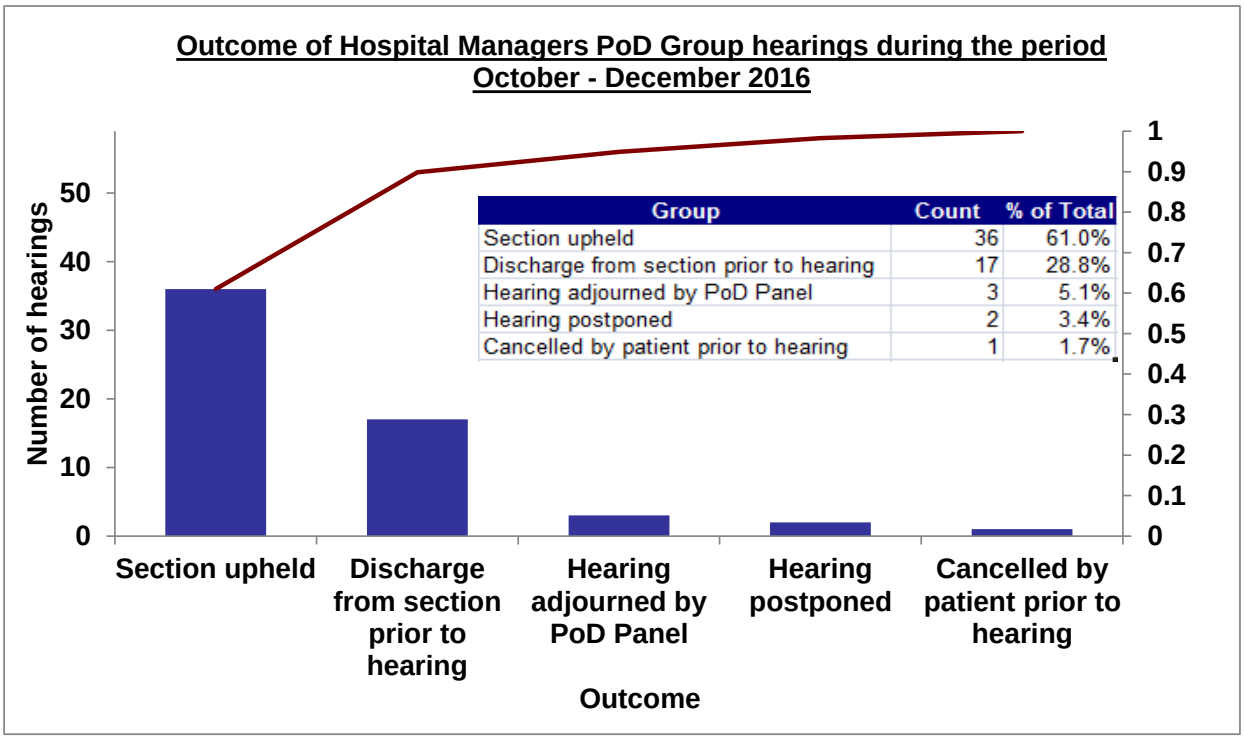
10.2



Group	Count	% of Total
Section 2	84	63.2%
Section 3	37	27.8%
Community Treatment Order	10	7.5%
Section 37	2	1.5%

Hospital Managers – Power of Discharge





Group	Count	% of Total
Section upheld	36	61.0%
Discharge from section prior to hearing	17	28.8%
Hearing adjourned by PoD Panel	3	5.1%
Hearing postponed	2	3.4%
Cancelled by patient prior to hearing	1	1.7%

10.2

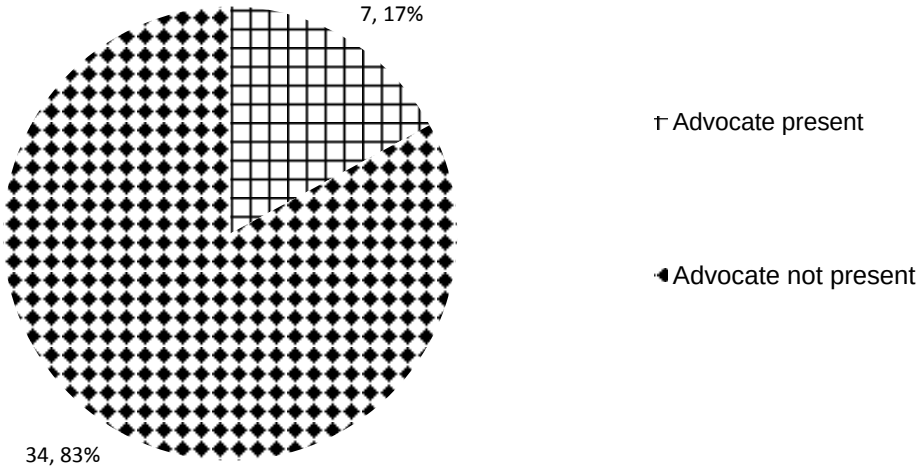
Two hearings were postponed for the following reasons:

- At the request of the patient- MHAM and MHRT arranged a day apart and therefore causing the patient distress.
- Concerns over whether patient had capacity to instruct an advocate or not.

Three hearings were adjourned for the following reasons:

- Query over capacity to instruct an advocate and reason for the hearing as the patient appealed but did not attend on the day.
- Social worker did not attend
- Advocate unwell and did not attend.

