Mental Health Capacity Legislative Committee

20 October 2020, 10:00 to 12:00

Agenda

1. Welcome & Introductions

Sara Moseley

2. Apologies for Absence

Sara Moseley

3. Declarations of Interest

Sara Moseley

4. Minutes of the Committee Meeting held on 21st July 2020

Sara Moseley

4 Draft Minutes - July 2020 v4.pdf (6 pages)

5. Action Log – 21st July 2020

Sara Moseley

5 Action Log.pdf (2 pages)

6. Chair's Action taken since last meeting

Sara Moseley

7. Any Other Urgent Business Agreed with the Chair

Sara Moseley

8. PATIENT STORY

8.1. The Cardiff and Vale Action for Mental Health

https://youtu.be/L4jToe_atjE

Ruth Walker

9. Mental Capacity Act

9.1. Mental Capacity Act Monitoring Report

Ruth Walker

9.1 MCA Monitoring Report FINAL.pdf (4 pages)

9.1 Appendix 1 MCA supporting info Oct 2020.pdf (5 pages)

9.1 Appendix 2 - IMCA Report September 2020.pdf (1 pages)

9.2. Internal Audit Report on DoLS

Ruth Walker

9.2 DoLs Internal Audit Covering Paper FINAL.pdf (2 pages)

9.2 Appendix 1 DoLS final report.pdf (16 pages)

10. Mental Health Act

10.1. Mental Health Act Monitoring Exception Report

Ian Wile

10.1 Mental Health Act Exception Report.pdf (6 pages)

10.1 Mental Health Act Monitoring Report July - September 2020.pdf (46 pages)

11. Mental Health Measure

11.1. **Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report** — Ian Wile

- 11.1 MHLC - Mental Health Measure.pdf (8 pages)

11.2. **CAMHS Compliance** — Scott McLean

- 11.2 CAMHS Mental Health Measure Oct 20.pdf (3 pages)

12. Items to bring to the attention of the Committee for Noting / Information

12.1. **Sourcing & Supporting Patient Stories Update** — Ruth Walker

- 12.1 Patient Stories.pdf (3 pages)
- 12.1 Appendix 1 Patient story request submission form.pdf (2 pages)
- 12.1 Appendix 2 Storyteller information sheet.pdf (2 pages)
- 12.1 Appendix 3 Storyteller consent form.pdf (2 pages)

12.2. **Feedback on Committee Training Session & Review** — Nicola Foreman

- 12.2 Feedback on Committee Training Session & Review.pdf (3 pages)

12.3. **Self-assessment of Committee Effectiveness & Forward Action Plan** — Nicola Foreman

- 12.3 Self Assessment of Committee Effectiveness.pdf (2 pages)
- 12.3 Appendix 1 Committee Effectiveness Results.pdf (9 pages)
- 12.3 Appendix 2 Committee Effectiveness Action Plan.pdf (1 pages)

12.4. **(i) Hospital Managers Power of Discharge Minutes (ii) Mental Health Legislation and Governance Group Minutes** — Jeff Champney - Smith / Robert Kidd

- 12.4 POD minutes August 2020.pdf (5 pages)
- 12.4 Minutes of MHLGG September 2020.pdf (6 pages)

13. Items for Approval Ratification

13.1. **IMCA Procedure** — Julia Barrell

- 13.1 IMCA Procedure Covering Paper.pdf (2 pages)
- 13.1 Appendix 1 IMCA Procedure 290920.pdf (11 pages)

13.2. **Lasting Power of Attorney and Court Appointed Deputy Procedure** — Julia Barrell

- 13.2 LPA & CAD Procedure Covering Report.pdf (2 pages)
- 13.2 Appendix 1 LPA and CAD procedure 290920.pdf (13 pages)

14. Review of the Meeting — Sara Moseley

15. To note the date, time and venue of the next meeting: Tuesday, 19th January 2021 at 09:00

Unconfirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 21st July 09:00pm – 12:30pm
Via Skype

Present:		
Sara Moseley	SM	Interim Chair and Independent Member – Third Sector
Eileen Brandreth	EB	Independent Member – ICT
Michael Imperato	MI	Independent Member - Legal
In Attendance:		
Julia Barrell	JB	Mental Capacity Act Manager
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Akmal Hanuk	AH	Independent Member - Community
Charles Janczewski	CJ	UHB Chair
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Simon McDonald	SM	Mental Health Act Manager
Scott McLean	SM	Director of Operations, Children & Women
Annie Proctor	AP	Clinical Board Director – Mental Health
Ruth Walker	RW	Executive Nurse Director
Ian Wile	IW	Director of Operations - Mental Health
Secretariat:		
Laura Tolley	LT	Corporate Governance Officer
Observers:		
Caroline Bird	CB	Deputy Chief Operating Officer
Apologies:		
Sunni Webb	SW	Mental Health Act Manager

MHCL 20/07/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everyone to the meeting.	**ACTION**
MHCL 20/07/002	**Apologies for Absence** Apologies for absence were noted.	
MHCL 20/07/003	**Quorum** The CC confirmed the meeting was quorate.	
MHCL 20/07/004	**Declarations of Interest** The CC declared an interest in the meeting as the Director of Mind Cymru.	

MHCL 20/07/005	**Minutes of the Committee Meeting held on 21st February 2020** The Committee reviewed the Minutes from the meeting held on 21st February 2020. **Resolved that:** (a) the Committee approved the minutes of the meeting held on 21st February 2020 as a true and accurate record.	
MHCL 20/07/006	**Action Log following the meeting held on 21st February 2020.** The Committee reviewed the action log and noted the following updates: **20/02/015 –** The Chief Operating Officer (COO) welcomed Committee opinion on commissioners being subject to their own governance arrangements in relation to MH services delivered on behalf of CVUHB by other LHBs. The UHB Chair commented that it would be very difficult to obtain assurance from a commissioner with their own governance arrangements, however, advised the Committee that Audit Wales were conducting a review of WHSSC governance arrangements so the Committee could gain some assurance from that. The Independent Member – ICT (IM-ICT) expressed concern as the Committee had a known weakness in this area. The Director of Corporate Governance (DCG) advised the inspection reports may be a clear route for assurance. In response, the COO advised he would look at the planned inspection list and timetable and update the Committee accordingly. **20/02/005 –** The Executive Nurse Director (END) advised the Committee that new national guidance was expected, however this may be delayed due to COVID-19, therefore, it would not be appropriate to undertake a review until the new guidance was in place. **20/02/009** – The Vale & Glamorgan DoLS report had been discussed and would be brought to the next Committee for noting. The END added that the Committee would be pleased to note that there were no areas of concern at present. **Resolved that:** (a) the Committee noted the action log and the updates provided.	**SC**
MHCL 20/07/007	**Chair's Action taken since the last meeting**	

	No Chair's action had been taken.	
MHCL 20/07/008	**Patient Story** There was no patient story available for this meeting, however the I informed the Committee as she had taken over DoLS and the Mental Capacity Act, going forward she would ensure that patient stories were presented at meetings. CC asked for assurance that our support of patients sharing their stories and how this would be managed was reviewed along with the way the Committee works.	**RW** **RW**
MHCL 20/07/009	**Impact of COVID-19 on Reporting and Monitoring** The Director of Operations – Mental Health (DO-MH) advised the Committee that all reporting arrangement targets had been stood down by Welsh Government, however the team had been involved in weekly Welsh Government meetings for assurance and assurances had been provided that Mental Health services had not stopped during COVID-19. The DO-MH advised the Committee that now the physical impact of COVID-19 was decreasing, a surge in mental health was anticipated, therefore to address this the UHB had agreed with third sector partners, Mind in the Vale and Cardiff Mind that contracts would increase by 25% for 3 months, in addition to building into the contracts that patients do not need to visit their GP for their first appointment. The DO-MH informed the Committee that strong partnerships had been developed which has enabled the transformation of mental health services. The UHB Chair expressed thanks to the Mental Health Clinical Board throughout COVID-19. **Resolved that:** (a) the Committee noted Impact of COVID-19 on Reporting and Monitoring.	
MHCL 20/07/010	**Mental Capacity Act Monitoring Report** The Mental Capacity Act Manager (MCAM) introduced the report and advised the Committee that nothing significant had changed despite COVID-19. The MCAM added that interesting issues had arisen during the period, mainly where patients did not have capacity to be involved in the RECOVERY clinical trial (treatments for COVID-19). The MCAM advised that the UHB needed to ensure that Clinicians were more aware of the Mental Capacity Act. The END informed the Committee that a meeting with the MCAM would be arranged to progress this further and an action plan would be developed and brought to a future meeting.	**RW**

	Resolved that: (a) the Committee noted the Mental Capacity Act Monitoring Report.	
MHCL 20/07/011	**The Vale and Glamorgan Local Authority Report on DoLS** The END advised this had been discussed and informed the Committee that there were no areas for concern at present. It was agreed that the report would come to the next Committee meeting for noting. **Resolved that:** (a) the Committee noted the Vale and Glamorgan Local Authority verbal update on DoLS	
MHCL 20/07/012	**Mental Health Act Monitoring Exception Report** The DO-MH introduced the report and confirmed the following: • The number of people detained increased slightly during COVID-19, however this was returning to normal. This was due to the clearing of two wards in preparation for COVID-19; • Number of administration errors had been made in regard to the Mental Health Act, now the UHB were out of the intense COVID-19 period, the errors had ceased; • A couple of lapses in Section 5; • Increase in Section 136, it was believed this was due to a wording error on the documentation; • Slight increase in CAMHS which has been recognised across Wales and England. The CC asked if CAMHS was included in recovery planning. In response, the Clinical Board Director – Children & Women (CBD-CW) confirmed the UHB had 40% more capacity than demand at present, therefore they are well prepared if a surge occurred. CC also sought assurance that patients who had been discharged were receiving follow up and care. **Resolved that:** (a) the Committee noted the Mental Health Act Monitoring Exception Report.	
MHCL 20/07/013	**Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report** The DO-MH introduced the report and confirmed the following; • Started to lose staff at the end of March due to COVID-19,	

	however, patient numbers dropped significantly which allowed the team to develop a single point of contact with the Council; • Capacity has started to increase and the UHB had sufficient capacity; • Team were keen to keep the single point of access as it significantly improved the service; • In relation to Part 1b of the measure, the UHB had remained fully compliant since August 2019; • Care & Treatment Planning – Improvement was required as the target was 90% and the UHB were just above 80%, this was declining therefore discussions with the directorate were being held to understand reasons; • Part 1 measure relating to Children & Young People – it was confirmed the UHB were at 92% and were confident the position would be sustained. The CC asked at the next meeting for there to be a focus on compliance for CAMHS. **Resolved that:** (a) the Committee noted the Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report.	**SM**
MHCL 20/07/014	**Items to bring to the attention of the Board / Committee for information and noting:** **1. Hospital Managers Power of Discharge Minutes** The CC asked how virtual hearings were being handled. In response, the Consultant Clinical and Forensic Psychologist (CCFP) confirmed a number of hearings had been held and positive feedback had been received. An area of concern raised with Welsh Government was in relation to nearest relative attendance. The DO-MH thanked the team for the work undertaken to enable virtual tribunals and hearings which resulted in the UHB complying with legislation as much as possible. **Resolved that:** (a) the Committee noted the Hospital Managers Power of Discharge Minutes. **2. Mental Health Legislation and Governance Group Minutes**	

	The CCFP advised the Committee that the issue relating to conveyancing remained, however conversations were being held with the newly appointed Director of Nursing – Mental Health, to progress this further. A further discussion was held on issues relating to the work of the MH Tribunal and capacity issues. The DO-MH agreed that this was an area we should be raising concerns about as a UHB. **Resolved that:** (a) the Committee noted the Mental Health Legislation and Governance Group Minutes.	
MHCL 20/07/015	**Policy and Procedure - Section 117** The Committee reviewed the Policy & Procedure – Section 117. **Resolved that:** (a) the Committee approved the Policy & Procedure – Section 117.	
MHCL 20/07/016	**Any Other Business** The CC confirmed a Committee Development session was to be arranged.	**NF**
MHCL 20/07/017	**Date & Time of next Committee Meeting** Tuesday 20th October 2020 9:30am – 12:30pm Via Skype	

Action Log
Following Mental Health & Capacity Legislation Committee
21st July 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCL 20/07/016	Committee Development session	CC confirmed a Committee Development session was to be arranged	02.09.2020	Nicola foreman	**Complete** 2 further sessions being organised.
MHCL 20/02/011	Section 135/136 Partnership Arrangements: Police Mental Health Crisis Concordat – Update	Sarah Mosely and Ian Wile to meet to discuss SM's concerns with the Concordat and the work undertaken at other Health Boards.	ASAP	Sara Mosely	**Complete** Discussion taken place.
MHCL 20/02/010	Mental Health Act Monitoring Exception Report	Steve Curry and Eileen Brandreth to meet to discuss the reporting of CAMHS data separately from adult data.	TBC	Steve Curry/Eileen Brandreth	**Complete** Discussions taken place.
Actions in Progress					
MHCL 20/02/009	Internal Audit Report – Deprivation of Liberty Safeguards (DOLS)	The Internal Audit Report on DoLS to be presented at the next meeting	**20.10.2020**	Ruth Walker	On agenda for October item 9.3
MHCL 20/07/006	Inspection Reports	DCG advised the inspection reports may be a clear route for assurance.	**20.10.2020**	Steve Curry	COO advised he would look at the planned inspection list and timetable and update the Committee accordingly – included in monitoring reports items 10.1 & 11.1

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 20/07/008	Patient Story	Patient story to be brought to next Committee meeting To provide assurance regarding support of patients sharing their stories and the management of this process.	**20.10.2020**	Ruth Walker	On agenda for October item 8 On agenda for October item 12.1
MHCL 20/07/010	Mental Capacity Act Clinician update	END informed the Committee that a meeting with the MCAM would be arranged to progress this further and an action plan would be developed and brought to a future meeting.	**20.10.20**	Ruth Walker	Verbal update to be provided by Julia Barrell
MHCL 20/07/013	CAHMS Compliance	The CC asked at the next meeting for there to be a focus on compliance for CAMHS	**20.10.20**	Scott Mclean	On agenda for October item 11.2
Actions referred to committees of the Board					
MHCL 19/10/012	HIW Mental Health Act Report	Bring all Estates concerns together to be reported at a Management Executive Meeting.	TBC	Nicola Foreman	Ongoing.
MHCL 19/06/008	Mental Capacity Act Monitoring Report	To discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave.	Date to discuss at HSMB	Stuart Walker	Agreement not reached with LNC at present. Discussions are ongoing.
MHCL 20/02/005		The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee			This item would be reviewed by the S&D Committee and reported back to a future meeting.

Report Title:	**MENTAL CAPACITY ACT (MCA) 2005 MONITORING REPORT**							
Meeting:	**Mental Health and Capacity Legislation Committee**					**Meeting Date:**	**20/10/20**	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	√
Lead Executive:	**Executive Nurse Director**							
Report Author (Title):	**Mental Capacity Act Manager**							

SITUATION

The Mental Health and Capacity Legislation Committee has requested that information about the use of MCA within the UHB should be tabled at each meeting, in order to retain awareness of this issue.

REPORT

BACKGROUND

The Mental Capacity Act 2005 (MCA) has been in force for 13 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

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

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

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

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

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

Training (mandatory)

- Face-to-face teaching from the MCA Manager including UHB-wide sessions at various locations, every other month – currently exploring with LED the options for delivering this training mainly through video conferencing;

- "Mandatory May and November" training, Senior Medical Induction and some Clinical Board Nurse Foundation Programmes – currently exploring with LED the options for providing this through video conferencing;
- Bespoke training on request;
- The All-Wales MCA e-learning course is available for use on ESR.

Information and advice

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

Policies and procedures

A number of policies and procedures are in place to support UHB staff in using the MCA. The Consent Policy includes information about MCA requirements. The MCA Manager also tries to ensure that other policies adequately and accurately reflect the MCA where appropriate.

Additional information

Use of MCA within the UHB

Appendix 1 sets out information that indicates the use of MCA within the UHB.

Independent Mental Capacity Advocacy (IMCA)

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

Court cases involving MCA

The UHB has been served with papers regarding a welfare case; has been a respondent in appeals against DoLS authorizations; and has been required to produce s.49 reports – these are reports that are ordered by the Court to be produced on matters relating to the patient, such as the patient's mental capacity to consent to treatment.

Two interesting cases that have been heard by the Court are –

Northamptonshire Healthcare NHS Foundation Trust [2020] EWCOP 40

This case was about whether a patient with anorexia had mental capacity to make her own treatment decisions and, if not, whether it was in her best interests to receive forcible treatment.

A Local Authority and AB [2020] EWCOP 39

This case concerned a woman who had been placed under Guardianship (MHA 1983) in supported accommodation and whether or not she was deprived of her liberty. As part of the judgment, The Judge observed that:

> "*supervision and control should be viewed as separate requirements in considering* [the acid] *test and the word 'continuous' applied to both*."

ASSESSMENT

Whilst there are individual clinicians and service areas that have developed an understanding of the MCA and comply with it, the position is not uniform across the UHB and there is still some way to go until the MCA is embedded in clinical practice. There remains an issue with regards to Doctors' training compliance and understanding of the MCA. This is also confirmed by Advocacy Support Cymru, the statutory Independent Mental Capacity Advocacy (IMCA) provider.

ASSURANCE is provided by:

This information does not provide direct assurance about compliance with the MCA, which can only be done by scrutinizing patient notes.

The reports at Appendix 1 and Appendix 2 provide some evidence of adherence to the MCA but only limited assurance.

RECOMMENDATION

The Committee is asked to:

- **NOTE** this report.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration	√	Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION
October 2020

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/7/19 – 30/9/19	32
1/10/19 – 31/12/19	45
1/1/20 – 31/3/20	39
1/4/20 – 30/6/20	29
1/7/20 – 30/9/20	34

There are no obvious themes or trends to the queries. Some are straightforward, whilst more are complex, including obtaining legal advice and responding to court cases.

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

Referrals from the UHB to IMCA are as follows:

Decision/Issue	April – June 2019	July – Sept 2019	Oct – Dec 2019	Jan – Mar 2020	April – June 2020
Accommodation	12	14	16	14	4
Adult Safeguarding	0	2	1	0	1
Care Review	3	5	1	1	0
Serious Med T/ment	8	10	9	3	6
DoLS s.39A	0	1	0	0	0
DoLS s.39C	0	0	0	0	0
DoLS s. 39D	8	6	6	7	0
DoLS RPR	65	89	81	90	23
TOTAL	**96**	**127**	**114**	**115**	**34**

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

Referrals to the IMCA service between April and the end of June were low, despite the Mental Capacity Act 2005 being unchanged by Coronavirus legislation. Referrals for the Relevant Person's Representative role (DoLS) were significantly lower.

3) Healthcare Inspectorate Wales (HIW) reports

There were two published inspection reports about UHB services in the period July - September 2020 –

- **UHW – Emergency Unit and Medical Assessment Unit – follow up inspection**

  This stated –

  - *…….. Mental Capacity Act training is mandated and the e-learning is accessible to all staff. Since the beginning of May completion of training is recorded on the Electronic Staff Record (ESR). Historical attendance at training will be captured and departmental compliance will be reportable within a month. Compliance with MCA training will be reviewed and monitored through the performance reviews*

  - *The Mental Capacity Act manager delivered face to face training for all nursing staff last year. This is repeated intermittently*

  - *There is a mental health link worker and a consultant lead identified to support staff around issues relating to DoLs and Mental Capacity assessments*

- **UHL, Elm and Maple Wards, Hafan y Coed**

  As part of the Immediate Improvement Plan, the UHB was required to inform HIW of details of the action taken to improve the compliance rates for training of staff who were non-compliant (this would include Mental Capacity Act training, which is mandatory).

Neither of the reports made mention of whether clinicians were complying with MCA regarding treatment and care.

4) Complaints from patients/carers

No complaints regarding clinicians' failure to comply with MCA was brought to the attention of the MCA Manager since the last report.

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

The January to March 2020 Casebook has now been published. 4 cases were upheld by the Ombudsman, none of which explicitly mentioned MCA issues. However, there was one case where it wasn't clear in the summary whether or not the patient had impaired mental capacity.

6) Staff MCA training as at 24th September 2020

The following table gives the numbers and percentages of clinical staff who are up to date with their mandatory MCA training. MCA training can be undertaken by completing the all-Wales MCA Level 2 e-learning course on ESR, or by face-to-face training provided by the MCA Manager.

An MCA training session was provided via video conferencing to the Poly-trauma Unit Nurses.

The compliance figures for doctors remain disappointing, as MCA is a key part of the legal framework that governs the provision of treatment and care.

CLINICAL BOARD	Prof Group	No. required to undertake training	No. who are compliant	Compliance %
Children & Women				
	Allied Health Profs	111	100	90.09
	Nursing & Midwif	1178	989	83.96
	Medical & Dental	198	74	37.37
CD&T				
	Allied Health Profs	753	596	79.15

	Nursing & Midwif	39	34	87.18
	Medical & Dental	109	46	42.20
Medicine				
	Allied Health Profs	3	2	66.67
	Nursing & Midwif	822	609	74.09
	Medical & Dental	251	65	25.90
Mental Health				
	Allied Health Profs	30	26	86.67
	Nursing & Midwif	529	401	75.80
	Medical & Dental	83	17	20.48
PCIC				
	Allied Health Profs	83	65	78.31
	Nursing & Midwif	355	276	77.75
	Medical & Dental	65	20	30.77
Specialist				
	Allied Health Profs	38	34	89.47
	Nursing & Midwif	848	651	76.77
	Medical & Dental	241	37	15.35
Surgery				
	Allied Health Profs	16	15	93.75
	Nursing & Midwif	445	333	74.83
	Medical & Dental	493	112	22.72

APPENDIX 2

Mental Health and Capacity Legislation Committee

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

Cardiff and Vale University Health Board

IMCA referrals

Total number of referrals received from April 2020 – June 2020 – 36 Referrals

- Serious Medical Treatment – **6**
- Long Term Move of Accommodation (LTMA) – **4**
- Adult Safeguarding – **1**
- Care Review – **0**
- Relevant Person's Representative (RPR) – **23**
- IMCA 39d – **2**
- IMCA 39C – **0**
- IMCA 39a – **0**

Service issues/Areas of concern

- General lack of referrals across all decisions.
- General lack of understanding and acknowledgement from professionals across the health board in relation to the role of the IMCA.
- IMCAs are repeatedly explaining to professionals the purpose of the Best Interests process, explaining in detail about the "less restrictive" principle and why the patient should be central to the process. IMCAs also question staff about the legal authority (or lack of it) they are using in order to impose a decision on a client who is objecting and protesting to the Best Interest outcome.
- Difficulty in getting through to certain wards/professionals - Some wards have been closed to visitors, so at times, all advocacy needed to be completed over the phone, however, certain wards have been very difficult to get hold of, and the IMCA has been concerned that this will/has delayed the best interests process.

Positive practises observed by IMCAs

- The IMCA team have had very positive experiences with the Patient Experience Team at Llandough Hospital and UHW, who have been facilitating conversations between the IMCAs and their clients on the wards.

Report Title:	**Internal Audit Report on Deprivation of Liberty Safeguards**							
Meeting:	**Mental Health and Capacity Legislation Committee**				**Meeting Date:**	**20/10/2020**		
Status:	**For Discussion**	**X**	**For Assurance**		**For Approval**		**For Information**	
Lead Executive:	**Executive Nurse Director**							
Report Author (Title):	**Executive Nurse Director**							

Background and current situation:

The purpose of the Deprivation of Liberty Safeguards (DoLS) Internal Audit was to evaluate and determine the adequacy of the systems and controls in place for the management of DoLS and provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

Executive Director Opinion / Key Issues to bring to the attention of the Board / Committee:

The level of assurance for the effectiveness of the system of internal control in place to manage the risks associated with established controls within the DoLS is reasonable.

Improvements have been made since the initial internal audit carried out in early 2018.

In April 2020 the Executive Nurse Director became the responsible officer and on reviewing the resources does not currently believe there is adequate resources to address the number of applications received. However, a new LPS process was due in Autumn 2020, due to COVID-19 this will now be delayed until spring when resources, systems and processes will need to be reviewed.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

Significant risks to achievement of a system objective or evidence present of material loss, error or misstatement due to poor key control design or non compliance with key controls.

Recommendation:

The Committee is asked to **NOTE** that further work needs be undertaken to progress the audit outcomes by the next meeting.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

Deprivation of Liberties Safeguards (DoLS)

Final Internal Audit Report

Cardiff and Vale UHB

2019/20

NHS Wales Shared Services Partnership

Audit and Assurance Services

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Auditor/s:	Lucy Jugessur, Cara Vernon
Executive sign off:	Stuart Walker, Medical Director
Distribution:	Jason Roberts, Deputy Executive Nurse Director Julia Barrell, Mental Capacity Act Manager Susan Broad, MCA / DoLS Co-ordinator
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

ACKNOWLEDGEMENT
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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1. Introduction and Background

The review of the Deprivation of Liberties Safeguards (DoLS) has been completed in line with the 2019/20 Internal Audit plan for Cardiff and Vale University Health Board.

The relevant lead Executive Director for this review is the Medical Director.

The Deprivation of Liberty Safeguards were introduced to prevent breaches of the European Convention of Human Rights (ECHR), Article 50 Right to Liberty and security of Person. The safeguards were introduced as an amendment to the Mental Capacity Act 2005 and came into force on the 1st April 2009. Thus, a legal framework now exists to provide authorisation to deprive vulnerable adults of their liberty in a care home or hospital setting. The safeguards are for adults aged 18 years and over who have a mental disorder and who lack capacity to decide where they need to reside to receive treatment and/or care.

If a hospital or care home, referred to as a Managing Authority, needs to deprive a person of their liberty, in their best interests, to keep them safe from harm, then the Managing Authority needs to apply for a DoLS authorisation (i.e. permission) through the DoLS team. Following assessment by a Best Interests assessor and a Doctor, if appropriate/needed the Supervisory Body (Local Authority or Health Board) gives permission to deprive a person of their liberty by granting a DoLS Authorisation.

DoLS is governed by law, Regulations and a Code of Practice that has statutory force- i.e. it must be followed, unless there is good reason not to. There is also a considerable body of case law on deprivation of liberty and DoLS.

In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. This is due to come into force on 1st October 2020.

The DoLS process within the Health Board was previously subject to Internal Audit review in 2015/16. The resultant limited assurance report was subject to detailed follow-up in early 2018 when it was identified that a number of issues were still outstanding. Given the time elapsed since the original review, it has been decided that the DoLS process will now be subject to a new full review.

2. Scope and Objectives

The objective of the audit was to evaluate and determine the adequacy of the systems and controls in place for the management of DoLS, in order to provide assurance to the Health Board Audit Committee that risks material to the achievement of system objectives are managed appropriately.

The purpose of the review was to establish if adequate procedures are in place within the Health Board to ensure that DoLS are consistently complied with and authorisations are obtained for all relevant patients.

The main areas that the review has sought to provide assurance on are:

- The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty;
- Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes;
- Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales;
- All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales;
- All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met;
- All DoLS authorisations are correctly signed by the Supervisory Body;
- Processes are in place for monitoring and reporting compliance with DoLS and any issues are appropriately escalated and addressed: and
- The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards.

3. Associated Risks

The potential risks considered in this review are as follows:

- Non-compliance with DoLS due to lack of processes / awareness;
- Patients may be unlawfully deprived of their liberties; and
- The Health Board is unaware of issues relating to DoLS compliance.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within the Deprivation of Liberties Safeguards (DoLS) is **Reasonable assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

The Audit was assessed as reasonable assurance as there have been improvements made since the previous Internal Audit review in early 2018. There has been a decrease overall in the number of DoLS standard and further requests being submitted and it was identified that they were being completed in a timelier manner. In addition, the review highlighted that the DoLS assessments were being authorised on a timely basis as the Health Board have identified additional staff members to undertake signing off the DoLS assessments.

There are still some issues identified as part of the review as there has been a vast increase in the number of urgent DoLS requests and staff are not able to always complete them within the required seven days as documented within the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards. Whilst this is a serious issue that the Health Board will need to seek to address, it is noted that all the sampled urgent DoLS requests have been completed but not in line with the stipulated time limits.

It was evident from our review that there has been a significant increase in awareness of DoLS as identified from our discussions with ward staff and having a specific Nurse managing the process within the Stroke unit. However, there has only been one DoLS training session carried out this year as the others have been cancelled due to the lack of numbers of staff attending.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Processes and Guidance				✓
2	Training & Awareness			✓	
3	Raising DoLS requests				✓
4	Assessment of Urgent requests		✓		
5	Assessment of Standard requests			✓	
6	Authorisations				✓
7	Monitoring and Reporting				✓
8	Liberty Protection Safeguards			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted no issues that are classified as weaknesses in the system control/design for Deprivation of Liberties Safeguards (DoLS).

Operation of System/Controls

The findings from the review have highlighted four issues that are classified as weaknesses in the operation of the designed system/control for Deprivation of Liberties Safeguards (DoLS).

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: The Health Board has appropriate processes and guidance in place to ensure compliance with DoLS in order to avoid unlawful deprivations of liberty

We note the following areas of good practice:

- There is a section on the Cardiff and Vale UHB Intranet for DoLS and available on there is documentation relating to DoLS such as the Law Societies document on "Identifying a deprivation of liberty: a practical guide" and the Department of Health document titled "Mental Capacity Act 2005 Deprivation of Liberty Safeguards".
- The UHB utilises and complies with the DoLS Code of Practice.
- A proforma has been developed within the Health Board to assess whether the ward should apply for a DoLS authorisation assessment for a patient.
- Audit selected a sample of wards to establish whether ward staff were able to identify patients that required DoLS. It was evident from discussions that ward staff were able to identify patients that require a DoLS and the forms that required completion.

We did not identify any findings under this objective.

Objective 2: Adequate training on DoLS (based on the guidance) is provided to all relevant staff and systems are in place to raise awareness of the UHB processes

We note the following areas of good practice:

- It was evident that the awareness of DoLS has increased within the Health Board based on discussions with ward staff. In addition, there has been an increase in the DoLS requests made to the DoLS team which shows an awareness of DoLS.

We identified the following findings:

- There are only 33 staff who have undertaken the statutory and mandatory training on DoLS.
- Audit was advised that a number of planned DoLS training sessions have had to be cancelled due to the number of employees that have been unable to attend. It was reported in the DoLS Annual Report that only one monthly training session has taken place so far this year and all others have been cancelled due to non-attendance.

Objective 3: Requests for urgent and / or standard DoLS authorisations are made for all relevant patients within the required timescales

We note the following areas of good practice:

- Audit visited a sample of four wards and the requests for urgent and / or standard DoLS authorisations were undertaken in a timely fashion. It was identified during the review that all DoLS documentation was available on the patients' files.

We did not identify any findings under this objective.

Objective 4: All requests for urgent DoLS authorisations are appropriately assessed within the statutory timescales

We note the following areas of good practice:

- All sampled urgent requests had been appropriately assessed and outcomes determined.

We identified the following findings:

- Audit reviewed a sample of 25 urgent requests to establish if they had been completed in line with the required statutory timescales and 22 urgent requests had failed to be completed within the seven days.

Objective 5: All requests for standard DoLS authorisations are appropriately assessed within a reasonable timescale and the level of risk is assessed and managed where the statutory timescales are not met

We note the following areas of good practice:

- It was identified from review of standard and further DoLS authorisations that they were adequately assessed and outcomes reached.

We identified the following finding:

- Audit selected a sample of 5 standard and further DoLS authorisations and two of the five had been completed within the 21 days. It was evident that there had been a vast improvement in the time taken to complete the standard and further authorisations.

Objective 6: All DoLS authorisations are correctly signed by the Supervisory Body

We note the following areas of good practice:

- It was identified in the previous Internal Audit review that there was a delay in the authorising of DoLS requests. As part of the current review Audit selected a sample of 30 DoLS requests and all had been authorised in a timely manner. The Health Board has increased the number of senior staff that are authorised to approve DoLS requests.

We did not identify any findings under this objective.

Objective 7: Processes are in place for monitoring and reporting compliance with DOLs and any issues are appropriately escalated and addressed

We note the following areas of good practice:

- The MCA / DOLs Coordinator provides a report to the quarterly Partnership Board which includes the Health Board, Cardiff Council and Vale Council on number of DOLs requests. This is broken down by the type of requests, withdrawn applications and applications completed and outstanding.
- There is a Health Board Safeguarding Steering Group which meets every two months and the DOLs information is reported into this group.

We did not identify any findings under this objective.

Objective 8: The Health Board has appropriate plans in place to manage the transition to the new Liberty Protection Safeguards

We note the following areas of good practice:

- The Health Board is aware that DoLS are being replaced by Liberty Protection Safeguards (LPS). The law is in place and the Standards come into force in October 2020. The associated Code of Practice has not been produced yet detailing the process to follow.

We identified the following finding:

- Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice to be produced.

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**1**	**2**	**4**

Finding 1 - Timescales for undertaking DOLs Urgent Authorisations (Operating effectiveness)	Risk
Audit obtained a report of all DoLS authorisation requests from January to July 2019 which included 230 urgent requests. A sample of 25 urgent requests was reviewed to establish if they had been completed in line with the required statutory timescales. Below are our findings: • 22 of the urgent requests had failed to be completed within the required 7 days. • The longest time it took to complete an urgent request was 26 days. For those 22 urgent requests not completed within 7 days it took on average 15 days to complete the urgent requests.	Patients may be unlawfully deprived of their liberties
Recommendation	**Priority level**
Staff should attempt to ensure that all Urgent assessments are undertaken within the stipulated seven days as detailed in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	**High**
Management Response	**Responsible Officer/ Deadline**
All attempts are made to ensure the DoLs assessments are carried out within the specified timeframes, however this remains a challenge with the current resource. Only 1.5 wte (out of 6 wte) staff are funded by health with the remaining staff funded by LA. This means that resource is shared between LA assessments also. This position will be reviewed in 2020 with introduction of LPS.	To be confirmed / October 2020

Finding 2 - DOLs Training (Operating effectiveness)	Risk
Audit were advised that July 2019 was the first month that any DoLS training has been carried out formally as there had not been the numbers previously. Six staff are required to undertake the training session for it to be feasible and they were not receiving the numbers so subsequently the training was cancelled. In addition, the DOLs Annual Report submitted to the Safeguarding meeting on the 25 July 2019 confirmed that only one monthly training session took place this year and all others have been cancelled. Audit was provided with DOLs training figures from Workforce and there had been 33 staff who had carried out the statutory and mandatory training on DOLs. Despite the low level of training undertaken, it is noted that the staff members on the wards visited as part of the review, demonstrated a good level of awareness of DoLS requirements and the associated processes.	Non- compliance with DOLs due to lack of processes / awareness
Recommendation	**Priority level**
The Health Board should ensure that staff are provided with appropriate DoLS training and where areas have low compliance these areas should be targeted.	**Medium**

Management Response	Responsible Officer/ Deadline
DoLs training has remained challenging, as it is directly related to the ability of clinical areas to release staff. The inability to release staff for Mandatory and Statutory training remains high on the UHB risk register. Formal monthly training continues to be supported by staff, although attendance poor. Bespoke training (one hour) drop in sessions are now being provided. Training is also incorporated into the general Safeguarding Training to continue to raise awareness of DoLs, however these results are captured in the safeguarding training numbers and not a formal record of DoLs training.	To be confirmed / October 2020

Finding 3 - Completion of standard and further authorisations (Operating effectiveness)	Risk
There were only 27 standard and further DoLS authorisation requests between January - July 2019 and therefore Audit reviewed three standard and two further DOLs authorisation requests to establish if they had been completed in line with the required statutory timescales of 21 days. For the three standard DOLs authorisation requests the following was noted: • One had been completed on the day it was received; • One had been completed in 26 days whilst the third had been completed in 85 days. • The average time taken was therefore 37 days. For the two further DoLS authorisation requests the following was noted:	Patients may be unlawfully deprived of their liberties

• One further DOLs authorisation request was completed in 21 days • The other request was completed in 24 days, just marginally over the required timescales for completion. There has however been an improvement in the number of days taken for the completion of standard and further DoLS authorisation requests as it took on average 80 days to undertake a standard and further DoLS assessment when we carried out the previous review.	
Recommendation	**Priority level**
Staff should attempt to ensure that all Standard and Further assessments are undertaken within the stipulated 21 days as set out in the Department of Health Mental Capacity Act 2005 Deprivation of Liberty Safeguards.	**Low**
Management Response	**Responsible Officer/ Deadline**
All assessments that are deemed as a priority have to be undertaken before the Standard and further assessments as outlined in line with WG priority tool.	To be confirmed / October 2020

Finding 4 - Liberty Protection Safeguards (Operating effectiveness)	Risk
The new Liberty Protection Safeguards (LPS) are coming into force in October 2020. The law is already in place but the Code of Practice has not been produced yet detailing the process to follow. DoLS will be running alongside LPS for a year from October 2020 – October 2021. Currently, there is no plan in place within the Health Board for implementing the LPS as they are awaiting the Code of Practice being produced.	The Health Board is unaware of issues relating to DOLs compliance
Recommendation	**Priority level**
The Health Board need to ensure that they produce a plan for implementing Liberty Protection Safeguards following the production of the Code of Practice.	**Low**
Management Response	**Responsible Officer/ Deadline**
Whilst LPS will come into force in October 2020, we are unable to formulate a plan without the implementation of the code. Scoping meeting planned for 12th December 2019 to develop framework and code and produce work plan across wales for 2020.	To be confirmed / October 2020

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

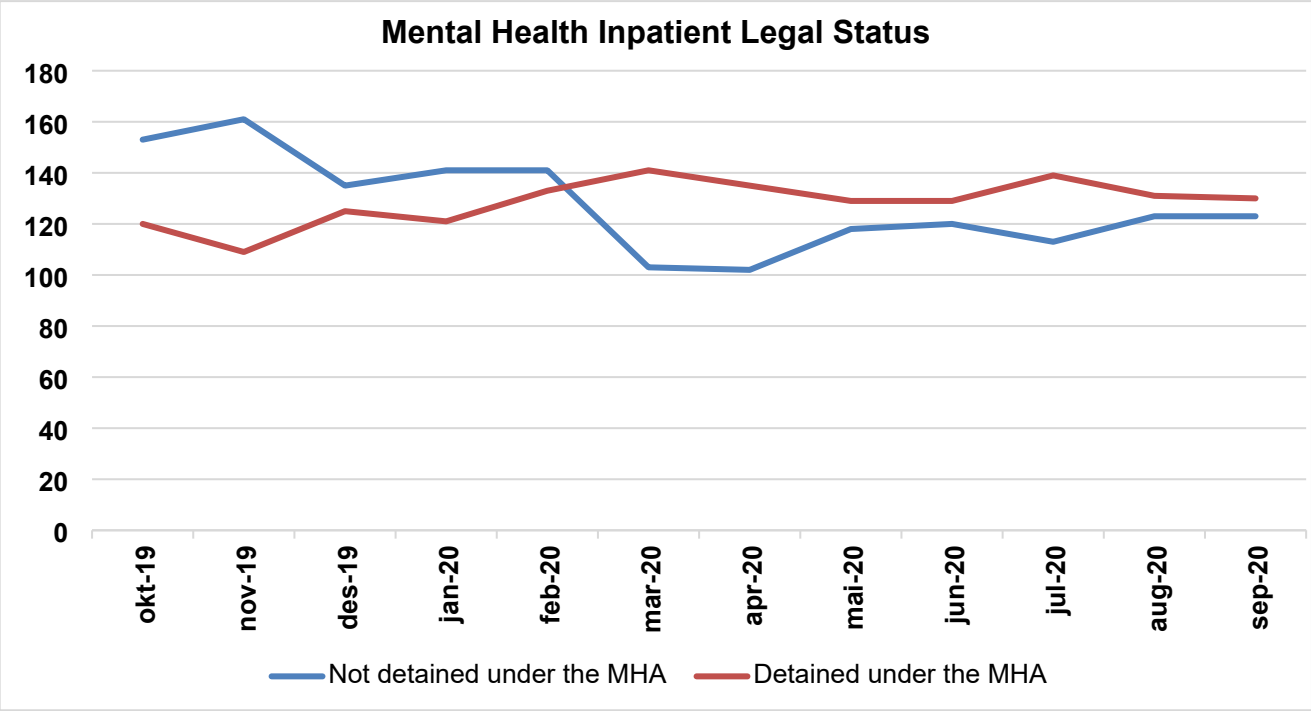
Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**20 October 2020**		
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**	**x**			
Lead Executive:	**Chief Operating Officer**										
Report Author (Title):	**Mental Health Clinical Board Director of Operations**										

Background and current situation:

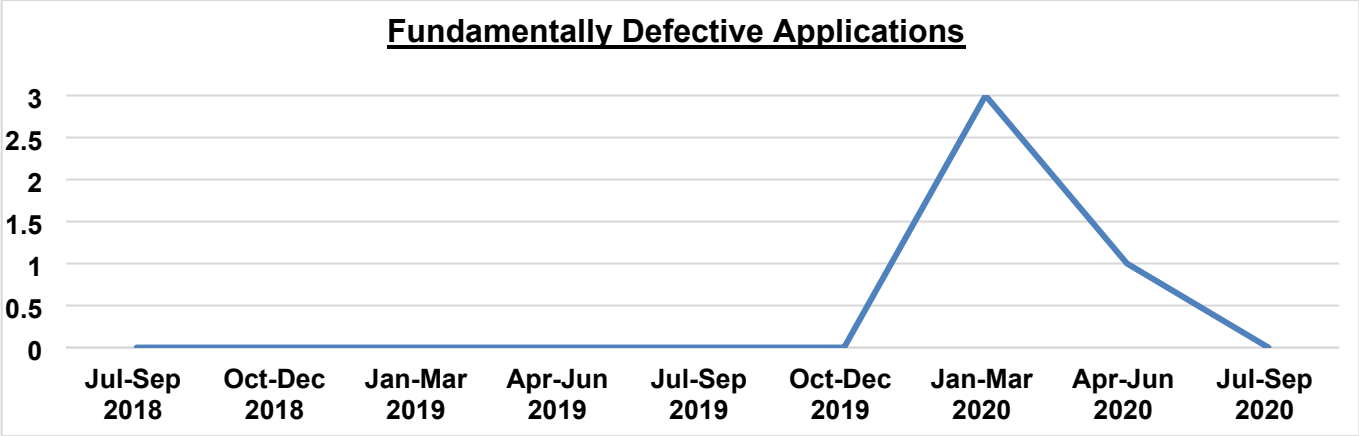
This report provides the Committee with further information relating to wider issues of the Mental Health Act (MHA). Any exceptions highlighted in the MHA Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that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

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:

Use of the Mental Health Act has remained fairly consistent. At the end of Qtr. 4, 58% of mental health inpatients were detained under the Mental Health Act. This indicates a 10% increase since Qtr. 3 reported in December 2019 and is likely to be COVID-19 related due to the closure of some wards and the increase in patients being discharged where possible to accommodate this. At the end of Qtr. 1 this number has reduced to and remains at 51%.