Number of patients represented by ASC during the period October- December 2016



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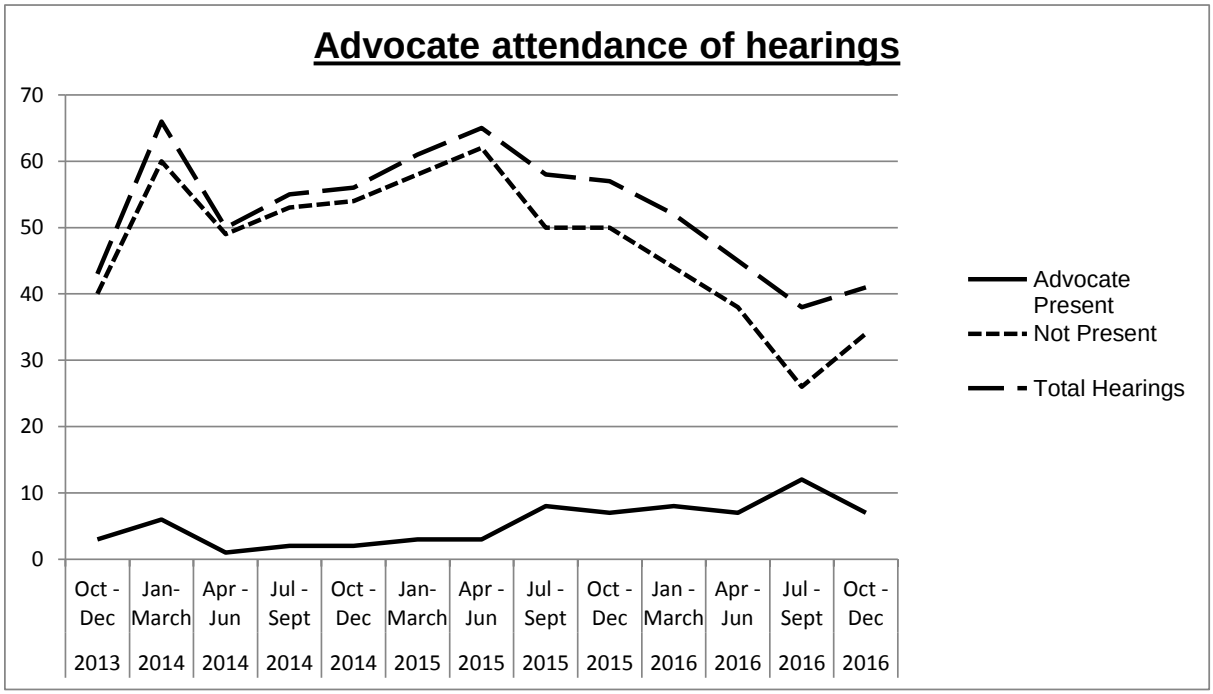
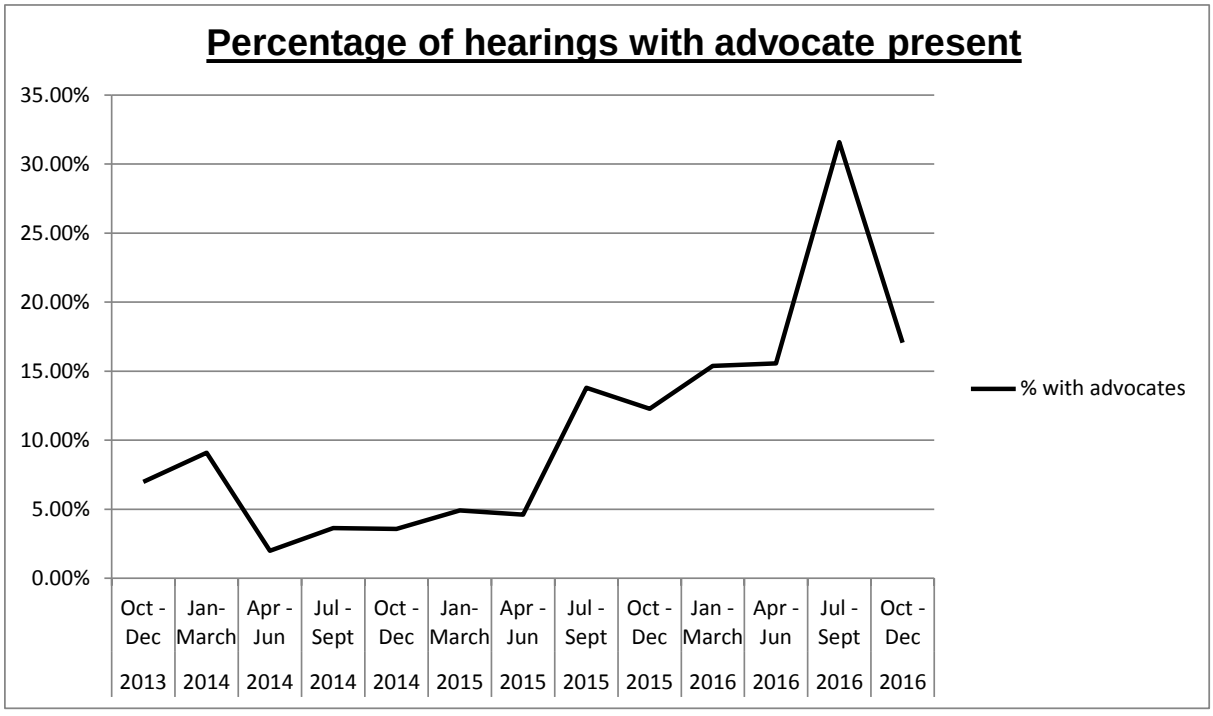
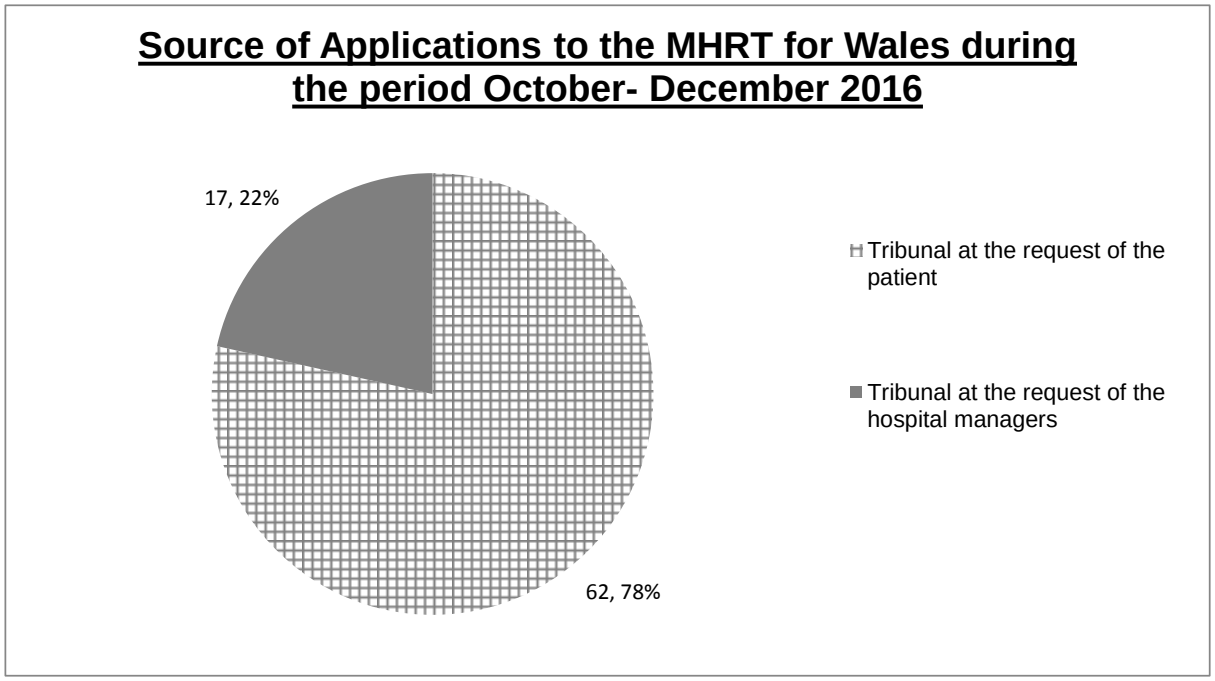
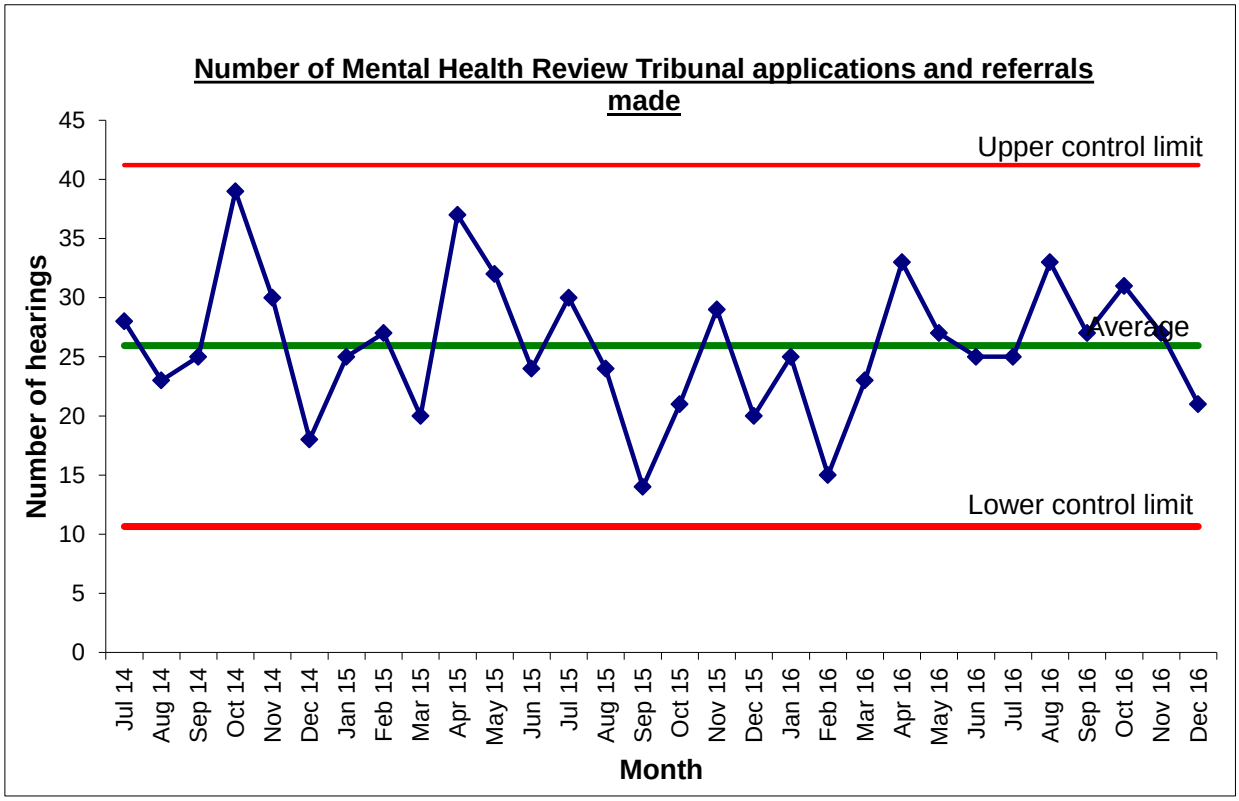

Advocate attendance of hearings
70
60
50
40
30
20
10
0
Oct - Dec 2013
Jan-March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan-March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
Advocate Present
Not Present
Total Hearings


Percentage of hearings with advocate present
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Oct - Dec 2013
Jan-March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan-March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
% with advocates

10.2

Mental Health Review Tribunal (MHRT) for Wales





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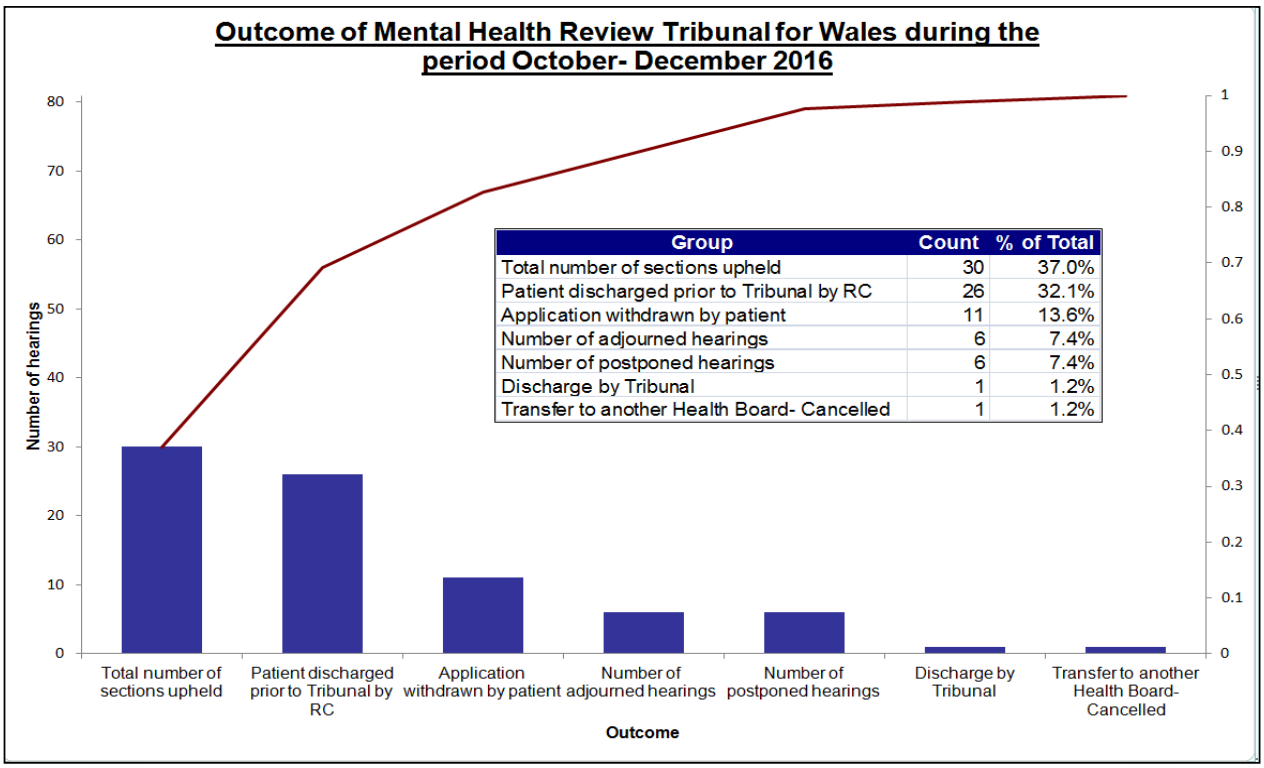


Group	Count	% of Total
Total number of sections upheld	30	37.0%
Patient discharged prior to Tribunal by RC	26	32.1%
Application withdrawn by patient	11	13.6%
Number of adjourned hearings	6	7.4%
Number of postponed hearings	6	7.4%
Discharge by Tribunal	1	1.2%
Transfer to another Health Board- Cancelled	1	1.2%

Six hearings were postponed during the period for the following reasons:

- Panel members unable to attend due to RTA
- On three occasions at the request of the legal representative
- Legal representative unavailable
- Responsible Clinician unavailable

10.2

Six hearings were adjourned for the following reasons:

- Social Worker did not attend due to confusion of timing/date of hearing.
- To enable the UHB to respond to a legal submission.
- Medical member delayed due to RTA- too late in the day to begin the Tribunal.
- At the request of the solicitor and patient- possible conflict of interest between patient and legal member of Tribunal panel.
- To allow time for legal representation to be arranged for the patient who had previously declined legal support.
- Patient physically unwell recently and wanted NR to attend who was not available on the day.

Summary of other Mental Health Act Activity which took place during the period October- December 2016

Exclusion of visitors

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

Section 19 transfers to and from Cardiff and Vale UHB

Eight patients detained under Part 2 of the Mental Health Act were transferred back to their locality health board from Cardiff and Vale UHB to a hospital under a different set of Managers.