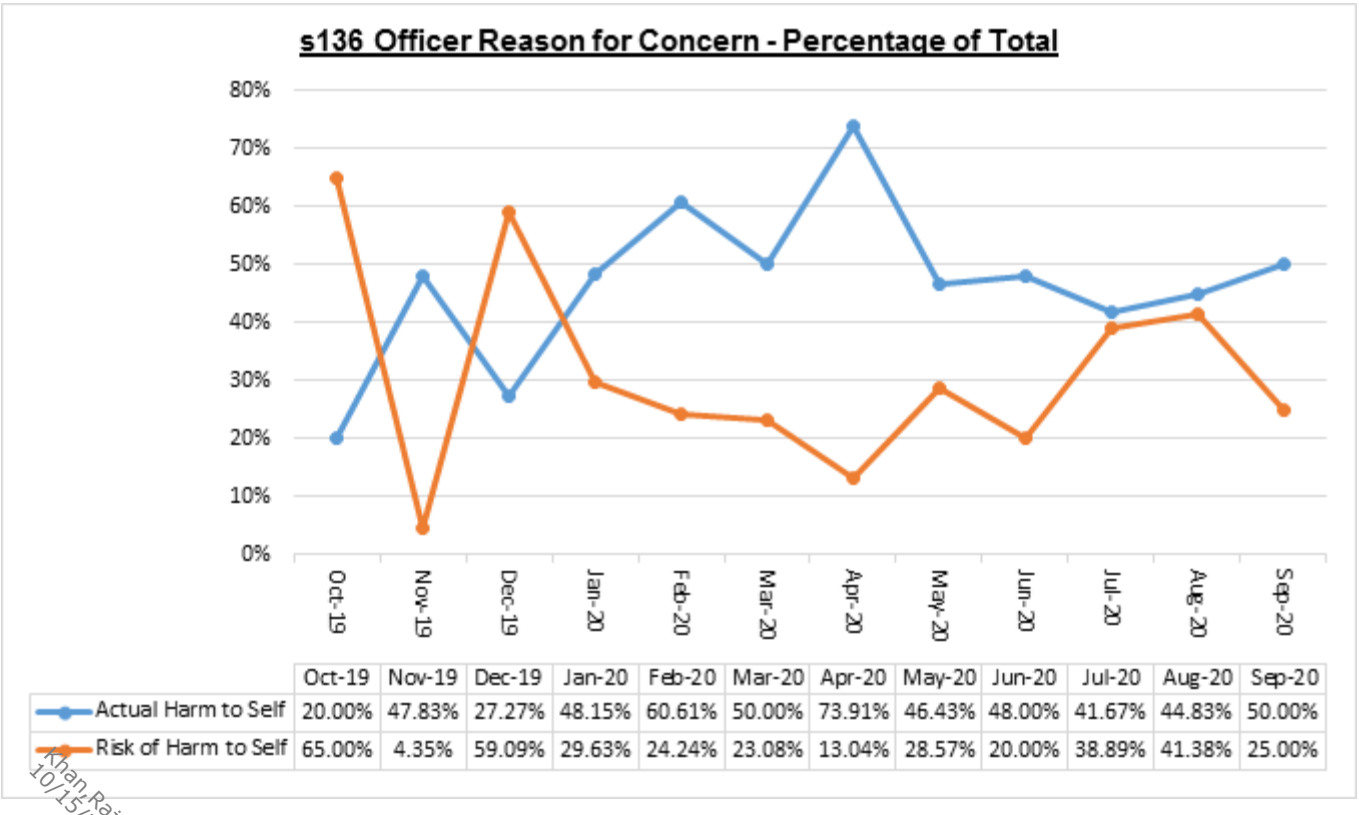
Fundamentally defective applications



During the period there were no fundamentally defective applications for detention recorded.

Section 136

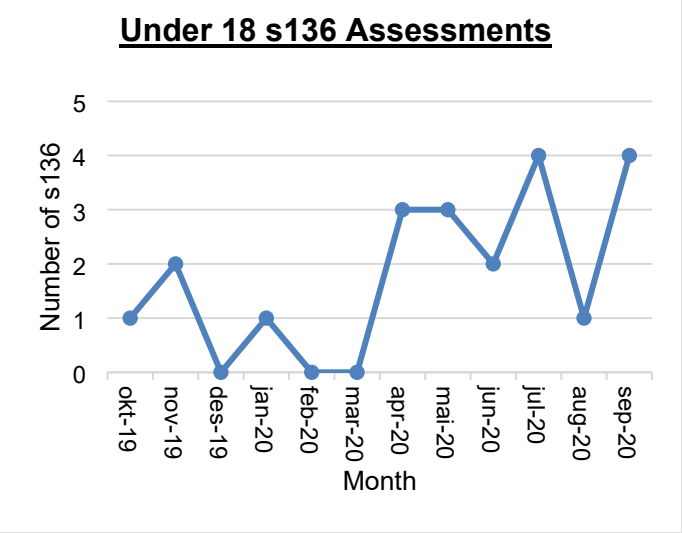
Qtr. 2 continues to indicate a significant consistent increase in cases where there reason for the use of s136 is actual harm. Further to discussion with the South Wales Police representative it is believed that the high level of "Actual Harm to Self" stems from a lack of clarity over its meaning. Officers are choosing this option if there are minor incidental injuries, as well as self-harm. This is an ongoing training issue within SWP which is being hampered by the current pandemic.

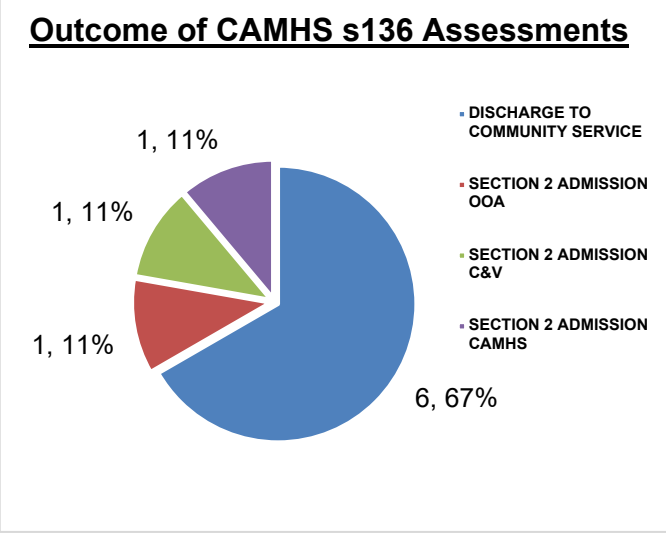


	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Actual Harm to Self	20.00%	47.83%	27.27%	48.15%	60.61%	50.00%	73.91%	46.43%	48.00%	41.67%	44.83%	50.00%
Risk of Harm to Self	65.00%	4.35%	59.09%	29.63%	24.24%	23.08%	13.04%	28.57%	20.00%	38.89%	41.38%	25.00%

Section 136 - CAMHS

The number of those under 18 assessed under section 136 continues to increase in comparison to previous periods. Three of these were in relation to the same patient.





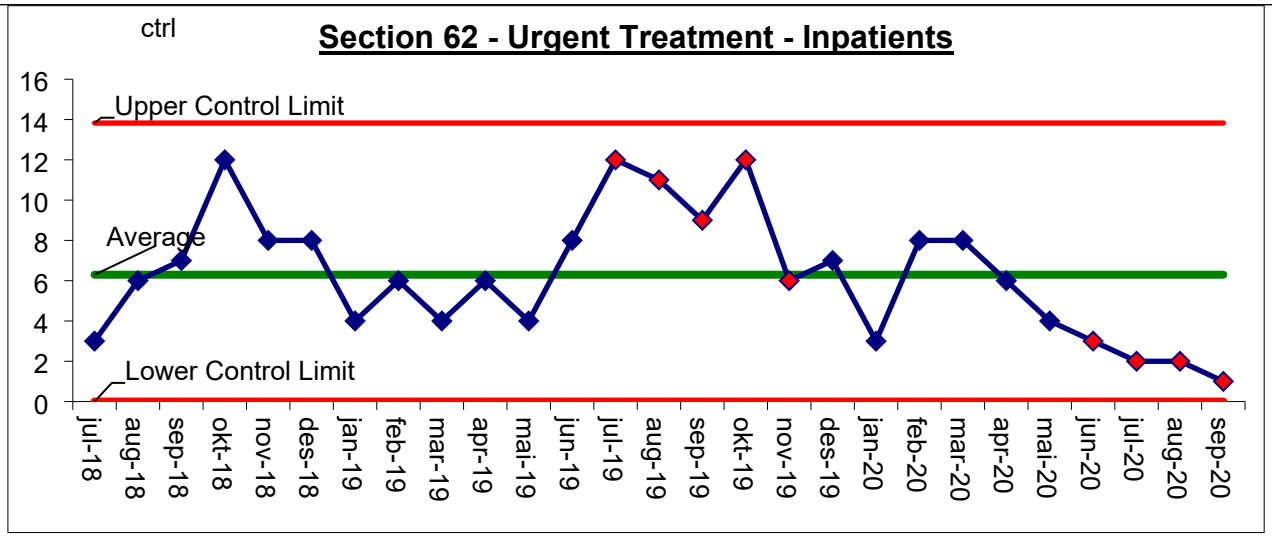
One young person was detained for 11 days under Section 2 in UHW until deemed medically fit for transfer to specialist CAMHS bed.

Section 62

The purpose of this section is to provide for treatment to be given as a response to an urgent situation where the procedures set out for section 57 (special treatments), 58 (medication after three months) or 58A (ECT) cannot be followed.

Hospital Managers should monitor the use of these exceptions to the certificate requirements to ensure that they are not used excessively or inappropriately.

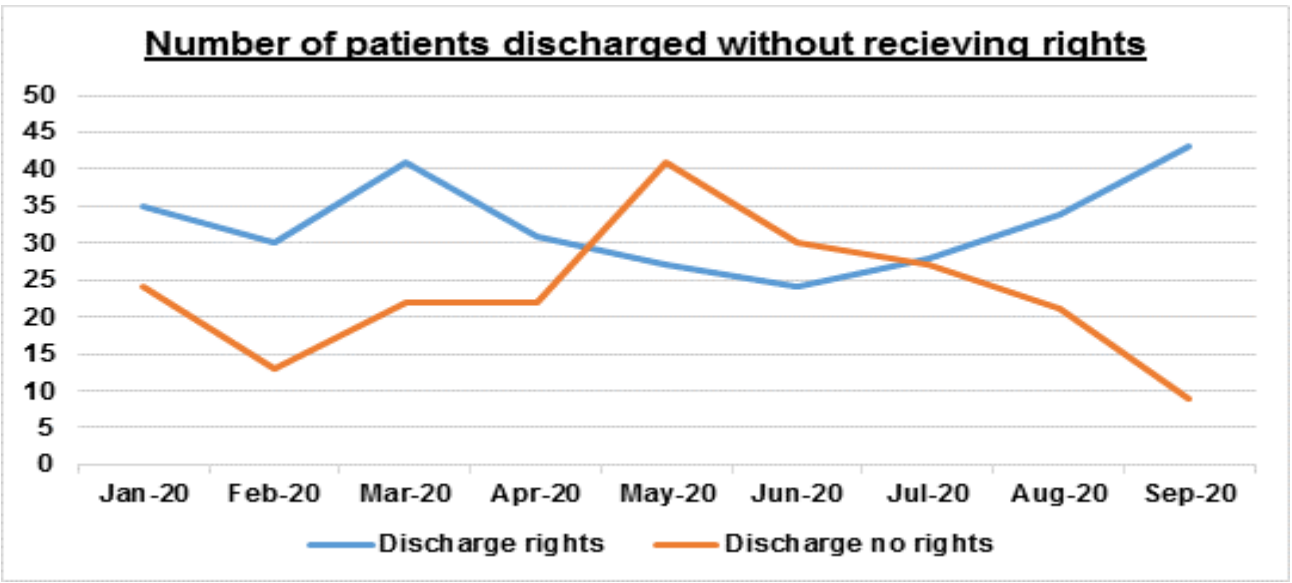
The use of section 62 has significantly reduced since COVID-19. It is likely that the reason for this decline is due to the SOAD service no longer conducting face to face examinations. This in turn has eliminated the delay in SOAD's issuing certificates which is the main reason for use of section 62.



Section 132

Section 132 of the MHA requires hospital managers to take such steps as are practicable to ensure that patients who are detained in hospital under the Act, or whom are subject to a community treatment order (CTO), understand important information about how the Act applies to them. This must be done as soon as practicable after the start of the patient's detention or the CTO.

An audit to monitor compliance has indicated that the UHB's compliance level was less than satisfactory. This issue has been addressed by the Mental Health Clinical Board. The chart below indicates that the situation has now improved significantly.



Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

Fundamentally defective applications
Arrangements between the Local Authority and UHB are working well, communication in relation to receipt of applications for detention under the MHA continues to improve. Development sessions have been reinstated by the Mental Health Act Office. A number of sessions have been delivered to Shift Coordinators who are responsible for receipt and scrutiny out of hours.

Development sessions
The Mental Health Act Awareness sessions have been reinstated and will take place on a monthly basis. In addition to the Receipt and Scrutiny workshops the Mental Health Act Department plan to impliment and deliver the following:

- Patient information
- Consent to treatment
- Section 17 leave and AWOL
- Community Treatment Order
- Part III, MHA

During the period the Mental Health Act Department has provided the following development sessions:

Date	Title	Total in attendance	General concesus feedback
06/08/20	Doctors Induction	15	Excellent/good feedback. Good/clear presentation with good examples and handouts.
11/09/20	Nurse Foundation programme	17	Excellent/good feedback. Very informative and good explanation. Trainer was very knowledgeable.
17/09/20	Receipt & Scrutiny Workshop	4	Excellent feedback. Informative and interactive with good examples.
22/09/20	Receipt & Scrutiny Workshop	3	Excellent/good feedback. Great examples/handouts.
24/09/20	Receipt & Scrutiny Workshop	1	Excellent feedback. Allowed time for questions.
25/09/20	Mental Health Act Awareness	2	Excellent feedback. Concise and informative, good case studies.

Recommendation:

Fundamentally defective applications
Continue to ensure effective communication between the Local Authority and UHB and promote Mental Health Act training across the UHB.

Section 136
Continue to monitor in the Mental Health Act Office. South Wales Police to take forward

identified training need.

Section 136 – CAMHS
Continue to monitor and report accordingly.

Section 132
The Mental Health Act Manager will continue to audit/monitor and report this issue to ensure compliance

Development sessions
Continue to develop a robust rota to ensure that development sessions in relation to all areas of the Mental Health Act are available and easily accessible.

ASSURANCE is provided by:

- **Mental Health Clinical Board Director of Operations**

The Board is asked to: **Support the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA.**

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	~~Yes / No /~~ Not Applicable *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

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

Report to the

Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

July - September 2020

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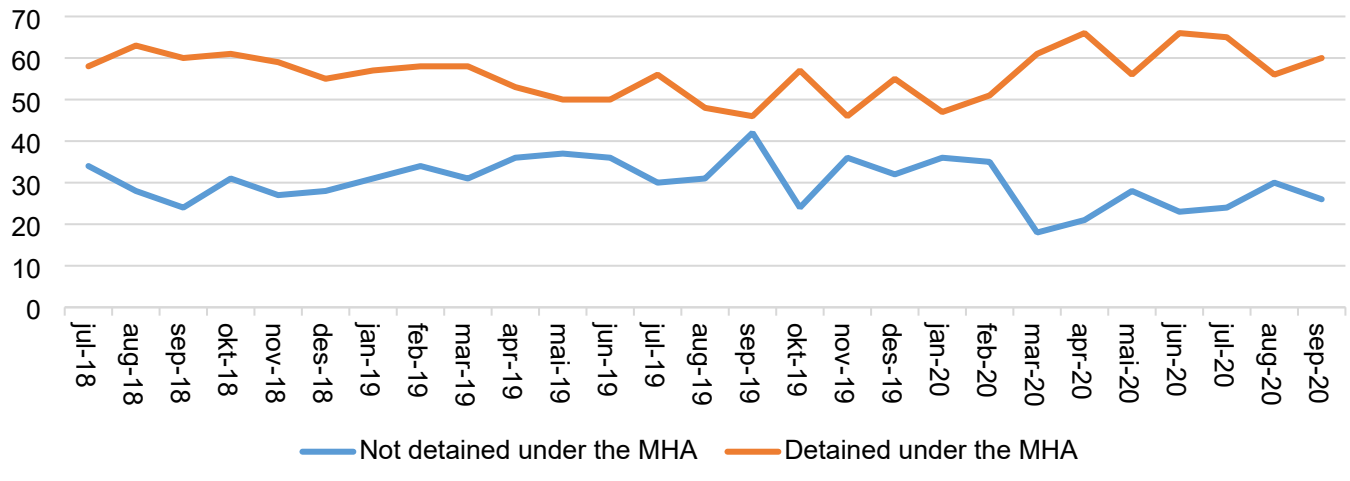
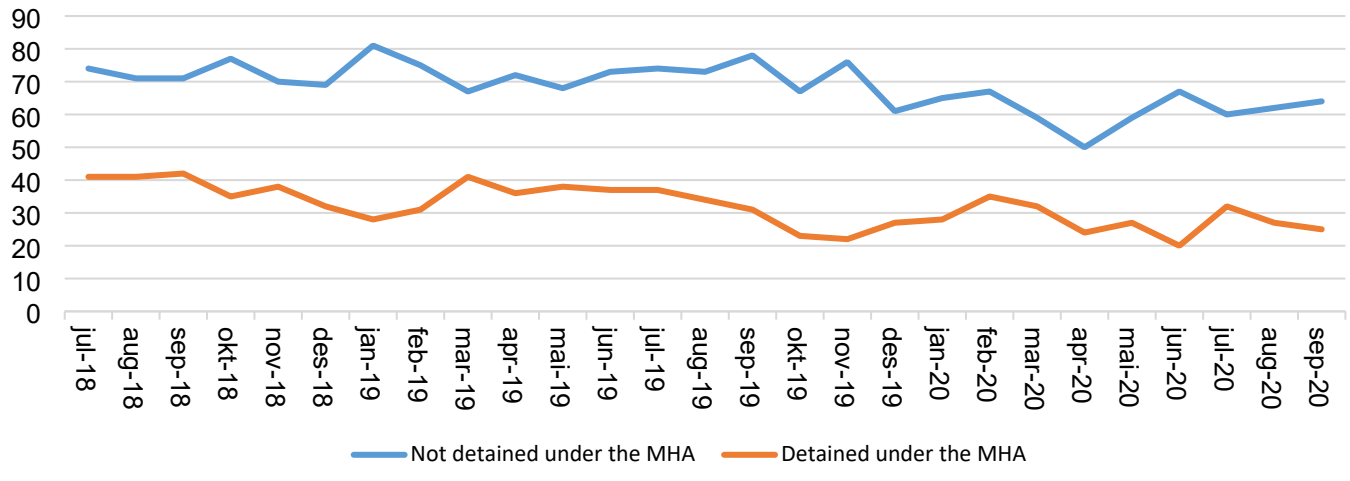
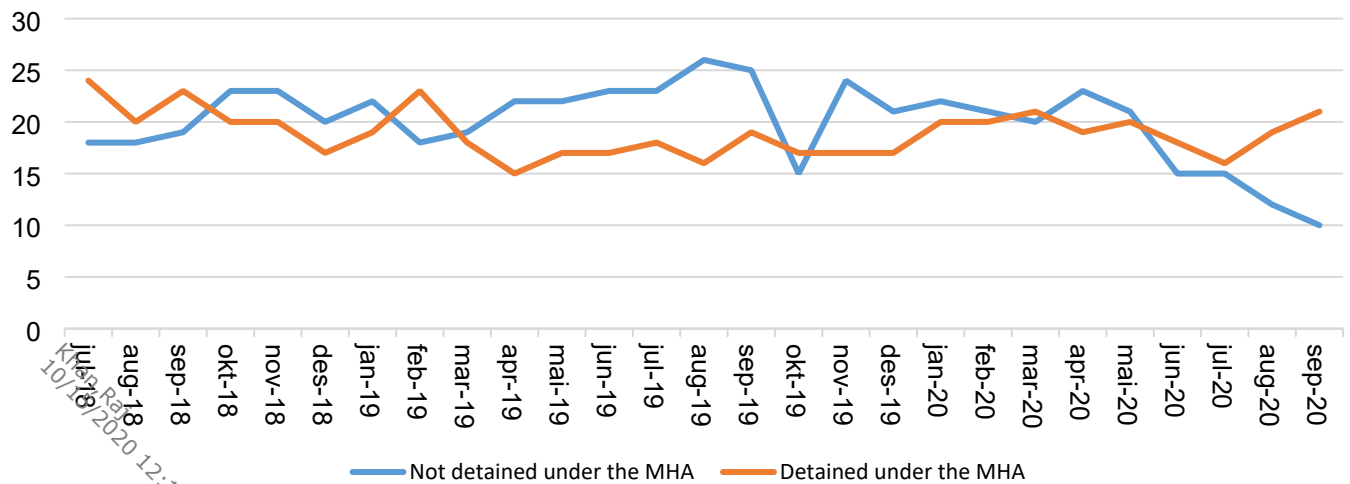


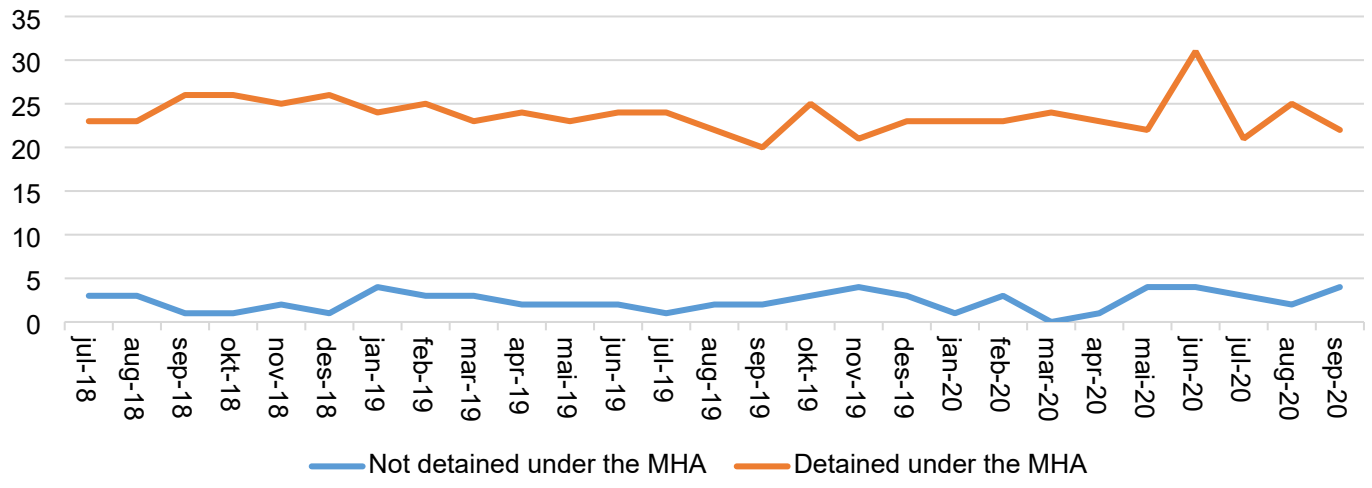
Mental Health Services for Older People - Detained MHA/Not Detained MHA



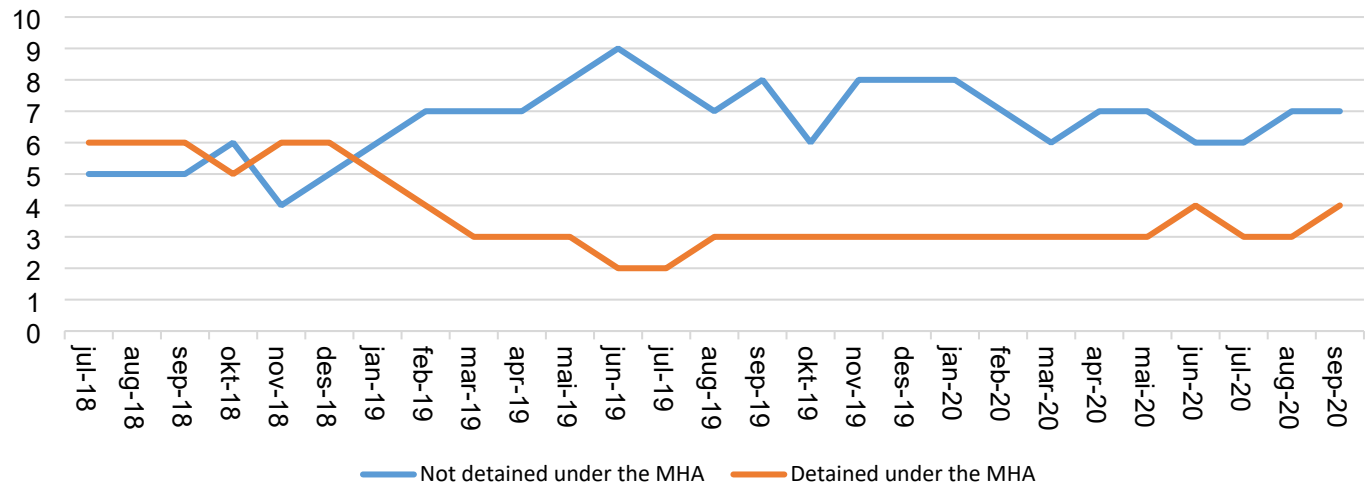
Rehabilitation - Detained MHA/Not Detained MHA



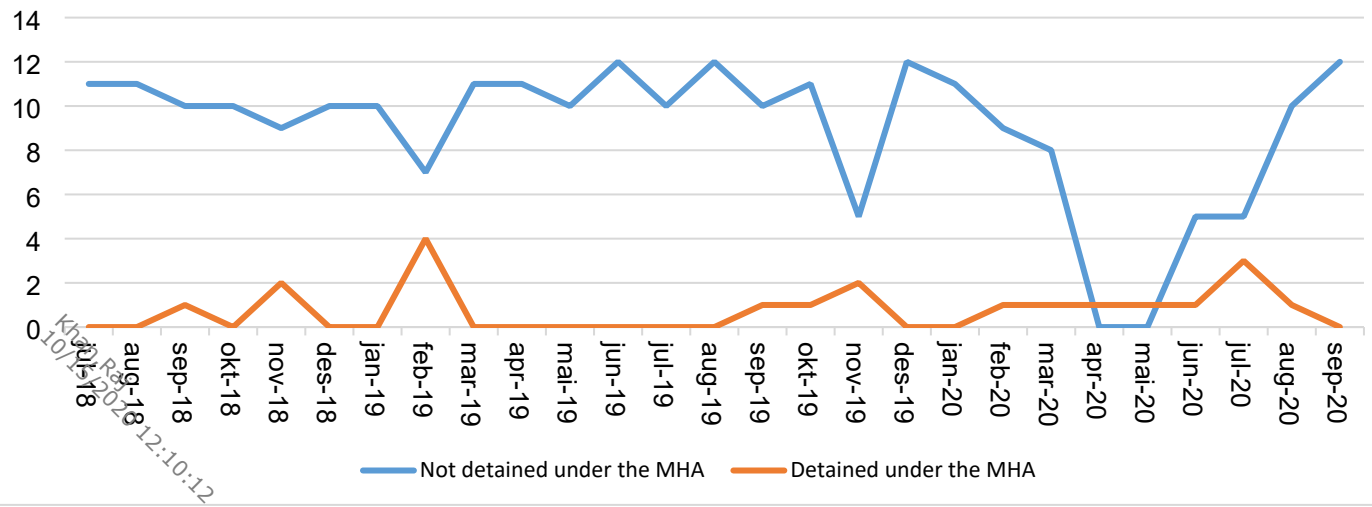
Low Secure - Detained MHA/Not Detained MHA



Neuropsychiatry - Detained MHA/Not Detained MHA

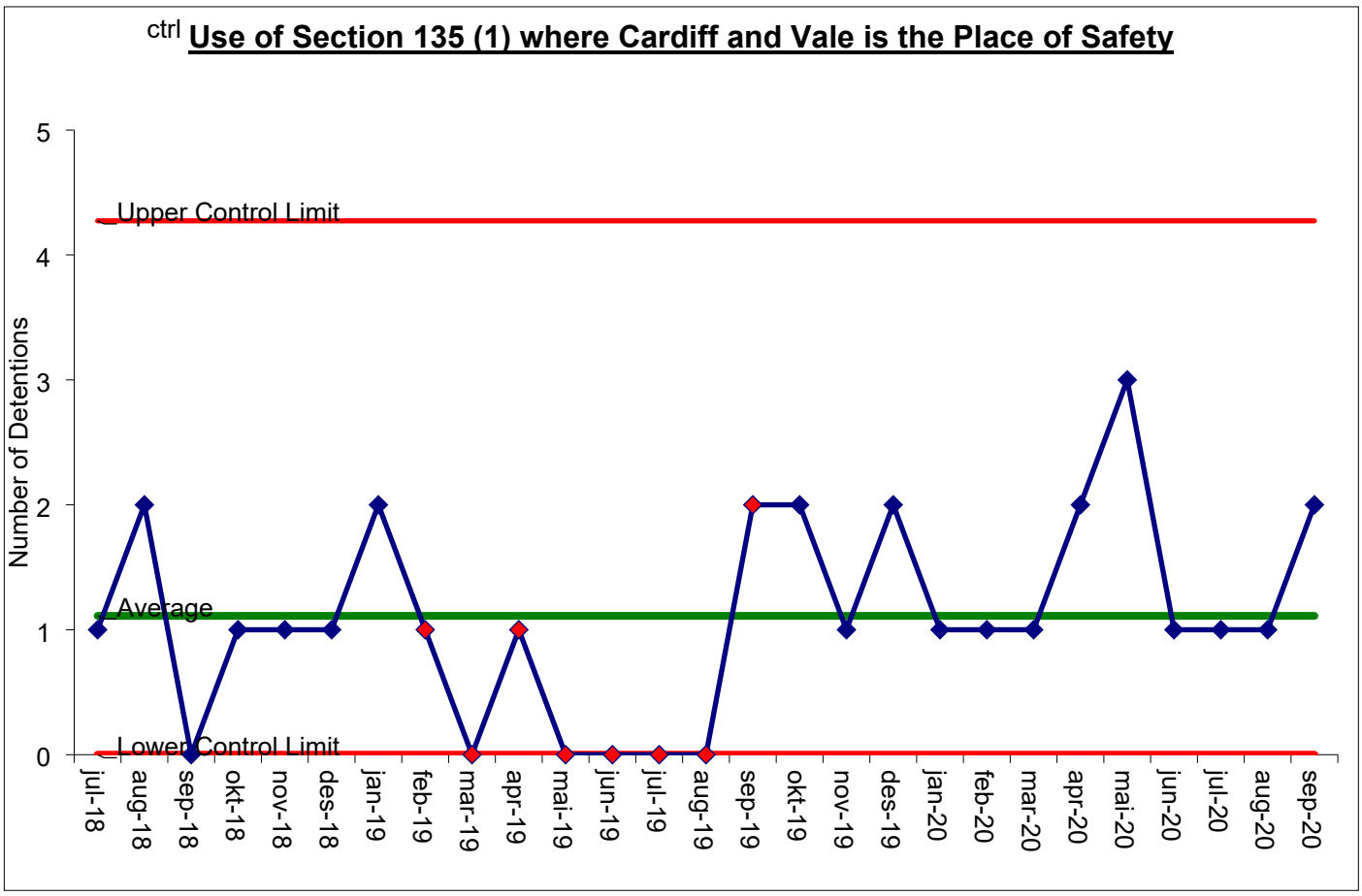


Addictions - Detained MHA/Not Detained MHA



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

During the period Section 135 (1) powers were used on four occasions. Three patients were subsequently admitted under Section 2, and one patient was admitted under Section 3.



Section 135(2) powers were not used during the period.

Voluntary Assessment

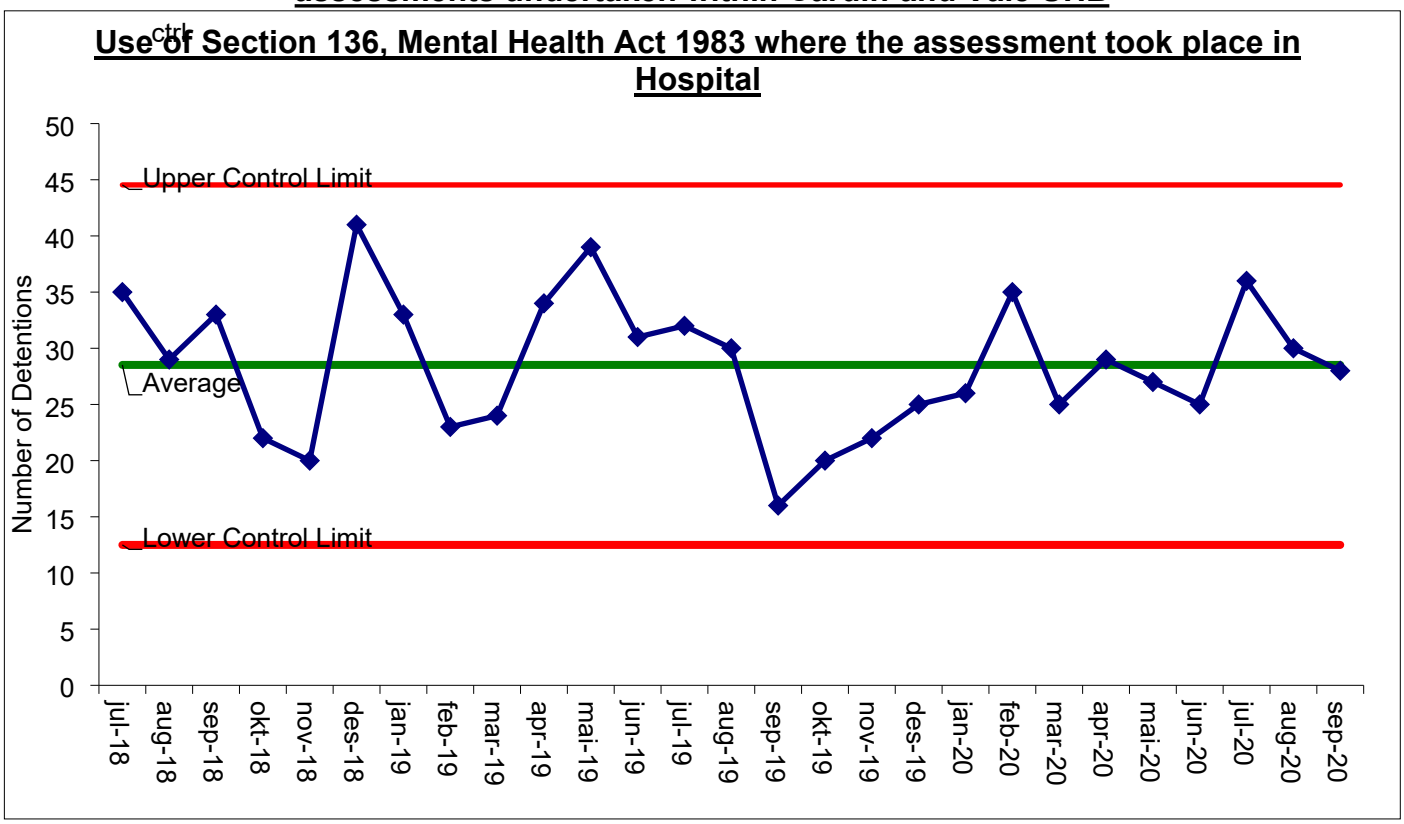
On the 14th of July, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

There has been an initial transition period where the AWMF has been underutilised, but this is improving. A number of measures have been put in place to improve compliance, including (at the advice of South Wales Police) our refusal to accept and assess anybody brought by the Police without the attempt of completing an AWMF.

For this period we have seen two people for a Voluntary Assessment and two were brought into hospital under the Mental Capacity Act.

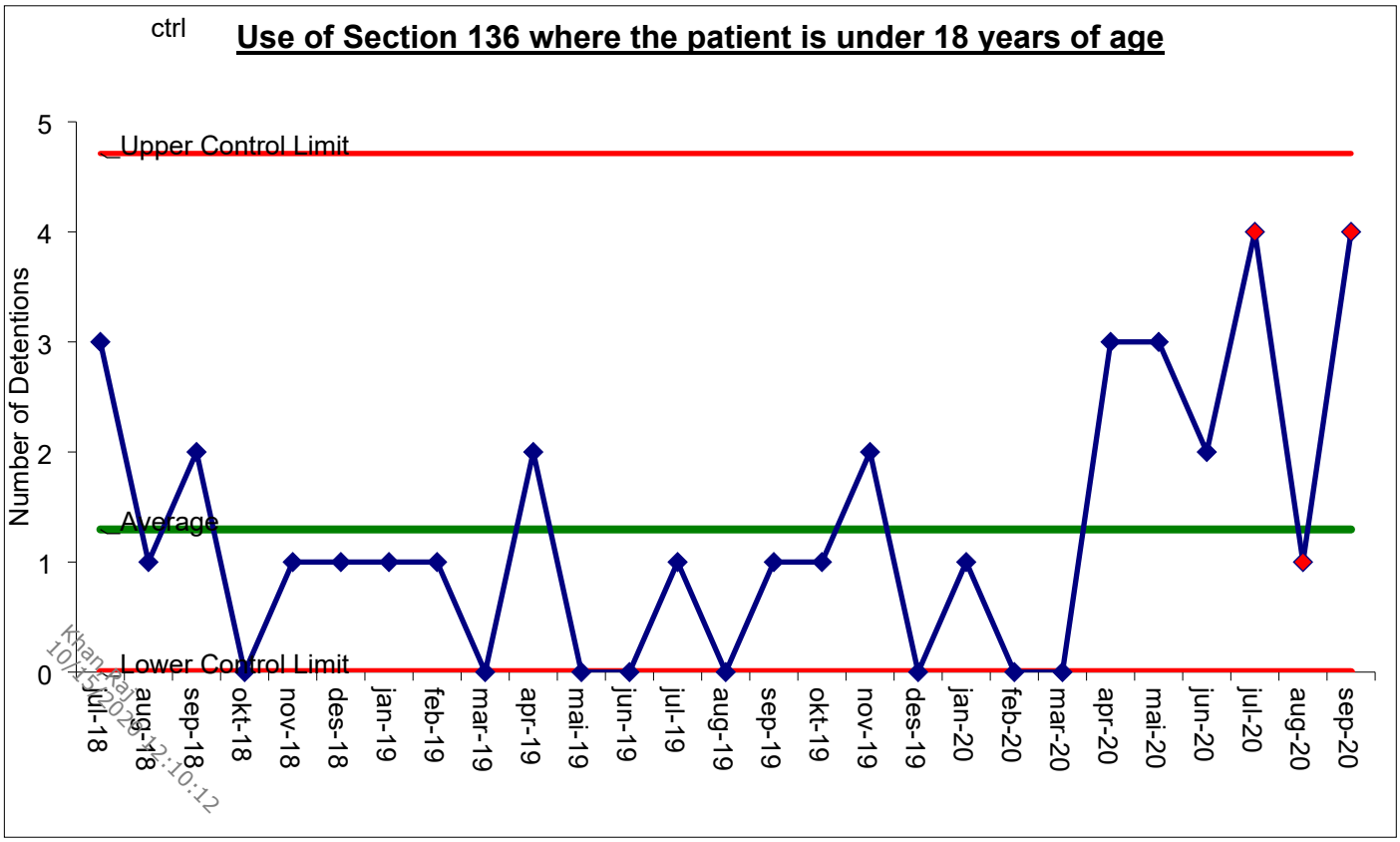
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB



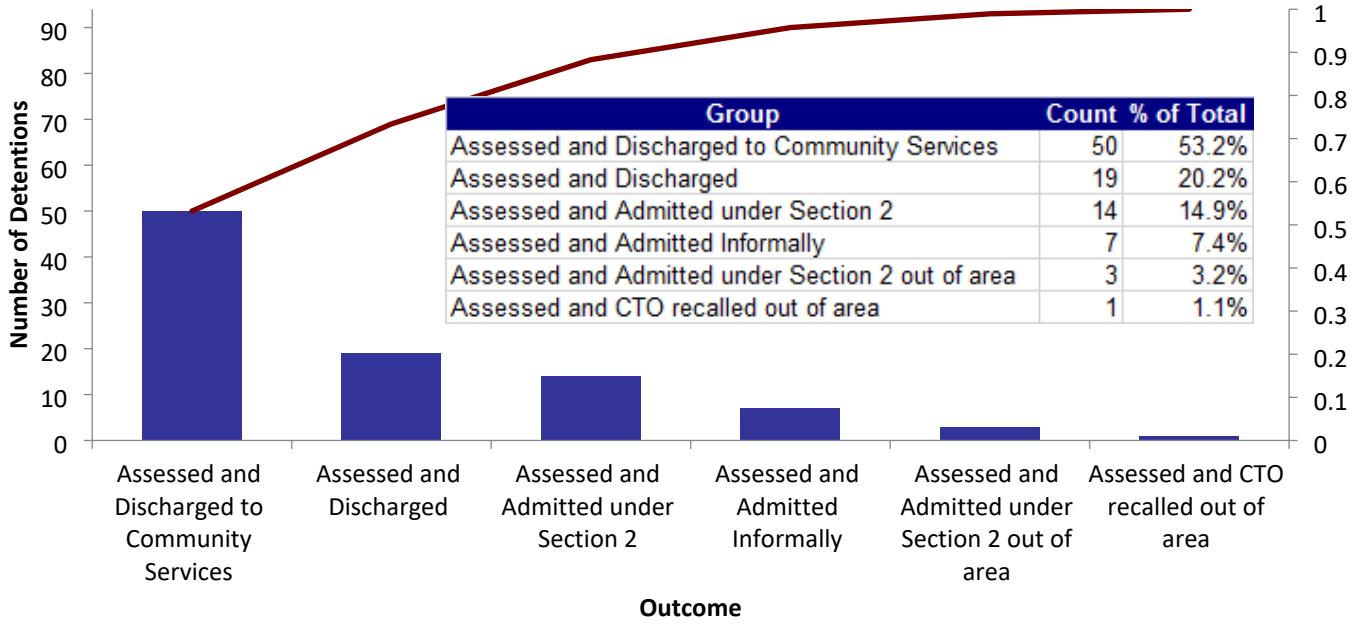
During the period a total of 94 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

Nine of those assessments were carried out on patients under the age of 18.