Four patients detained under Part 2 of the Mental Health Act were transferred back to Cardiff and Vale UHB as their locality health board from a hospital under a different set of Managers.

Death of detained patients

None to report.

Section 117

Section 117 continues to be monitored by the MHA Department. As at 30 December 2016 Cardiff and Vale UHB maintain responsibility for 1604 patients eligible to section 117 after care.

During this period Cardiff and Vale UHB updated the 117 register to include a further 26 and discharged 28.

10.2

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.

Update section 117 aftercare Policy Implementation

Mental Health Legislation Committee

April 2017

Executive Lead: Chief Operating Officer
Author: Director of Operations and Delivery – Mental Health
Financial impact - NA
Quality, Safety, Patient Experience impact – Service User discharge from Specialist mental health services
Healthcare Standard Number 1 and 6 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Board/Committee is asked to:

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

SITUATION

There is a duty on health and social care providers to deliver aftercare under Section 117 of the Mental Health Act following discharge of patients from detention in hospital for treatment. The section entitles services users who have at any point been admitted to inpatient care under a Section 3 treatment order, to have this indefinite period of mental health secondary aftercare unless discharged from the Section.

This does not mean that those eligible receive a different or enhanced service, care plan or post discharge arrangements, only that they are entitled to the same services as anyone else on secondary care (CMHT) caseloads, but for an indefinite period or until discharged.

BACKGROUND

S.117 aftercare was introduced into mental health services during the initial redesign phases of mental health services as a measure to stop or reduce people falling through the services 'net'. Recent Mental Health Measure legislation, which encourages more flexibility for service user pathways between primary and secondary care service, conflicts in part with these S.117 rules which make it difficult to discharge back to primary care, even when care needs are relatively low. This has prompted national discussions in this area.

The Mental Health Clinical Board commenced a review of central 117 processes in 2013/4 which was supported by Director of Nursing prompted follow up review by internal audit. This report states that the Cardiff and Vale region at that time had 'no assurance' in terms of 117 processes, although much progress had been made in this area.

ASSESSMENT

During the 2013/4 period the Head of Operations and Delivery for the UHB established an internal multi-agency project group to manage and monitor any actions in developing internal processes. This project group includes membership from the Clinical Board Nurse, Clinical Director, Mental Health Act administrator, Local Authority and operational representation. The group's objectives and actions between 2013 and 14 as well as in response to the recent internal audit report were:

Using the work already in progress in addition to the recommended actions suggested by internal audit, this paper describes the phased and ongoing efforts to develop:

1. centralized integrated electronic processes to identify people eligible for S.117 aftercare
2. Centralized integrated electronic processes to inform practitioners which of their service users on their caseloads are eligible for 117 aftercare.
3. Information and guidance to practitioners on what their responsibilities are in relation to 117 aftercare
4. Centralized integrated electronic and manual processes to monitor compliance with s117 aftercare.

Update on these actions:

1. ***Centralized integrated electronic processes to identify people eligible for S.117 aftercare*** – Completed
2. ***Centralized integrated electronic processes to inform practitioners which of their service users on their caseloads are eligible for 117 aftercare*** – This is now established and the Mental Health Act administrator now provides a quarterly report to the Director of Operations and the Clinical Governance committee on the individual patients subject to117 aftercare- this is circulated to all clinical teams to be cross reference by practitioners. There remain a small number of individuals from old records that are being gradually taken through a local protocol to off list them from 117 aftercare, having moved from the area or other reason. This number has reduced from over 600 in 2014/5 to 144 in March/April 2017. The ongoing work to reduce these numbers to nil through a now established process will continue with a view to complete this work over the next18 months. A 117 policy is now in place from 2014 requiring an update shortly. This information also includes an electronic record of the date of last know review of care of the service user - which is especially flagged if this has not happened for over 1 year which would be considered the maximum time elapsed for a review. In addition, IT Support has been sought to ensure these eligibility lists will be alerted to clinicians on service users PARIS records. It has been agreed that where service users are s.117 eligible, this will be flagged 'on every screen' on PARIS.

3. **Information and guidance to practitioners on what their responsibilities are in relation to 117 aftercare.** A Local Protocol has been updated in draft and circulated to all clinical teams - Training is ongoing – there is further training identified for Integrated team managers to be delivered by the Mental Health Act department over two sessions. Draft Protocol describing the discharge from s117 for untraceable service users in use following approval via a training session by the Community senior nurses. Care plans are regularly audited for evidence of 117 aftercare. There is currently an established and long standing method of care and treatment planning and review training delivered centrally with standard tools.
4. **Centralized integrated electronic and manual processes are in place to monitor compliance with s117 aftercare.** Mental Health community clinical teams undertake monthly audits of at least a sample of 10 service users to include all services users discharged from hospital since the last audit and a random sample of others. Audit results to be reported through Clinical Board via the directorate performance meetings and be part of the mental health measure reporting. The audit includes whether the Care and Treatment Plan (CTP) reflects the service users current needs, whether a copy has been offered to the service user or others where appropriate, whether 117 aftercare has been appropriately recorded on PARIS and whether the CTP has been reviewed in a timely way.

Update – Police Crisis Concordat for Mental Health

Mental Health Legislation Committee

April 2017

Executive Lead: Chief Operating Officer
Author: Director of Operations and Delivery – Mental Health
Financial impact - NA
Quality, Safety, Patient Experience impact – Improves section 135/6 outcomes
Healthcare Standard Number 1 and 6 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Board/Committee is asked to:

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

SITUATION

The Police are facing increases in crisis type demand on their front line services, akin to the experience of other public sector organizations such as health, ambulance and the social services. A proportion of this involves people presenting to police services in crisis related to their mental health, well being, social circumstances and addiction issues. These issues are often multiple and complex.

Alongside the police, local UHB mental health, ambulance, social services and EU departments have seen increased crisis activity related to the same, with some individuals presenting to services repeatedly.

Efforts have been made by statutory services to collaborate and manage this demand, such as the Alcohol treatment Centre, the mental health/ambulance triage system, models of Mental Health liaison in EU, the frequent fliers project in EU and so on.

Part of the Welsh Police Force's response to their increasing demand (due to the significant amount of time taken up by the police related to mental health and alcohol issues) was the police-led development of the 'crisis concordat' (see attached). The concordat predominantly focussed on initially reducing 135/6 arrests assessed in police custody and then reducing the number of 136 arrests overall. This report gives an update on the implementation of this action plan.

BACKGROUND

The police are concerned with the amount of time it spends on what it describes as mental health crisis work or work that was being undertaken which had an emotional and crisis context. This work does not appear to be in the main the core business of secondary care mental health services and is seen by the Mental Health Clinical Board as an area of demand that sits between the police, social care, addictions services, emergency health and housing services. With few options for the police to access support other than via 135/6 mental health act, there were high numbers of people being detained under these sections, both in custody and brought to mental health emergency services.

Within secondary mental health this appeared as a very low conversion rate of 135/6 arrests that were admitted into Mental Health services. This number is the lowest in Wales at approximately 10% with also the highest number of 136 arrests in Wales in Cardiff and Vale. This suggests a number of issues ranging from lack of police experience, poor take up of mental health based crisis training, local police policy towards reducing the use of drunk and disorderly and public order offences, lack of police choice in disposing of mental health related work etc. Whatever the reasons, the police felt that it was a lot of their time taken up with work they perceive as other services' core business.

ASSESSMENT

The draft concordat attached was seen by the various agencies to contain a range of initiatives that would address this demand and was circulated in Wales a number of times through 2015. In general, the Mental health Clinical Board agrees with the content and the initiatives described by the police, that where people require detention by the police under 135/6 that this should be always be a supported decision and a last resort, particularly where people are intoxicated beyond the ability to assess. The UHB also agrees with the police that where 135/6 arrest is justified, that as few as possible should be assessed in police custody. The focus of the police concern and their outcomes, was to reduce the number of 136 assessments undertaken in police custody (50:50 UHB and Police at that stage) then to minimize the number of people arrested under 136 overall.

To support the police in their decision making through the implementation phase of the concordat, Helen Bennett was contracted by the police and supported by C&V, to complete a literature search of the different collaborative models available to achieve these objectives and make recommendations on what and how to implement – the attached concordat is the completed work.

Some difficulties have been experienced with the constitution of project implementation work as it was also recommended by the police that the Mental Health Clinical Boards in the region fund these options. The MHCB and adjacent UHBs have repeatedly asserted that any developments within the plan required resource support from the full range of stakeholders.

In the meantime, the oversight of the implementation of the concordat has been taken into the agenda of the regional mental health and learning disabilities commissioning group chaired by a forensic psychiatrist in ABMU and supported by a WG policy lead. The implementation team for the concordat has been agreed to sit under and report to that meeting which has representation from the local UHB mental health services and others. A lead project officer has been appointed by the police to oversee the implementation of the concordat and its various work-streams, for which requests for membership will be circulated shortly.

The Mental Health Learning Disability and South Wales Police Planning Groups has now decided that this work will be sub-divided into five domains:

- Training
- Liaison/triage
- Place of safety
- Alternative place of safety
- Incident/case review/transport

Mr James Thomas will have oversight of all these groups and would also be chairing the training sub-group.

The police are now looking populate the appropriate level of management and healthcare professionals into these sub-groups who are able to deliver what are effectively “task and finish” groups.

Progress of these initiatives will be presented before the Welsh Assembly Government on the 18th May 2017.

Mental Health Crisis Call Concordat Delivery Plan: April 2016 – March 17

Improving the care and support for people experiencing or at risk of mental health crisis in respect of 135/136 of the Mental Health Act

Custodian of the Delivery Plan: Area - Mental Health Learning Disabilities & Criminal Justice Partnership (Planning) Board covering the South Wales Police geographical area

Introduction

The Mental Health Crisis Care Concordat is a shared statement of commitment, endorsed by senior leaders from the organisations most heavily involved in responding to mental health crisis. As partners we agree to work together and to intervene early, if possible, to reduce the likelihood of people presenting a risk of harm to themselves or others because of a mental health condition deteriorating to such a crisis point.

The Concordat sets out how partners and 3rd sector can work together to deliver a quality response when people with acute mental health crisis, need help, have contact with the Police and who are likely to be detained under section 135 or section 136 of the Mental Health Act 1983.

This delivery plan sets out how the Crisis Care Concordat will be delivered across the South Wales Police Force Area. The action plan has been jointly developed by members of the Mental Health Learning Disabilities & Criminal Justice Partnership (Planning) Board, who have responsibility for delivery of the aims set out in the Concordat. The Board is co-chaired by Rob Goodwin (ABMU) and Mark Brace, Assistant Police and Crime Commissioner. A number of workshops were convened with strong attendance to develop and agree the delivery plan. Individual members of the partnership board have accepted responsibility for communicating the process and outcomes to their host organisations.