Included in the above data are those under 18 years of age. This is extracted below;-



Outcome of Section 136 where the Assessment took place in Hospital during the period July - September 2020



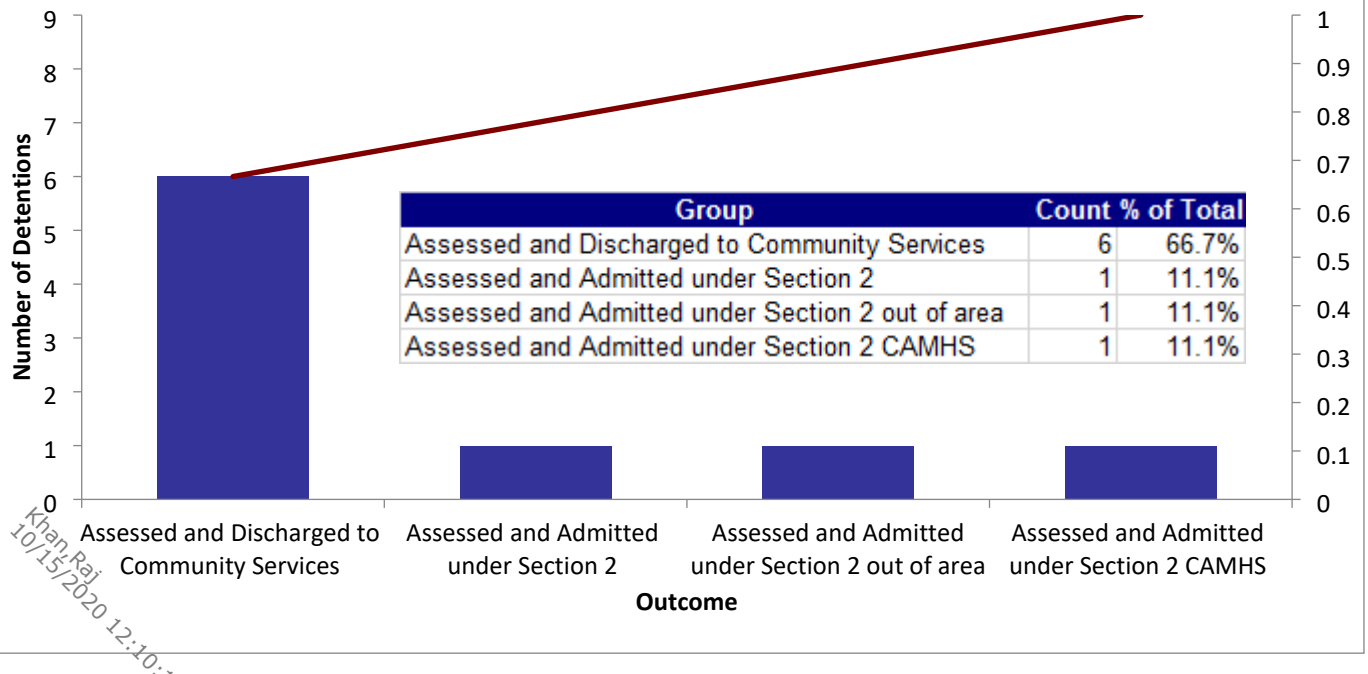
Group	Count	% of Total
Assessed and Discharged to Community Services	50	53.2%
Assessed and Discharged	19	20.2%
Assessed and Admitted under Section 2	14	14.9%
Assessed and Admitted Informally	7	7.4%
Assessed and Admitted under Section 2 out of area	3	3.2%
Assessed and CTO recalled out of area	1	1.1%

The pareto chart highlights that 73.7% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

One of those assessed was detained under Section 2 and admitted to a hospital under a different set of Managers.

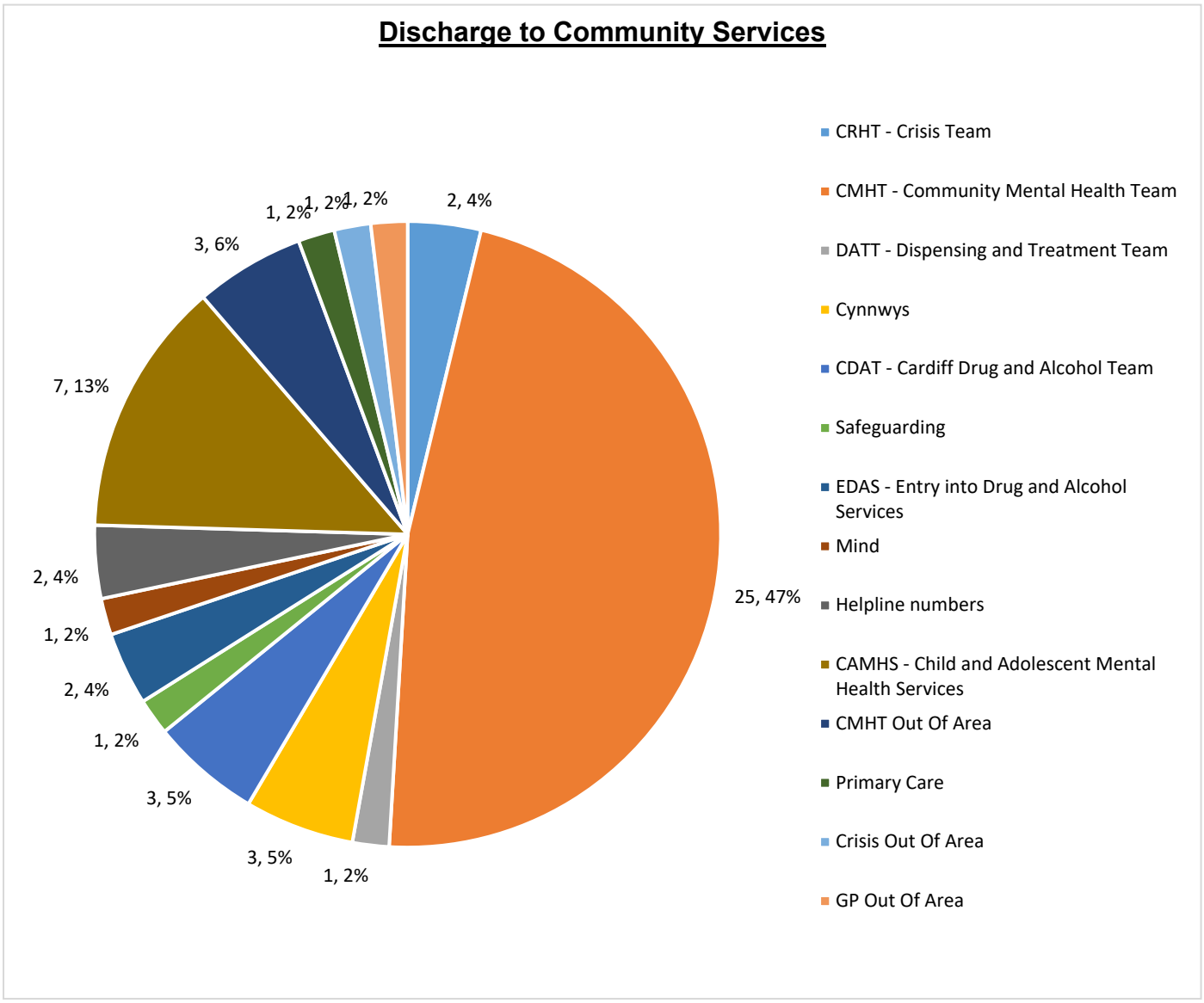
Included in the above data are the outcomes for those under 18 years of age. Those outcomes are as follows;-

Outcome of Section 136 where the patient in under 18 years of age

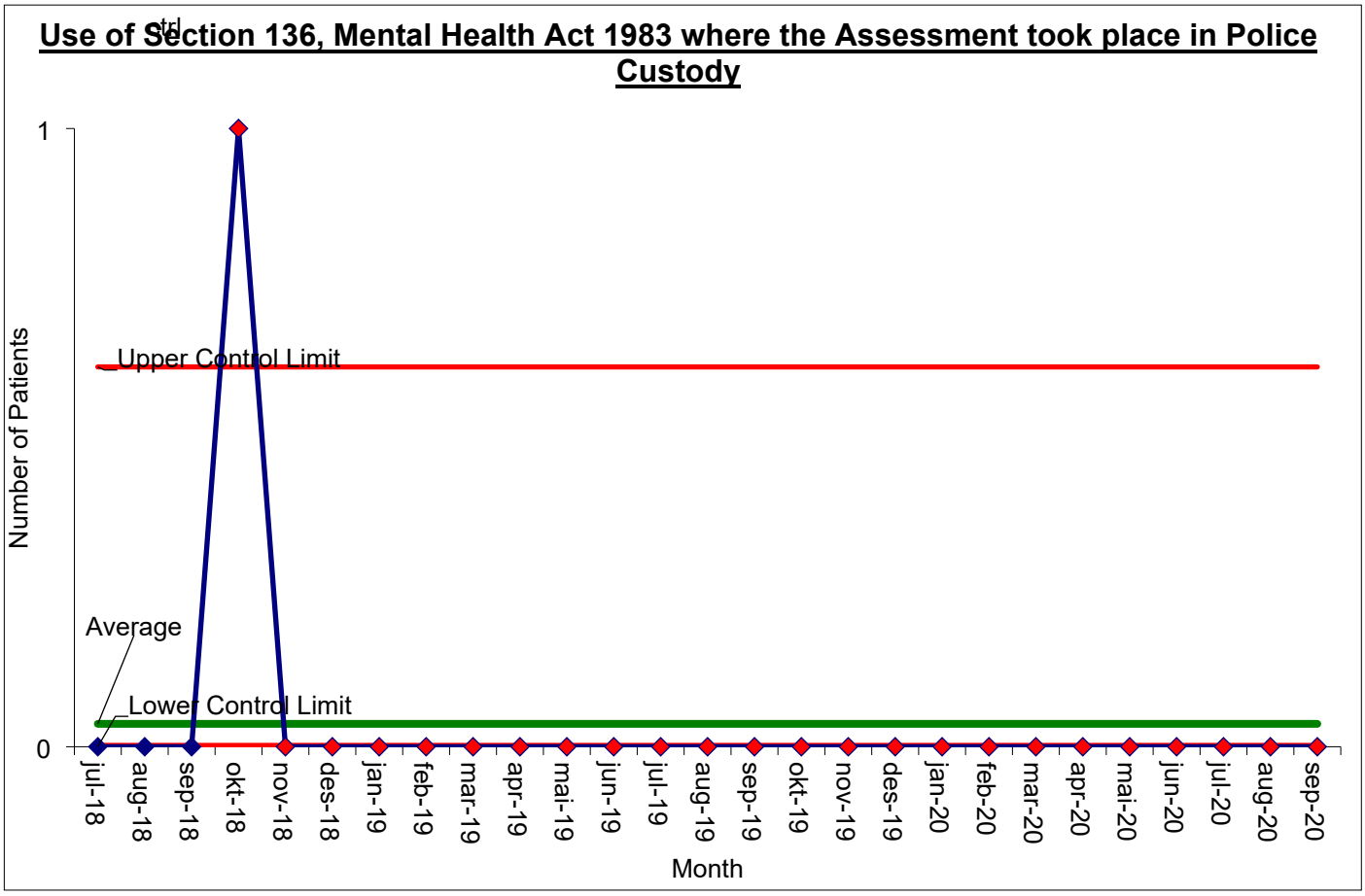


Group	Count	% of Total
Assessed and Discharged to Community Services	6	66.7%
Assessed and Admitted under Section 2	1	11.1%
Assessed and Admitted under Section 2 out of area	1	11.1%
Assessed and Admitted under Section 2 CAMHS	1	11.1%

The below chart is a breaksown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

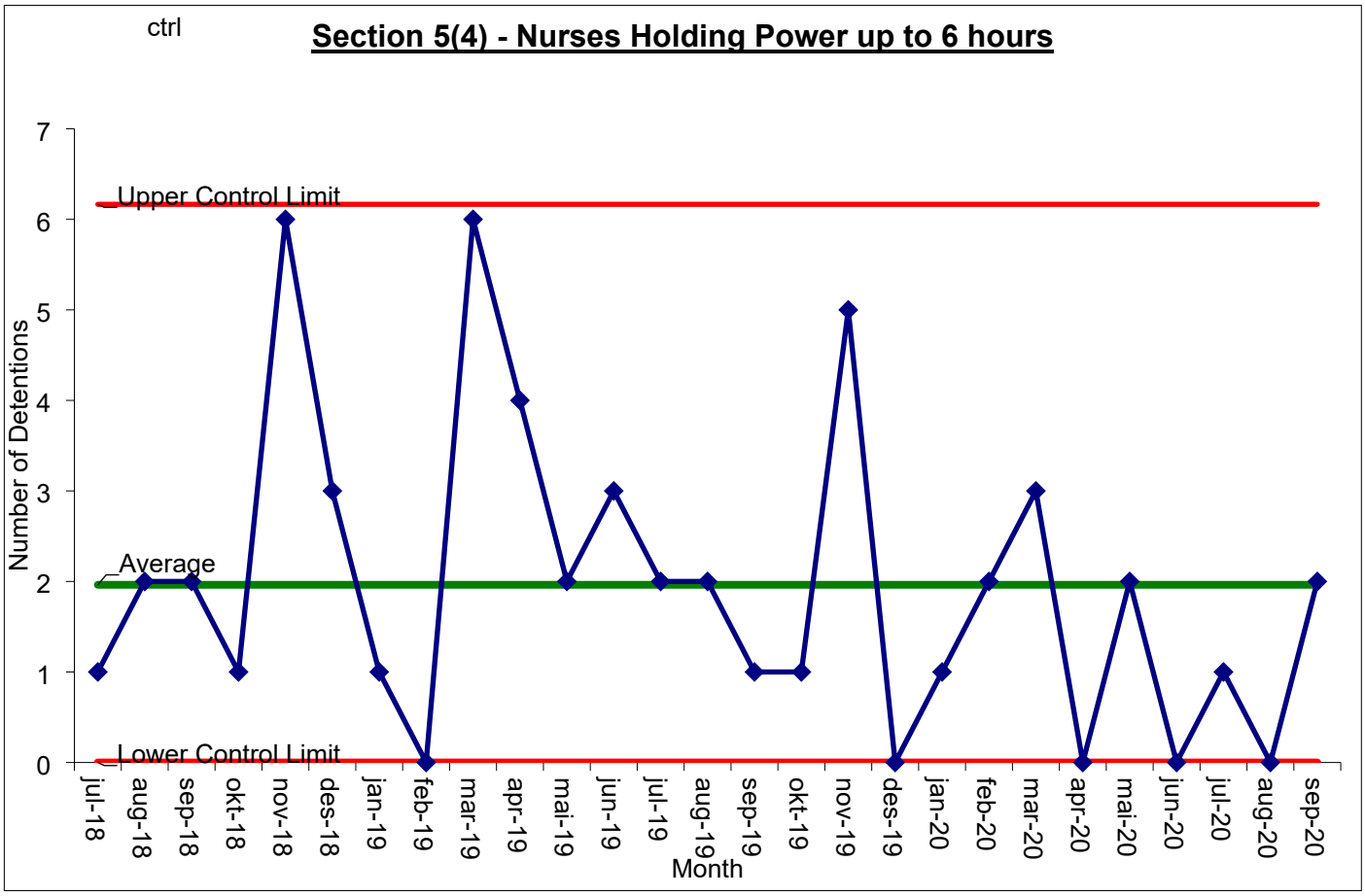


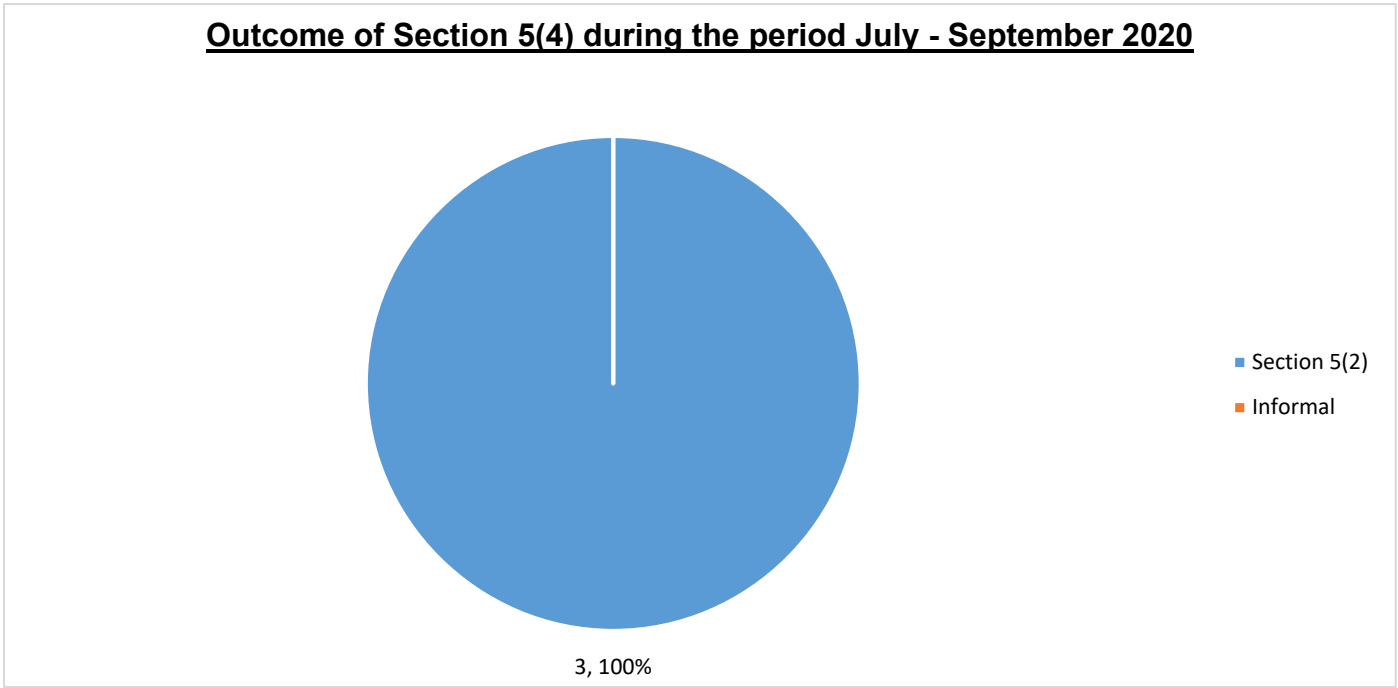
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station



During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

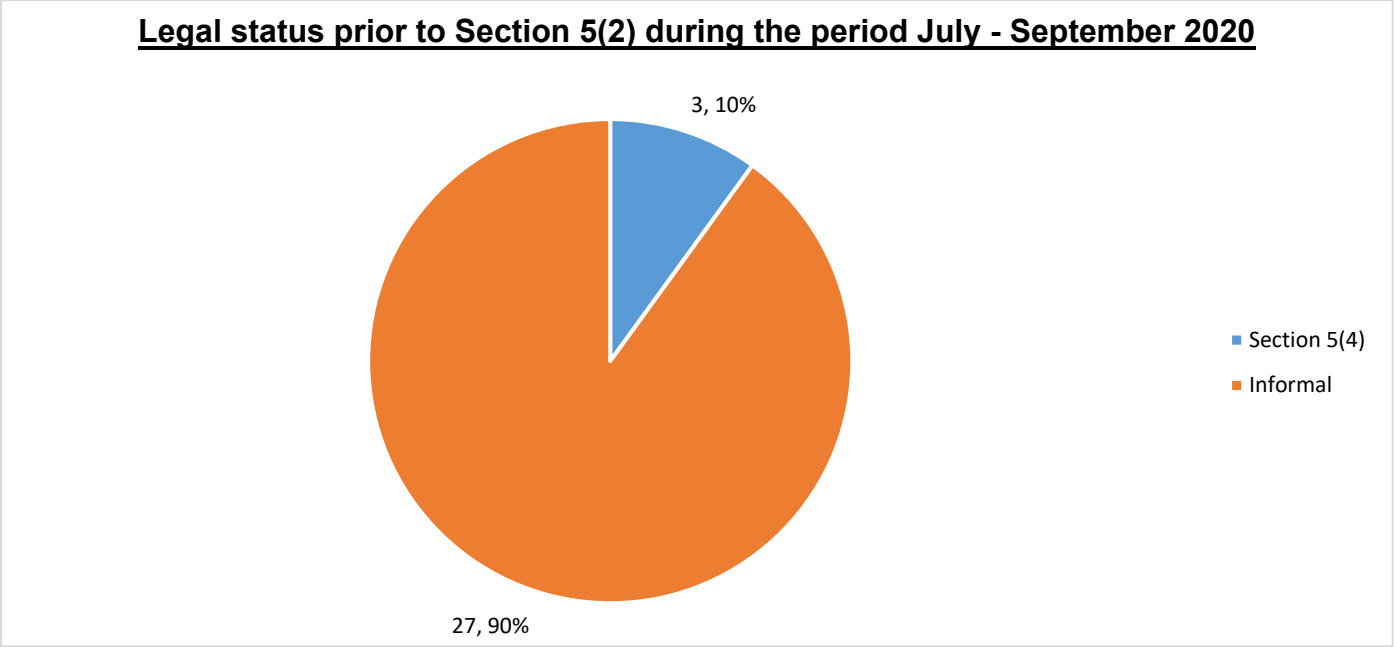
Section 5(4) - Nurses Holding Power

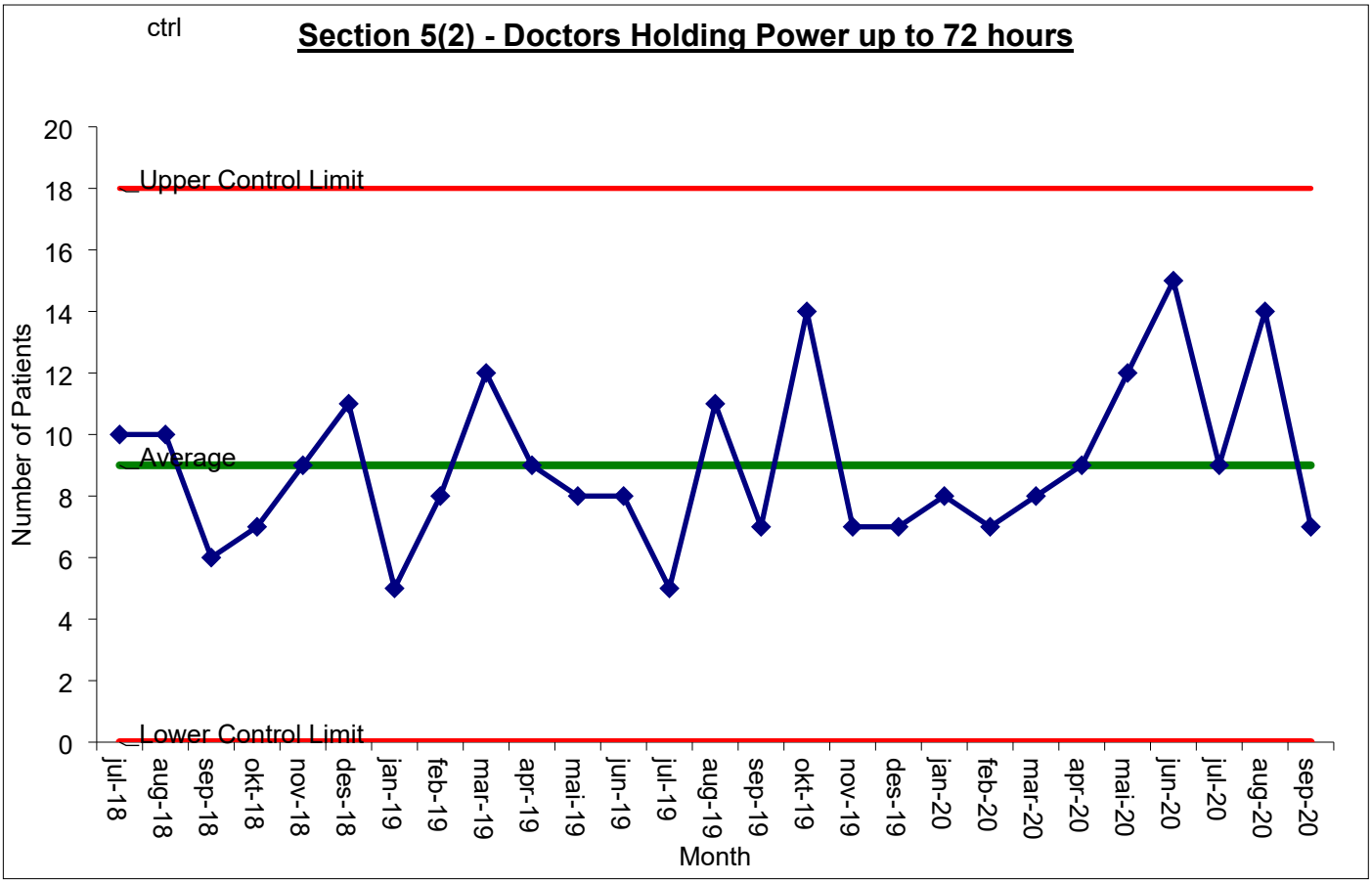


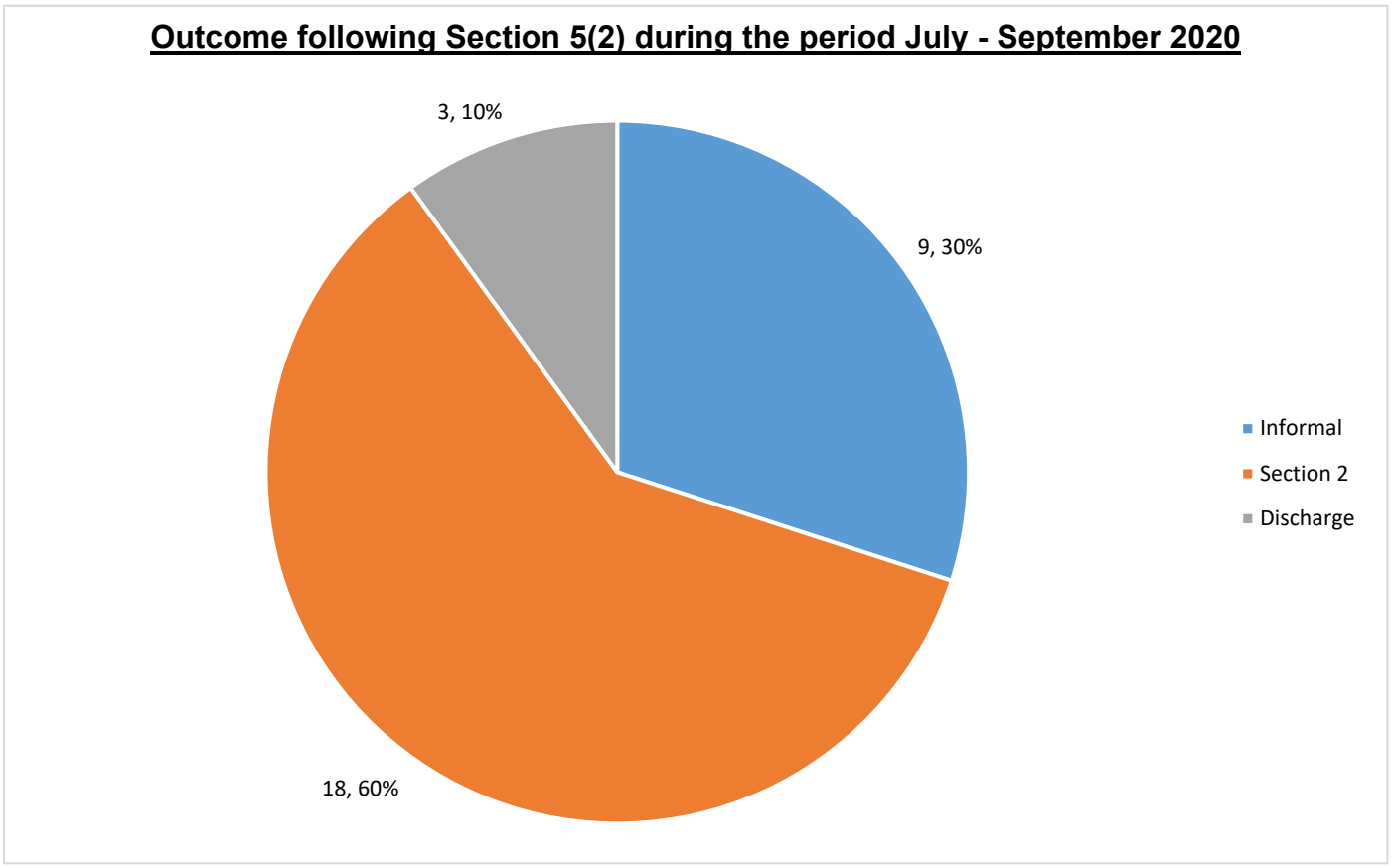


Khan Raj
10/15/2020 12:10:12

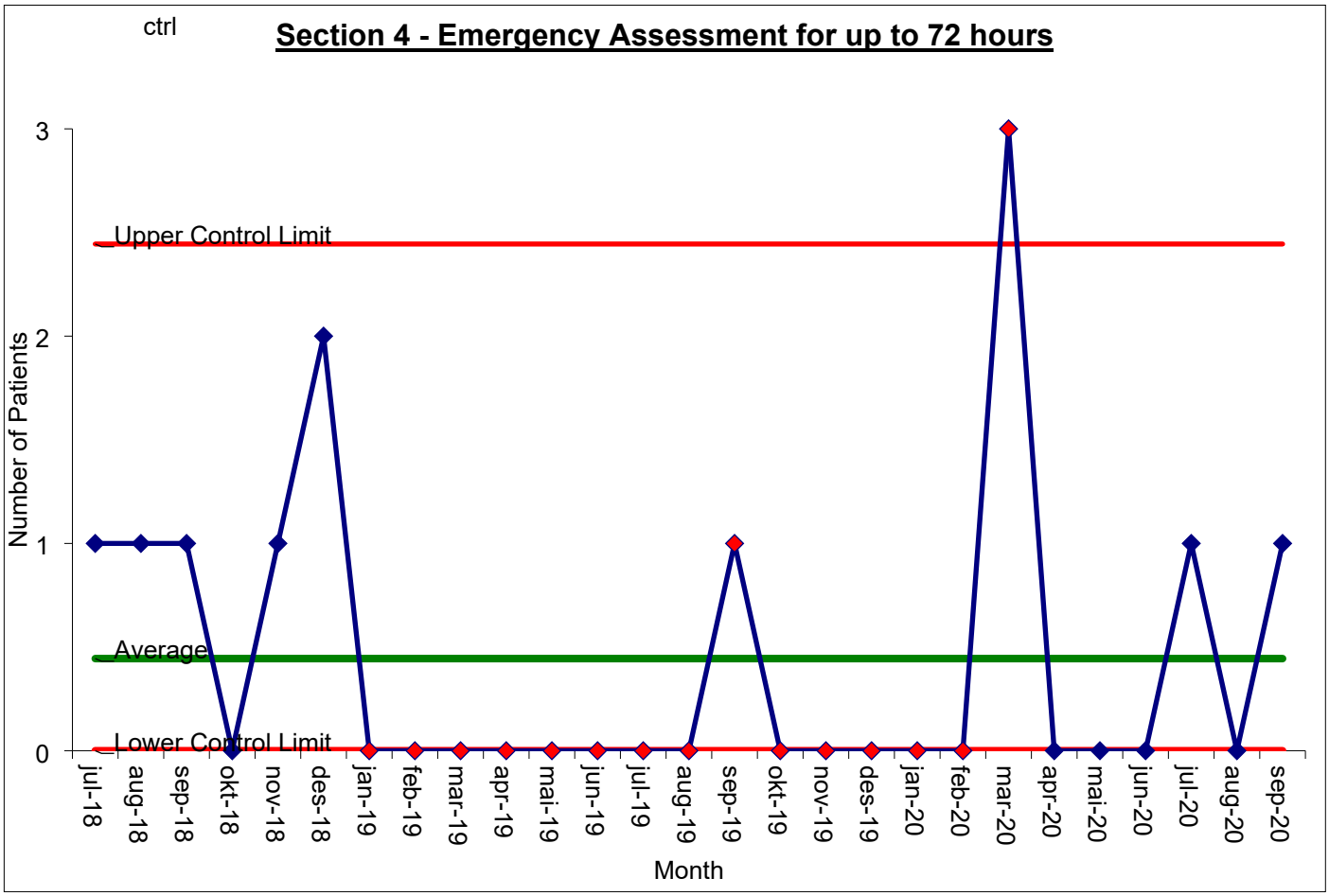
Section 5(2) - Doctors holding power



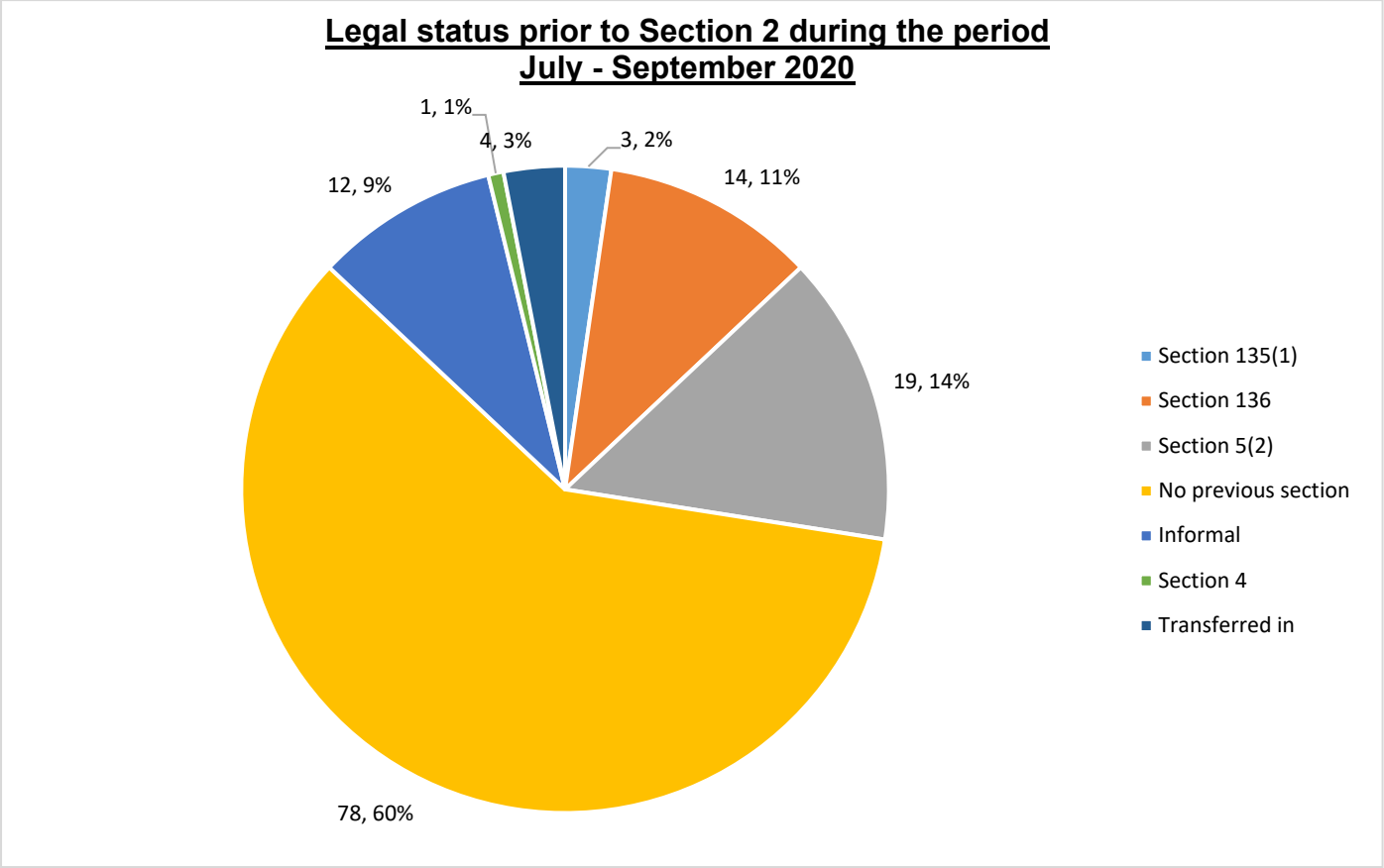


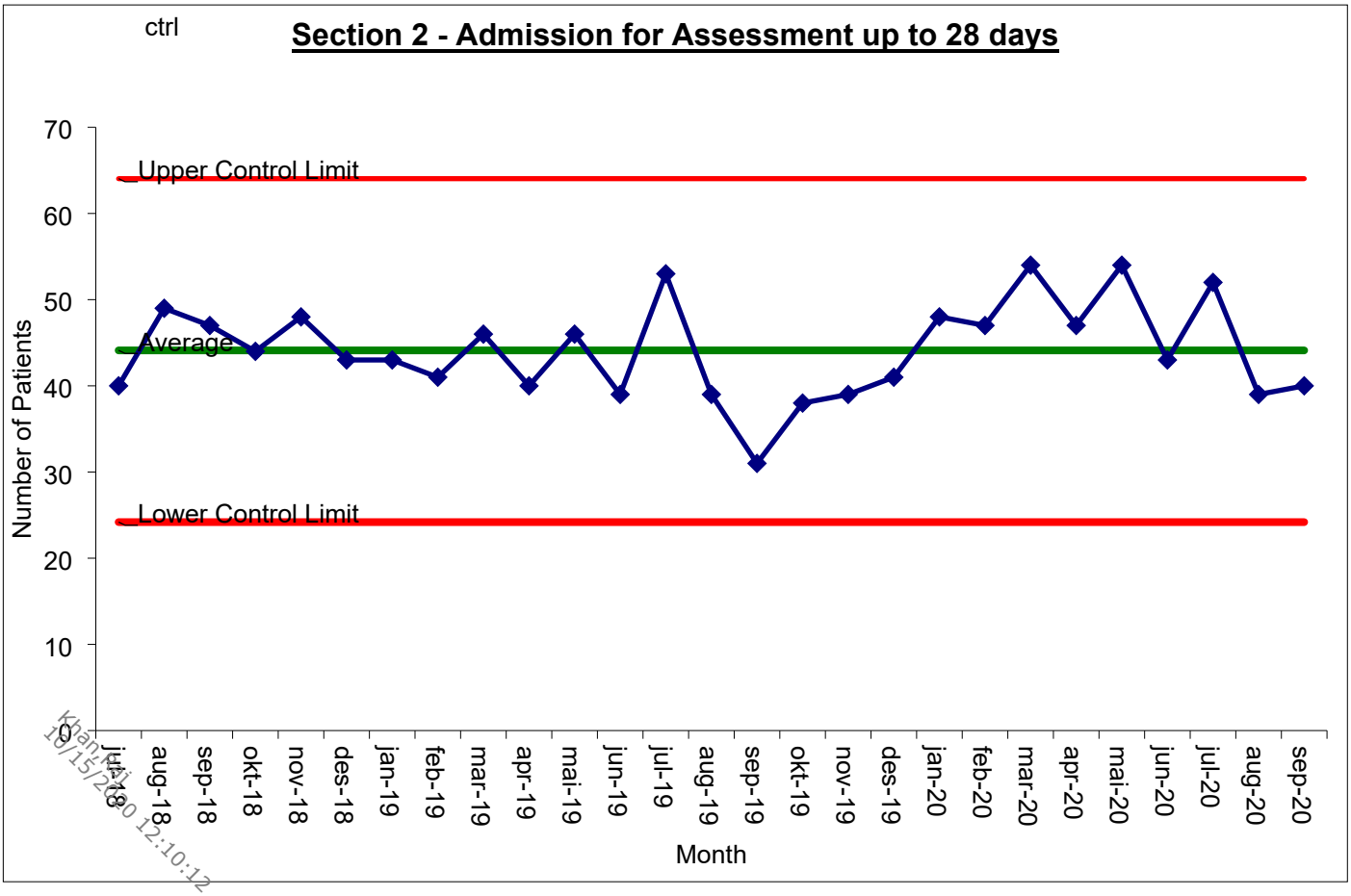


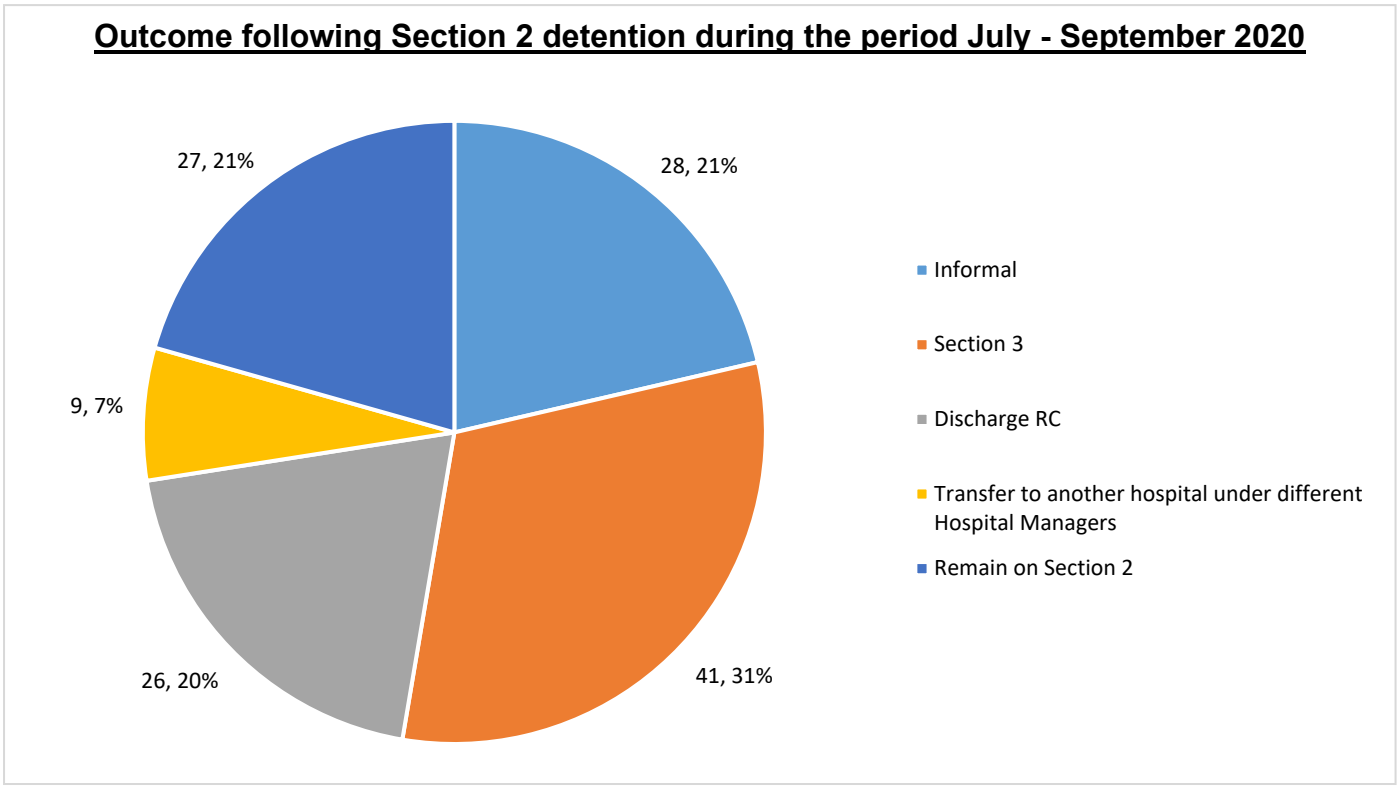
Section 4 - Admission for Assessment in Cases of Emergency