The delivery plan reflects a shared multi-agency commitment to working collaboratively to deliver change. The plan establishes a set of outcome measures, which delivers a seamless pathway of care for vulnerable individuals experiencing Mental Health issues.

The measures established within the plan have been developed in partnership with service users, and reflect the individual nature of mental health crises, and the need for service specific barriers to be broken through in new and transformational ways. It is acknowledged that delivery of this plan will require further, more detailed consultation with service users regarding their experiences and perspectives in order that the plan is truly representative. This will include the use of advocates and how they can contribute to the delivery of the plan.

There will also be further work required to map out the potential contribution from 3rd sector organisations who have a significant part to play in the delivery of the concordat.

What will the delivery plan do?

There is a growing demand for mental health services across Wales and that there are limited resources available to meet this demand. The Welsh Government has recently announced a reduction in waiting times for people wanting to access treatment for mental health problems, however, there is still issues for individuals who need support from appropriate and effective services[1]. The Crisis Care Concordat identifies the need to use alternatives for individuals in mental health crisis.

Current evidence in the Cardiff and Vale UHB area suggests that 45% of detentions under S136 of the Mental Health Act 1983 receive no further action following assessment[2]. The individual's experience of the current system of detention under S136 involves being transported to a place of safety that is either a hospital or a police station. A full Mental Health Act assessment is then convened in order to find out if the individual has a mental health problem and requires admission.

This delivery plan replaces regional 'Section 135 / 136' delivery plans and places a focus on the following indicative performance indicators:

- % Reduction on overall rate of use of Section 136
- % Ratio – Achieve a Health/Police place of safety ratio of (85/15)
- % Zero tolerance to child and young person coming into police custody unless under exceptional circumstances of violence
- Strategic development of alternative places of safety (non-Health/Police)

[1] New measures to ensure faster mental health treatment in Wales. http://www.wales.nhs.uk/news/39188
[2] Early intervention to prevent individuals with mental health and/or learning disabilities in crisis entering the Criminal Justice System (2015) South Wales Police

Governance

The success of the plan will be measured through quarterly meetings of the Mental Health Learning Disabilities & Criminal Justice Partnership Planning Board, which is co-chaired by representatives from Health and the Police Force, in demonstration of the co-operative commitment to deliver progress. The Board will receive progress reports from nominated leads, will scrutinise progress and will provide robust challenge and leadership, to drive forward change.

An evaluation framework will be established, and commissioned for external completion to provide an independent analysis of success and areas for continued improvement.

A communications strategy will be developed to ensure there is consistent communication at strategic and operational levels, in a language relevant to audiences within health, police, ambulance and local government.

Actions & Outcomes

The plan establishes a set of actions and outcome measures to inform activity at a regional level, these outcomes are:

- To provide an integrated training framework across all relevant agencies, to improve awareness and decision making.
- To improve multi-agency working at the point of crisis through the establishment of clear referral pathways and pathways of care.
- To implement new models of care which provide safe places for treatment as an alternative to Section 136.
- To agree protocols for places of health based safety where hospital is the only viable option, and a protocol with CAMHS to ensure every child is appropriately safeguarded and protected within a health environment.
- To create a multi-agency review framework to ensure services are responsive to need and individual systems are working together.
- Development of a nationally consistent approach to dealing with people in crisis who either are intoxicated or displaying an unmanageable risk of violence.
- Existing 136 joint policy will need to be reviewed in light of the delivery plan.

Points of Collective Commitment by Partners

- To work to reduce the use of powers of detention under section 135 or 136 of the Mental Health Act 1983 ("the MHA") generally and to cease to use police custody suites as a place of safety, except in exceptional circumstances such as significant violence; and never for a child/young person under the age of 18.
- To ensure there is access to mental health professional advice at the point of crisis, available 24 hours each and every day.
- Police vehicles will rarely be used to convey people in crisis save for the most violent of individuals and only exceptionally to transport people between NHS facilities.
- NHS Transport or other health vehicles (not necessarily an ambulance) should be commissioned to convey people to hospital who are in mental health crisis.
- The use of any restraint will accord with best practice and be the least restrictive as applied to health settings; and will comply with all appropriate guidelines issued by the NHS and the College of Policing.
- To adhere to the Mental Health Act 1983 Code of Practice for Wales (the Code) guidance in relation to the use of powers of detention under section 135 and 136. Health and local authority partners are to ensure adequate provision of facilities for section 135 and 136 detentions for both adults and young people.
- Partners should agree where assessment of intoxicated individuals can safely take place in health based settings and their needs appropriately met.
- If a young person under 18 is detained under section 135 or 136 and taken to a police station for assessment, a serious untoward incident will be recorded allied with an agreement by partners to undertake an immediate case review to determine whether this could have been avoided in order to learn from that incident.
- MHA monitoring groups within health boards will review every section 135 and 136 detention within police custody to determine its appropriateness.
- Partner agencies will share relevant, need to know information, in the interests of patient and public safety. The collection of data such in relation to section 135 and 136 detentions is reported accurately.
- Partners and the third sector should be supported to widen their ambition in developing 'new' places of safety and providing alternatives to in-patient care at all stages e.g. sanctuary houses, drug and alcohol support.
- Monitoring delivery of local action plans in relation to section 135 and 136 as required by this Concordat, will be reviewed by local Mental Health and Criminal Justice Partnership Boards

	How will we do it?		How will we know?	Who is Responsible?
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency Time -scale**
Outcome 1: Better Training and Awareness of Police Officers in Mental Health (and Learning Disability) *(To provide an integrated training framework across all relevant agencies, to improve awareness and decision making).*				**April-March 2016/17**
1.1 Development of a partnership training plan.	Plan for joint police / LHB/LA/WAST/ 3rd sector multi-disciplinary training; to be developed by new training sub group, with named representatives from each partner organisation. Agree syllabus and method. This could include staff exchanges and desktop exercises with partners.	To include awareness of local mental health and substance misuse services and how to engage them. Understanding of locally agreed roles and responsibilities. Training package to include feedback from service users. Specialist areas to include fitness for detention, interview, Mental Health Act and Mental Capacity Act.	Number of staff attending training and positive evaluation of training and briefings. Emphasis on first responders. Training will incorporate perspective of service users.	MHCJPB Police/LHB/LA/WAST /YJB / 3rd sector
1.2 College of Policing products are implemented during 2016/17.	Police area to deliver Authorised Professional Practise (APP) requirement.	Circulate content of APP to partners.	% Volume of delivery to police officers.	Wales Chief Police Officer Group
1.3 Develop *the decision making mobile app (lication) for police officers.*	Project outlined and developed – funding to be confirmed and pursued, with a view to the APP having a wider potential for partners and service users.	Consult with ICT / Project Fusion regarding options. Focus groups to be held in June 2016 with police officers to help develop the application.	Application to be rolled out to police officers. The mobile app will enable police officers to make evidenced based decisions in real time to assist when an individual is in mental health crisis. It will give clear pathways for the individual, which can be recorded to support the police officer.	PCC to confirm responsibility.

	How will we do it?		How will we know?	Who is Responsible?
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency** **Time-scale**
• **Outcome 2: Better liaison between police officers and mental health practitioners at the point of crisis.** *(To improve multi agency working at the point of crisis through the establishment of clear referral pathways and pathways of care).*				**April – March 2016/17**
2.1 Develop clear communication pathways between the police and local adult and CAMHS crisis and / or mental health teams to assist in the application of s135 / 136. (Aspiration is for this service to become 24/7).	Feedback from first responders to the local CJ liaison groups to report on the provision of prompt and effective advice. To include access to the Health Board forces veteran's service.	Circulation of local adult and CAMHS crisis and / or mental health team contact information.	Crisis and / or mental health teams to monitor the number of calls from local police and the outcomes, which will be mapped against the use of s135 / 136. This task will be undertaken by the local CJ teams.	MHCJPB/Police/LHB/LA
2.2 Police Forces (in partnership) to consider introducing a triage system suitable for their respective areas.	Consultation with partners; options appraisal based on evidence from across UK. E.g. include access to WAST clinical desks and development of multi-agency representation within the Police Public Service Centre (PSC).	Alternative pathways are understood, utilising clinical advice and live antecedent history of service user. Develop a triage scheme for South Wales based in the PSC to include ambulance service and mental health nurses on high usage days and nights (Thurs, Fri, Sat and Sun) nights and all day at the weekend	Delivery of local Triage scheme(s) agreed by Board. To provide clear detailed timely information and advice from one place to reduce the time when an individual is in crisis and to link quickly with appropriate help.	PCC/Police/LHB/LA/WAST/ 3rd sector
2.3 Improve Information Access: accurate flagging of intelligence (warning markers) and updates on those with MH issues on Police database, and ensure care and treatment plans are accessible to partners when required.	Areas to use existing information sharing protocols (ISP) and to ensure maintenance of database, designed to provide safeguards.	Continue to use ISP with all partners to ensure the timely and effective sharing of information. Ensure that partners within the PSC have access to Health and social care databases. Escalation procedures to be identified between partner agencies.	Clear evidence of informed decision making so that those in crisis receive appropriate crisis care at the earliest point.	All partners / 3rd sector

2.4 Develop signposting materials with partners and service users.	Local Community Voluntary Service (CVS) organisations to help develop local packages and incorporate suicide and self-harm prevention plans.	Circulate relevant details front line staff and service users.	Seek to monitor the uptake of such services by those in a MH crisis.	Local CVS
2.5 Review the joint Section 136 Mental Health and Learning Disability policy.	Consultation with partners to develop changes in practice and the implementation of the new Police and Crime Act 2016.	Agree a framework for the development of a joint policy recognising the requirement to meet the needs of partners and persons with lived experience.	Clear evidence of better practise so those in crisis receive crisis care at the earliest point.	MHCJPB/PCC/Police/LHB/LA WAST/3rd sector
		Appropriate use of section 136 voluntary assessment.	Monitor material effect of voluntary assessment on services and service users.	MHCJPB/PCC/Police/LHB/LA WAST/3rd sector
		Considered practise of police waiting with intoxicated persons at a health place of safety.	Monitor and map the number of intoxicated persons received at a health place of safety.	MHCJPB/PCC/Police/LHB/LA WAST/3rd sector
		Adopt all age approach to the management of persons in crisis and review section 136/section 46 Children's Act 1989.	Clear evidence of referrals to Social Services.	MHCJPB/PCC/Police/LHB/LA WAST/3rd sector