Section 2 – Admission for Assessment



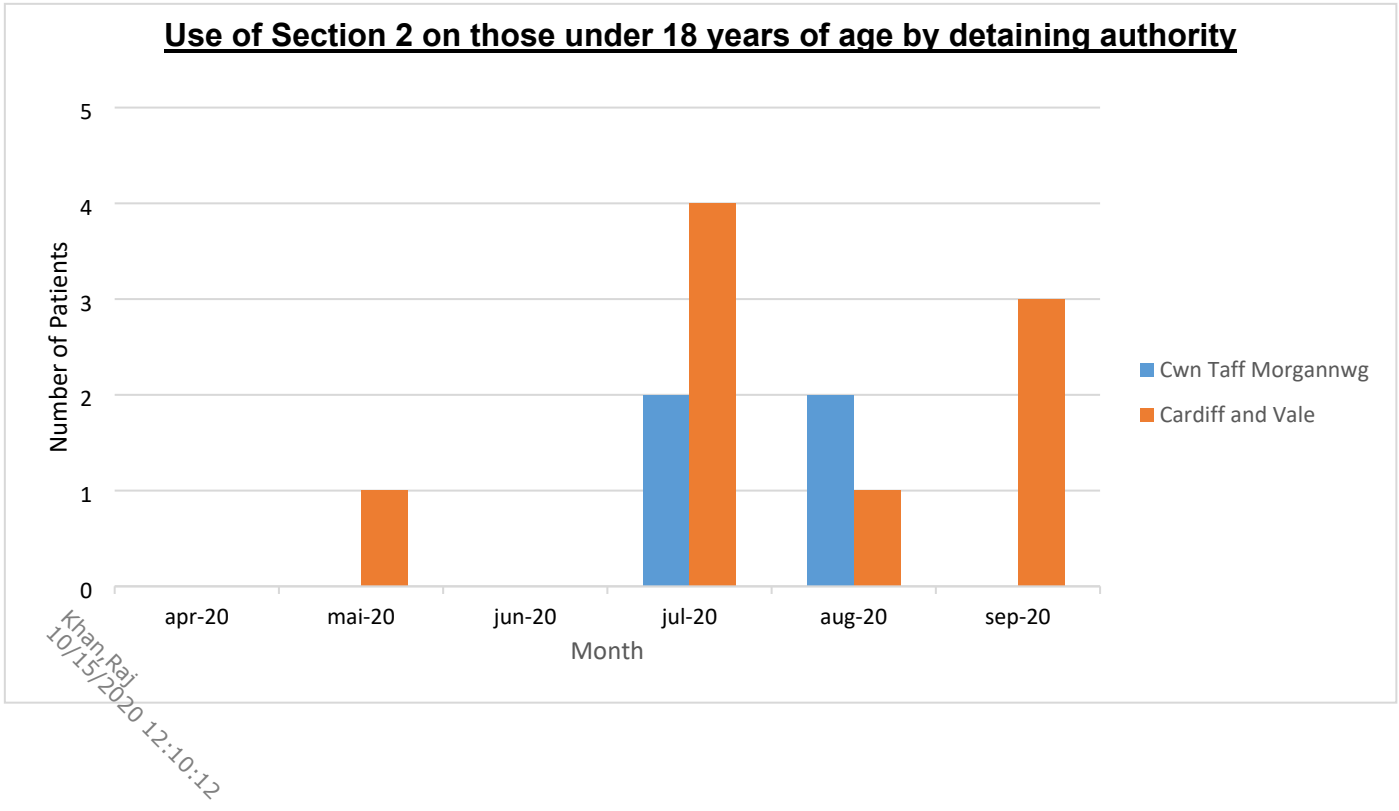


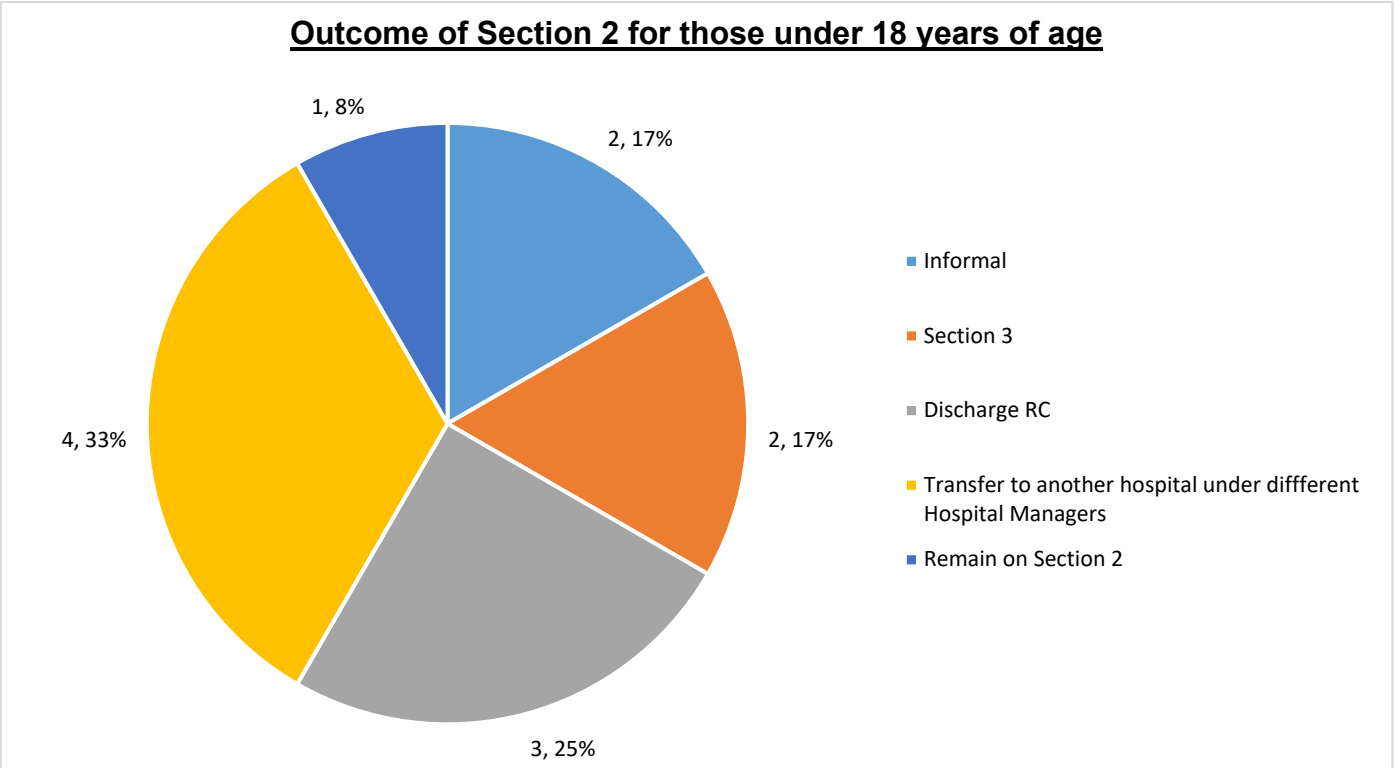


CAMHS Commissioned Inpatient Data

Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

Included in the above data are those under 18 years of age. This is extracted below;-





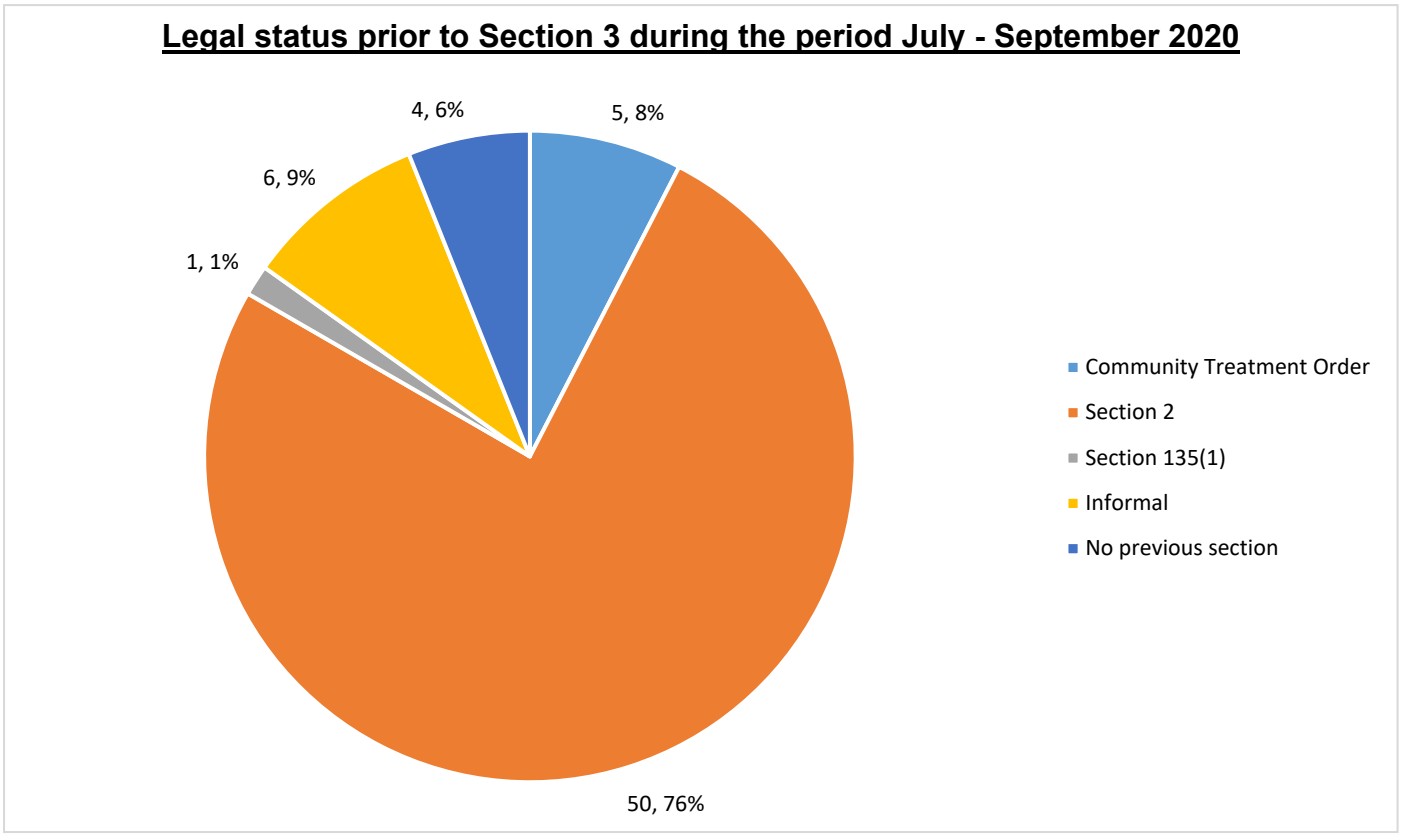
Of those transferred out from Cardiff and Vale UHB;-

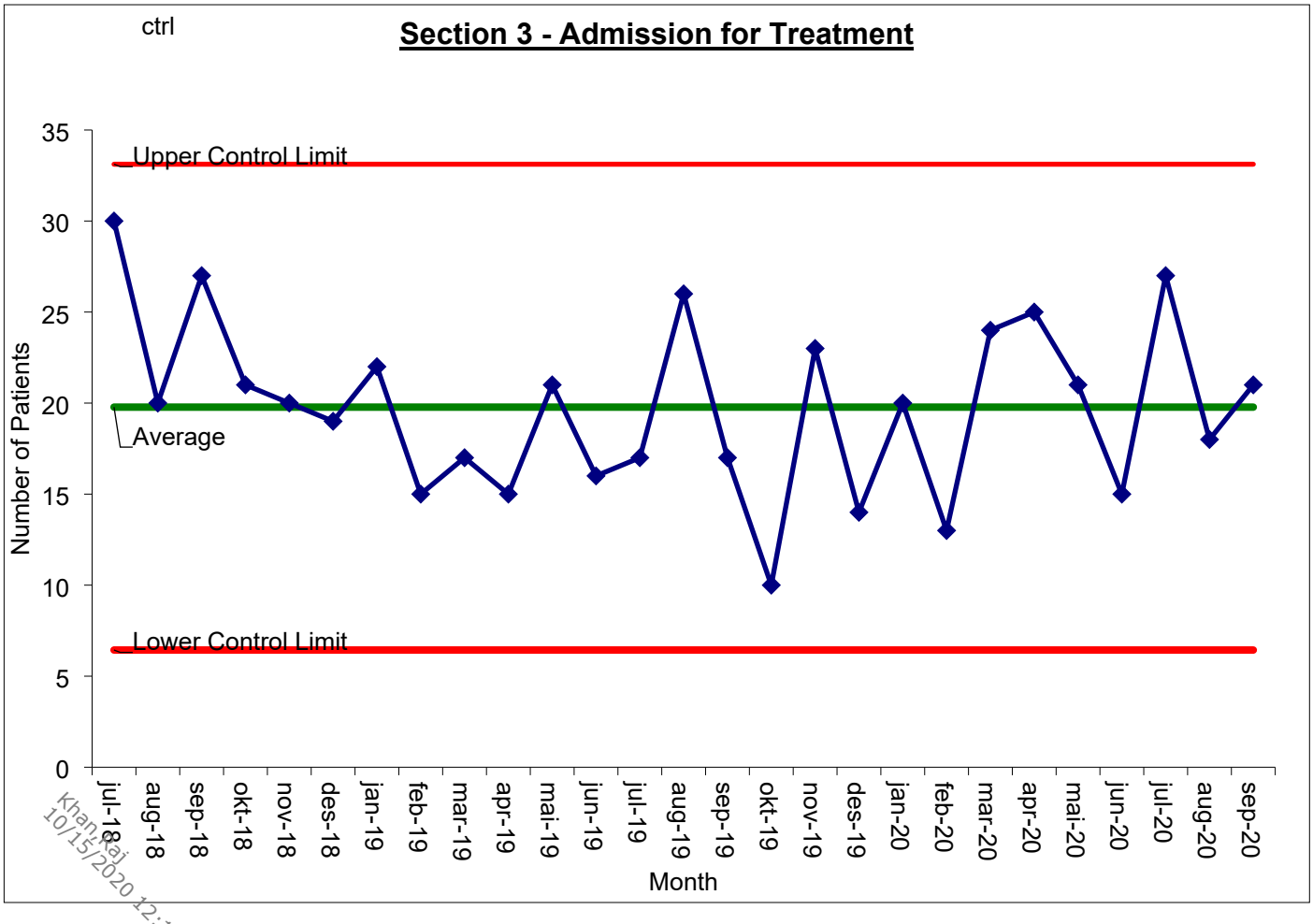
- Two to commissioned services in Ty Llidiard, Cwm Taff Morgannwg UHB
- One to Hillview Hospital in Ebbw Vale
- One to Cygnet Hospital in Bury, Lancashire

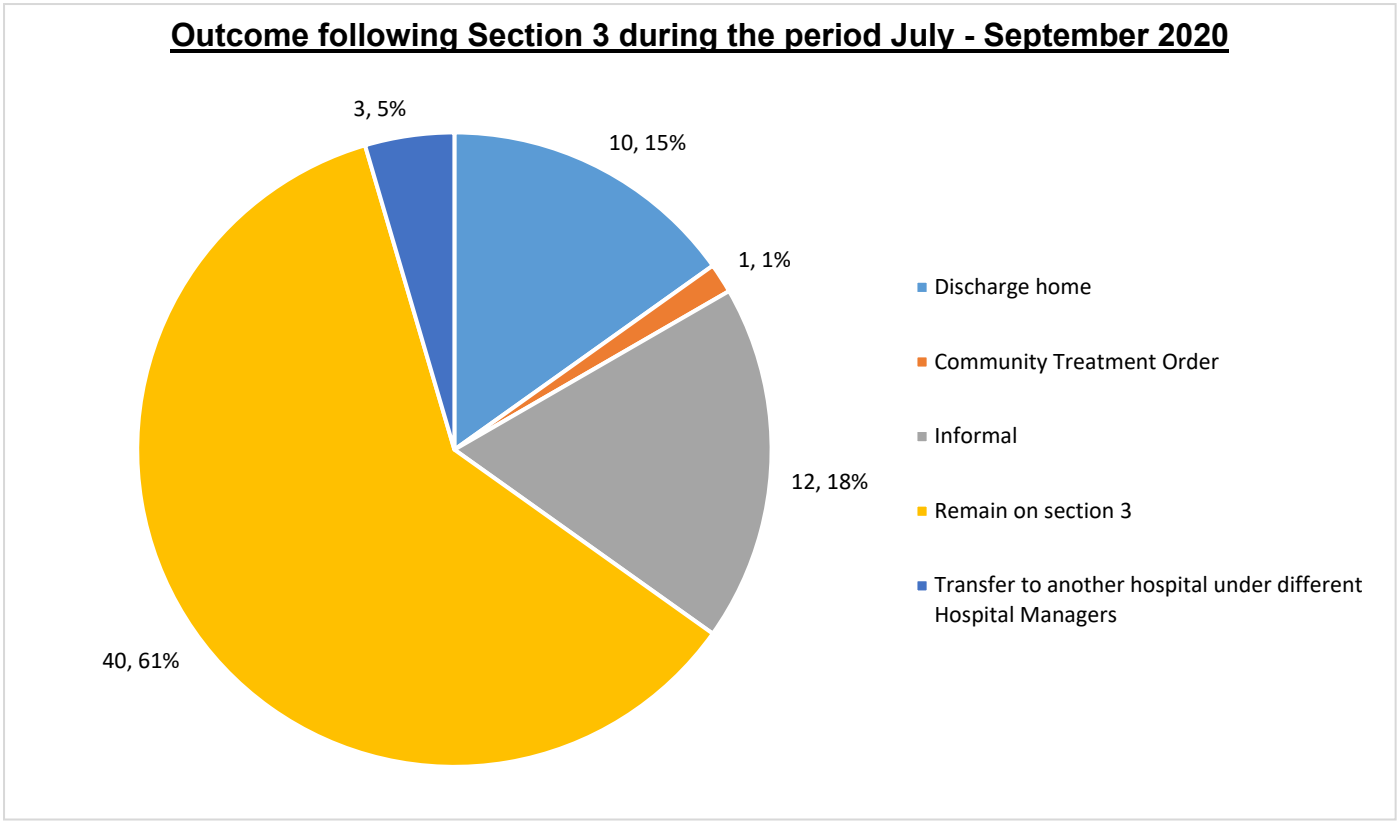
One patient appears on both Cwm Taff Morgannwg and Cardiff and Vale as they were transferred, so that would be a detention that was new to that authority.

Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period July - September 2020







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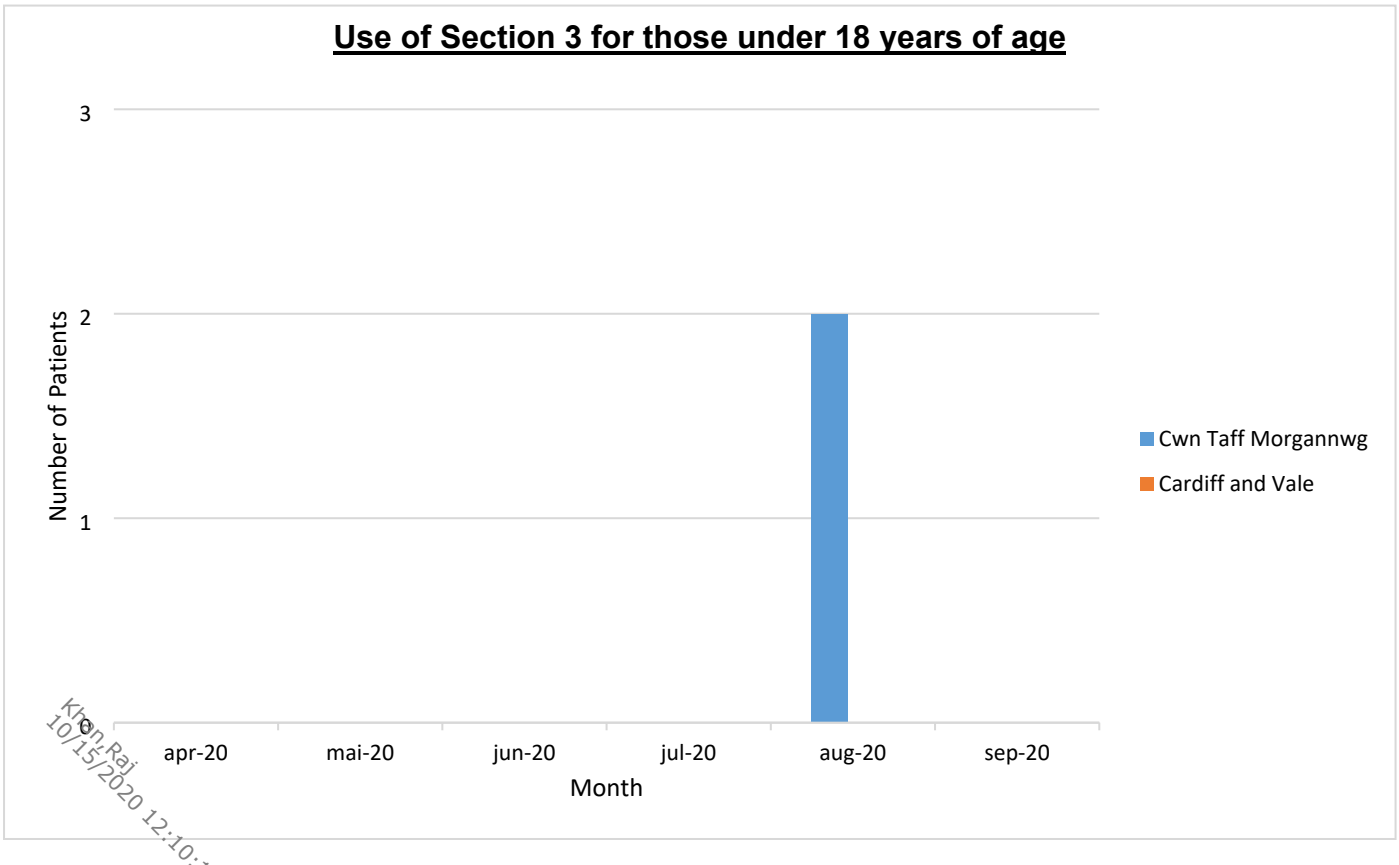
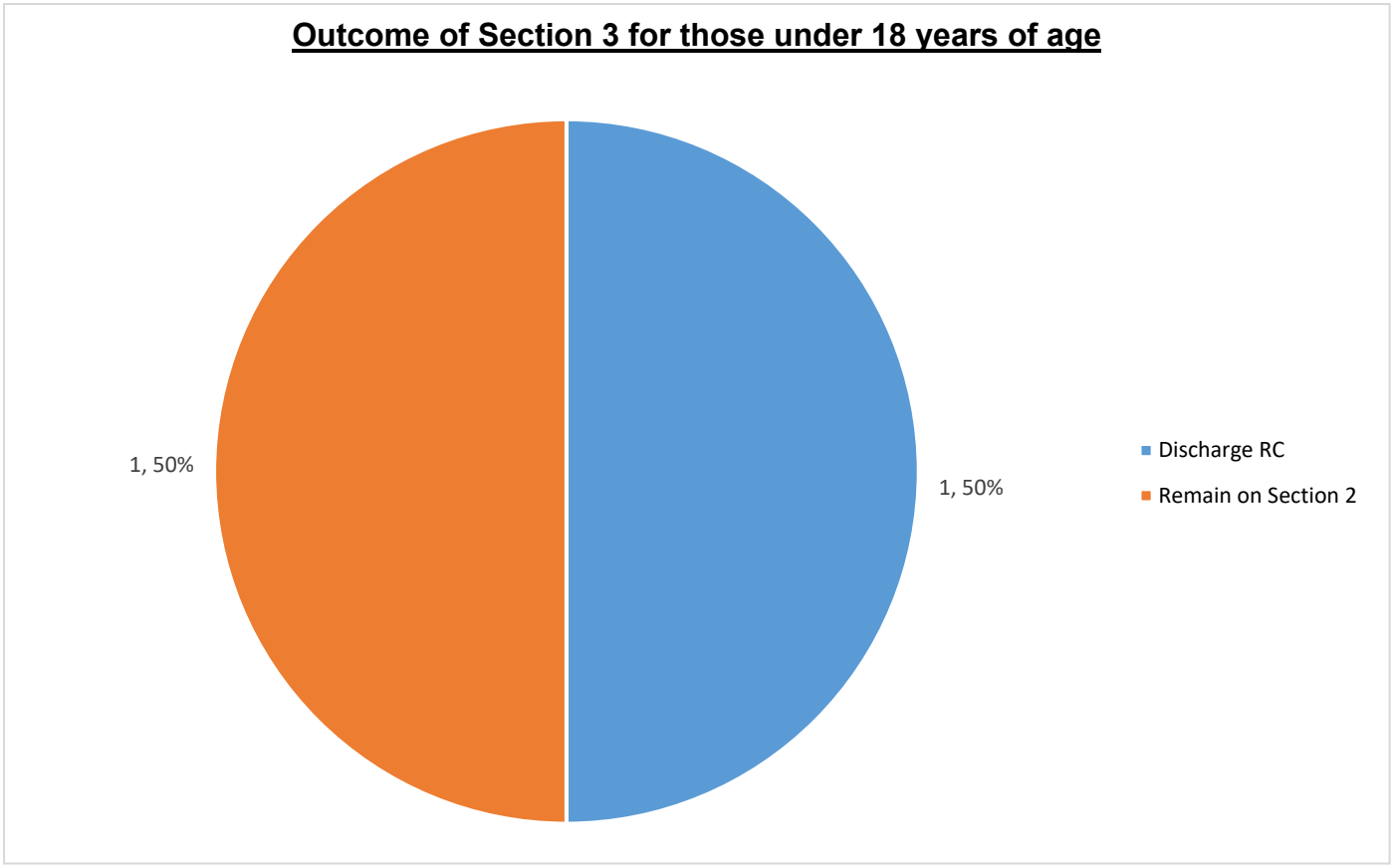
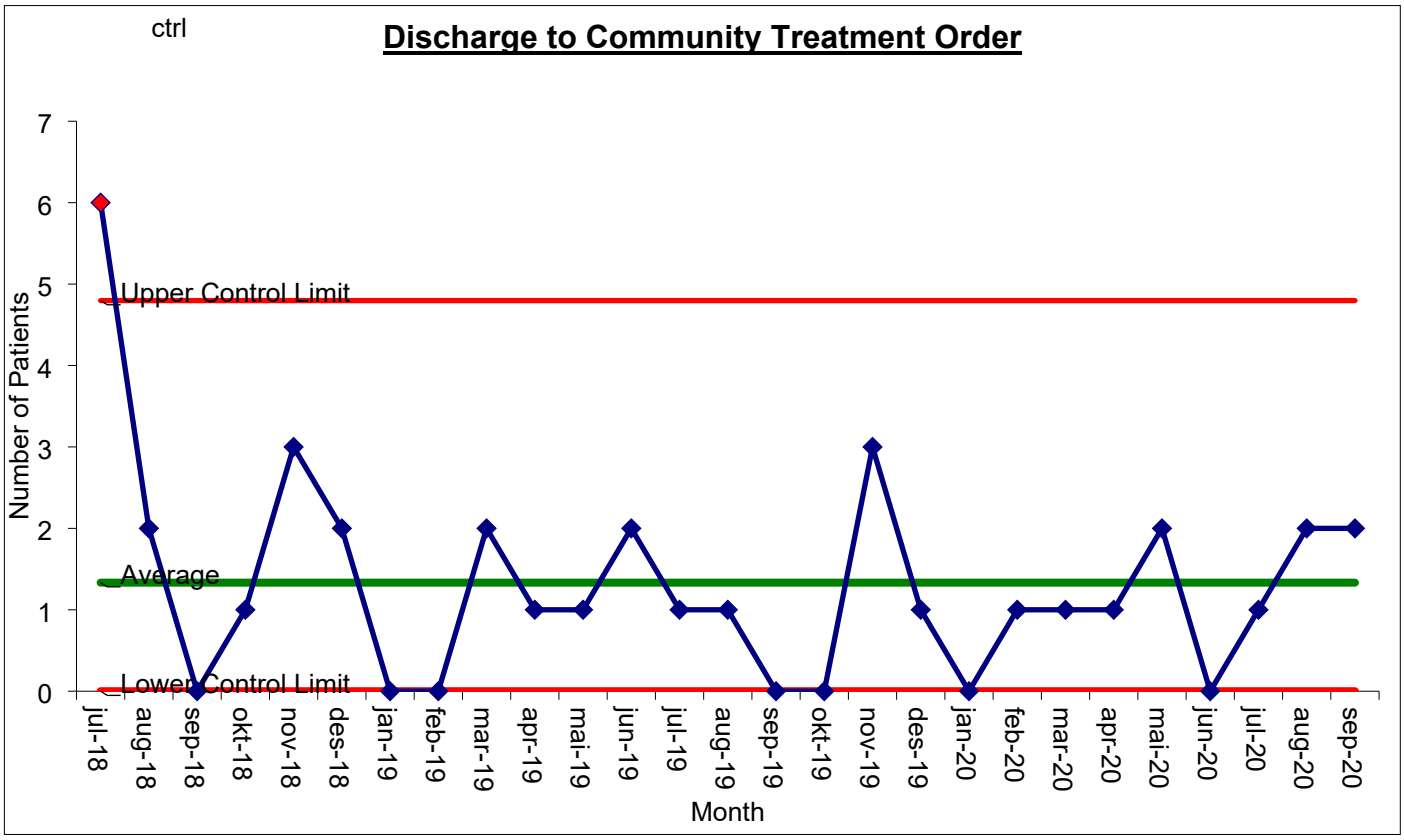


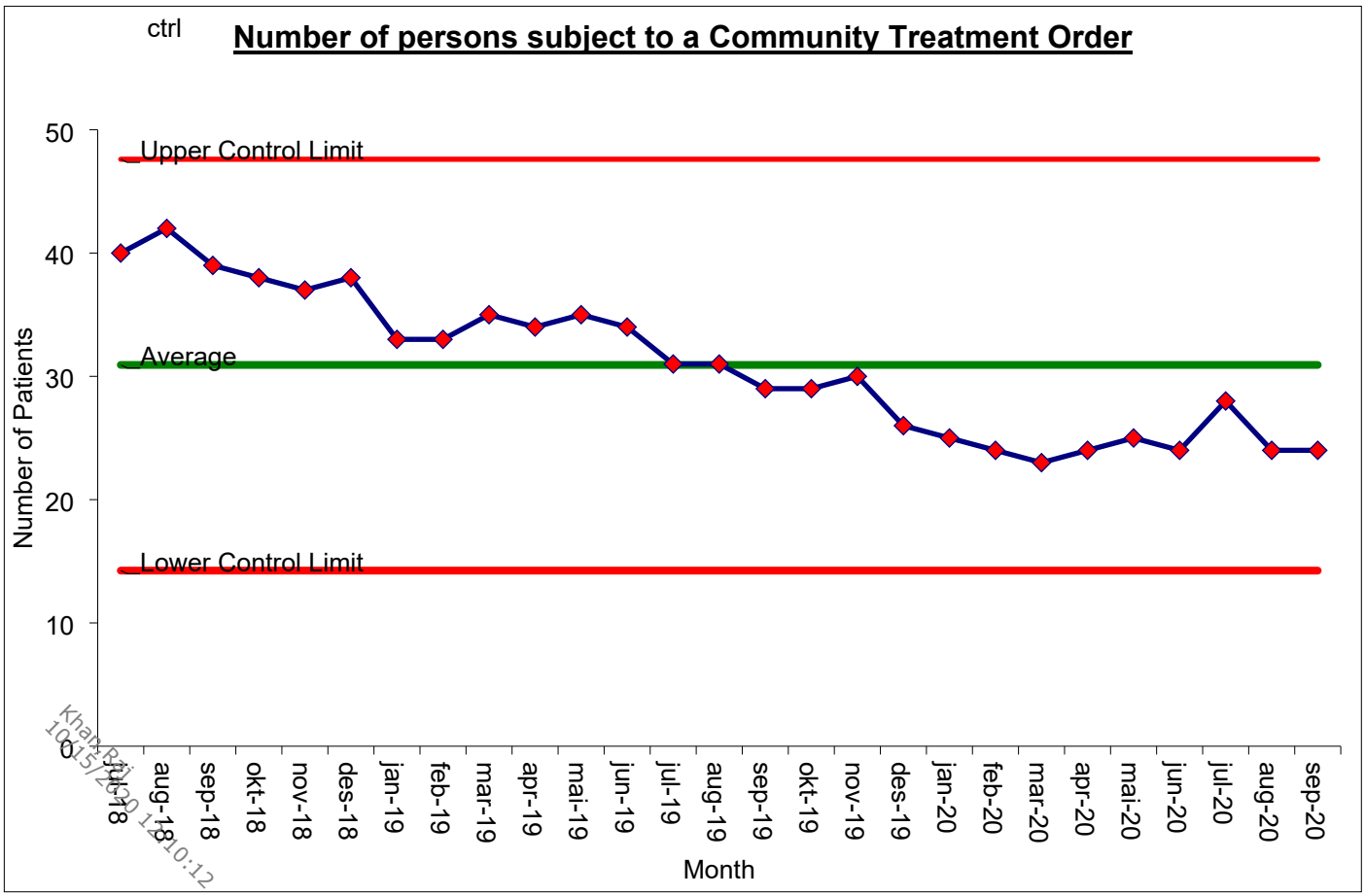


Community Treatment Order

During the period April - June 2020, five patients were discharged to Community Treatment Order.

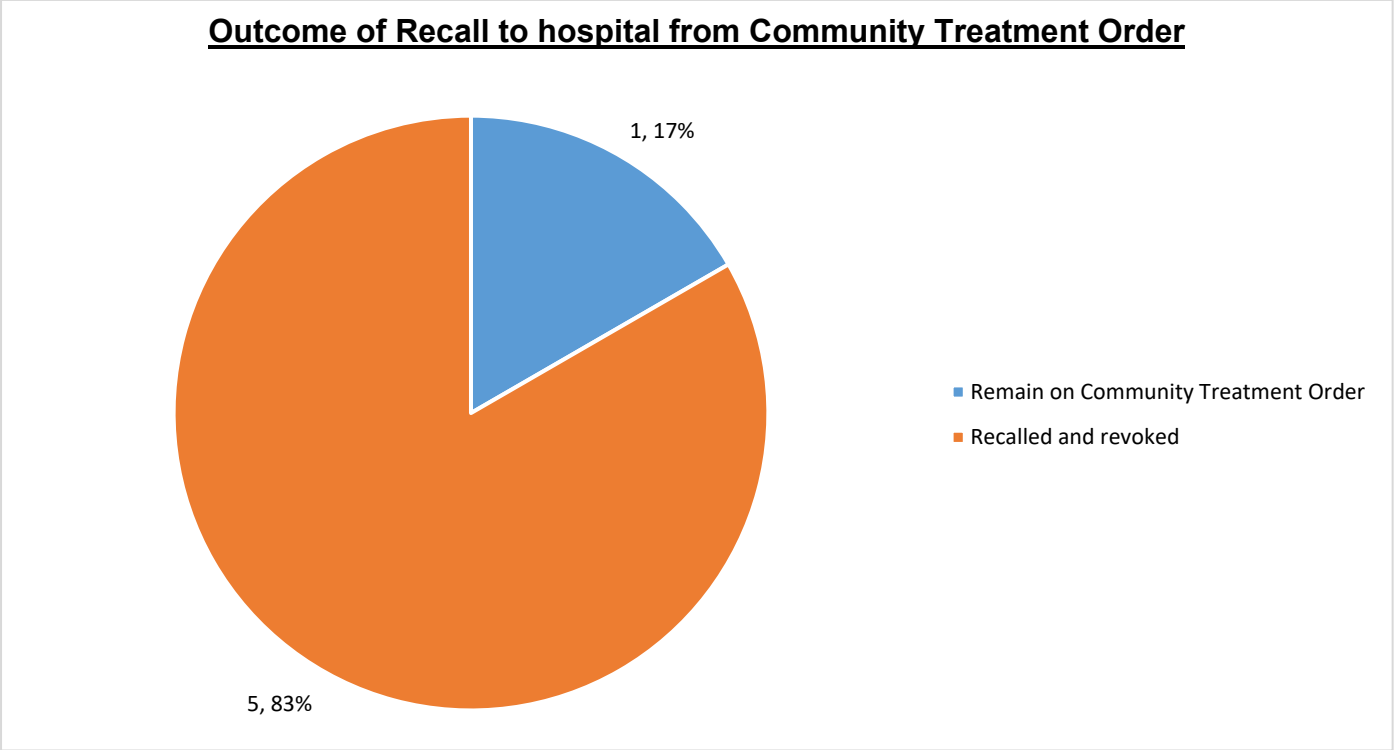
As at 30 September 2020, 24 patients were subject to a Community Treatment Order (CTO).