	How will we do it?		How will we know?	Who is Responsible?
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency Time-scale**
Outcome 3: Suitable alternatives to S136 at the point of crisis *(To implement new models of care which provide safe places for treatment as an alternative to Section 136).*				**April-March 2016-2017**
3.1 Local partnership commitment to support development of alternative places of safety.	Review, consider and implement the recommendations SWP-PCC's upstream intervention plan (applicable pan-Wales).	Partnership approach in developing sanctuary style 'safe house' as an alternative place of safety. This could include a substance misuse recovery element.	Diversion of s136 cases into newly provided sanctuary provision provided by the third sector. Provide a peer led service to reduce stigma, medicalisation and decriminalisation for the individual. Help individuals build resilience for the future and provide timely intervention and support.	PCC/LHB/LA's/Third sector
3.2 To review the contribution of the Swansea help point and the Cardiff Alcohol Treatment Centre (ATC) in the reduction of alcohol related s136 detentions.	Review in partnership with all relevant partners.	Ensure staff are aware of relevant pathways for specialist Mental Health services when needed as these centres are not set up to provide this service.	Reduction in the amount of s136 Mental Health cases.	PCC / LHB / Police / 3rd sector

	How will we do it?		How will we know?	Who is Responsible?
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency** **Time-scale**
• **Outcome 4: Ready availability of health based places of safety where S135 / 136 is the only option.** *(To agree protocols for places of health based safety where hospital is the only viable option, and a protocol with CAMHS to ensure every child is appropriately safeguarded and protected within a health environment).*				**April-March 2016/2017**
4.1 Improve access to appropriate health based places of safety to manage patients who present with moderate violent intent and/or are suffering from substance misuse intoxication, including appropriate transport arrangements in accordance with the Concordat.	Critical appraisal of local/regional facilities and operational protocols in consultation with police to minimise waiting times for police and patients. Develop a nationally consistent approach to dealing with people in crisis who are either intoxicated or displaying an unmanageable risk of violence. This will need to involve consultation with local A&E departments to discuss the provision of medical support for people who are severely intoxicated.	Agreed framework of admissions/reception protocol. Consensus of moderate violent intent: role of Police and LHB. LHB's and CAMHS to confirm locations of their HBPOS, for both assessment and admission. Agree framework for admissions / reception protocol recognising there will be a potential increase to demand for health services and a need for additional resources; this will be required to fully meet these needs. This will require an all wales approach which could be facilitated by the establishment of an All Wales Group to look at this complicated area.	% (85/15) ratio of health based place of safety (using 2014/15 baseline). Reduction in use of police vehicles used to convey s135 / 136 patients, and corresponding increase in WAST based transportation.	MHCJPB/LHB/LA/WAST/ Police

	WAST resources to convey patients in accordance with the criteria laid down in the Concordat.			
4.2 Agree protocol with CAMHS around the referral to Local Safeguarding Boards when a child is detained under s136 and taken to police custody (given that this will be in exceptional circumstances only).	Access to appropriate facilities for C&YP are available within a health based setting. Review of facilities.	Bed/placement availability reviewed daily by LHB to aid police access.	Zero tolerance to a C&YP being taken to a police based place of safety. In cases of an unmanageable risk of violence the risk will be managed jointly.	Police/LHB/YJB
4.3 To ensure when a patient is in a police custody suite that LHB's Criminal Justice liaison Teams provide appropriate support.	Response times for the provision of a medical assessment within 4 hours. LHB's will aim to provide 24 crisis services within the locality which could help to provide support.	Liaison between police and CJ liaison teams.	CJ Liaison teams to provide assessment figures for people with MH problems.	Police/LHB/LA

	How will we do it?		How will we know?	Who is Responsible?
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency Time-scale**
Outcome 5: A dynamic joint review process to ensure concordat failures are identified and addressed in quick time. *(To create a multi-agency review framework to ensure services are responsive to need and individual systems are working together).*				**April-March 2016/17**
5.1 Fast time critical case review where significant concerns have arisen in the arrest and detention under section 135 / 136 powers.	Partners to agree fast case review process to review all cases and identify any concerns and failures. Process to be applied within 7 days with Children/Adult Safeguarding Boards notified of outcomes.	Protocol to set out convening/secretariat process; format of meeting/review and communication plan.	Reports to safeguarding boards will reflect area activity. Material effect on reducing Adult and C&YP being held in police custody under s136.	MHCJPB / Police/ LA/ LHB/WAST / 3rd sector
5.2 Periodic slow time reviews across police/LHB/LA areas to examine section 135 / 136 data trends.	Partners to consider frequency of local/regional meetings to examine section 135 / 136 data and to critically examine operational activity. Data to be collected by partners and include service users' experiences and comments, including the use of advocates where applicable.	Use data to inform/change operational approach with a particular focus on episodes/volumes of detentions.	Identifying where lessons have been learnt and the impact.	Police/LHB/LA/YJB/ WAST / 3rd sector

	How will we do it?		How will we know?	Who is Responsible
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency Time-scale**
Outcome 6: Frame an outline specification for a commissioned local/national evaluation study.				
6.1 Contribute to a national evaluation, pan Wales study of the impact of the Concordat.	Fully contribute as part of a commissioned study through the national Task and Finish Group. Ensuring there is service user experience reflected in any evaluation.	Identification of national strategic improvement imperatives that will improve outcomes.	Confirm the statutory roles of Health Inspectorate Wales and Her Majesty's Inspectorate of Constabulary. Present findings to Welsh Ministers and National Mental Health Partnership Board and respond accordingly.	National Task and Finish Board /All Partners. Health Inspectorate Wales and Her Majesty's Inspectorate of Constabulary.

	How will we do it?		How will we know?	Who is Responsible
Key Actions	**Planning and Commissioning**	**Improvement Approach/Training and Development**		**Lead Agency Time-scales**
Outcome 7: Communication Strategy				
7.1 Agree a Regional communication strategy that will inform stakeholders and partners about the Concordat and its impact.	The MHCJPB will prepare a written strategy, agreed by partners and its impact monitored at each board meeting.	The strategy will focus on reporting outcomes with key messages being conveyed to 'internal' and external stakeholders.	Written product produced Regional events designed to appraise the Concordat are held and jointly led by Police/LHBs.	MHCJPB
7.2 A Regional and National practice based seminar is convened annually to share and promote best practise; critique impact of the Concordat; identification of improvements.	The MHCJPB will convene a Regional seminar, targeted at relevant stakeholders that will consider area wide impact of the Concordat; the focus will be on practice lead performance and outcomes.	What has worked/is working; what needs attention and by whom; assessment of stakeholder commitment.	Assessment of performance data and outcomes. Service user critique.	MHCJPB /LHB/ Police/WG/LA/ 3rd sector.

Power of Discharge Group – Hospital Manager's Annual Report 1st April 2016 - 31st March 2017

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

Attachment 5

1. **Membership**:-

There are nineteen Hospital Managers at present:-

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

During the past year each member of the group usually sits on a Hearing Panel an average of 3-4 times a month so that they can maintain their skills and experience. I must make a mention of the Mental Health Act Manager and her team and commend them for the way in which they manage to bring together three Mental Health Managers, Doctor, Nurse, Social Worker, IMHA, Patient and, sometimes Solicitors and family members, on the same date with all the correct reports and documents. They do this with efficiency and good humour and their work is much appreciated by the Group Members.

Unfortunately we have lost four members of the group during the last year for various personal reasons, including our one service user member who had some 18 years experience with the group. He will be missed as he brought a unique insight to the role.

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

Section upheld	145
Discharged from Section prior to hearing	44
Hearing adjourned by PoD Panel	14
Hearing postponed in period	22
Cancelled by patient prior to hearing	3
CTO applied before hearing	3

Advocates have represented patients at 43 Panel Hearings (30%) an increase of 12% compared to 2015/2016.

Power of Discharge Group – Hospital Manager's Annual Report 1st April 2016 - 31st March 2017

3. **Training Activity**

   The group continue to have regular training sessions which are well attended and the members have given a positive response too. We have recently had a very interesting and helpful talk from the Senior Hospital Pharmacist on the drugs used in treating mental disorders and their side effects. Additionally we have talks on the role and work off the Independent Mental Health Advocates as well as updates on Mental Health Law, DoLs and the Mental Capacity Act. The Mental Health Act Manager has done an excellent job in arranging the training programme for the Group.

4. **Quarterly Power of Discharge Group Meeting – Development Sessions**

   The development sessions at the beginning of the quarterly business meetings have been replaced with a quarterly training session. Members are invited to attend a morning session covering a variety of topics. Since April 2016 the group have covered:

   - Practical issues re: MHA assessments and further detention
   - Mental illness
   - E-Expenses
   - Decision writing workshop
   - Role Advocate
   - Medication, how it works and the side effects

   This allows the group to have allocated time to take in the information presented.

5. **Recruitment**

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

6. **Appraisals**

   Appraisals were held during March 2017 using a Self-Assessment Questionnaire and one-to-one interviews with Marcus Longley, Vice-Chair.

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

   Self-reflection
   This is the bed-rock: everyone has a responsibility to reflect regularly on their performance, and to take action accordingly. There is also an opportunity in

Power of Discharge Group – Hospital Manager's Annual Report 1st April 2016 - 31st March 2017

the regular PoD meetings and development session to raise matters of interest or concern.

Observation of hearings
The Vice Chair observes a selection of hearings during the year and the Mental Health Act department to reinstate clerking of hearings to ensure that procedures are properly followed, and that individual Managers act appropriately.

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

7. **Recommendations**

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

The period covered July 2015 - June 2016. The Vice Chair, PoD Group compiled the Analysis and led the debate in January 2017.

Main highlights for discussion included:

- Care Plans (18%) - continue to be a problem, mainly relating to risk assessment.
- Advice on future treatment/care (14%) - remains one of our main areas of concern. No particular trends are emerging.
- Professional attendance/preparation for meetings (11%) - this increase is of some concern, no particular trend.
- Accuracy of reports (11%) - Very similar issues to last year's (result of reports containing information disputed by the patient/family)

The Group were pleased to note that there had been an increase in compliments submitted to professionals and their teams than previously.

John Owen
Chair Power of Discharge Group

April 2017

All Wales Mental Health Act Benchmarking Report **April 2017**

Executive Lead: Chief Operating Officer
Author: Head of Operations and Delivery – Mental Health
Financial impact - NA
Quality, Safety, Patient Experience impact -
Healthcare Standard Number 1 and 6 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Board/Committee is asked to:

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

SITUATION

The Welsh Health Board's responsibilities as Hospital Managers are to ensure compliance with the Mental Health Act. This is formally delegated to UHB staff, particularly mental health staff and mental health act administration departments as per the Hospital Managers' Scheme of Delegation. The Hospital Managers must ensure that patients are detained only as the Act allows, that their treatment and care fully comply with it, 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 other legislation which may have an impact.