Recall of a community patient under Section 17E

During the period, the power of recall was used on six occasions. On 5 occasions the patients CTO was revoked, on one occasion the patient remained under their Community Treatment Order.



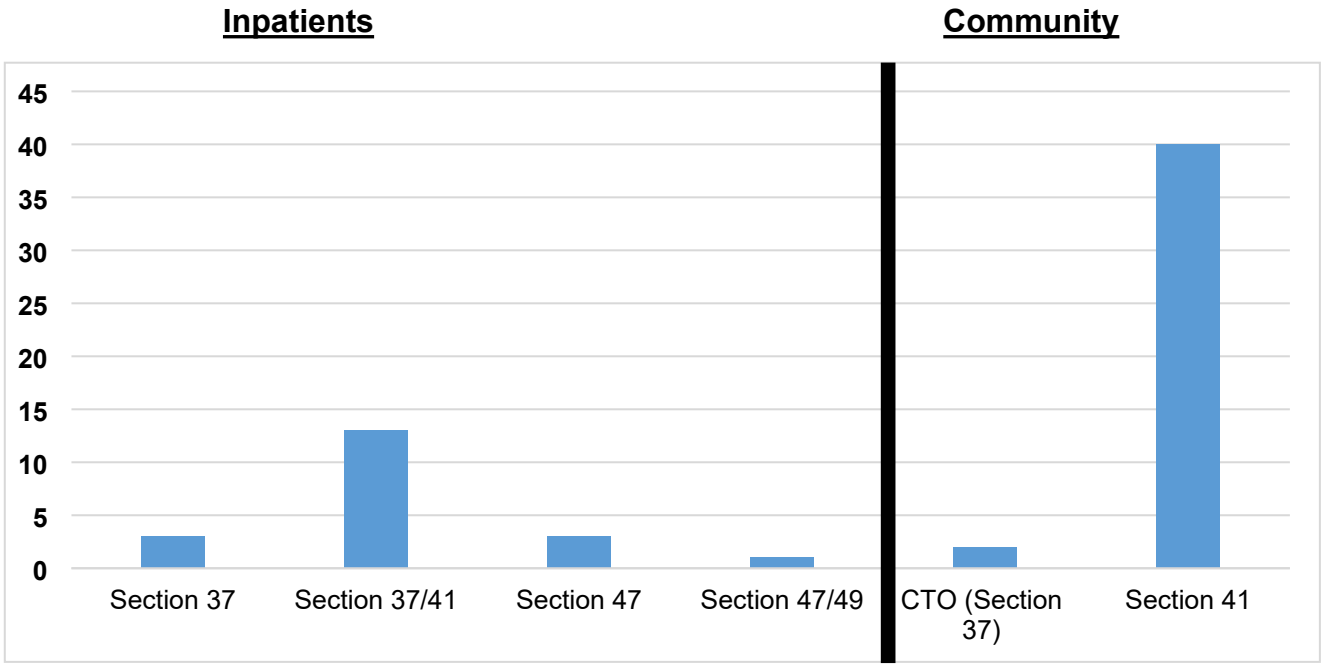
CAMHS Commissioned Inpatient Data

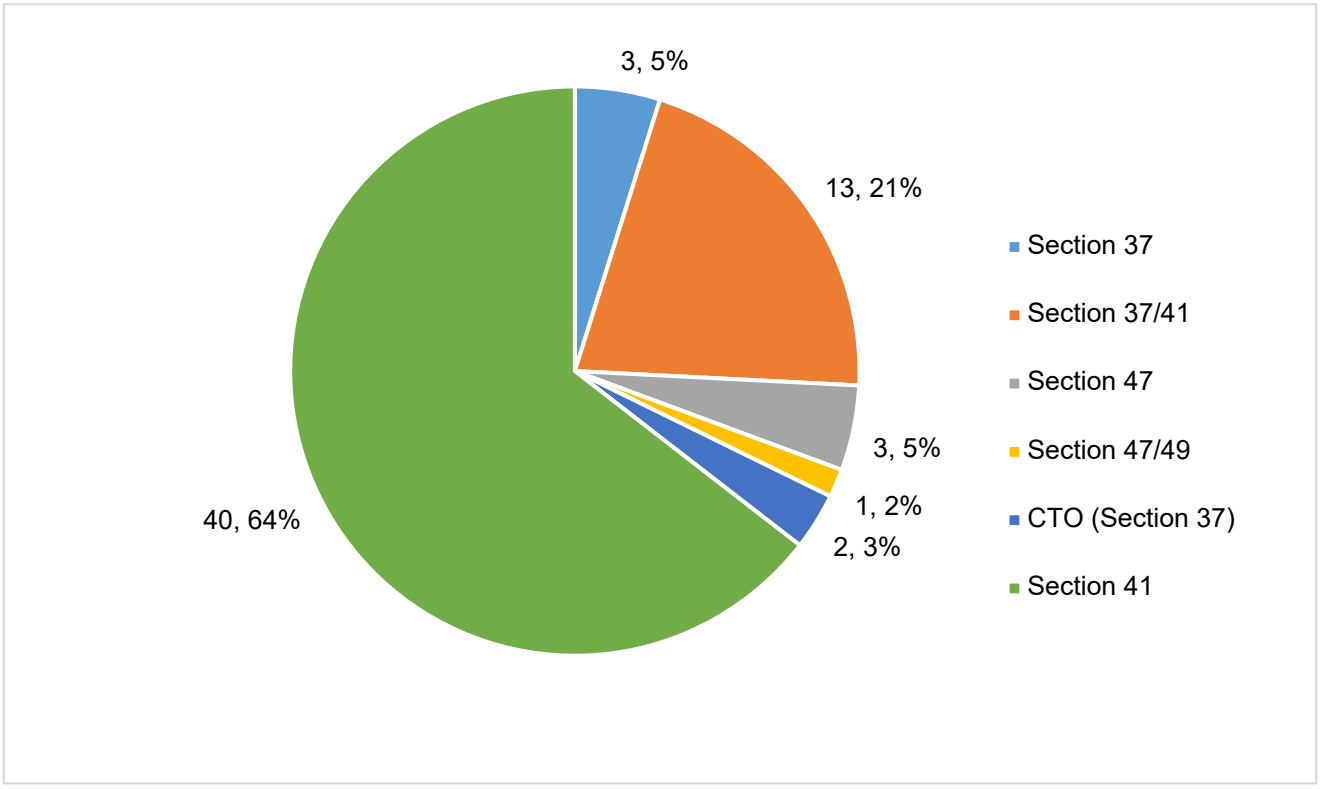
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

In this period there were no CAMHS patients who became subject to a Community Treatment Order

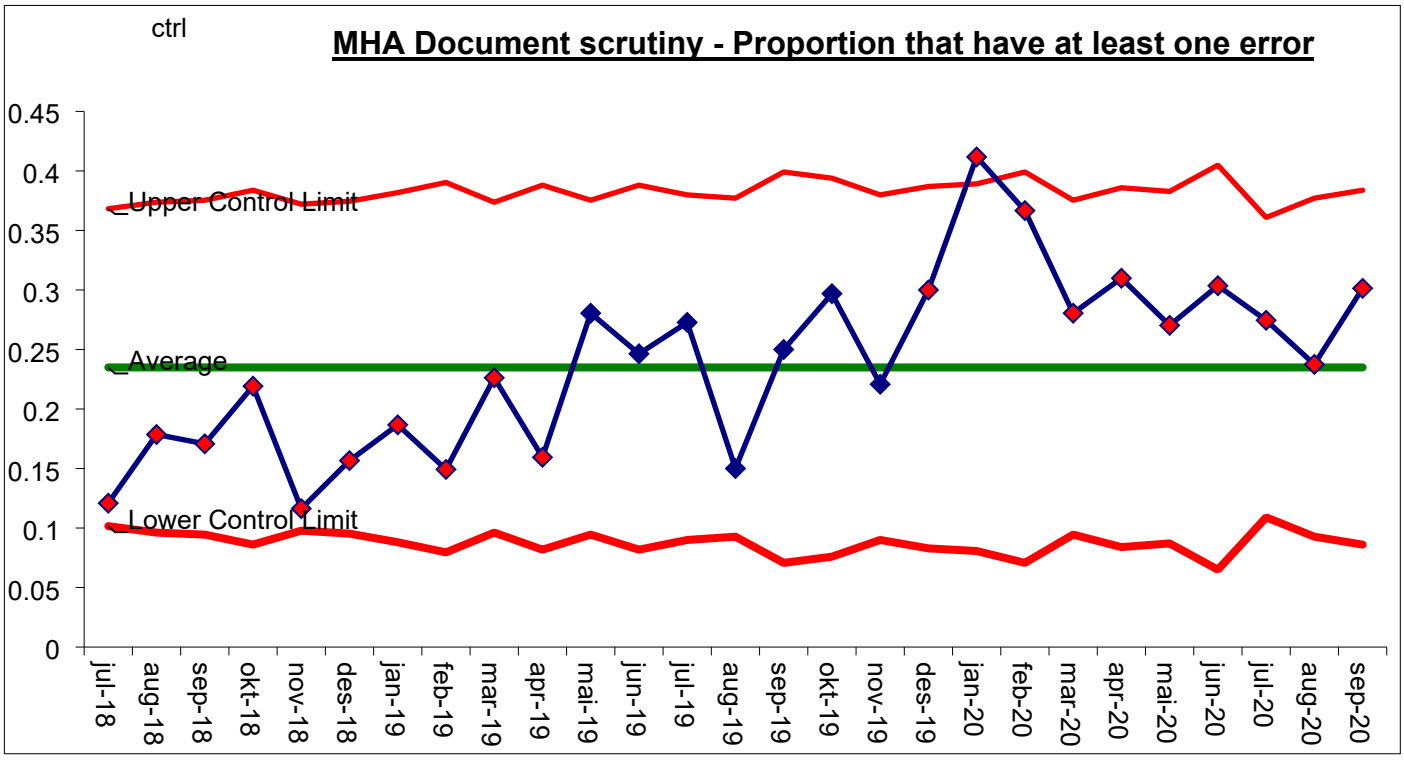
Part 3 of the Mental Health Act 1983

The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 30 September 2020.





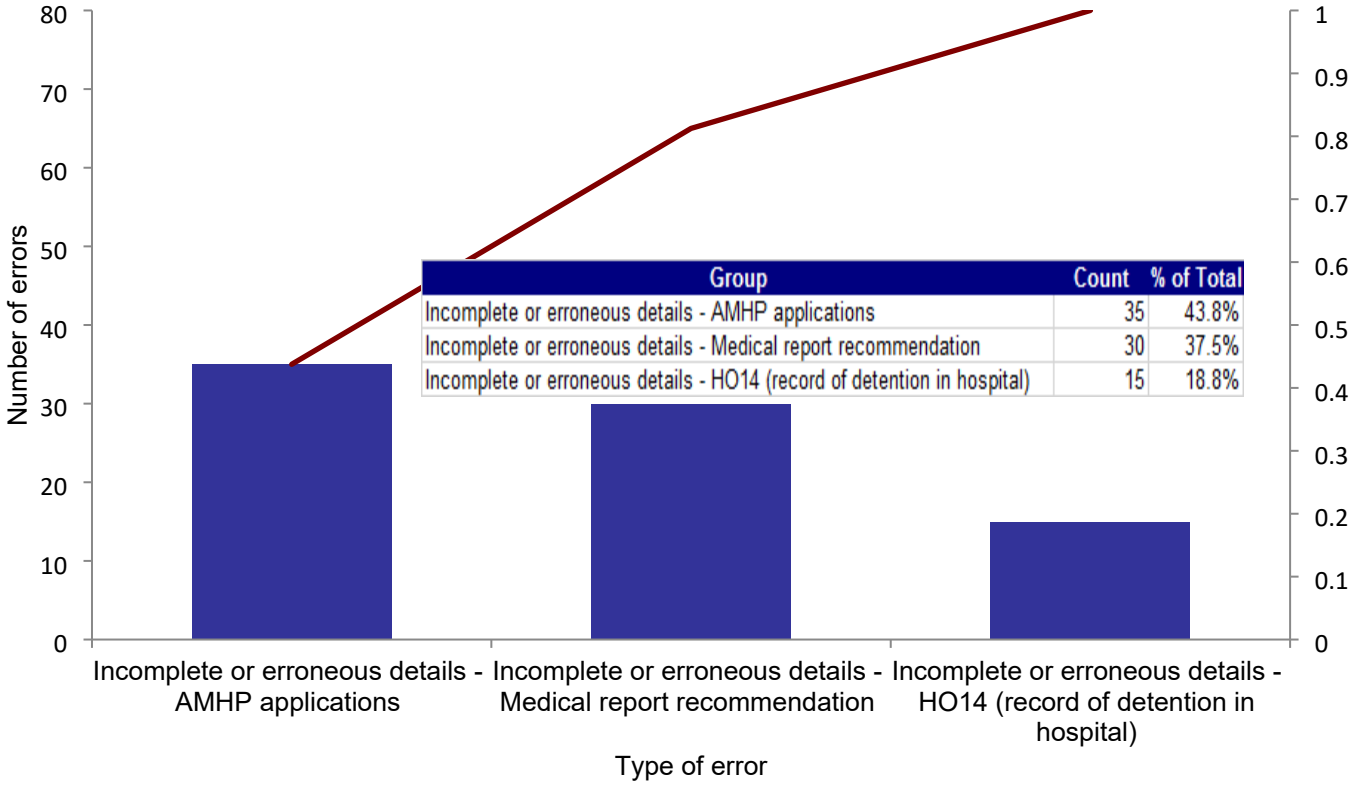
Scrutiny of documents during the period



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

Group	Count	% of Total
Incomplete or erroneous details - AMHP applications	35	43.8%
Incomplete or erroneous details - Medical report recommendation	30	37.5%
Incomplete or erroneous details - HO14 (record of detention in hospital)	15	18.8%

Rectifiable errors on documents during the period



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Incomplete or erroneous details - Medical report recommendation	30	37.5%
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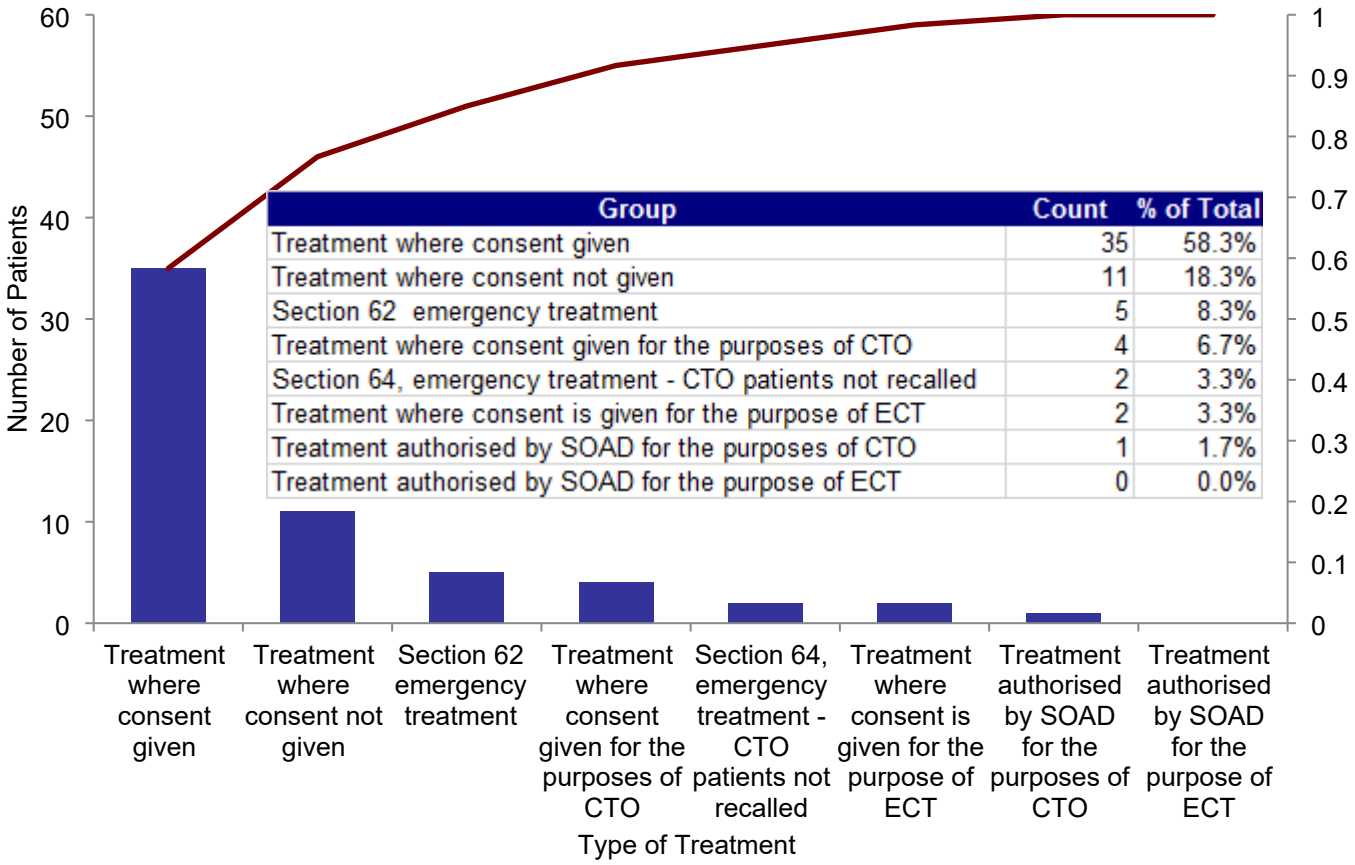
Analysis of the treatment provisions under Part 4 and Part 4A, MHA during the period



Group	Count	% of Total
Treatment where consent given	35	58.3%
Treatment where consent not given	11	18.3%
Section 62 emergency treatment	5	8.3%
Treatment where consent given for the purposes of CTO	4	6.7%
Section 64, emergency treatment - CTO patients not recalled	2	3.3%
Treatment where consent is given for the purpose of ECT	2	3.3%
Treatment authorised by SOAD for the purposes of CTO	1	1.7%
Treatment authorised by SOAD for the purpose of ECT	0	0.0%

Urgent Treatment

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

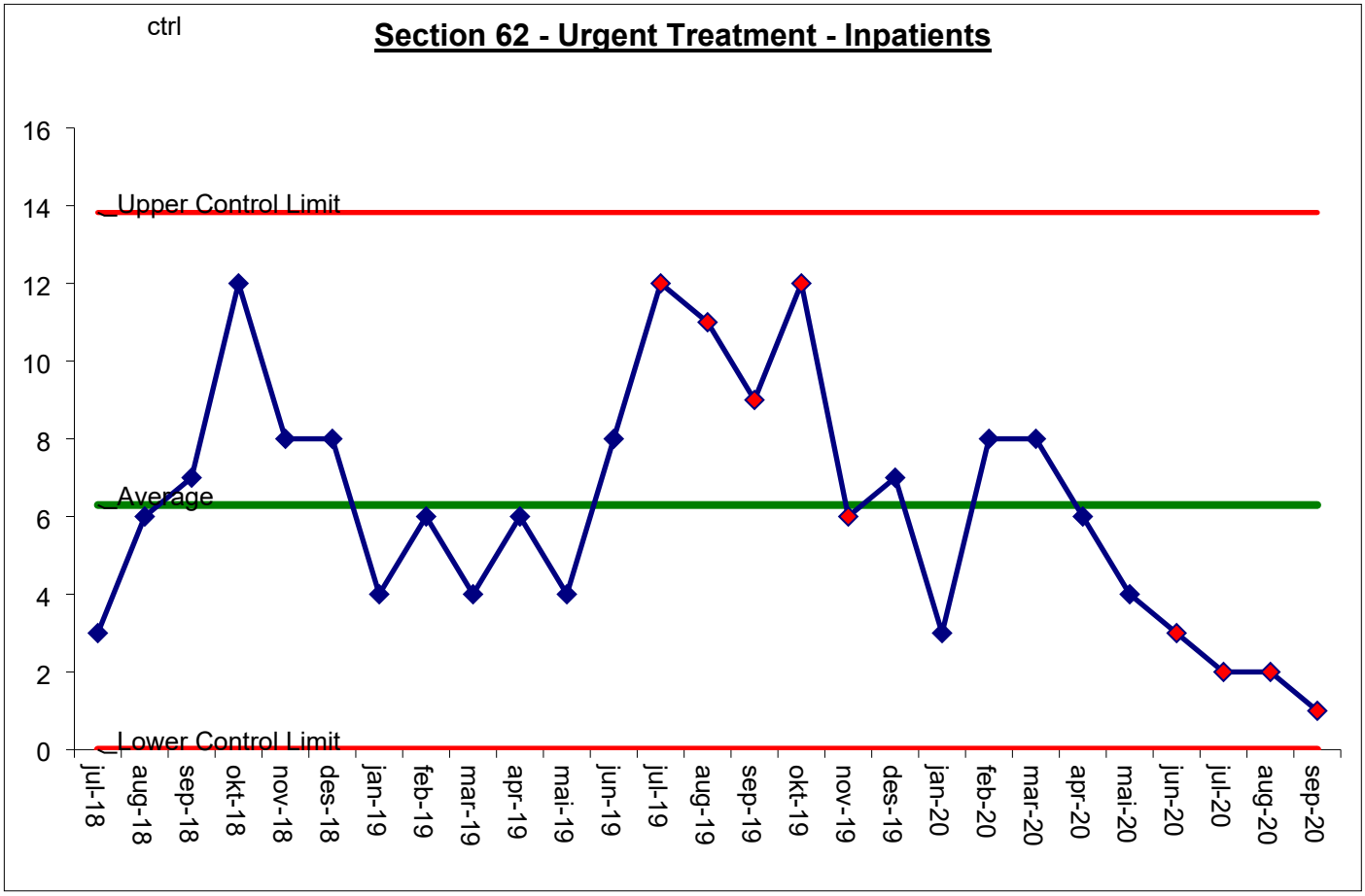
Urgent treatment is defined as treatment that is:

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

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

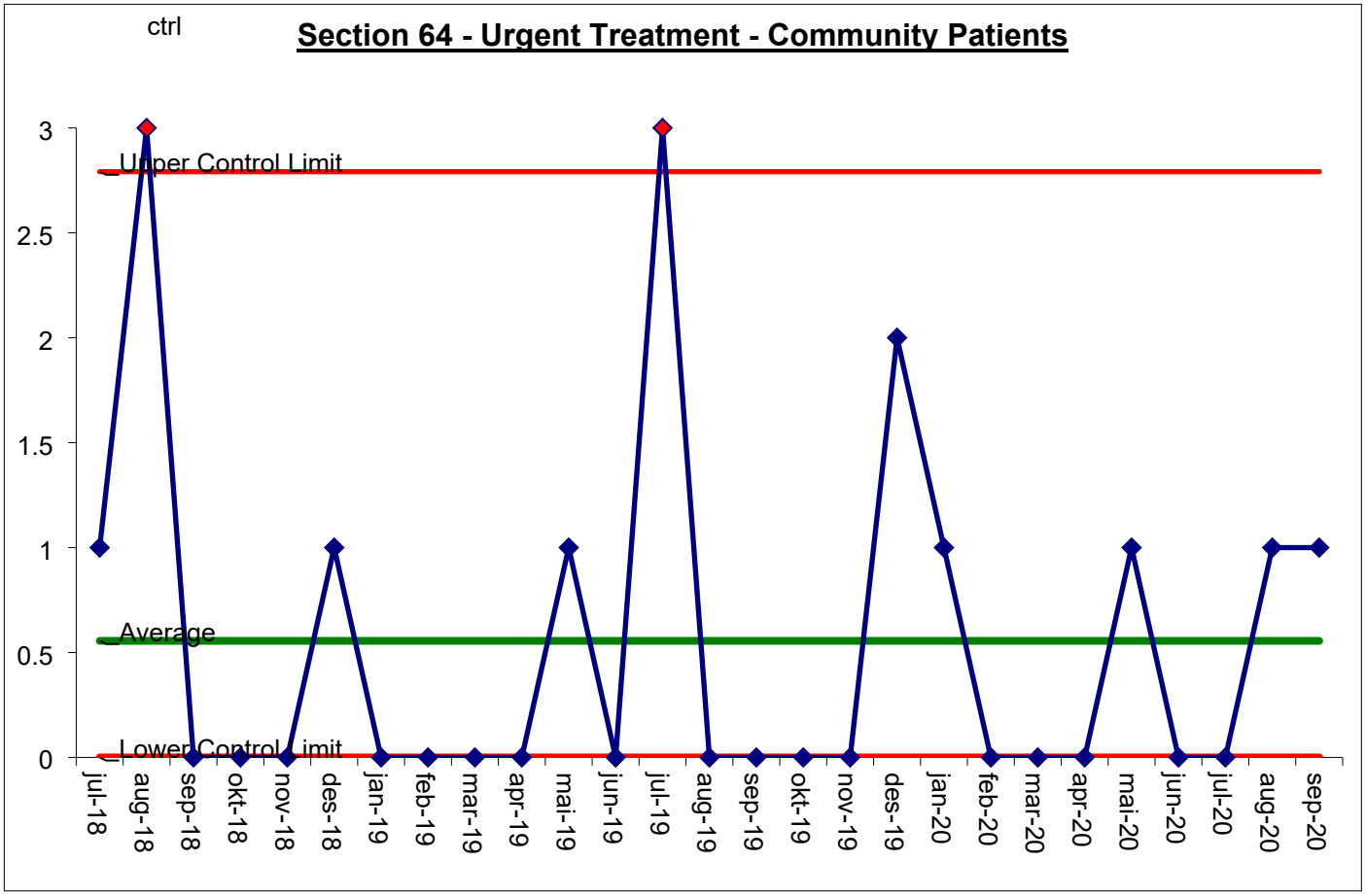
Urgent treatment can be used in any of the following instances:

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



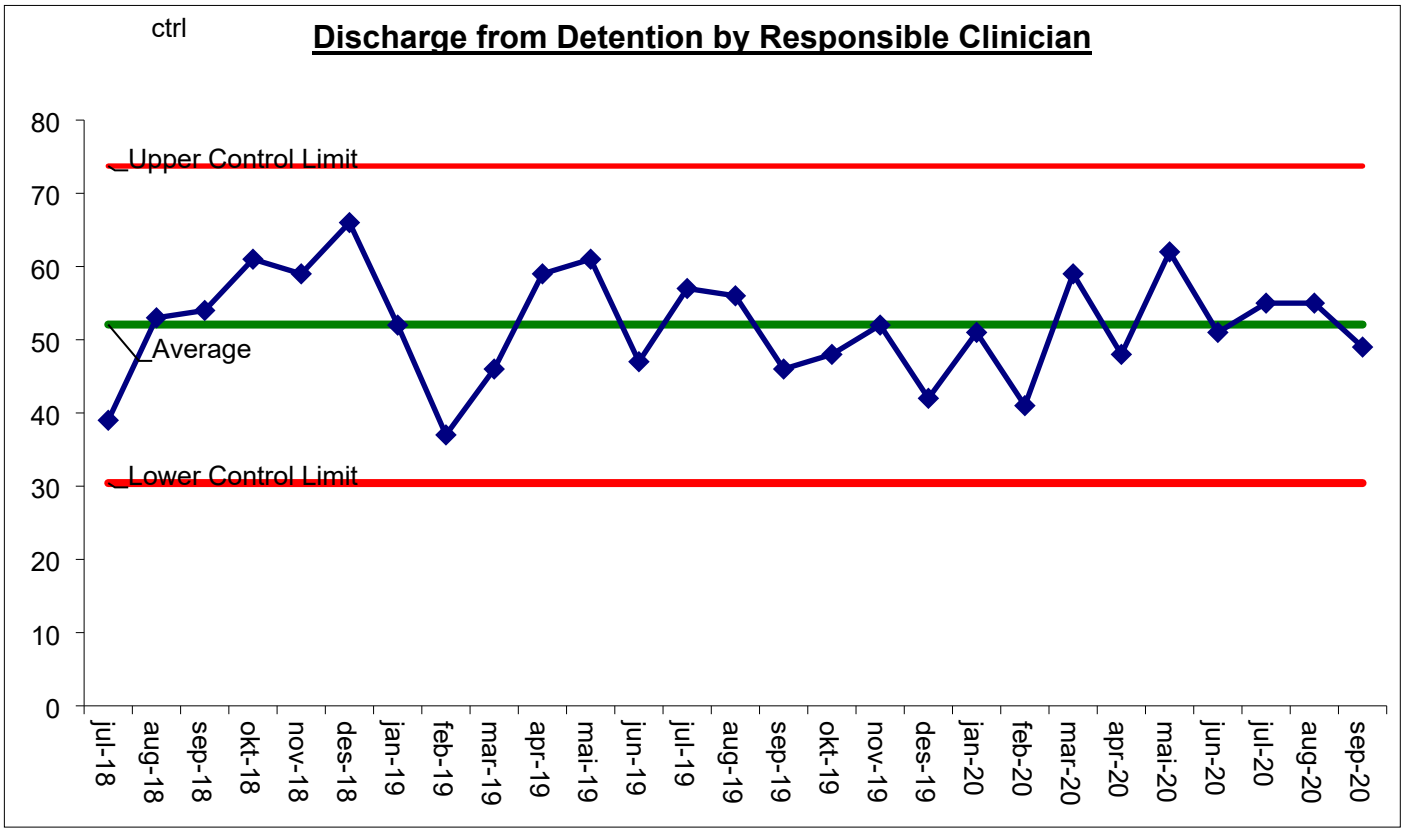
The above chart highlights that Section 62 was used on 5 occasions for the following reasons:

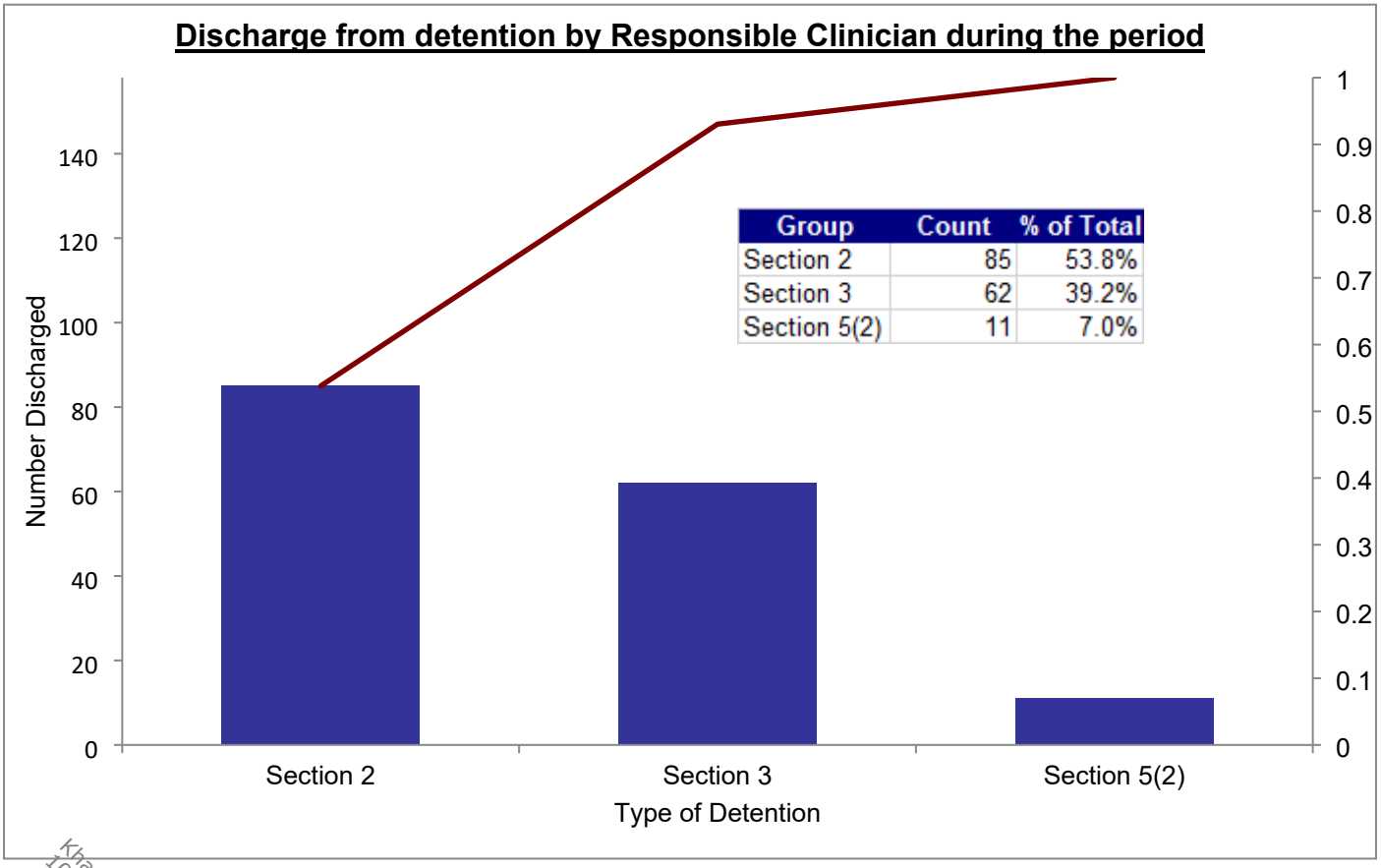
- Pending SOAD – 3 month rule x 3
- Pending SOAD further to revoke of CTO x1



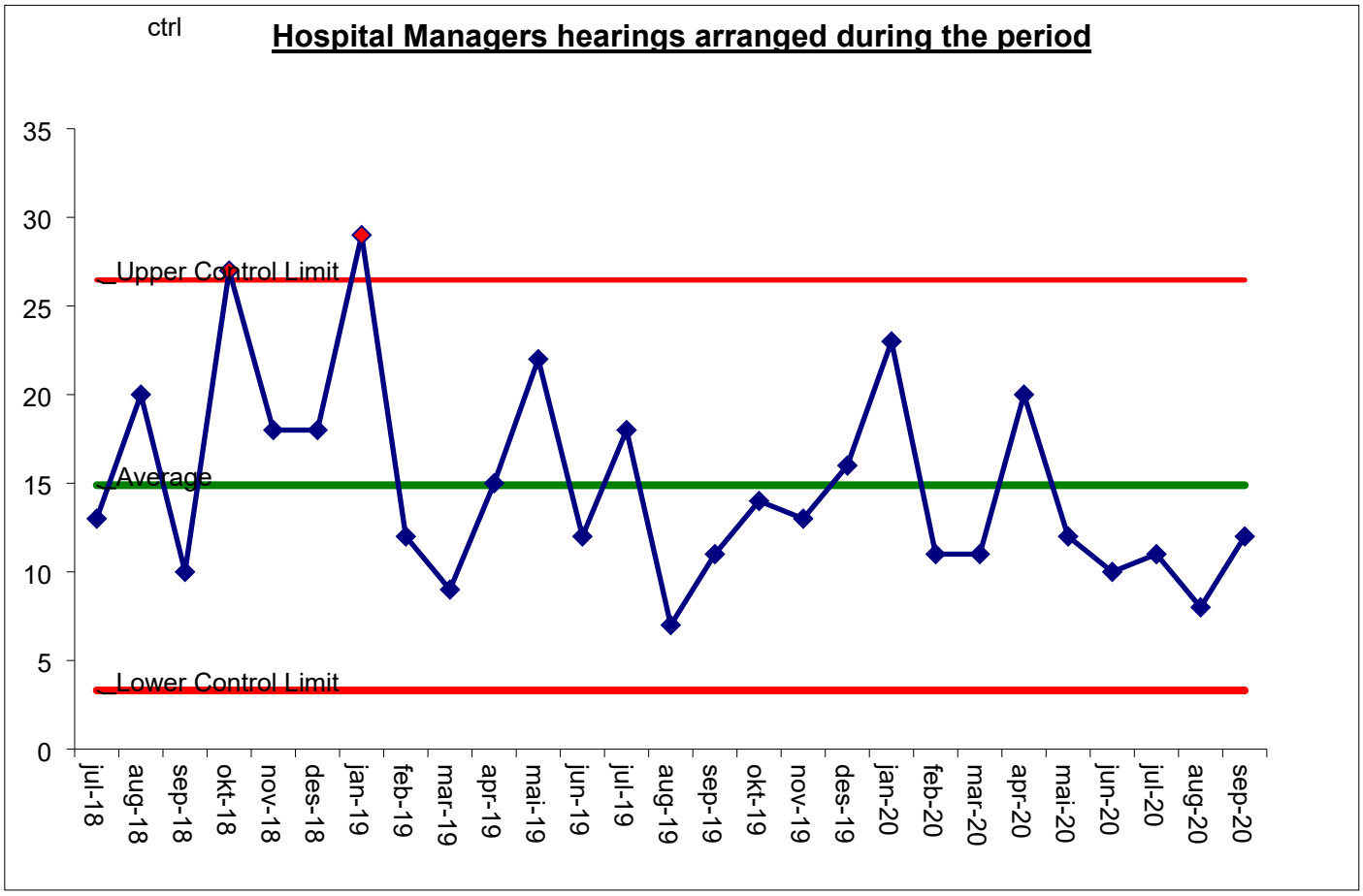
The above chart highlights that Section 64 was used on two occasions during the period pending a SOAD due to the one month rule.