Within this responsibility this paper recaps on how Cardiff and Vale MHCB has explored, made recommendations and has now collated benchmark information in relation to additional measures to provide Health Board Mental Health Legislation Committees with assurance in three specific areas:

1. **Invalid detentions** under the Mental Health Act - With a proposal that they are all:
    - consistently reported to allow for monitoring, investigation and improvements,
    - reported to a standardized definition to allow for comparison and performance management,
    - investigated to a minimal standard with a standard response to repeated breeches to allow for consistency and fairness of approach.

The overall aim is to have zero invalid detentions.

2. **A Common Data Set** of mental health act activity and compliance – With a proposal of an All Wales agreement for critical mental health act activity relevant to current service changes to inform management decisions with the aim of sharing this information on a regular basis to allow for benchmarking and improvements to be planned.

3. **Errors protocol** - a proposed protocol for responding to professionals who make repeated mistakes I relation to the application of the Mental Health Act.

BACKGROUND

The Cardiff and Vale General Manager led an initial working group of Mental Health Act Administrator Representatives of C&V, Hywel Dda, Aneurin Bevan and Cwm Taf Health Boards. This was followed by attendance at the all-Wales mental health act administrators meeting for October 2016, where this document was presented on behalf of the UHBs at the initial working group. All UHBs in Wales represented at this meeting. At this meeting agreement was established for the rationale for the data collection but not all UHBs were able to commit to the extent of data collection described in this paper. It was further agreed to circulate an electronic copy of the report for individual UHB mental health act administrators offices to assess their ability to contribute to this routine bi annual data collection exercise with the support of their line managers and/or clinical governance leads. It was suggested and agreed that the core mental health act data collected would initially reflect the collation capacity of the majority of UHBs. This information was copied to mental health service leads for information and support. Cardiff and Vale UHB offered to collate this information from January '17 on behalf of the Welsh UHBs and circulate to all UHBs regardless of their ability to collect it to allow for information and ideas exchange. **Areas of agreement Reached:**

1. Agreed Invalid Detentions Definition

The experience of the Health Boards consulted with, were that they are reporting a number of invalid detentions on a regular basis whereby patients have been detained without authority for a number of reasons reported to their Legislation Committees. Some of these incidents have resulted in detention for a number of hours to a number of days/weeks due to procedures not being followed mainly in relation to receipt of an application for admission for assessment or treatment.
The information gathered from an analysis of these incidents suggests that reporting could be simplified into two categories in relation to a definition and level of seriousness as follows:

- *Rectifiable Errors – concerned with errors resulting from inaccurate recording – invalid detention which can be retrospectively validated*

- *Fundamentally Defective Errors – concerned with errors other than the above.*

Definition - These two categories were chosen with reference to the Code of Practice (Ch10.15) which states any rectification, or correction, is mainly concerned with inaccurate recording, and it cannot be used to enable a fundamentally defective application to be retrospectively validated.
Rectifying or correcting cannot be used to cure a defect which arises because an element of the procedural process leading to the detention has simply not taken place at all. Therefore a form may be 'incorrect', for example, if names, dates or places are mis-stated, but which, if corrected, would not make the decision to admit a patient an unjustified one, and it may be 'defective' if the signatory has failed to complete all the sections, or delete alternative options.

An unsigned form should not be accepted as rectifiable.

In terms of investigation and reporting of invalid detentions, rectifiable or not, the minimum standard suggested by the working group was to ensure an incident report was completed and a summary provided to the local MHLC at each meet containing:

- Numbers
- Short description of breech identifying cause
- Summary of follow up actions taken to mitigate future risk.

The individual UHBs to discuss implementation of these minimum standards with line managers and Q&S departments.

2. Agreed Common Data Set (See Assessment Section)

UHB agreement arrived at WAS to collate a minimum data set, easy to collect, currently available for the majority of UHBs, had existing definitions and would be useful to share. The following more specific reasons for collating core data were:

- General Mental Health Act Activity – activity data which reflected the volume of use of the act and therefore could support further questions related to acuity, bed availability, community services capacity etc. With 135/6 data to gauge response to the police concordat and collaboration with partners responding to people in crisis. Useful to subdivide into gender age and speciality to monitor demand and equality.
- Rectifiable and fundamentally defective errors – see rationale above in this paper

3. Agreed Errors Protocol Standard

Agreement reached to adopt a common approach again to support consistency of application, response and ultimately to support the reduction or absence of people detained unlawfully.

ASSESSMENT (See Attached)

Mental Health Measure Monitoring Report **April 2017**

Executive Lead: Chief Operating Officer
Author: Head of Operations and Delivery – Mental Health
Financial impact - NA
Quality, Safety, Patient Experience impact -
Healthcare Standard Number 1 and 6 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Board/Committee is asked to:

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

SITUATION

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee.

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.

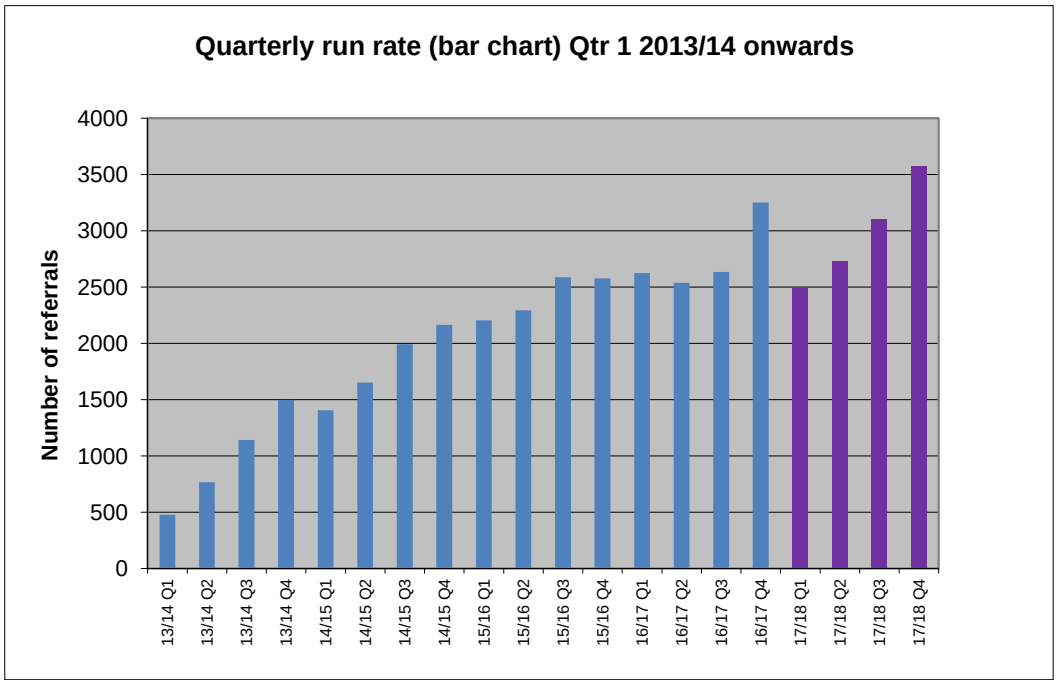
ASSESSMENT

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

For Quarter 4 2016/17 PMHSS received over 1,000 referrals per month for each of the three months; 1026, 1015 and 1210 respectively. The reported “levelling off” mentioned in the previous Monitoring Report, whereby for four consecutive Quarters changes in referral rates were minimal, i.e., between -3% and +4%, has not continued. There has been a 23% increase in referrals between Quarters 3 and 4 2016/17. Some of this increase can be attributed to the PMHSS/PCCS Single Point of Entry (SPoE) pilot (which began in mid-January) involving the surgeries in the Cardiff West Cluster, but not all. One explanation for this other cohort of increased referrals is possibly due to surgeries in other clusters also assuming a SPoE mechanism for referrals into PMHSS and PCCS. There are two surgeries in particular whose referrals rates have markedly increased since January ’17 and from whom anecdotally requests for counselling and/or counselling assessments have increased. This is being looked at but Figure 1 below shows the Quarterly 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.

Figure 1:

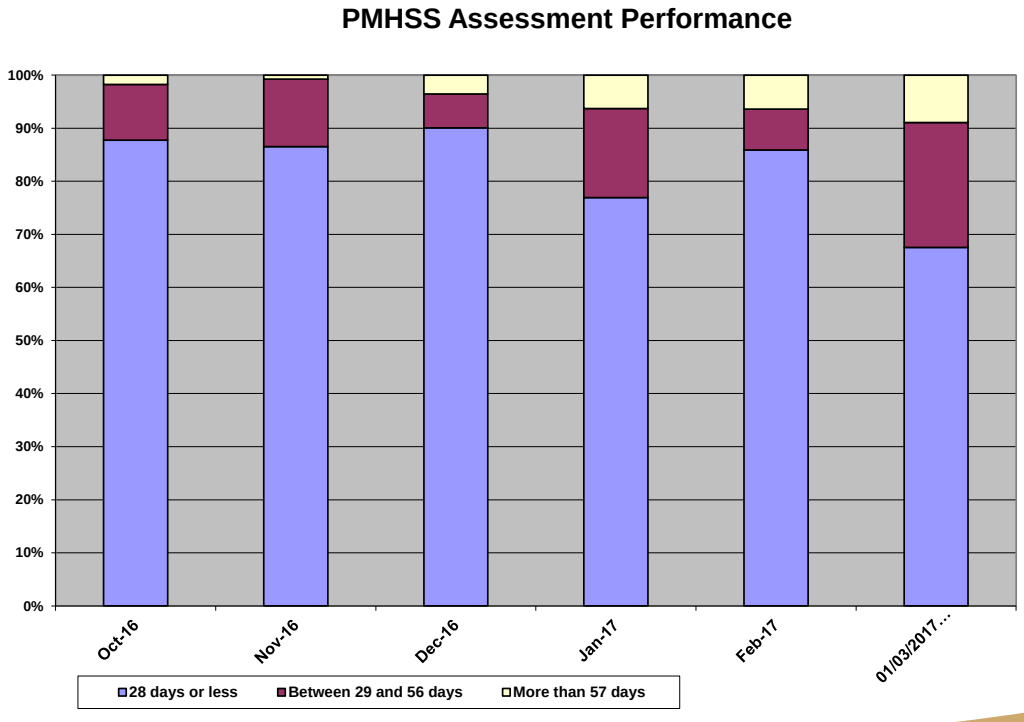


As stated in the previous Monitoring Report, additional funding has afforded the service the ability to increase its capacity for Band 4 Clinical Psychology Assistant Practitioners and Band 6 PMHSS Practitioners. At time of writing three of the four additional Band 4's are in post with the fourth due at the end of April and two of the five additional Band 6's are in post with the other two having only very recently been appointed and one having gone on maternity leave following interview. The latter's post is being partly covered by 0.4wte Band 6 secondment. In addition, since the last Monitoring Report we have lost and replaced one of the Band 7 Team Leaders but this has subsequently created a Band 6 vacancy which is due to go out to internal advert imminently. Bank shifts continue but the pool of staff availability has steadily reduced over time although we are hopeful that a recent recruitment drive will pull some more staff into the Bank pool.

See Figure 2 for details but pressure on meeting Tier 1 performance targets remains high due to a culmination in the aforementioned sharply increasing referral numbers in the last Quarter but also an increase in the number and variety of group and one-to-one interventions being offered by the service. The two breaches in compliance in the latter half of 2016/17, i.e., in January and March have been due to:

1. Under-18 Part 1 assessment performance pulling the overall UHB summary below 80% in January when over-18 assessment performance for that month was at 84% and,
2. The culminating effect of three consecutive months of 1000+ referrals but without the increase in staff that we were hopeful would be in post, plus the effect of the aforementioned under-18 assessment performance, detrimentally affected the UHB summary for March .

Figure 2



Current under-18 assessment activity, i.e., that activity which is provided solely by Children & Young Persons (CYP) Primary Care Team, is well below the Welsh Government target. In effect this shortfall in compliance can detrimentally affect the overall UHB summary by as much as 10%. The recent CYP Primary Care Team Waiting List initiative (whereby Bank staff have been utilised to assess the backlog of referrals aged 16 and 17) has further detrimentally affected the UHB summary as those being assessed have invariably waited 57 days or more.

The team is currently at 90% plus for the 28 day target of providing an intervention following completion of a Part 1 assessment.

Mitigation of risk

- PMHSS went live with a Bank staff arrangement in August ’15 and have a small pool of staff to draw from. Shifts are currently on Monday and Tuesdays between 5pm and 8pm and every other Saturday between 9am and 5pm. A mini audit of this arrangement revealed that at least 15% of all Part 1 assessments are carried out by the Bank staff. PMHSS has also offered secondment opportunities when slippage money has been identified. This arrangement too has had a positive impact on assessment performance.
- The Clinical Board is currently reviewing all community vacancies for scrutiny as to whether the resource can be redirected to the PMHSS team to assist with demand, even on a temporary basis.

CYP Issues

The clinical board is currently in regular contact with CYP services regarding:

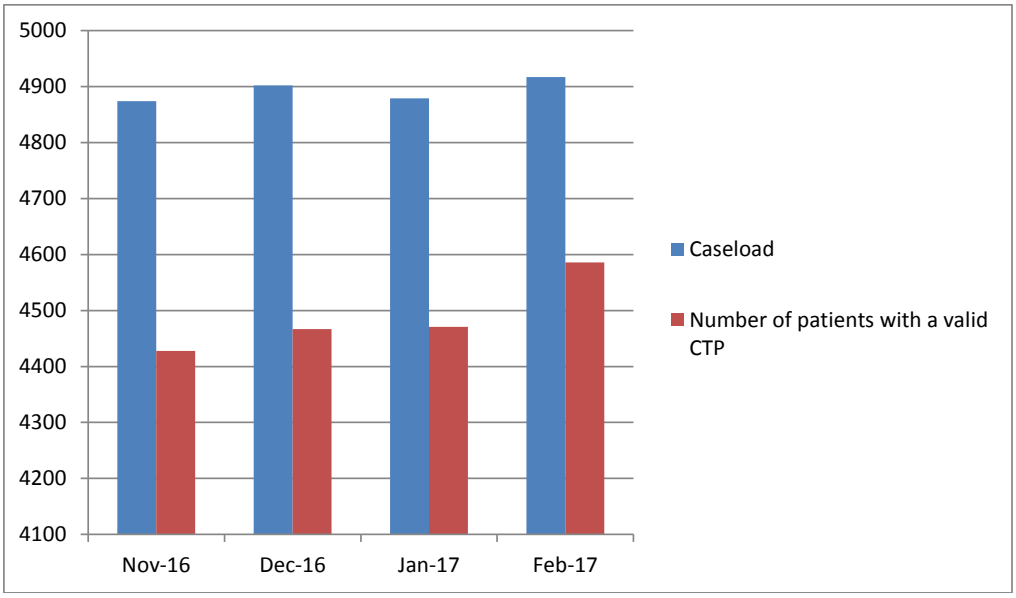
- The average referral rate for financial year 2016/17 was 93 but for the latter half of the year it was 107. The previously documented discrepancy between CAMHS and C&V MHCB activity numbers has improved since CYP went on to Paris in October ‘16 but still has a little way to go before being entirely reliable. Regarding the aforementioned increased funding, a proportion of that funding has gone to CYP to increase capacity.

Part 2 & 3 : Care and Treatment Planning

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:

Metric	Nov-16	Dec-16	Jan-17	Feb-17
Total number of patients in receipt of secondary MH services in C&V	4,874	4,902	4,879	4,917
90% of Service users have a valid CTP	4,428 90.8%	4,467 91.1%	4,471 91.6%	4,586 93.3%



Performance Issues
Adult, Older Adult and Leraning Disabilty are all reprorting performance of 90% and above. CAMHS are reporting improved figures over the last 4 months but their performance is below 75%. Despite the steady improvement, the Mental Health Clnical Board lead for part 2 and 3 will attended the local CAMHS service to discuss performance related issues.

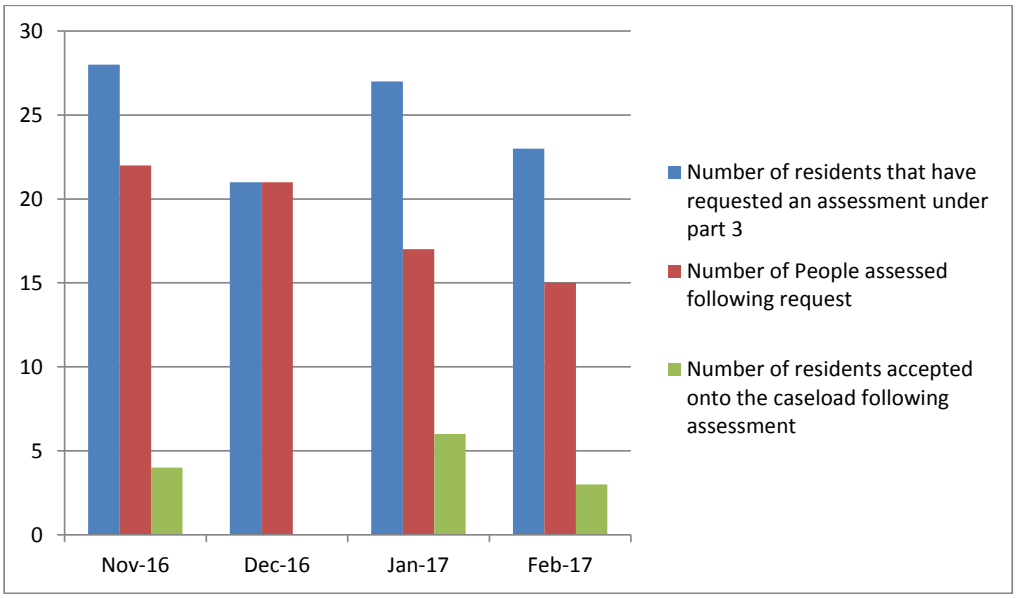
The National Together for Mental Health Delivery Plan – 2016-2019 has highlighted the Mental Health Clinical Board will need to consider the following additions to the CTP audit in the coming months:

- The number/percentage of CTP's where housing, finance and employment needs are addressed with treatment plans to enable to the identification of recovery focused objectives.
- An increased percentage of service users and carers throughout the UHB who positively rated (either strongly agreed or partly agreed) that they were satisfied/felt involved with their CTP on an annual review.

Part 3
Right to request an assessment by self –referral

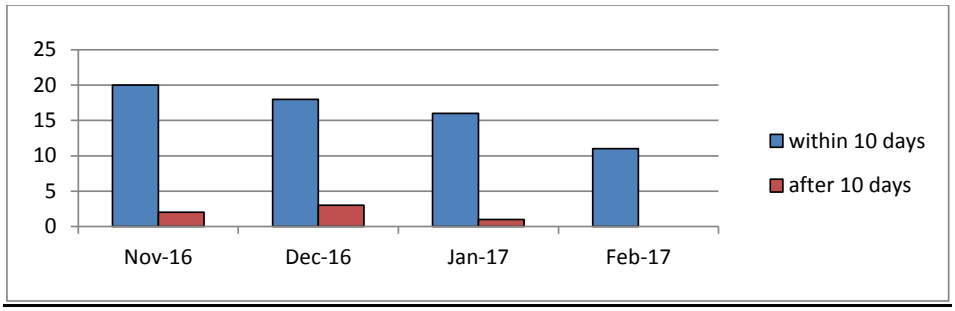
Service user's who have previously received secondary mental health services and have been discharged have a right to self refer for an assessment of their mental health for up to three years following discharge.

Metric	Nov-16	Dec-16	Jan-17	Feb-17
Number of residents that have requested an assessment under part 3	28	21	27	23
Number of People assessed following request	22	21	17	15
Number of residents accepted onto the caseload following assessment	4	0	6	3



All part three requests and outcomes are scrutinised prior to reporting. There continues to be a high number of DNA/CNA rate following requests being made to teams.

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 Services

The UHB is 100% compliant with part 4 of the measure to provide in-patient advocacy service across the University Health Board. The last return to Welsh Government as at January 2017 demonstrated a total of 26 new patients and a continuing caseload of 107 patients over a three month period in line with new reporting requirements under the “Duty to Review” for Post-Legislative Assessment of the Mental Health (Wales) Measure 2010

The Community Advocacy continues to be commissioned separately with a very high uptake and this service has been extended for a further 3 years with Advocacy Support Cymru aligned to the inpatient service.

Mental Health and Capacity Legislation committee Draft Work Plan 2016-2017	May	Aug	Nov	Feb
Patient Story	Mental Health Measure	Mental Health Act S117	Mental Health Act	Mental Capacity Act
Clinical Board review of ensuring MCA compliance (remitted from HSMB 19.2.15)	Clinical Board MCA compliance report: Medicine / Special	Clinical Board MCA compliance report: Surgery / PCIC	Clinical Board MCA compliance report: Women & Children / Dental	Clinical Board MCA compliance report: CD&T / Mental Health
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) *Standing item*	x	x	x	x
Section 117 Compliance	x			
Section 136 Partnership arrangements	x			
Monitoring MHA impact of changes to community services				x
HIW MHA Annual Report	x		x	x
HIW MHA Inspection Reports (as received)	x	x	x	x
Hospital Managers Power of Discharge sub-Committee Annual Report	x			
Hospital Managers Power of Discharge sub-Committee minutes	x	x	x	x
Mental Health Measure				
Mental Health Measure Monitoring Report	x		x	
Part 1 – Compliance update		x		
Part 2 - Quality of Care & Treatment Plans			x	
Western Vale transfer Monitoring Report - (this item merged with monitoring report)	x			
Provision of Mental Health Support to Prisoners (CRAF ref 5.1.16, risk rating 12) *Last update October 2014*				
Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) *Risk rating 16*		x		x
MCA Training update (now merged with the above item)				
DoLS Monitoring Report	x	x	x	x
Deprivation of Liberty Safeguards: Implications of Supreme Court Ruling (now merged with above item)				
DoLs Audits		x		x
Committee Governance				
Committee Work planner	x			x

Review of Effectiveness			x	
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference				x
Review of Terms of Reference				x

20

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMITTEE HELD AT 10AM ON 11TH APRIL 2017 IN THE MENTAL HEALTH SEMINAR ROOM AT HAFAN Y COED.