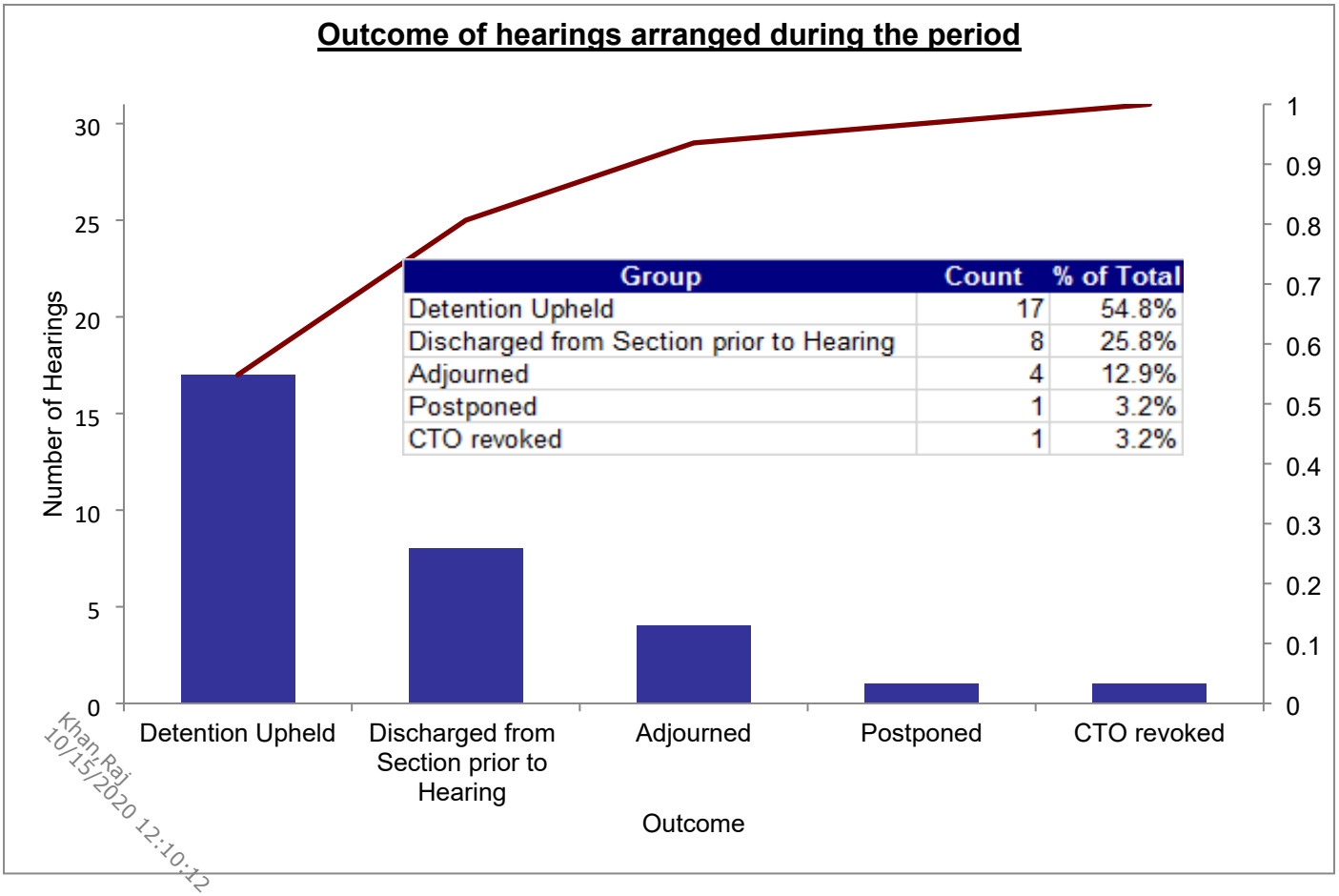
Discharge





Hospital Managers – Power of Discharge

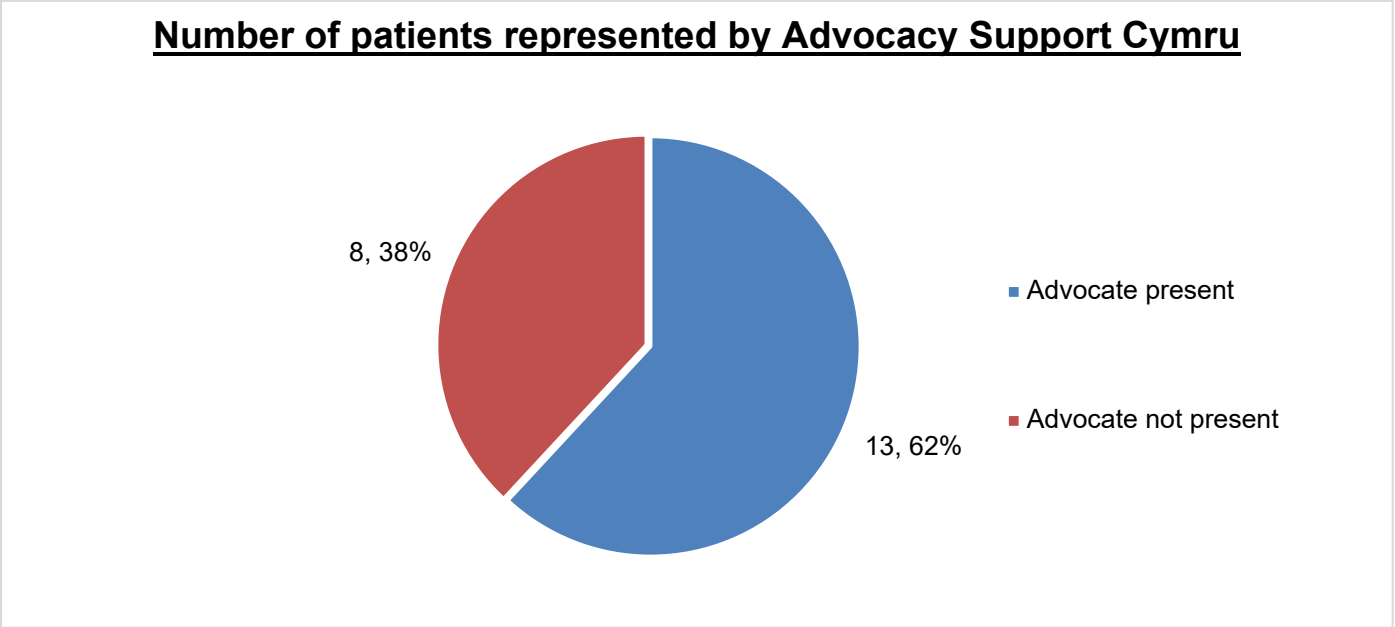


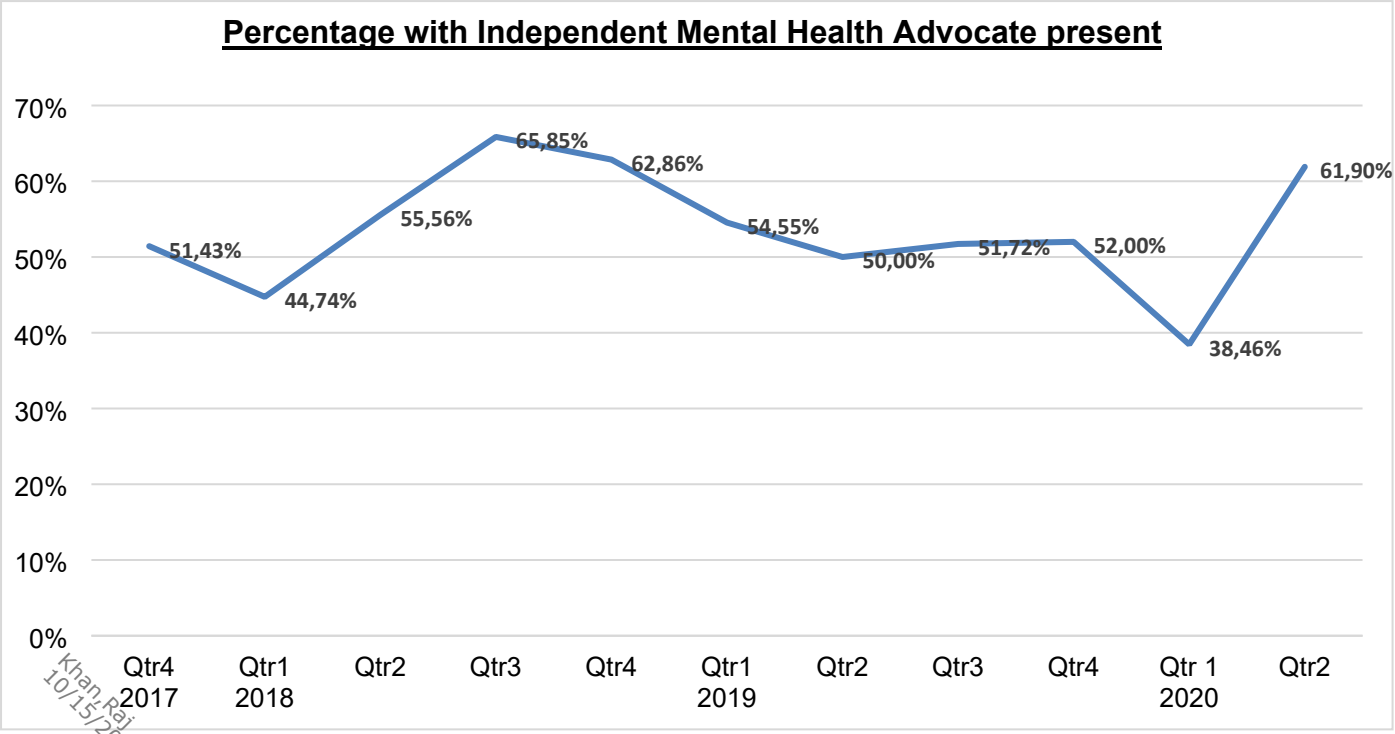


Four hearings were adjourned for the following reasons:

- To enable support from an Independent Mental Health Advocate
- Further information required by the panel
- Patient had not received the reports prior to the hearing
- Panel could not come to a unanimous decision

One hearing was postponed because the medical report had not been submitted by the Responsible Clinician in good time prior to the hearing.

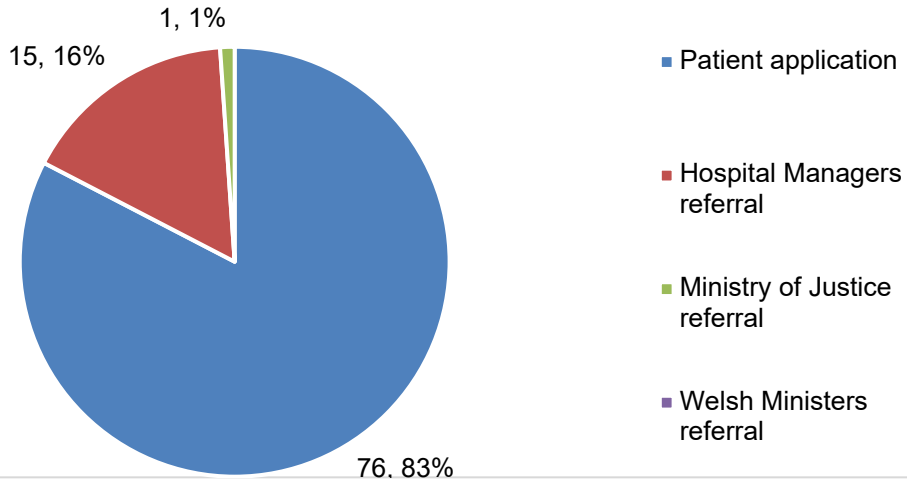




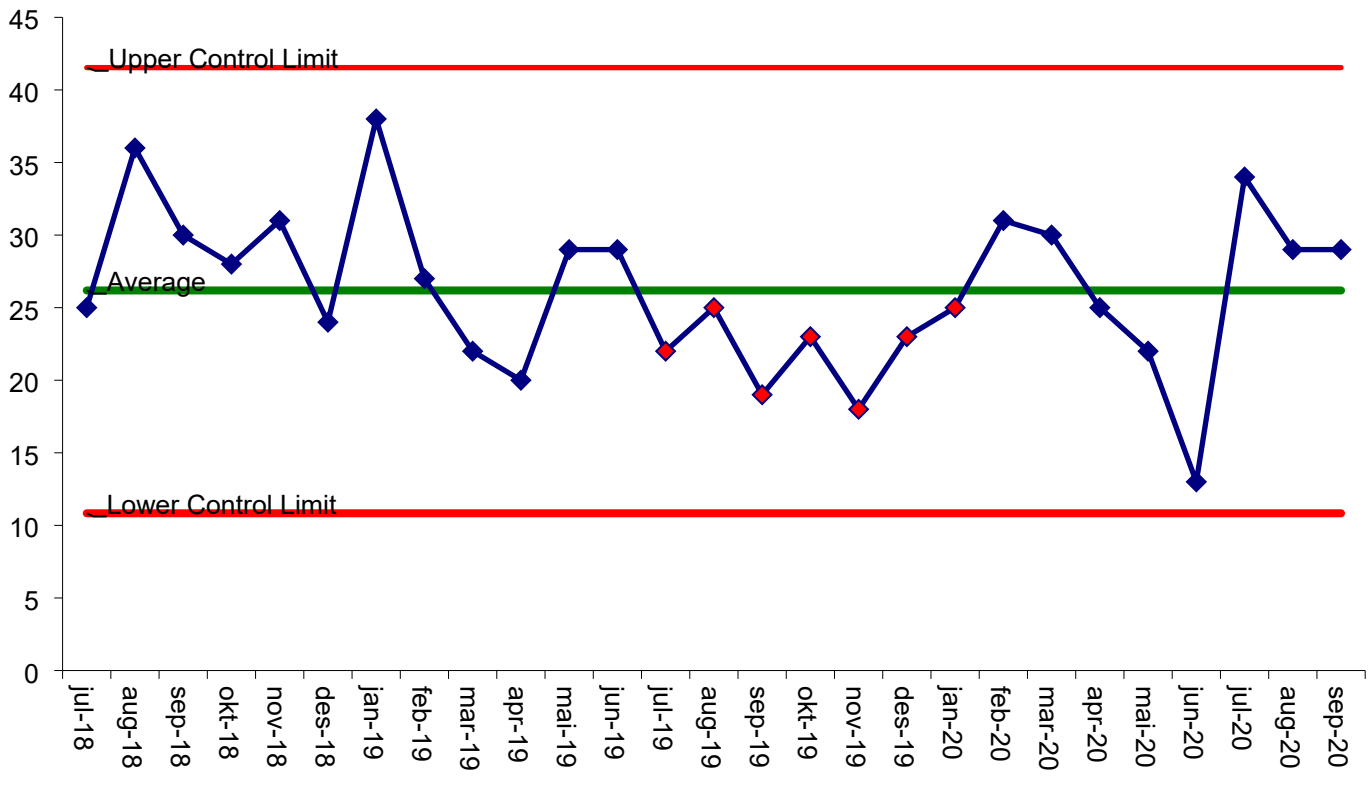
During the period the Mental Health Act Office made ten referrals to Advocacy Support Cymru where the patient was deemed not to have capacity make this decision. All ten referrals resulted in advocacy support at the hearing. On three occasions an advocate was instructed by the patient.

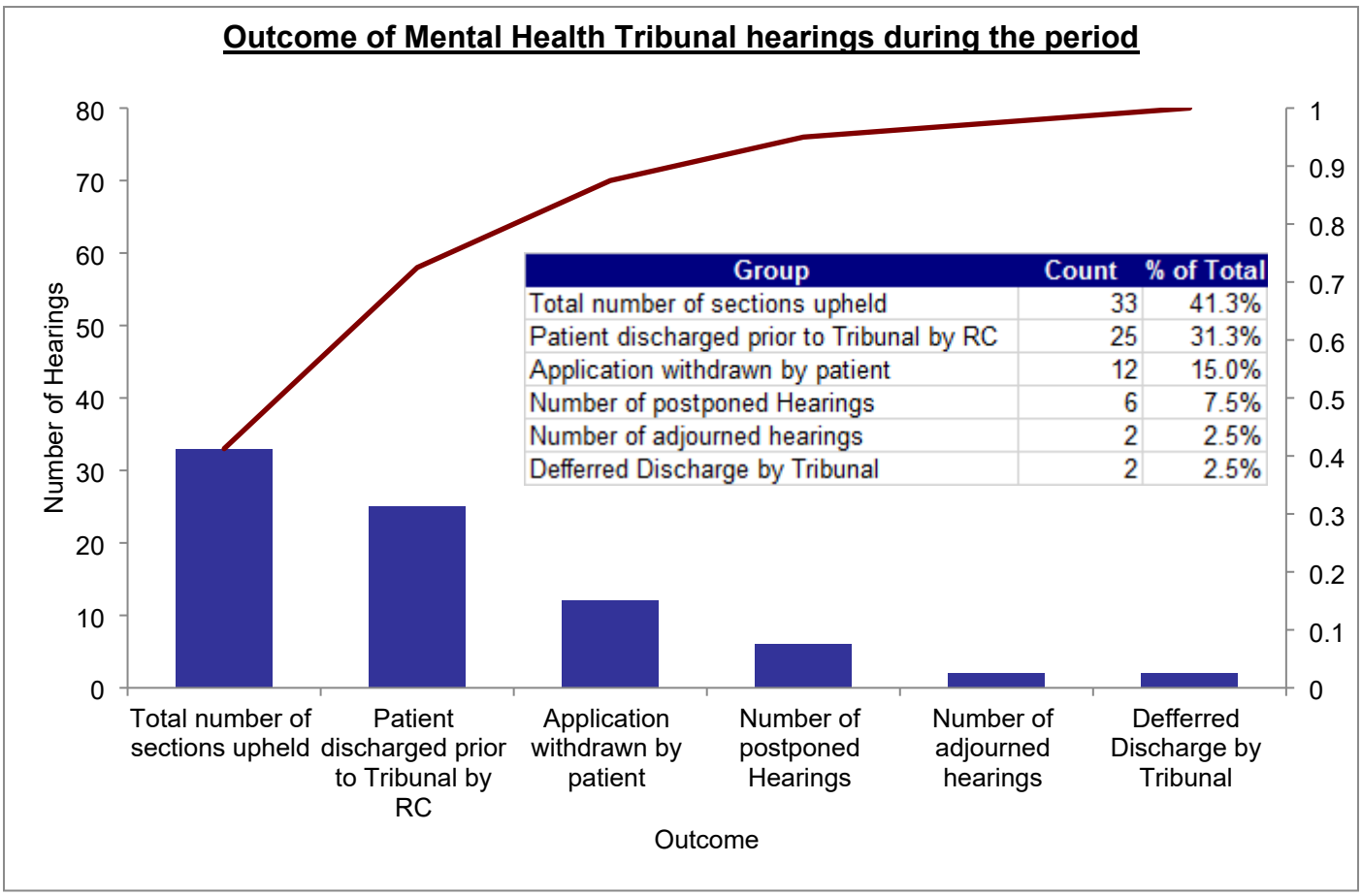
Mental Health Review Tribunal (MHRT) for Wales

Source of Applications to the Mental Health Review Tribunal during the period



Number of Mental Health Review Tribunal applications and referrals during the period





Group	Count	% of Total
Total number of sections upheld	33	41.3%
Patient discharged prior to Tribunal by RC	25	31.3%
Application withdrawn by patient	12	15.0%
Number of postponed Hearings	6	7.5%
Number of adjourned hearings	2	2.5%
Defferred Discharge by Tribunal	2	2.5%

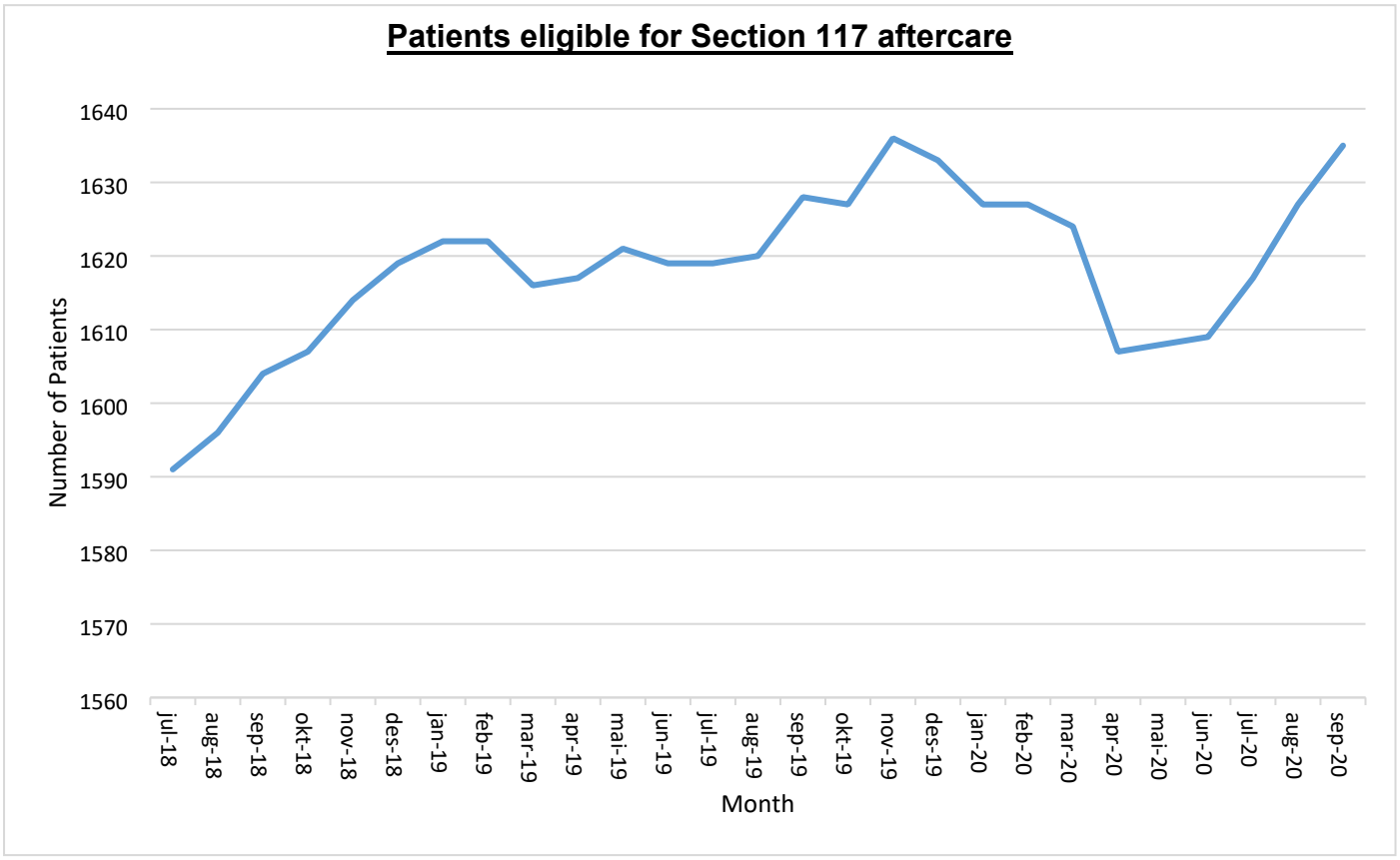
Two hearings were adjourned for the following reasons:

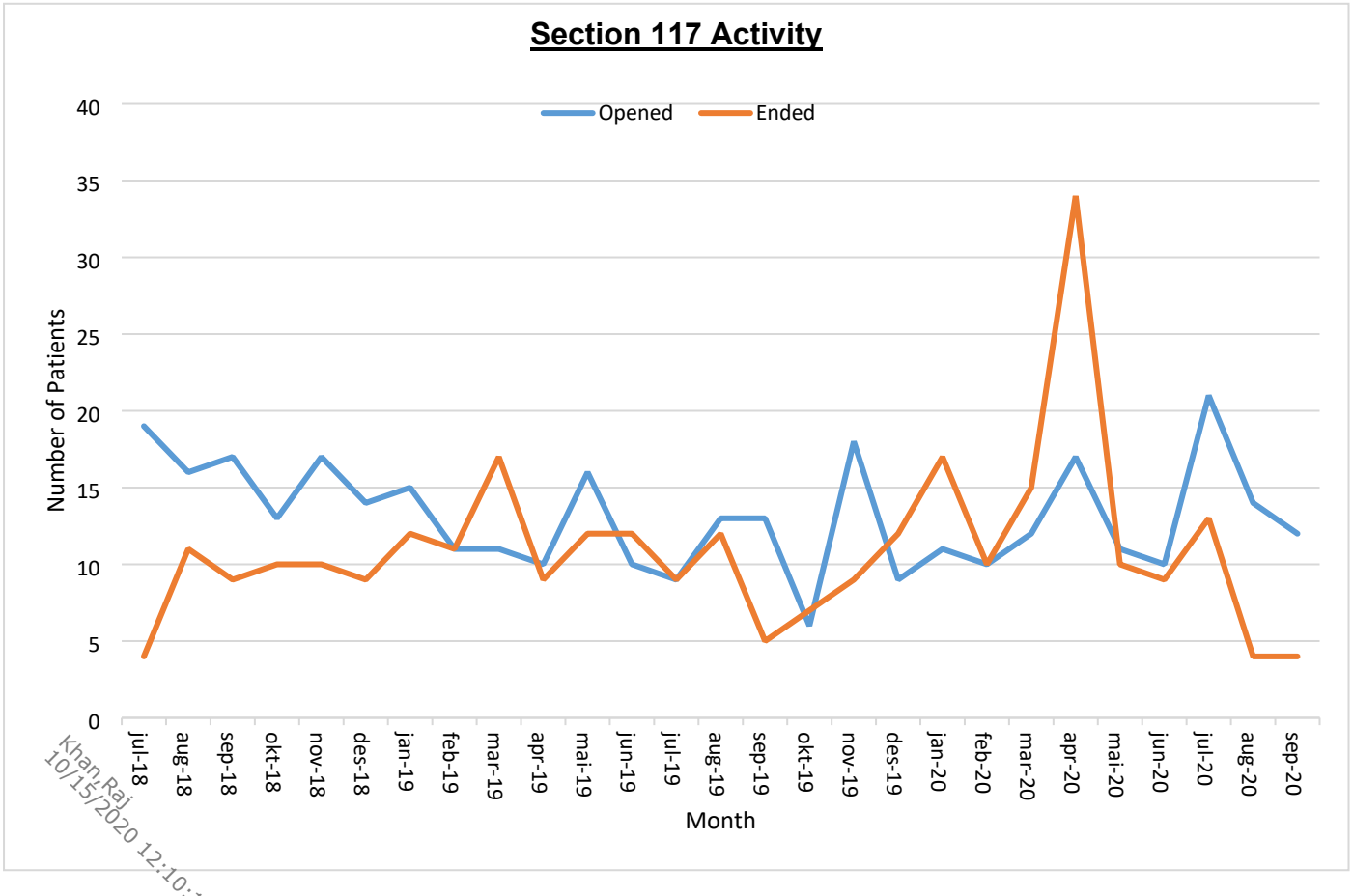
- One to obtain an Interpreter
- Further information required in relation to capacity status to appoint Legal Representative

Six hearings were postponed for the following reasons:

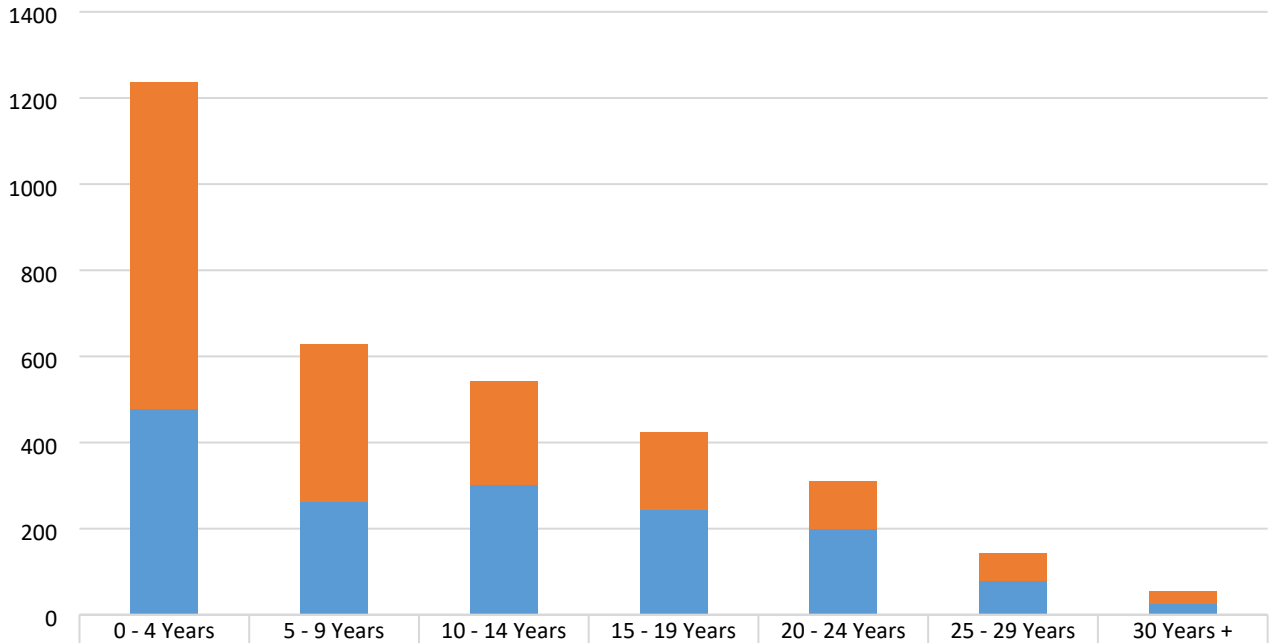
- Further information required
- Hearing arranged outside detention period by Tribunal Office
- Care Coordinator unavailable
- To obtain an independent psychiatric report
- Legal representative unavailable on two occassions

Section 117 Aftercare





Periods of time that patients remain eligible for Section 117 aftercare



	0 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	20 - 24 Years	25 - 29 Years	30 Years +
Ended	759	366	240	179	110	64	28
Ongoing	479	263	303	244	199	80	26

Summary of other Mental Health Activity which took place during the period

July – September 2020

Exclusion of visitors

Due to COVID -19 there is no visiting allowed on any of our mental health wards at present.

Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- Twelve patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:

    - Two to return to their home area
    - Seven to a specialist unit
    - Three to CAMHS

- Eleven patients detained under Part 2 of the Mental Health Act were transferred into Cardiff and Vale UHB from a hospital under a different set of Managers for the following reasons:

    - Two from PICU bed
    - Eight to return to their home area
    - One to step down

Death of detained patients

During the period there were no deaths of detained patients.

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 initially for up to 24 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 detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place of safety as long as the maximum time 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.
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO 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.
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 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 CTO
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 CTO 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 CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.

REPORT TITLE:	Mental Health Measure (Wales) 2010 incl. Part 2								
MEETING:	Mental Health and Capacity Legislation Committee						**MEETING DATE:**	**20/10/20**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Chief Operating Officer								
REPORT AUTHOR (TITLE):	Director of Operations, Mental Health								

PURPOSE OF REPORT:

To provide assurance to the Committee on the four parts of the Mental Health Measure.

REPORT:

SITUATION

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government (WG) on a monthly basis, with reports back to the UHB Performance Monitoring Committee. For the information of the Committee the Delivery Unit has restarted its 90 day cycle of mental health service reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

BACKGROUND

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

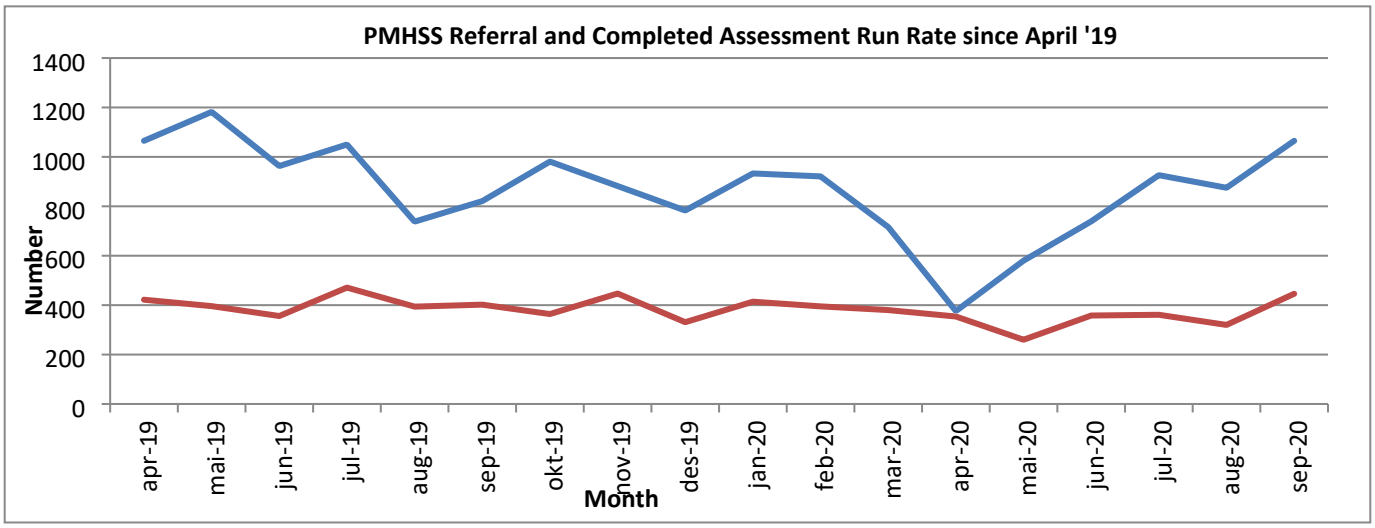
ASSESSMENT AND ASSURANCE

For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

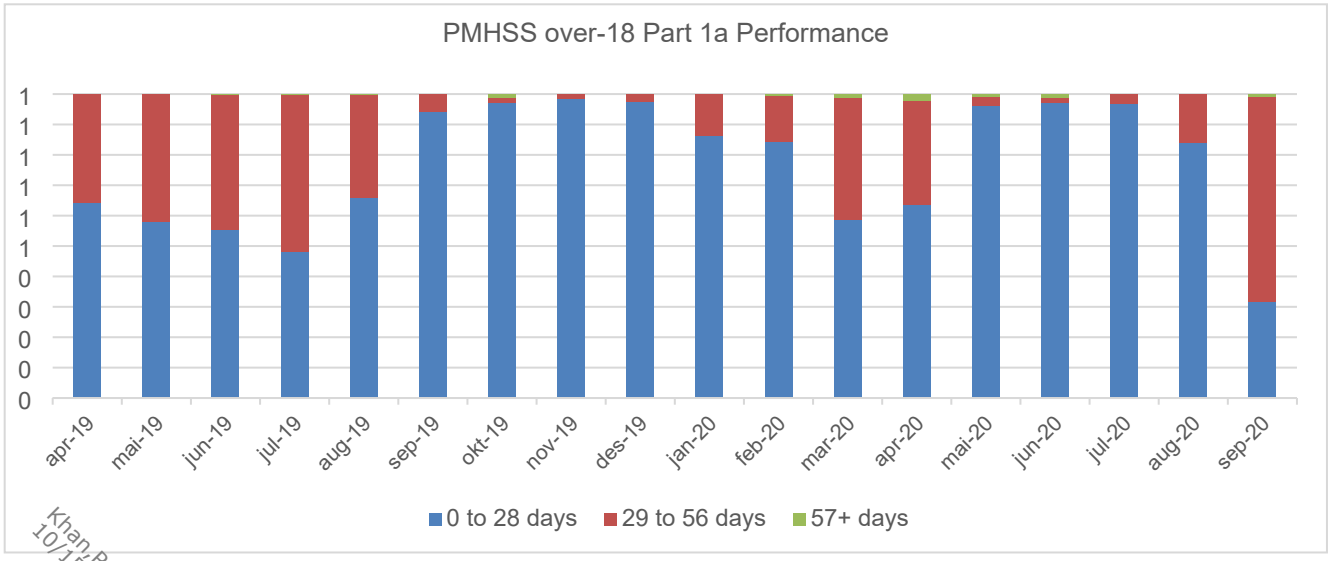
Part 1 : PMHSS

Part 1a – target: 28 day referral to assessment compliance target of 80%

Referral activity for Q1 & Q2 2020 has seen a gradual increase in referral rates reaching close to pre-lockdown rates at Month 06. Completed assessment rates have remained fairly uniform looking at the financial year as a whole (See Graph 1).



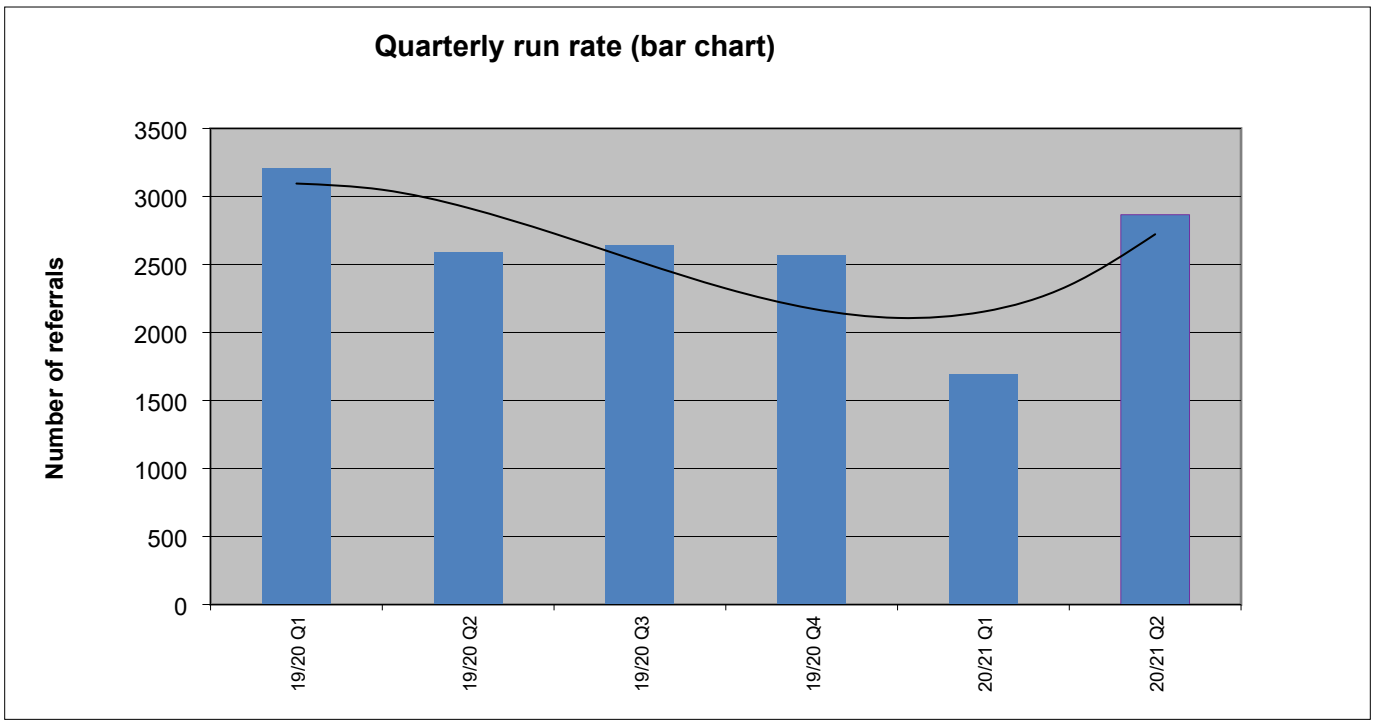
Regarding the over-18 Part 1a performance, this has been compliant with the Tier 1 target from September until February 2020 (see Graph 2). The initial impact of COVID-19 seems to have affected performance in the early stages of lockdown but compliance was reinstated quickly before a shortfall in four qualified (3.6wte) staff in August subsequently affected performance in September. This staffing issue was partly rectified in early September but the service remains 1.0wte down due to maternity leave.



Barring huge spikes in referrals (as per October ’18) or a large loss of qualified staff (as per early ’19), we are confident we will be able to regain and maintain this performance for the over 18

cohort into the foreseeable future.

Early forecasts pre-COVID-19 suggested an increase in referrals based on previous referral behavior but at time of writing it has become very apparent that referral numbers post-lockdown dropped quite dramatically (See Graph 3).



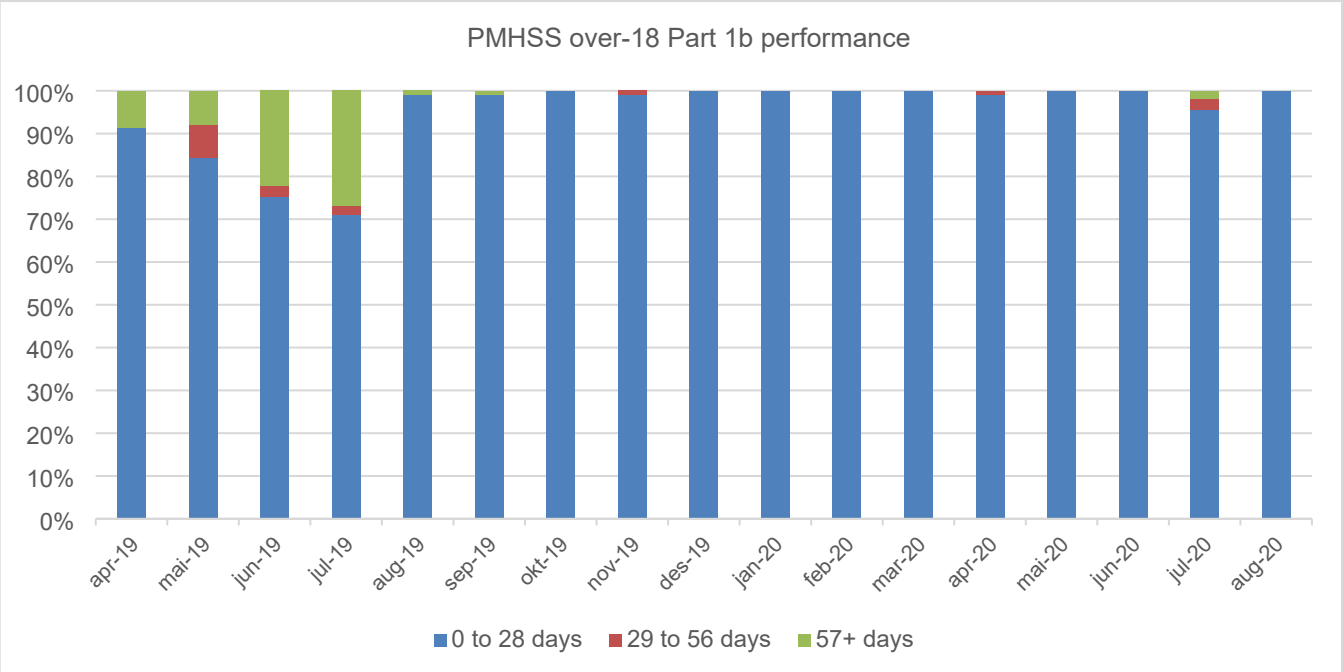
In addition to this, as we saw a significant reduction in referrals from March 2020 onwards, the Mental Health Clinical Board took a decision to amalgamate the PMHSS and Primary Care Counselling referrals. This decision was based on the strategic direction of the service to make access to MH services simplified for GPs and Service Users, avoiding referrals to the PCCS going to the back of their waiting lists for up to 6 months. These service users are now screened and triaged by the merged SPOE. The service is monitoring this closely and protecting this new SPOE as it is subject to a Tier 1 target, with investment into the 3rd sector and the Primary Care Liaison team.