Present:

Mr John Owen- Chair, PoD Group
Mr Jeff Champney- Smith- Vice Chair, PoD Group
Mr Rashpal Singh- PoD member
Mr Tony Summers- PoD member
Mrs Wendy Hewitt- Sayer- PoD member
Mr Mike Lewis- PoD member
Mrs Mary Williams- PoD member
Mrs Elaine Gorvett- PoD member
Mrs Elizabeth Singer- PoD member
Mr Alan Parker- PoD member

In attendance:

Mrs Patricia Hallett-Prospective PoD member
Mr Owen Baglow- Clinical lead for quality, safety and governance
Mr Marcus Longley- Vice Chair
Ms Sunni Webb- Mental Health Act Manager
Mrs Bianca Simpson- Lepore- Mental Health Act Admin Manager

Apologies:

Mrs Sarah Vetter- PoD member
Mr Huw Roberts- PoD member
Mrs Mair Rawle- PoD member
Mr John Copley- PoD member
Mrs Teresa Goss- PoD member
Mrs Sharon Dixon- PoD member
Mr Peter Thomas- Mental health police liaison officer

1 Welcome and Introductions

Mrs Patricia Hallett was introduced to the group. All those present were informed that Mrs Hallett is booked to observe hearings in the near future so that she will hopefully be able to commence sitting on panels very soon. Members offered their assistance if Mrs Hallett has any queries with regard to her PoD role. The Vice Chair of the Health Board and the Clinical lead were introduced to the group for the benefit of anyone who hadn't previously met either of them.

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

A discussion was held within the group around the issue of offering patients and advocate the opportunity to have a private discussion with PoD members prior to a hearing. The Chair of the PoD group commented that he has no problem with this happening as advocates are the voice of the patient. All PoD members agreed that this is common practice if an advocate or patient requests a private discussion so the centre of the debate is whether the PoD members should actively invite a private discussion or whether they should wait for the advocate/ patient to request this. Several members voiced concerns over timing of hearings if the process became more formalised. Several members felt that actively inviting a private discussion could result in information being disclosed which should have been discussed in the hearing itself. They also fear that problems outside of the PoD members remit may end up being discussed unnecessarily. Despite the mentioned concerns one PoD member did feel that process of asking for if a private discussion was require should be formalised as PoD members should not rely on advocates/ patients being diligent enough to request for themselves each time without prompting. Overall those present agreed that the process will have to be managed properly but that they are happy to have private discussions on an ad-hoc basis. PoD members will make clear that any not for disclosure information should be submitted prior to the hearing if at all possible. PoD members also noted that the code of practice also states that advocates should be able to have a private conversation if required.

Some time ago the PoD members would as a matter of course go to the ward to inform the patient of whether or not he or she had been discharged after a managers hearing. This practice seems to have fallen away and PoD members were concerned that the code of practice is no longer being followed as it should be. At present PoD members rely on ward or community staff to inform patients but there is

nowhere on the current minutes to record accurately who will be doing this. It was agreed that in future PoD members will query with ward staff whether it is clinically appropriate for a PoD member or a nurse to relay the decision to the patient. If it is decided that it is not appropriate for a PoD member to go to the ward the reasons for this must be clearly recorded. The PoD members must delegate this role to a named person and again this must be clearly recorded. In the case of CTO patients who do not attend their hearing, the most appropriate person to convey the decision should be identified at the hearing and again recorded on the minutes.

ACTION- MENTAL HEALTH ACT ADMIN MANAGER TO UPDATE POD MINUTES TO REFLECT CHANGES IN PRACTICE.

The do not resuscitate policy was discussed between members and one case in particular was mentioned as having caused concerns. It was agreed that PoD members should be provided with a copy of the DNR policy to alleviate any queries they may have in its implementation. Discussion of this policy led on to debate as to what the PoD members remit permits and whether queries like this should be raised in hearings. It was agreed that matters such as this one should be raised in the recommendations after hearings where they can be directed to the appropriate professional. Any matters of concern with professional practice should be brought directly to the Mental Health Act Manager who will be able to pass them through the correct channels. It was agreed that PoD members need to be clear as to their role and that this is potentially a training need. The Vice Chair of the PoD group expressed his concern that PoD members need to be cautious of what is discussed opening at hearings and what potentially is more appropriate for the peer supports groups/ training sessions. All those present agreed they would like to broaden their knowledge of policies. It was agreed that the Mental Health Act Manager would distribute all relevant polices as requested.

ACTION- MHA MANAGER TO SEND OUT POLICIES.

The covert medication policy was also discussed between members. They would like to know how the decision to use convert medication is come to. It was noted that the majority of uses seem to be for older people but that professionals do try to avoid using the policy if at all possible. Concerns were raised over whether capacity assessments were being properly carried out and recorded. This is not just a problem with recording of covet medication capacity assessments but a more

widespread problem with how capacity assessments as a whole are recorded. PoD members would like to see the policy in order to decide how to go forward.

ACTION- COVERT MEDICATION POLICY TO BE DISTRIBUTED.

The interface between the Mental Health Act and the Mental Capacity Act has been a longstanding issue for many people working with both pieces of legislation. Some PoD members queried whether some patients detained under the MHA could in fact be treated using the MCA instead. The Vice Chair of the PoD group reiterated that the Code of Practice states that as long as the reasons for detention under either Act are well justified and recorded then professionals should not be too overburdened with which piece of law they use. It was noted that the Mental Health Act provides more protections and safeguards for the patient and that this may explain why professionals use the MHA. A debate over whether patients could be detained under the MHA and be subject to a Deprivation of Liberty at the same time was held. There were different opinions as to this matter and it was agreed that clarity needs to be sought.

ACTION- LOOK INTO THE DOLS/ MENTAL HEALTH ACT ISSUE.

CTO medication was also discussed between PoD members. PoD members were reminded that the law does not permit any community patient to be forcibly given medication and that CTO conditions must reflect this by only stating “to receive” medication rather than “to take”. PoD members discussed a case whereby there was some debate over wherher the patient should have been on a CTO or extended Section 17 leave. It was agreed that this is a matter of professional judgement and that if a doctor feels that a patient may not willingly take their medication extended section 17 may be more appropriate as this allows easier recall to hospital. CTO patients should not be recalled regularly purely for the purpose of taking medication. If this is happening professionals need to consider how appropriate the use of CTO is.

4 Minutes of meeting held on 16th January 2017

One item in the minutes was queried. The CCTV policy and cameras in patients rooms was raised as a concern at the previous meeting. It was confirmed that

patients are infrormed of cameras on admission and that the cameras do not record patients rooms directly but instead record who opens/ closes the doors. PoD members were happy with this response.

5 Matters Arising:

PoD members were informed that the activities team is now fully staffed and that activities such as dog walking, gardening and trips to Cosmeston lakes would hopefully come to fruition in the near future. The Vale Ways voluntary walking group are keen to get patients involved. Unfortunately the group are still unaware of whether the friends of Whitchurch Hospital voluntary group has transferred over to Hafan Y Coed. The Chair of the PoD group has agreed to investigate this through contacts he has personally.

6 MHA Activity Monitoring report January- March 2017:

The number of adjournments and postponements of Tribunals and Managers hearings has declined in the last quarter. This is a positive change and the PoD members were pleased to note this. They queried whether the three patients discharged by the Tribunal were seen by the hospital managers before being discharged. It was agreed the MHA Office could feed back this information at the next meeting.

One PoD member made an observation that the peaks in MHRT and Hospital managers hearings are often at similar times despite them performing a different role.

ACTION- LOOK INTO MHRT QUERY

7 Recommendations from Power of Discharge Group hearings- January- March 2017

PoD members were pleased with this quarters responses to recommendations and commented that they contained more substantive information than previously. One PoD member commented that the issue of out of date/ incomplete care and treatment plans is still of great concern to her. She questioned the Clincal lead and was informed that work is being done to try and foster a better approach to getting CTPs completed in the spirit in which the Mental Health Measure intended. Cedar

ward in particular is being looked into as CTPs should be up and running within two weeks of admission. Another PoD members questioned the relevance of receiving CTPs to the PoD group members decision as to whether to discharge a patient. It was confirmed that the code of practice does require hospital managers to receive a copy of the CTP prior to a hearing but this query again sparked the debate on the remit of the PoD group. It was confirmed that David Kaged (Welsh Health Legal) would be doing a session on the role of hospital managers on the 4th May 2017. All PoD members will be invited to attend this. One other PoD member raised a concern that one of the recommendations submitted was responded to but that no positive outcome for the patient could be found. The Vice Chair of the PoD group informed those present that the PoD members had done what they could in this instance but that unfortunately their powers are only limited. PoD members are entitled to inform families of the complaints procedure if family members feel very strongly about any situation.

ACTION- INVITE POD MEMBERS TO DAVID KAGED SESSIONS

8 Training

The next training session is on 30th June and will cover the following points:

Risk assessment

CTP

Code of Practice update

One PoD member expressed concerns over what she feels is a grey area in terms of whether to discharge a patient who perhaps may make unwise decisions but that is not necessarily as a result of their mental illness. She has suggested that a paternalistic approach is still taken to mental health patients and that perhaps this needs to be discussed further. It was agreed that the matter will be raised again at the next peer support group.

9 Any other business

The annual report is similar to previous years reports and comes in no particular format. The Vice Chair of the Health Board appreciates this report and finds it useful.

The new Code of Practice states the PoD members should be on fixed term rather than permanent contracts. It was agreed that each year on appraisal each PoD members contract would be discussed and renewed if appropriate. This will avoid extra processing being added to both the PoD members and the Vice Chairs workload. The Vice Chair of the UHB confirmed he has seen all PoD members and

is happy with their conduct. It was noted that he has been re-appointed for another four years.

An updated list of PoD members will be sent out as soon as possible.

It was confirmed that the Chair of the PoD groups term as Chair is coming to an end and that the Vice Chair would take over his role in October 2017. Expressions of interest for the Vice Chair position should be submitted to the MHA Manager by the end of June 2017.

11 Date of future meetings to be held at 10.00hrs in the Seminar Room, First Floor, HYC, UHL:

18th July 2017
17th October 2017
09th January 2018