The early indications are:

- Reduced demand for counselling. Since inception (Apr. '20) referral numbers to PCCS have averaged 150 per month compared with a monthly average of over 550 in 2019/20
- Better uptake of a first appointment for counselling. Approximately 75% of the referrals to PCCS in April '20 had at least one session of counselling. At time of writing it is too early to comment on retention but early indications are it is as good as and certainly no worse than pre-SPOE retention.

Part 1b – 28 day assessment to intervention compliance target of 80%

Having clarified reporting processes, PMHSS has been compliant with the Part 1b performance target since August (See Graph 4). This has continued during the COVID-19 period.



Part 2 – Care and Treatment Planning

Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

Care and Treatment planning is a complex and challenging area to get right, particularly co-producing outcomes based care planning which requires cultural change from services. Prior to the COVID-19 period the service was following an action plan co-written with the Delivery Unit which included a multi-dimensional improvement approach, including commissioned 'Care Aims' training, routine auditing of care and treatment plans, moving SUs expectations into practice through support of the Recovery College, simplifying documentation and defining a 'relevant patient' under the Measure therefore clarifying who and who does not require a formal Care and Treatment Plan. This plan remains relevant.

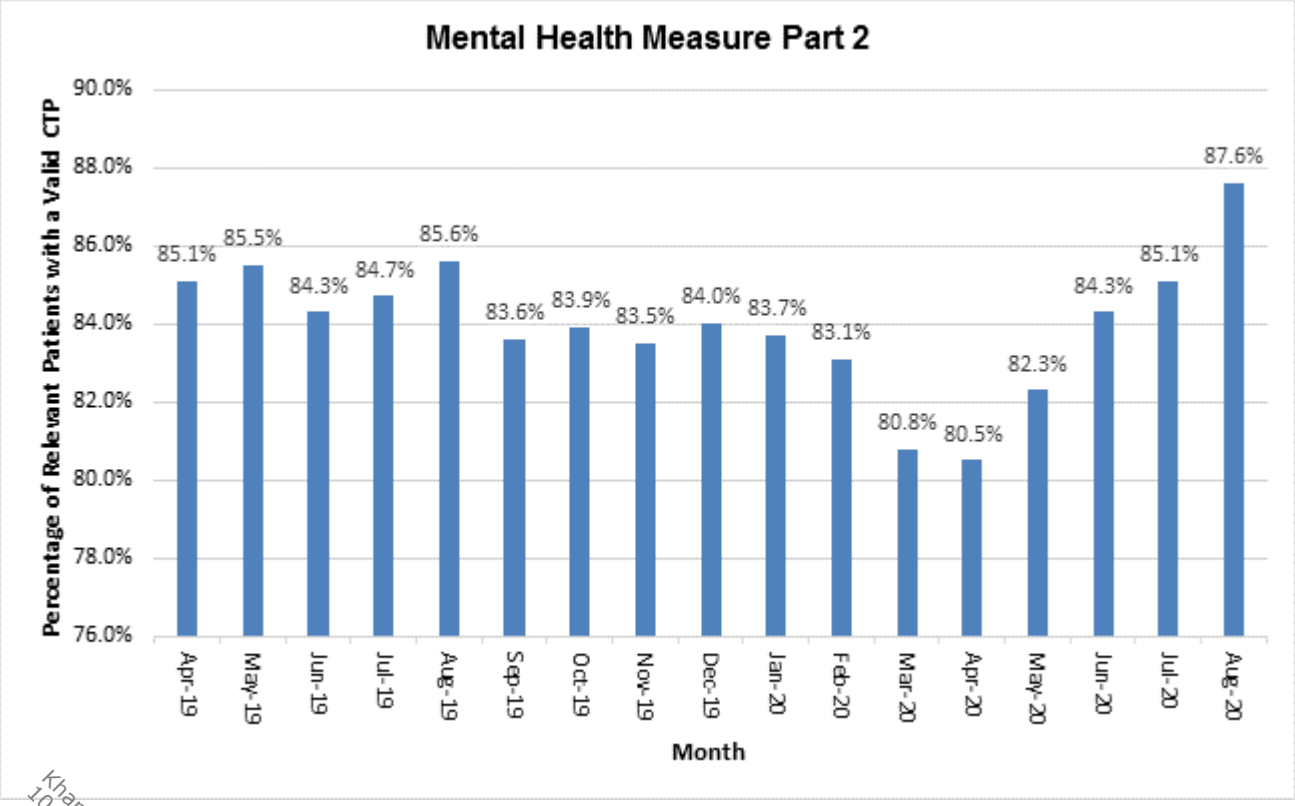
The future success of Care and Treatment planning is also tied to the strategy around out-patient transformation, within which many of the poorer examples of care and treatment planning sit. A program of work has now commenced with Dr Neil Jones leading the work stream and the Director of Operations supporting.

The Delivery Unit (DU) identified the following challenges for local and national Mental Health services. Below are the specific recommendations by the DU which were then augmented into an action plan presented to this Committee at the last meeting. This action plan was updated in April

2020 with another update intended for the end of the calendar year.

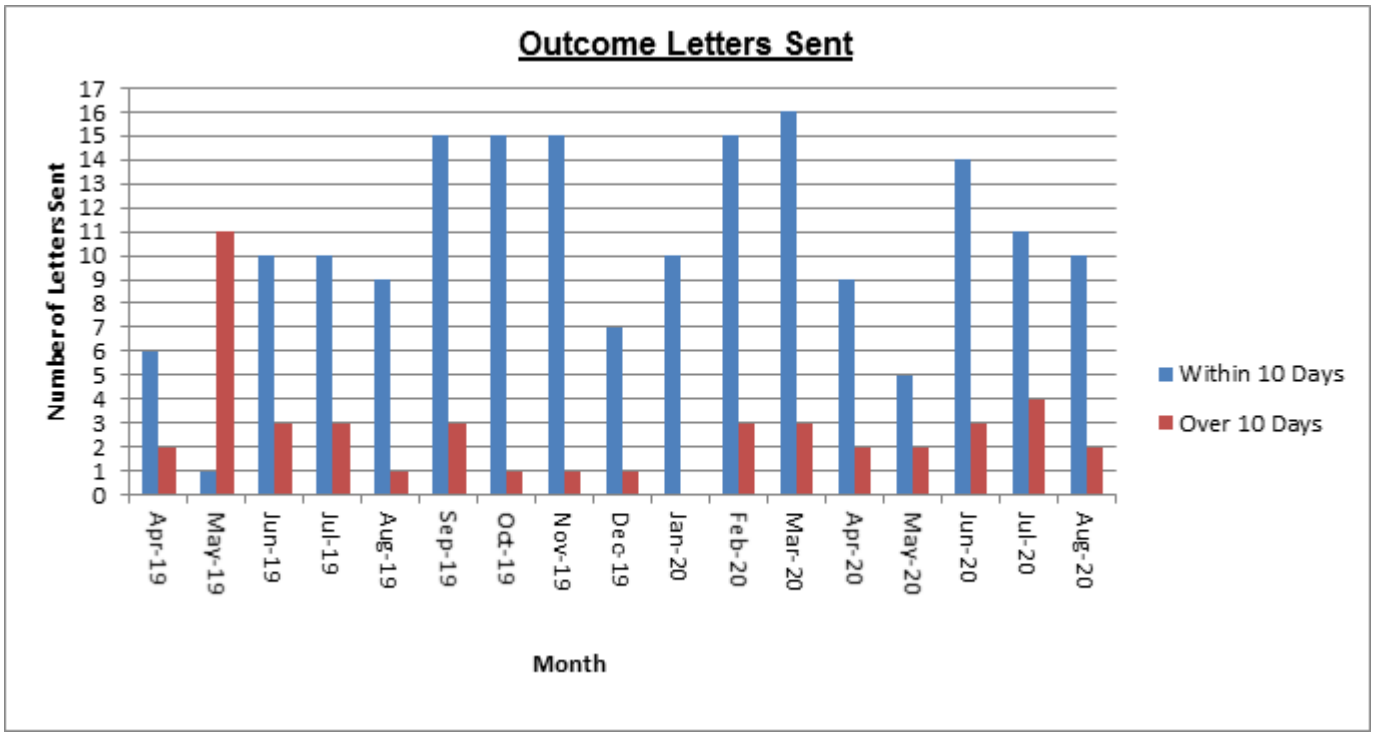
1. The Health Board and partner agencies should re-commence a training programme that emphasises the development of outcome focussed and co-produced care and treatment planning.
2. The Health Board and partner agencies should ensure that the formulation of risk and the management of an individual's safety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

Since the previous Mental Health and Capacity Legislation Committee meeting Care Aims and Open Dialogue training has commenced in spite of the COVID-19 restrictions and compliance with CTP completion has reached almost 90%.



Part 3 - Right to request an assessment by self –referral.

The target relates to service users who have self-referred, having a confirmation letter regarding the outcome of their assessment within 10 days. The below chart details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.



The performance of the service fluctuates with steady improvement seen between September 2019 and December 2019 with 100% compliance in January. Since then the teams have seen circa 80% compliance. No data was collected through the COVID period with teams now being supported again to meet this administrative standard.

Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

Part 4 continues with 100% Compliance.

The IMHA service continues to run a reduced service. In response to the pandemic ASC (Advocacy support Cymru) have been unable to meet with clients face to face, but have offered support via skype, phone, text, letters and email. ASC have been able to help clients prepare for meetings and have joined meetings/ward rounds and Managers Hearings remotely.

The referral rate has slowed down, which is to be expected due to the restrictions to conduct open sessions/awareness raising.

ASC continue to receive referrals from the Mental Health Act Office and are also receiving phone calls/emails from existing clients on a daily basis with instruction to act, contact professionals etc.

WG have confirmed with Procurement that we are able to proceed with the 12 month extension

of IMHA contracts. This extension will cover the period of 1 January 2021 – 31 December 2021. Procurement have been working with Legal and Risk who have confirmed that we can rely on regulation 72 of the Public Contracts Regulations to vary the contracts as a result of circumstances outside the control of the contracting authority that could not have been foreseen at the time of the contract being entered into. These circumstances refer to the proposed amendments to the MHA, possible TUPE implications as a result of the changes and as a result of COVID-19 which could put more pressure on this market should they be expected to go through a competitive procurement at this time.

There has been an increase in referrals post lockdown but the service continues to be compliant with the Measure.

Advocacy Support Cymru have reported that Adult and MHSOP Services have been very helpful throughout the lockdown period with Advocates increasingly having to rely on staff as they have not been able to access wards to speak with patients face to face, also working with non-instructed patients the majority are unable to talk with over the phone. The Mental Health Act Office have been proactive and creative in facilitating hearings remotely, to ensure patients' legal rights are upheld.

The IMHA agreement is due to expire on the 31st December 2020 and it was the intention of NWSSP Procurement services to merge the existing contracts and renew on an All Wales basis with a commencement date of 1 January 2021. The renewal process was halted due to a delay in the recommendations following the review of the Mental Health Act being communicated. As such the existing agreements were extended for 12 months in line with Regulation 72 (1)(c) of the Public Contract Regulations 2015. The Health Boards are currently meeting with Procurement to agree collaboratively the options beyond December 2021.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	x	8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x
4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	

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

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

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

EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

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

REPORT TITLE:	Mental Health Measure (Wales) 2010								
MEETING:	Mental Health and Capacity Legislation Committee						**MEETING DATE:**	**20/10/20**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Chief Operating Officer								
REPORT AUTHOR (TITLE):	Scott McLean – Director of Operations, Children and Women's Clinical Board								

PURPOSE OF REPORT:

To provide assurance to the Committee on the parts of the Mental Health Measure applicable to children and young people (aged <18).

REPORT:

ASSESSMENT AND ASSURANCE

Part 1 : Children & Young People (CYP) Primary Mental Health Services

Part 1a – 28 day referral to assessment ≥80%

Compliance against the part 1a target **has been achieved and sustained since May 2020.** Following a decline in referrals during the first peak of the pandemic, referral levels increased from June 2020 to near pre-COVID levels. Following the reopening of schools in September, there was an increase in referrals above the greater than that of the same month last year.

The service is continuing to deliver its full offer via virtual (telephone and video) and face to face means and expects to continue to utilise these mediums as part of blended service offer to better meet the needs of CYP requiring support from the service. The service continues to closely monitor its capacity in order to meet the incoming demand.

Part 1b – 28 day assessment to intervention ≥80%

Significant improvement work has taken place over the previous months in order to improve compliance against the part 1b target. **In August, the service achieved the compliance target for the first time in 16 months, the position was sustained in September.** The service continues to monitor their capacity for the delivery of interventions.

Part 2 – Specialist CAMHS: ≥90% patients with a valid Care and Treatment Plan

The service continues to underperform against the target as a result of initial difficulties experienced during the initial few months of the pandemic, namely decreased engagement from patients in the CTP process and a high number of new patients requiring one.

The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate. Improvement in compliance remains a priority for the service.

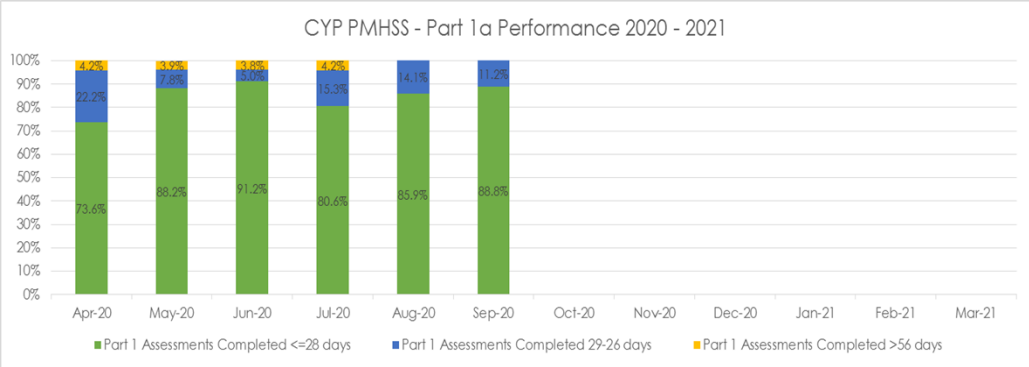
SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:			
This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity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

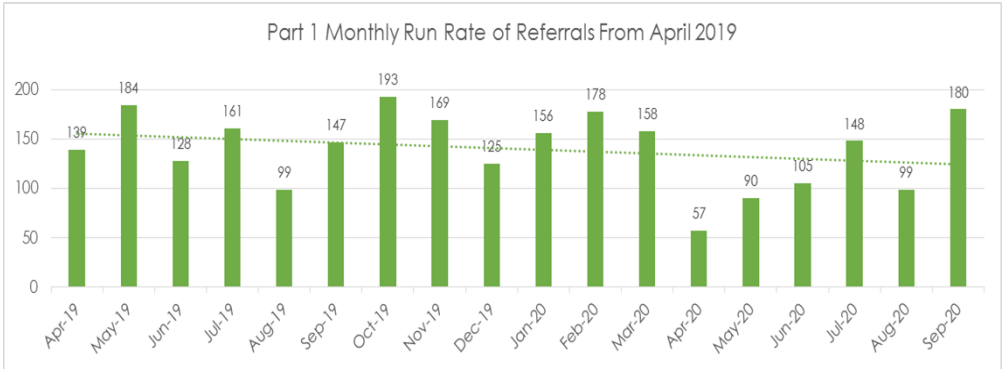
Please highlight as relevant the Five Ways of Working (Sustainable Development Principles) that have been considered. Please click here for more information											
Sustainable development principle: 5 ways of working	Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x	

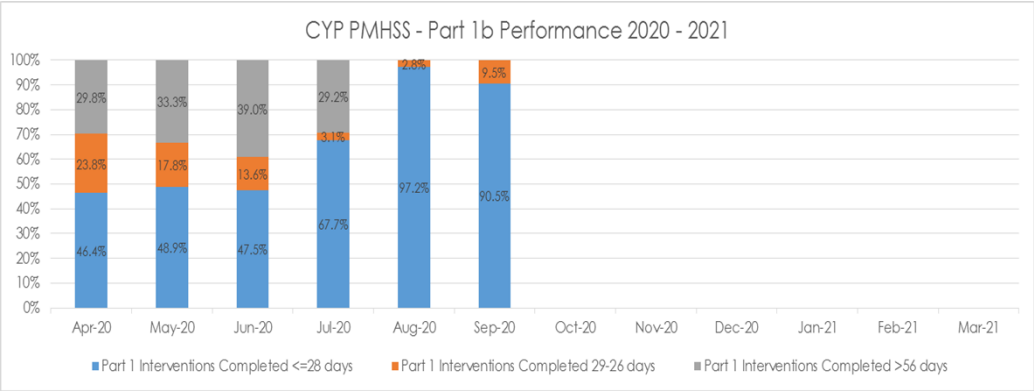
EQUALITY AND HEALTH IMPACT ASSESSMENT COMPLETED:	Not Applicable

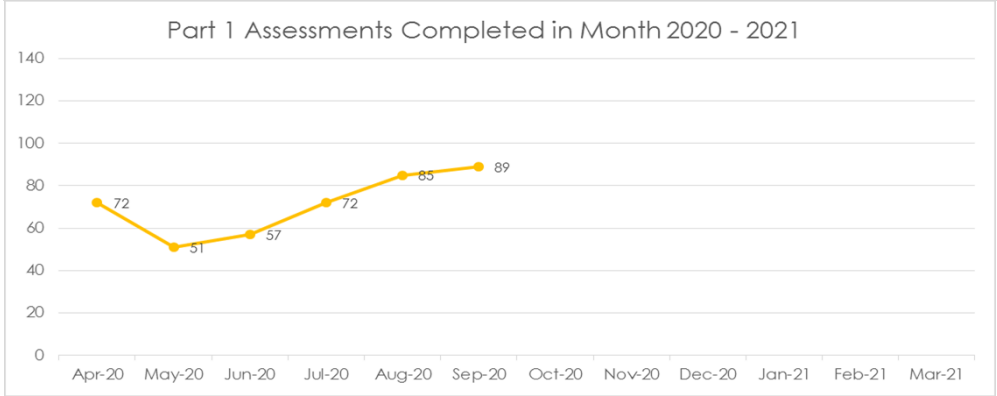
Kind and caring Caredig a gofalgar | Respectful Dangos parch | Trust and integrity Ymddiriedaeth ac uniondeb | Personal responsibility Cyfrifoldeb personol

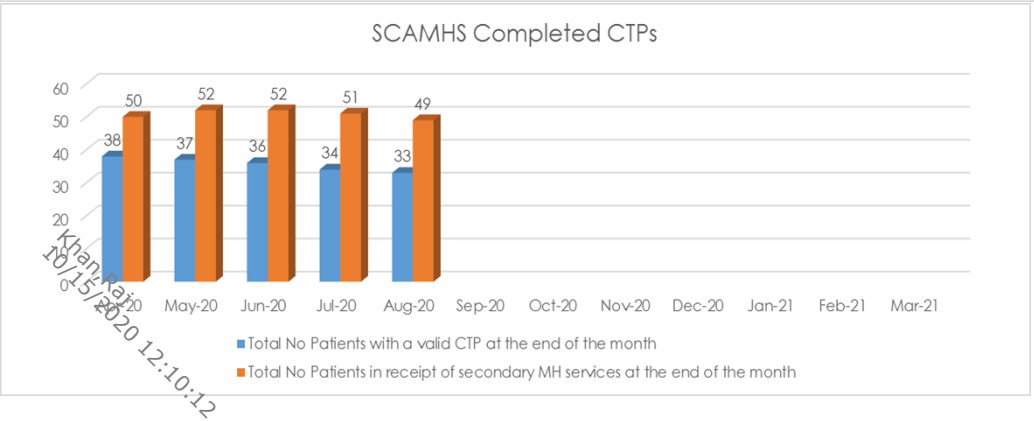
Mental Health Measure (Wales) 2010 : CAMHS SERVICE PERFORMANCE TO SEPTEMBER 2020

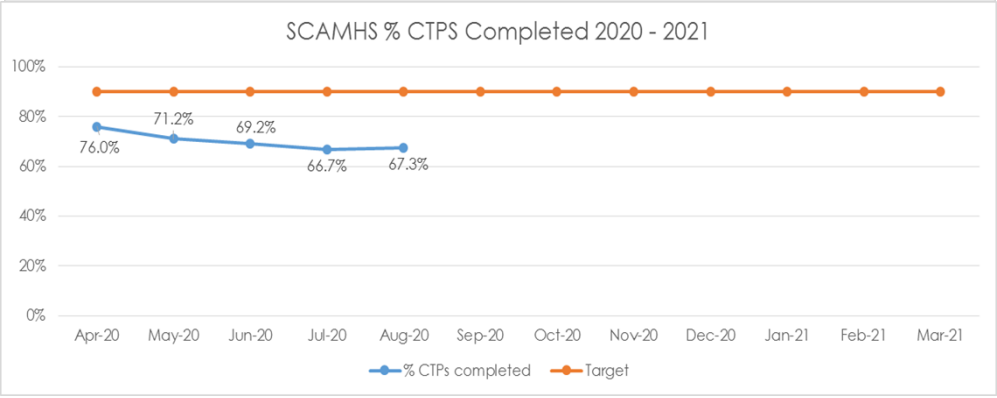












Report Title:	**Sourcing and Supporting Patient Stories**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	20/10/20	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	**Executive Nurse Director**								
Report Author:	**Assistant Director of Patient Experience**								

Background and current situation:

"Digital storytelling" describes the practice of everyday people who use digital tools to tell their 'story'. Simply put, digital stories are multimedia presentations that combine a variety of communicative elements within a narrative structure.

Patient stories bring experiences to life and make them accessible to other people. They encourage the NHS to focus on the patient as a whole person rather than just a clinical condition or as an outcome.

Healthcare has the opportunity to shift the "traditional view" of the user as a passive recipient of a product or a service to the new view of users as integral to the improvement and innovation process.

Patient Stories and Quality Improvement

Quality improvement depends on frontline staff generating fast improvement cycles in the setting where the work is delivered. Due to the fast and localised nature of quality improvement work, it suits a variety of different tools to identify and monitor projects.

Patient stories have unique features which make them appropriate in quality improvement projects:

- Stories are subjectively told from the point of view of the narrator and therefore the attention focuses on the individual and not the organisation/condition;
- The narrative structure of the story aligns events (time vs. plot) and helps make sense of the experience;
- Stories are non-linear and are made of a complex network of events, actions, relationships and environments;
- Stories have an ethical dimension that reflects society's expectations of "good behaviour";
- Stories are action-oriented and focus on events and actions, and provide insights into what could have happened;
- Stories help bridge the gap between the formal codified space of the organisation (job description, roles, accountability) and the informal unwritten rules and sub-cultures.

Patient stories ensure that the patient voice is heard at the most senior level of the organisation. This helps ensure that improvement of services is centered on the needs of its users.

Whatever the sources of information on patient, carer and staff experiences (e.g. interviews, films, transcripts, forum feedback, surveys, complaints, compliments), we are looking for the same thing – emotions, which are the route to understanding people's experience of the care process.

In other words:

- **What** people feel when they use our service
- **When** they feel it

To date most stories have been opportunistic, the plan over the next year is to build a library of stories with tags identifying key words that can be used in plethora of situations to embed some behavioral awareness.

One of the key elements is communication and examples of where we get it right and where it can be improved - concerns and compliments will form some of this work.

Members of the Patient Experience Team have undertaken training in story telling which includes digital editing, story capture and presentation etc. We intend to train 10 volunteers across the Health Board to support this work and align them to Clinical Boards.

In preparation we have designed some of the supporting information

Appendix one - Patient story request submission form
Appendix two - Storyteller information sheet
Appendix three - Storyteller consent form

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

The paper provides the Committee with the plan to develop the digital story library within the UHB. This will allow this Committee an opportunity to hear the voice of our patients' experiences at each meeting.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc:)

RECOMMENDATION:

The Committee is asked to **NOTE** the work the Patient Experience team are undertaking in partnership with patients and the Clinical Boards on Patient stories.

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

Patient story request submission form

Please complete this form to request a patient story facilitator to record a patient or staff story.

Briefly describe the situation/potential story.
Who will benefit from the story being made?
Who will listen to the story?
What is the potential for the story to lead to service improvement?
Who will be responsible for any actions required?
Is this story opportunity instead of a complaint or part of a complaint? Yes/No
Which delivery unit are you in?
Has the delivery unit nurse director been made aware that a story is being recorded Yes/No
Has the delivery unit governance lead been made aware that a story is being recorded? Yes/No

Requesters name:
Role:
Contact details:
Has the offer of doing a story been made to the patient? Yes/No
Patient's name:
Patient's contact details:

The story facilitator should complete the following section before uploading the finished story, with this form and the signed consent to the holding tap on the patient story sharepoint site.

What is the theme of the story?
Please give us one sentence to describe this story.
How is the story being used in the delivery unit?
What action plan was developed as a result of the story?
Please provide a final closing statement to the story ideally no more than 20 word. Include how the story is having an impact and any service improvements that have happened as a result.
Has this statement been added to the end of the story? Yes/No
Has the consent level been put on an initial screen at the start of the story? Yes/No
Has a thank you letter or email been sent to the storyteller? Yes/No
Story Facilitators Name:
Contact details:
Date:
Any further information:

Please select up to three tags which describe this story – these will be used for indexing.

[ ] Complaints [ ] Mental Health [ ] Children [ ] Maternity/birth

[ ] Therapy [ ] Dementia [ ] Pressure ulcer [ ] Falls

[ ] Best Practice [ ] Breast reconstruction [ ] Palliative care/end of life

[ ] Listening [ ] Community Care [ ] Cancer

Storyteller information sheet

Thank you for taking the time to share your experience with Cardiff and Vale University Health Board (UHB).

We want to hear about your personal experience (good and bad) so we can identify ways to continue to improve our services for patients, carers and staff.

The story you are will be audio recorded and then, either transcribed or put together with images (photographs or drawings of your choice) to create a short video clip.

You will not be filmed; you can remain as anonymous as you choose in your story.

Nothing will be shared with other people until you have reviewed the material and signed a consent form.

The story will not form part of your medical records and it will not affect any future care or engagement you or your family may have with us as your health care provider.

Cardiff and Vale UHB will store your story safely and make it available for use in meetings and training sessions. You will be able to choose if the story is shared more widely on the internet. You may at any time ask us not to use or share your story further. Simply contact us using the details below and we will delete all your information to the best of our ability.

We know that sometimes people have experiences that are upsetting. If this has happened to you, or if telling your story is upsetting, the person recording the story will talk to you and, with your permission, they will arrange for someone to meet you and provide support.

Safeguarding and patient safety

Just occasionally, a person may tell us about something that might indicate they are in danger, or tell us about something that is dangerous in our services.

If we think you are in danger in any way we have a legal obligation to tell our Health Board Safeguarding Lead, who will then investigate to see if action should be taken, and whether they need to inform the statutory safeguarding authority.

If your story reveals that there is a situation that is unsafe or may put patients or staff in danger, we will take immediate action to make it safe. We will only reveal your story details as necessary to identify the issue and to take appropriate action.

If you have questions before or after your interview or wish to withdraw consent at any time, you can contact the following UHB representative:

Contact name: Position:

Telephone: Email:

For further information please see our privacy notice on:
http://www.cardiffandvaleuhb.wales.nhs.uk/privacy-policy

Storyteller consent form

I have understood the information contained within the Storyteller Information Sheet, a copy of which I have been given to keep. I agree to tell my story regarding my recent experience in the Health Service.

My story can be digitally recorded and used by Cardiff and Vale University Health Board to improve their services. I can withdraw my consent at any time and do not have to give any reason for withdrawing.

I am willing for my story to be shared with:

1. The health professionals dealing with your care [ ]
2. Any health and social care professionals [ ]
3. At Board meetings and conferences, where members of the public or journalists may attend [ ]
4. Internet and social media (i.e. Twitter, Facebook etc) [ ]

I have permission to use all the images I have provided Yes/No/Not relevant

Title of my story (optional): ……

The name I would like to be acknowledged by as the storyteller is: ……..

I consent to Cardiff and Vale University Health Board keeping my story indefinitely unless I withdraw consent in the future.

Print name: Date:

Signature:

Contact details (email or telephone)

Address:

Thank you for agreeing to tell us your story.

Contact details for Cardiff and Vale UHB representative.

I have informed the above person about this interview, and I am sure they understand the content of both the Storyteller Information Sheet and this Storyteller Consent Form.

Name: Position:

Signature Email:

Report Title:	**Feedback on Committee Training Session and Review**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	20/10/20	
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**		**x**
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance**								

SITUATION

The Committee's Terms of Reference are due for review and it was agreed that it would be valuable to undertake this exercise as part of a Committee Development Session which would also include up to date training on key legislation for the Committee.

Executive Director Opinion /Key Issues to bring to the attention of the Board/ Committee:

The paper provides the Committee with a summary of the first Committee Development Session and plan for further sessions culminating in Terms of Reference review.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):

The Committee has a very clear role in advising the Board of any areas of concern relating to the UHB's responsibilities under mental health legislation, and provides assurance that the UHB is discharging its statutory duties under the relevant legislation.

The Committee Development Sessions have been designed to provide Committee members with up to date training around the relevant legislation and provide an opportunity for consideration of the existing Terms of Reference and discussion around any changes that may be required.

The first session was held on 2 September 2020 and solely focused on the Mental Health Act 1983 presented by the Mental Health Act Manager. The session was well attended by Committee members and UHB Executives. It was agreed at this session that two further sessions would be helpful with one devoted to the remaining key areas of legislation i.e. the Mental Capacity Act 2005, DoLS and Mental Health (Wales) Measure 2010 and a final session to look at patient involvement and Committee function to review and revise the Terms of Reference as necessary.

The following points were made at the Development Session:

- Important that service users are included in future sessions to inform discussion around their role;
- Routine UHB training sessions on the relevant legislation are open to attendance by Committee members and attendees;

- Would be useful to consider where case law fits;
- Are we trying to fit everything relevant to Mental Health within the remit of this Committee and is that appropriate?
- First principle is to ensure we meet given requirements;
- Guardianship under the Mental Health Act is managed by the Local Authority, should the Committee have a monitoring role in its use?
- Code of Practice provides the principles and guidance on how the Act should be applied in practice and tells us what we should be monitoring, good to consider where this should feed into;
- Legislative and Governance Group should pull through items for Committee;
- Good to know what should be covering and what is missing to determine Terms of Reference and how values aspect and Equality Act are included;
- Need to ensure the right qualitative and quantitative data is provided to Committee;
- The Committee work plan can provide a standard prompt of what should be covered and then anything further impacting / legislation / case law can be considered;
- There is an order of assurance – activity level, exception level, process level; with the process level sitting with the Committee or supporting Group;
- END needs to know if things going to plan and if not going to plan together with the reasons why and what is being done to rectify;
- Can we use information to change practice and as a tool for improvement for example by feeding section 136 data to Police colleagues via Local Partnership Forum?
- Length of Detainment, is this for the Committee or should monitoring sit entirely with Mental Health Department?
- Committee function is to look at where breaches have occurred, what were the consequences and what has been done to stop recurrence.

The updated Committee Terms of Reference will be presented to Board for approval. It is anticipated that the remaining development sessions will be held before the end of 2020 enabling updated Terms of Reference to be presented to Board in the early part of 2021.

RECOMMENDATION:

The Committee is asked to:

NOTE the feedback on the first Committee training session and plan for further training and review of Committee Terms of Reference including function and membership.

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	x	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver care and support across care sectors, making best use of our people and technology	x

4. Offer services that deliver the population health our citizens are entitled to expect	x	9. Reduce harm, waste and variation sustainably making best use of the resources available to us	x
5. Have an unplanned (emergency) care system that provides the right care, in the right place, first time		10. Excel at teaching, research, innovation and improvement and provide an environment where innovation thrives	

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term	x	Integration	x	Collaboration	x	Involvement	x

Equality and Health Impact Assessment Completed:	Not Applicable

Report Title:	**Committee Effectiveness Review 2019-20 Results and Actions**								
Meeting:	Mental Health & Capacity Legislation Committee						**Meeting Date:**	20 Oct 2020	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Corporate Governance**								

SITUATION

It is good practice and good governance for Committees of the Board to undertake a self-assessment of their effectiveness on an annual basis, in line with the requirement of Standing Orders. This is done for all Committees of the Board.

The questions in this year's self-assessment mirror those included in last year's review; they are key considerations in the Good Governance Handbook and this approach enables us to reflect on progress with last year's action plan. Survey Monkey was again used as a tool to gather the feedback.

ASSESSMENT

Attached at Appendix 1 are the results for the Committee Effectiveness review undertaken by Committee Members in addition to the Executive Director Lead for the Committee; where comments have been provided these are also included. The responses show that the Committee has maintained standards and achieved improvement in a number of aspects of Committee effectiveness since the last survey, however there has also been a deterioration in scores in some areas, all of which are highlighted.

Attached at Appendix 2 is a proposed action plan to improve the areas in which the results fell below 100%.

RECOMMENDATION

The Committee is asked to:

- Note the results of the Committee's self-assessment Effectiveness Review for 2019-20.
- Approve the action plan for improvement to be completed by March 2021 in preparation for the next annual self-assessment which will feed into the 2020-21 Annual Governance Statement.

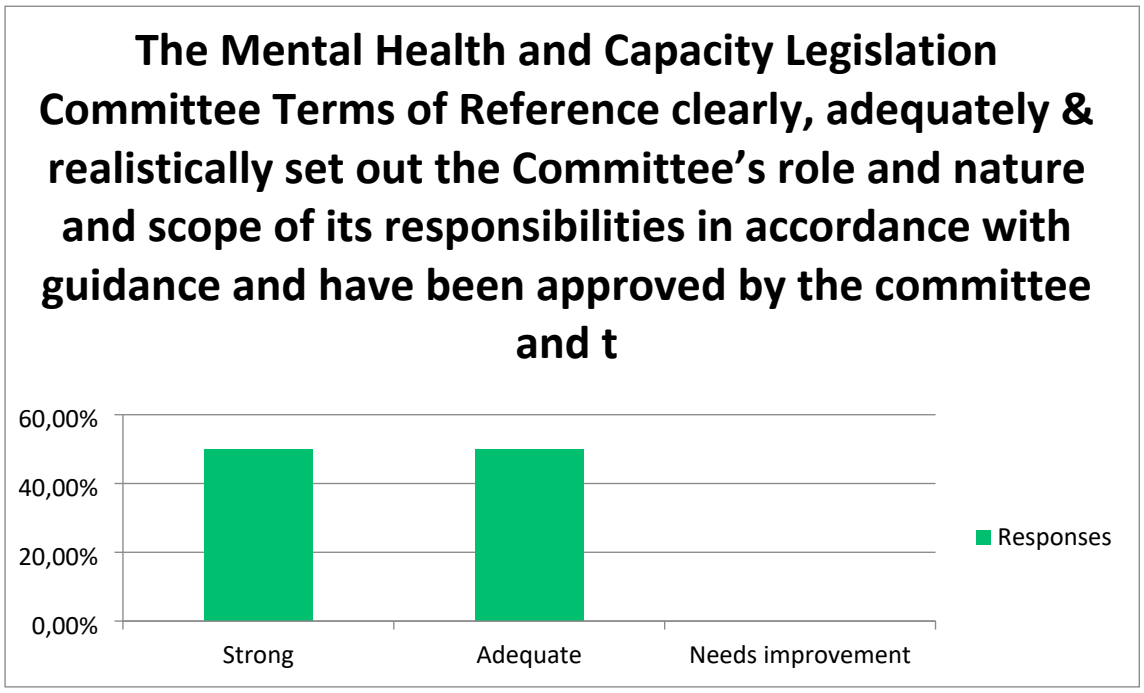
Shaping our Future Wellbeing Strategic Objectives *The UHB objectives relevant to this report*			
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	x	7. Be a great place to work and learn	x
3. All take responsibility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

Five Ways of Working (Sustainable Development Principles) considered									
Prevention		Long term	x	Integration		Collaboration		Involvement	

Equality and Health Impact Assessment Completed:	Not Applicable

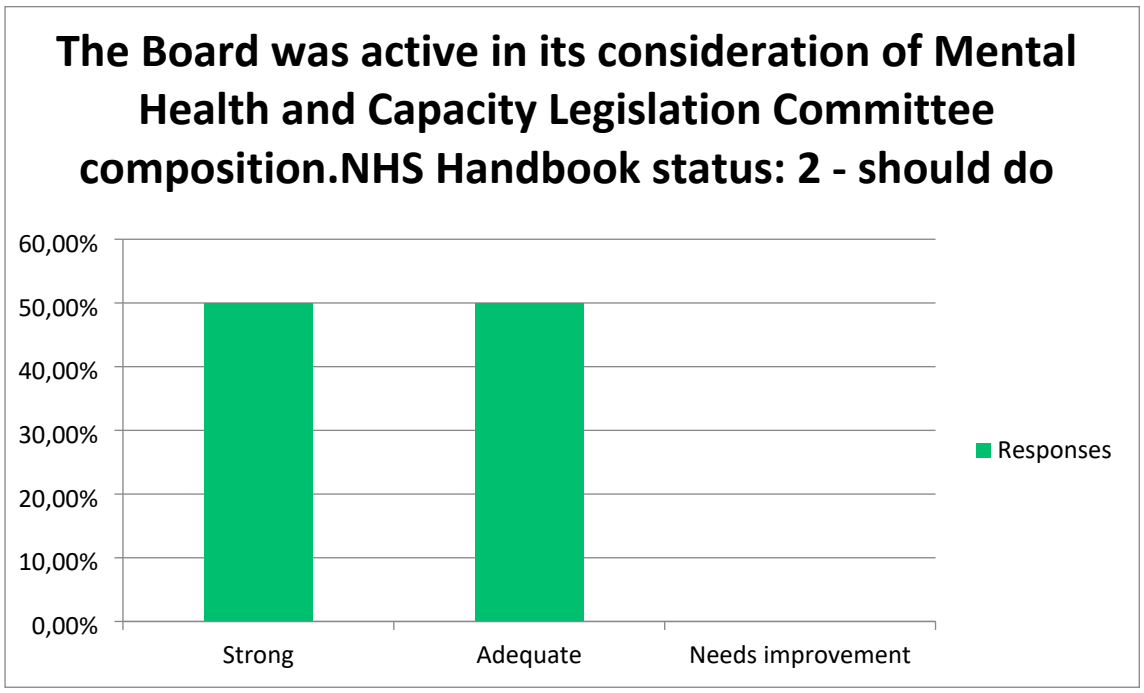
Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20



A deterioration on last year's results where 100% scored as "Strong"

Comments
"At the time I attended this Committee the TOR were strong, focussed appropriately and accurately reflected the working requirements of the Committee".

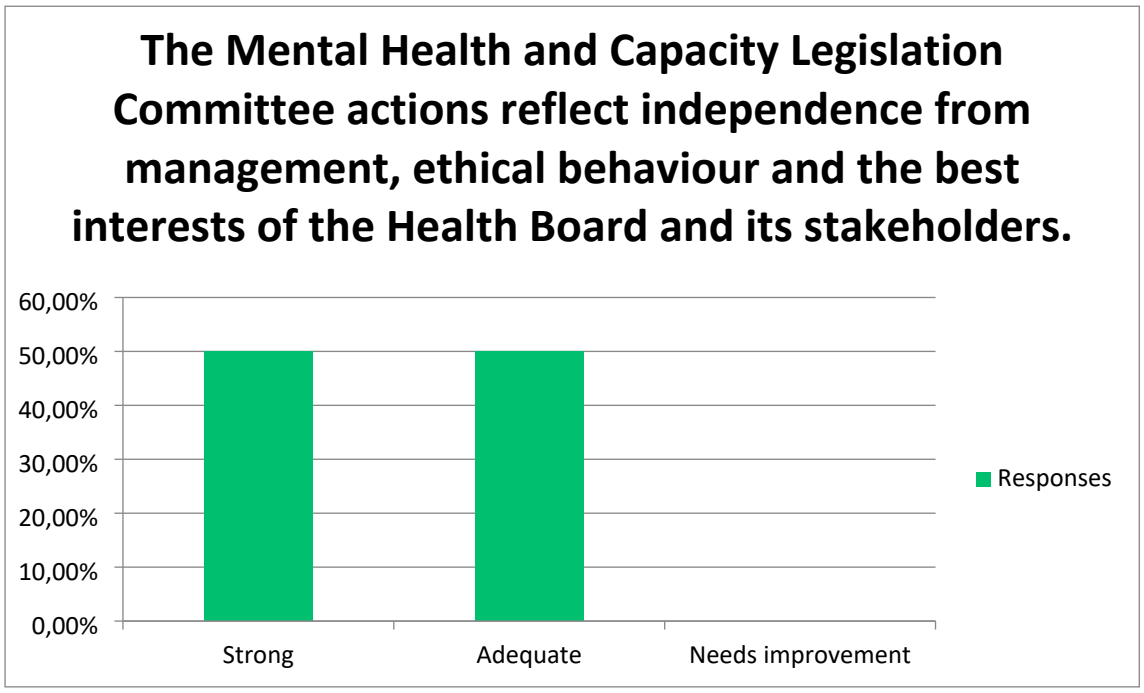


No change from last year's feedback

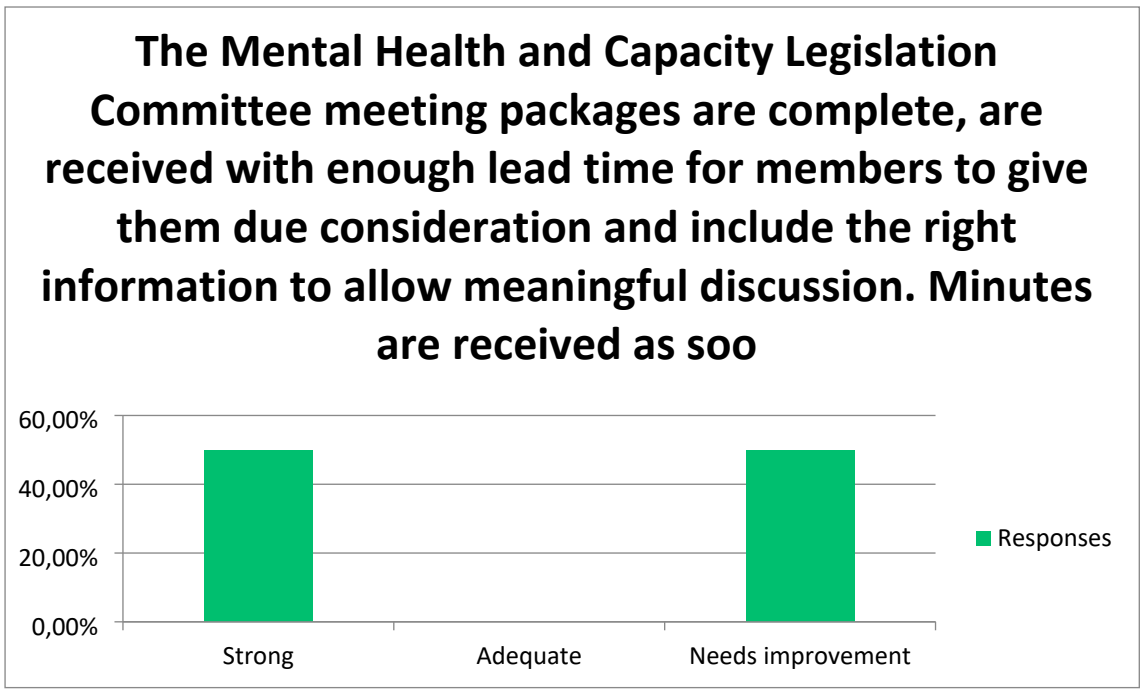
Comments
"Active consideration provided through the Vice Chair and Chair of the Board".

Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20



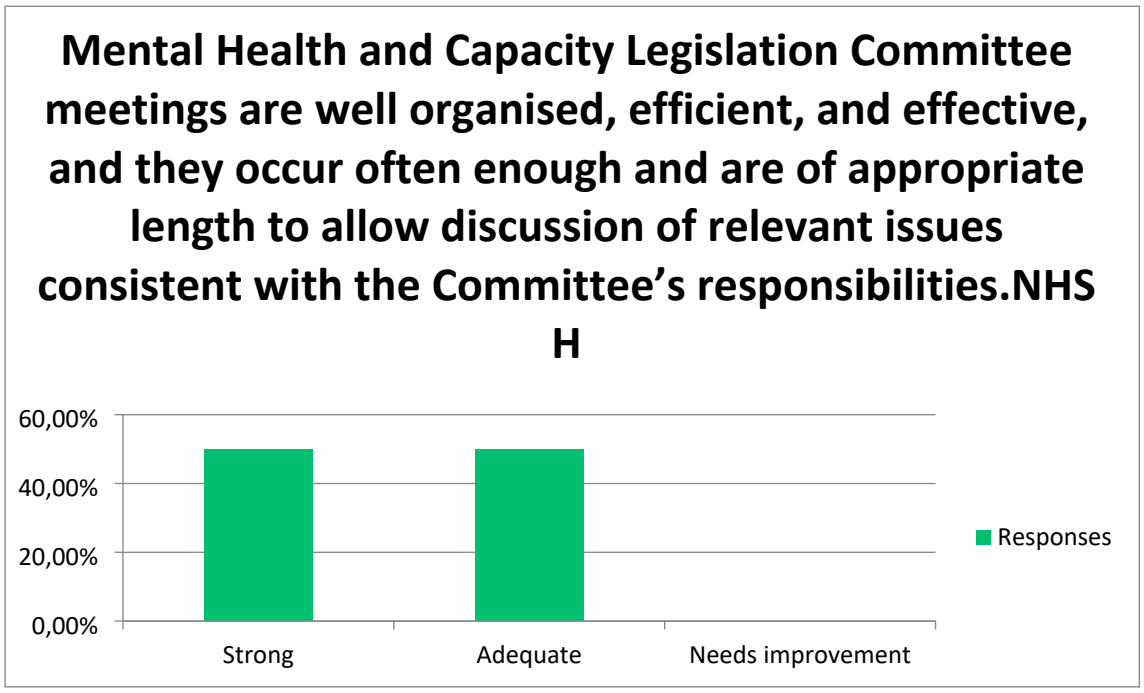
No change from last year's feedback



A deterioration from last year's position where all responses were "Strong" or "Adequate"

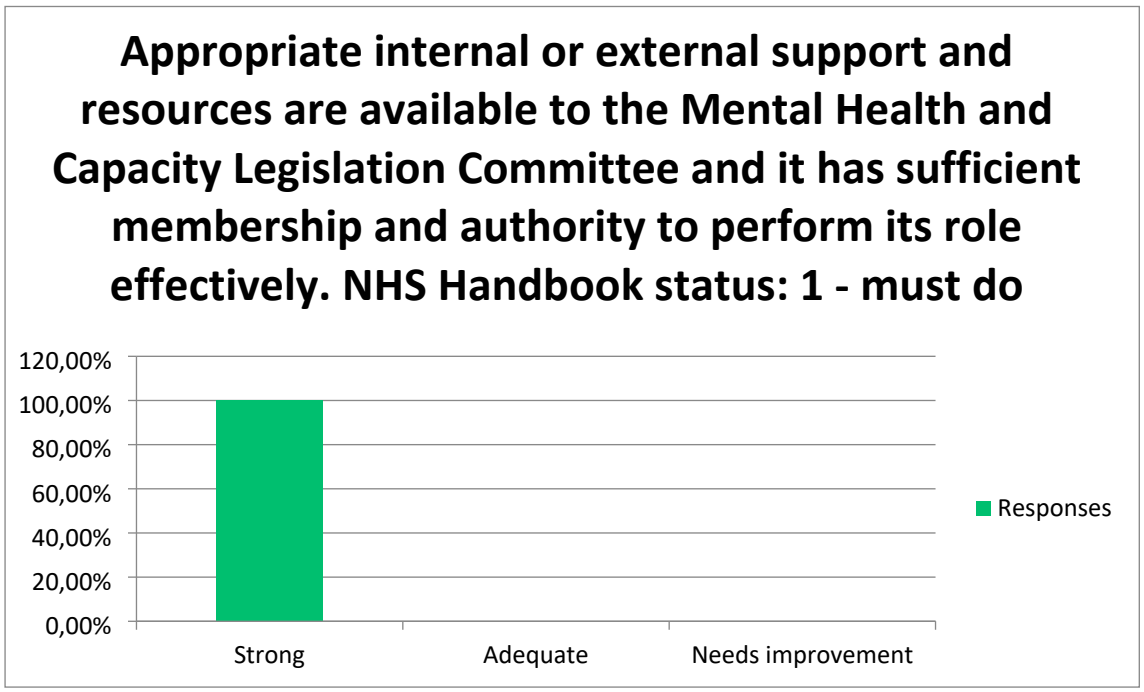
Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20



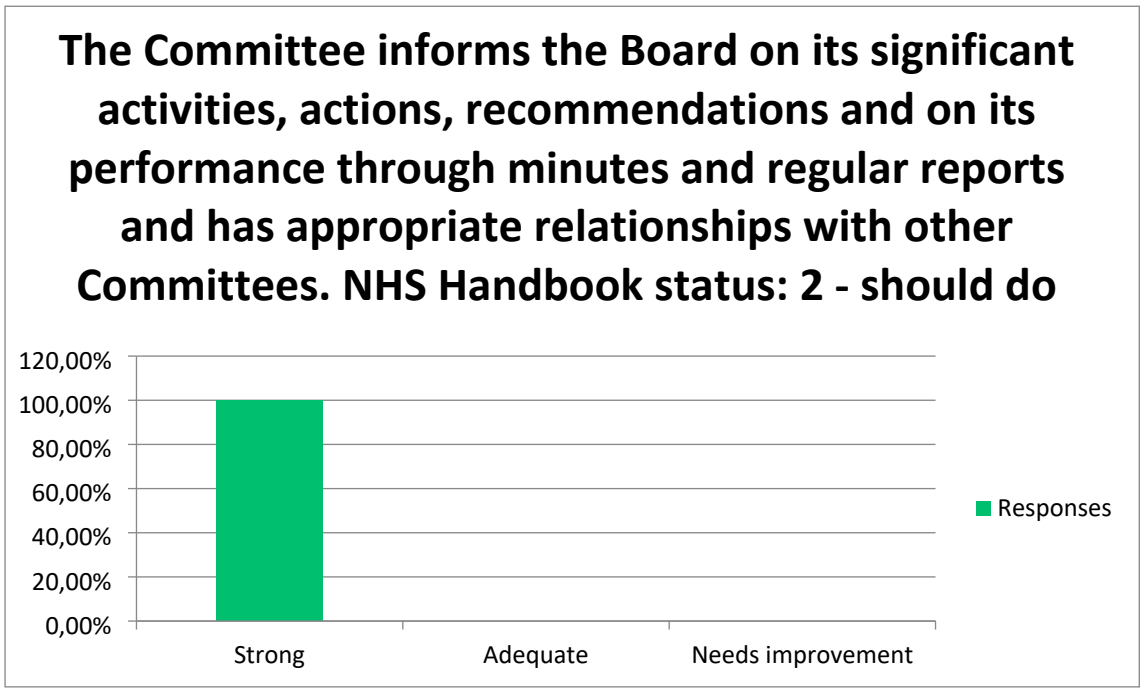
A deterioration from last year where 100% scored as "Strong"

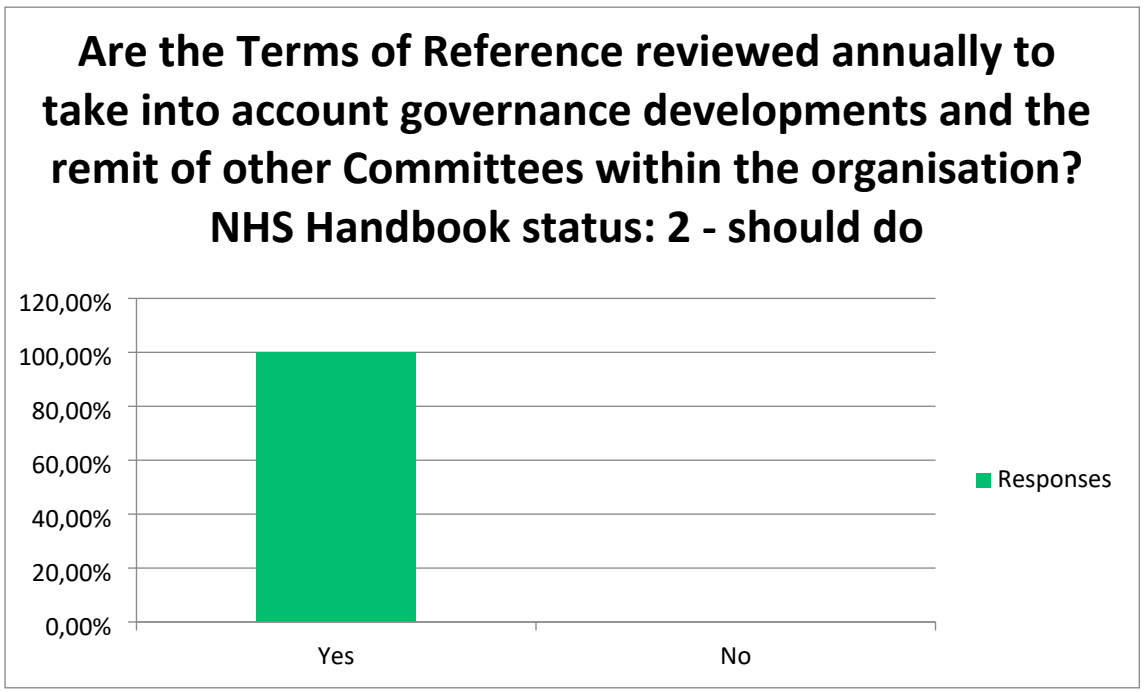
Comments
"Attendances were in early part of the year only but the meetings were efficient and well structured".



Improvement on last year

Comments
"Strong support always provided".



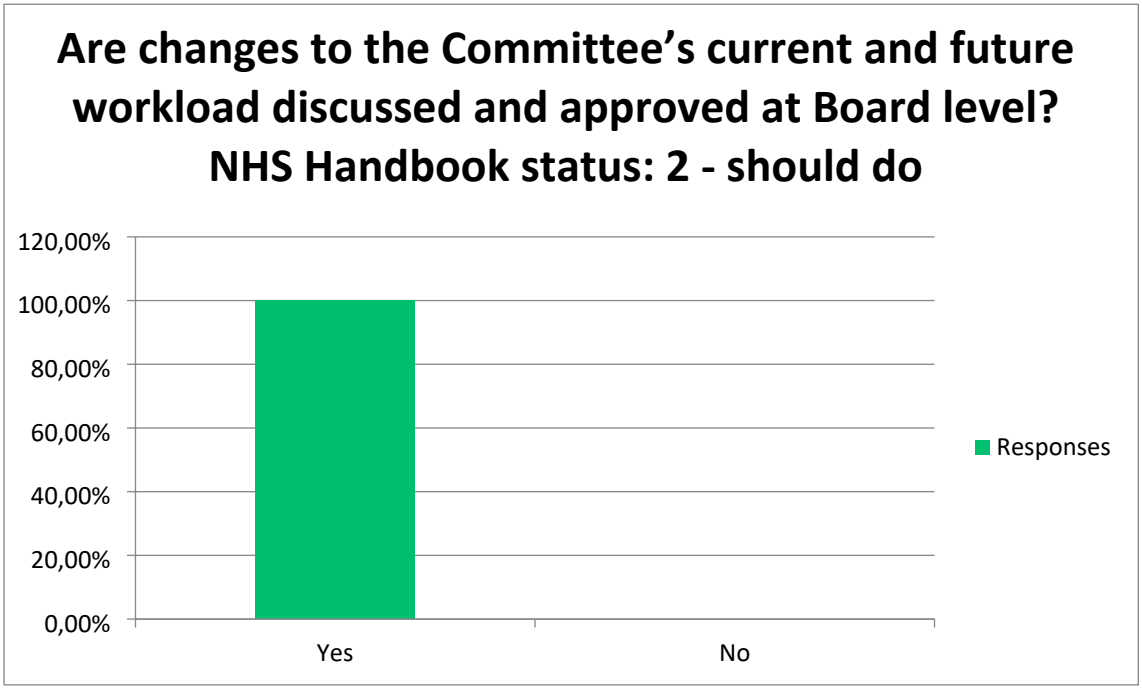


Comments

"Currently fit for purpose".

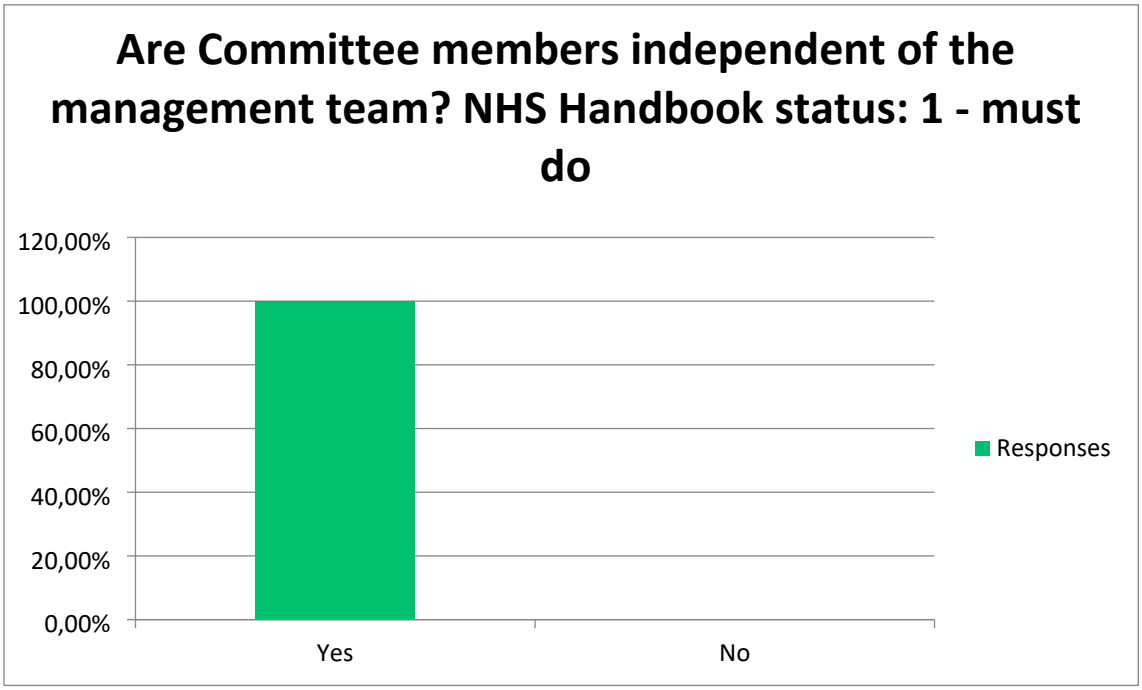
Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20



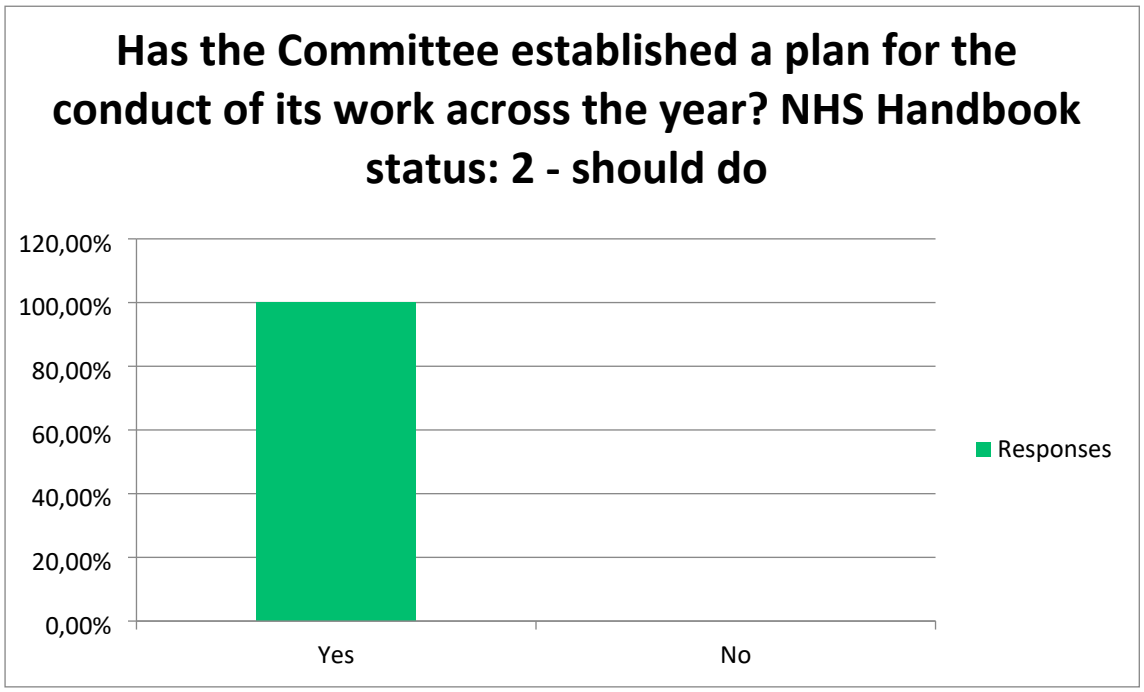
Comments

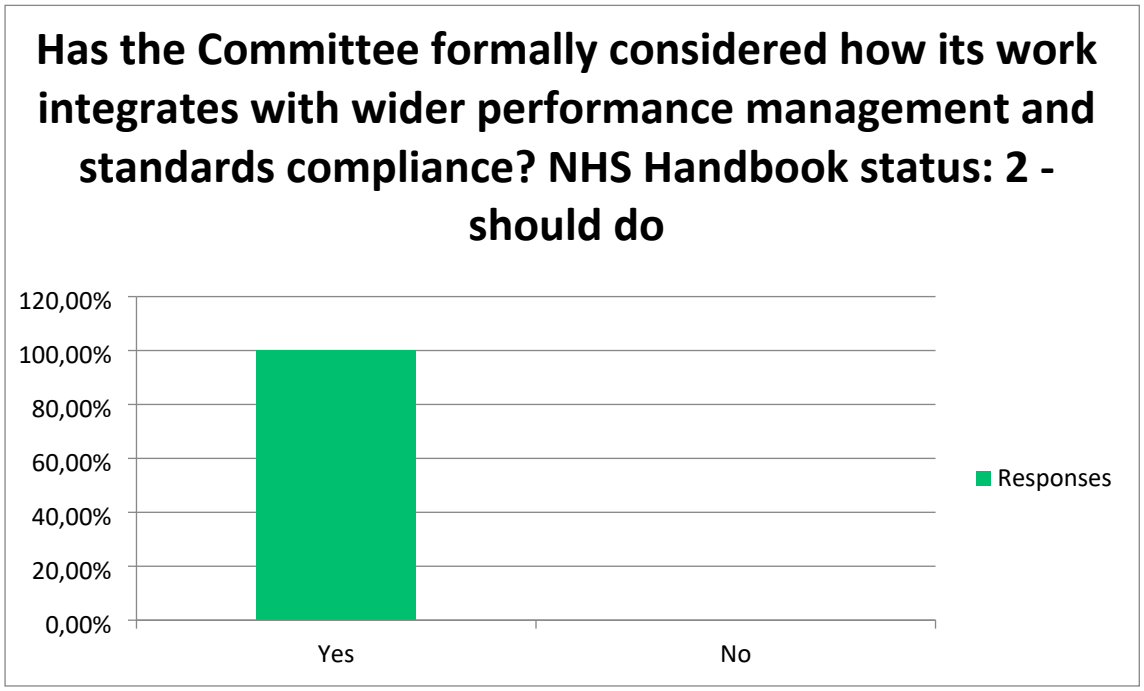
"Discussed with Director of Corporate Governance, Vice Chair and Chair of Board".



Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20

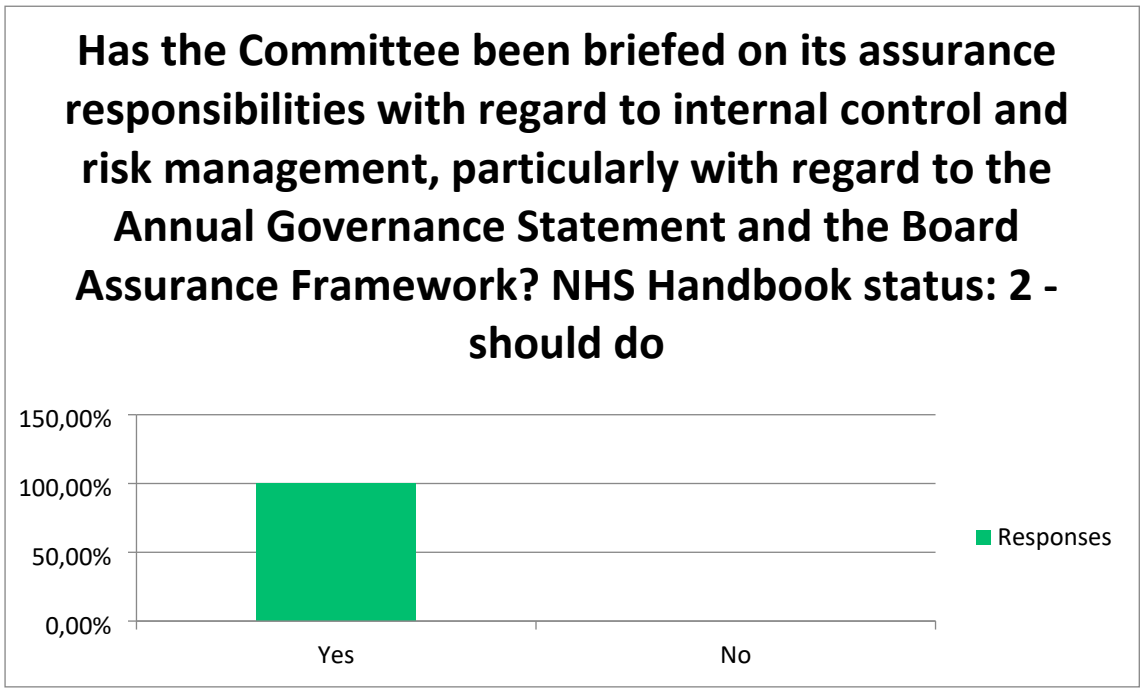


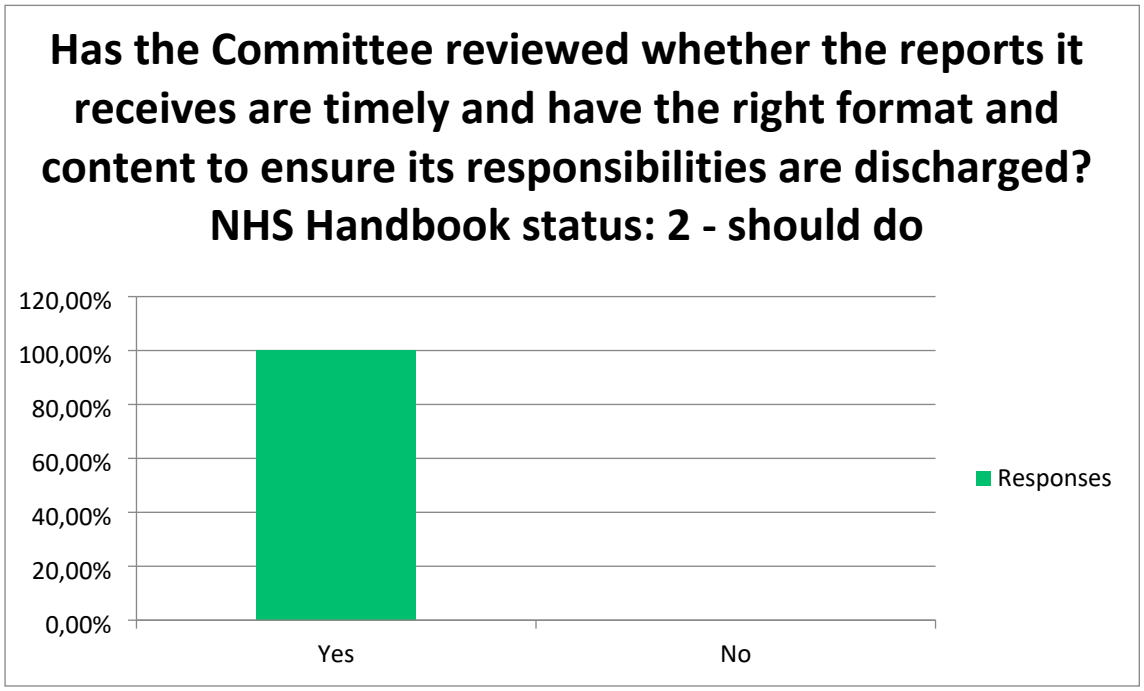


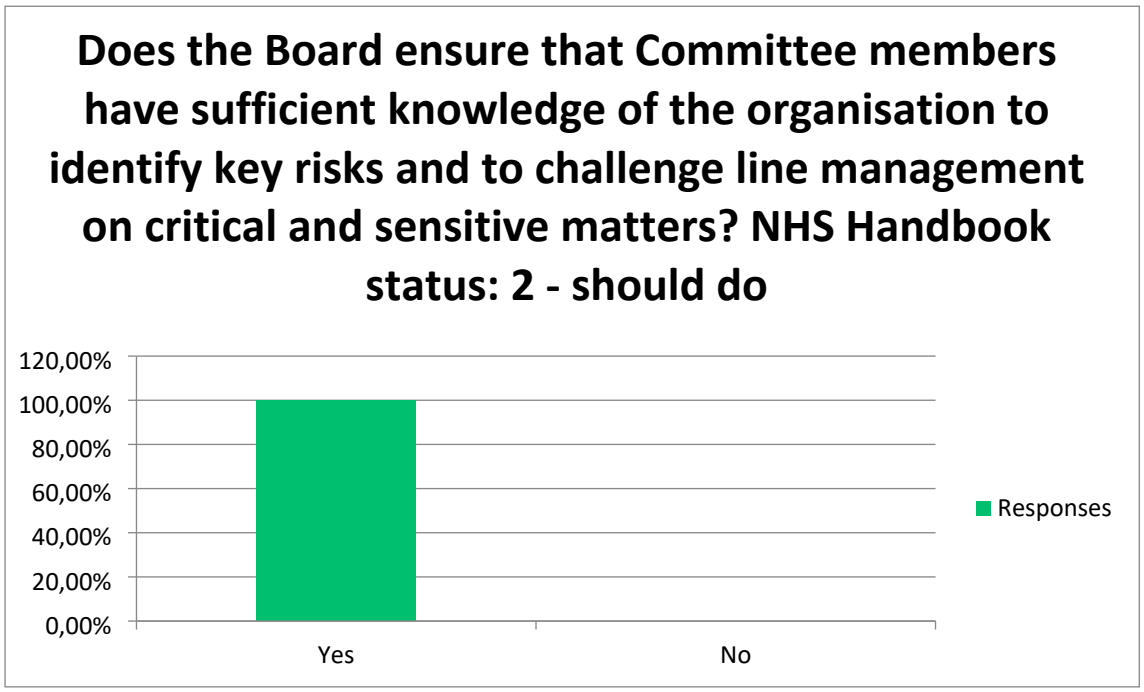
Improvement on last year

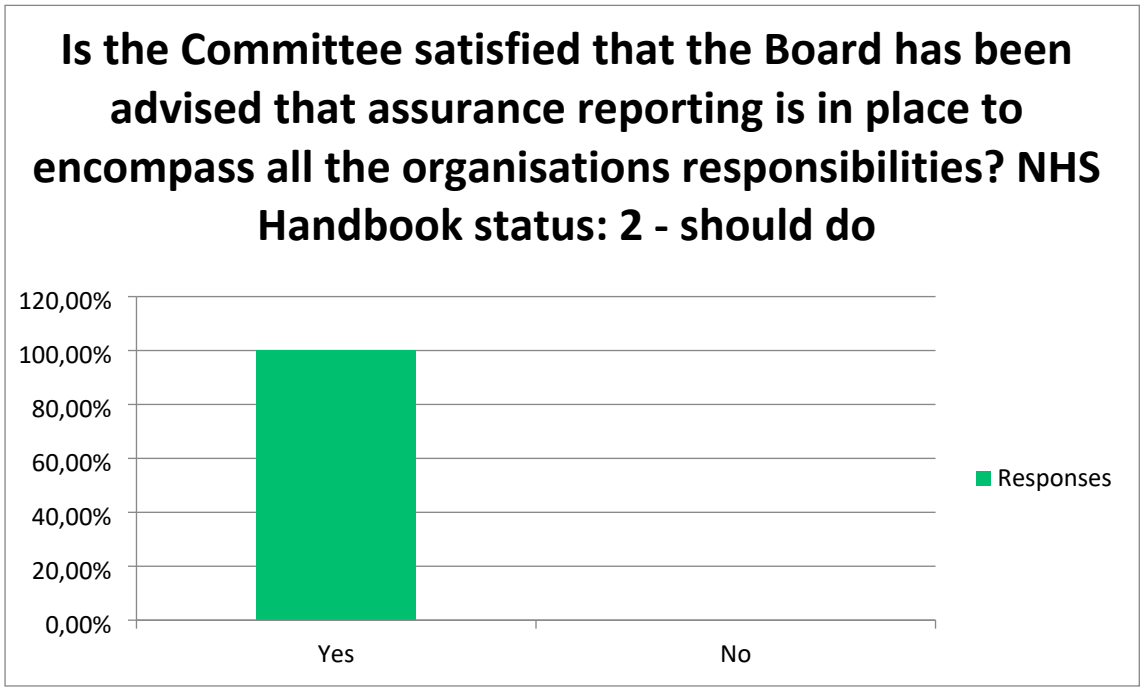
Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20







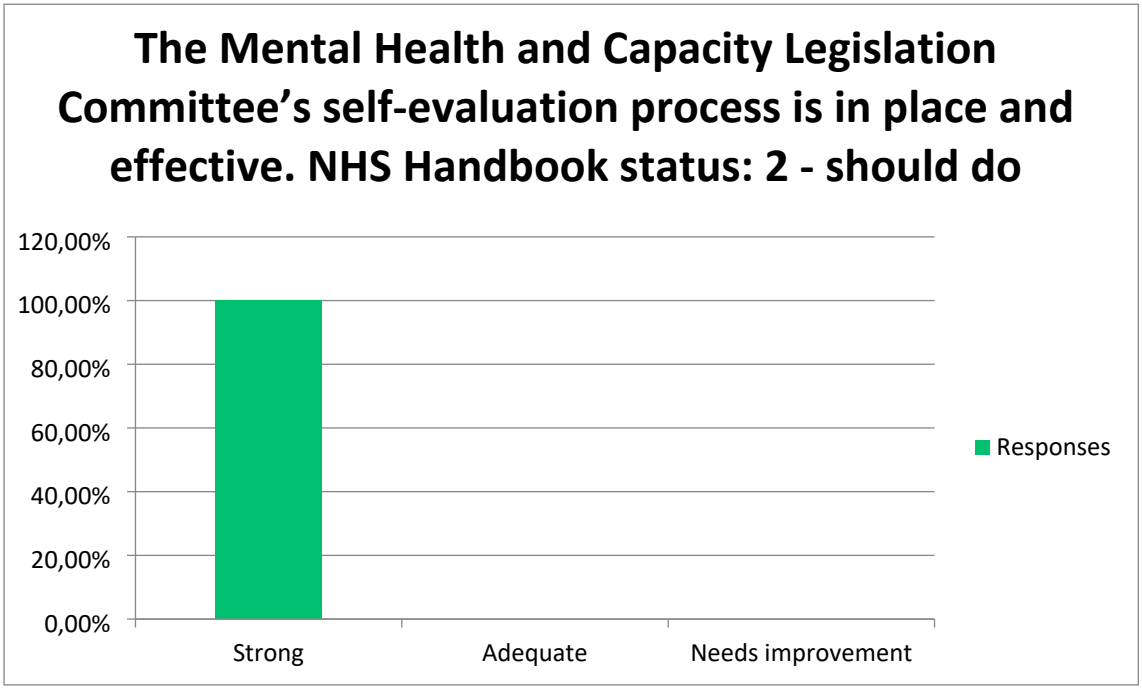


Comments

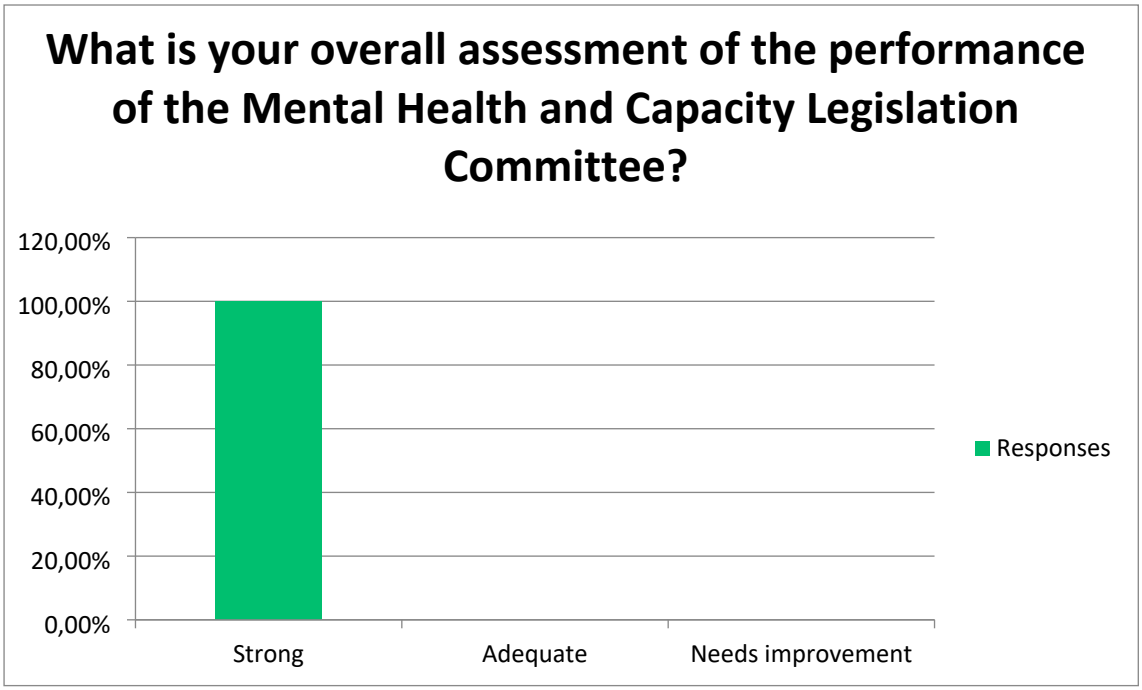
"I would question the suitability of this question".

Appendix 1

Mental Health & Capacity Legislation Committee Effectiveness Results 2019-20



Improvement on last year



Improvement on last year

Appendix 2

Mental Health & Capacity Legislation Committee – Self Assessment 2020 Action Plan

Question asked	Action Required	Lead	Timescale to complete
The Mental Health and Capacity Legislation Committee Terms of Reference clearly, adequately & realistically set out the Committee's role and nature and scope of its responsibilities in accordance with guidance and have been approved by the Committee and the full Board.	Series of Committee Workshops are underway to review Committee's role and Terms of Reference.	Director of Corporate Governance	March 2021 for next review
The Board was active in its consideration of Mental Health and Capacity Legislation Committee composition.	Terms of Reference setting out Committee composition are annually reviewed and approved by the Board.	Director of Corporate Governance	March 2021 for next review
The Mental Health and Capacity Legislation Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.	The Chair and Vice Chair of the Committee are Independent Board Members and membership composition includes other Independent Members to ensure this standard is met.	Chair/Director of Corporate Governance	March 2021 for next review
The Mental Health and Capacity Legislation Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.	Meeting packages to be reviewed and uploaded within the timescales set out within Standing Orders. The Corporate Governance Department have clear timescales for delivery and Executive Directors are also required to ensure their reports are submitted on time. The Corporate Governance Department and Executive Director Teams are working closely to achieve this. The issuing of rules for submitting of papers, will further strengthen this in 2020.	Director of Corporate Governance / Executive Lead	From October 2020
Mental Health and Capacity Legislation Committee meetings are well organised, efficient, and effective, and they occur often enough and are of appropriate length to allow discussion of relevant issues consistent with the Committee's responsibilities.	Robust agenda setting with Chair and Executive Director which is overseen by the Director of Corporate Governance will improve on this going forward.	Director of Corporate Governance / Executive Lead and Committee Chair	By November 2020 and March 2021 for next review

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON 04 AUGUST 2020 VIA SKYPE

Present:

Jeff Champney-Smith	Chair, PoD Group
Liz Singer	Vice Chair, PoD Group
Teresa Goss	PoD Member
Huw Roberts	PoD Member
Sharon Dixon	PoD Member
Dr John Copley	PoD Member
John Owen	PoD Member
Carol Thomas	PoD Member
Alan Parker	PoD Member
Sarah Vetter	PoD Member
Peter Kelly	PoD Member
Michael Imperato	PoD Member
Alex Nute	PoD Member
Carol Thomas	PoD Member
Amanda Morgan	PoD Member

In attendance:

Sunni Webb	Mental Health Act Manager
Simon McDonald	Deputy Mental Health Act Manager

Apologies:

Simon Williams	PoD Member
Mary Williams	PoD Member
Mair Rawle	PoD Member
Mike Lewis	PoD Member

1 Welcome and Introductions

The meeting was held via Skype and the Chair welcomed all to the meeting. He informed the meeting that Elaine Gorvett had resigned from the group. He formally recorded his thanks to Elaine who had given tirelessly to PoD over many years. To

celebrate her long service a night out is planned when the current restrictions allow. Simon Williams is unable to participate in Hearings at present due to his personal circumstances. He will review his position in due course.

2 New Members and Independent Members

The Chair welcomed Michael Imperato, an Independent Member of the Health Board, to his first PoD meeting.

3 Members points for discussion

Two matters were raised by members:

- **Patient Written Statements –** At a recent Hearing the patient had provided a written statement for the panel's consideration. This document was not shared with the clinical team. The Panel had been divided as to whether this statement should have been shared. After a discussion it was agreed that the issue should be taken to the Mental Health Legislation and Governance Group for further discussion and advice. The situation with regards to Professionals asking the Hearing to withhold information from a patient was much more clear cut. There has to be evidence that disclosure would be detrimental to the health and safety of the patient or an other. **Action Chair**
- **Disclosure of reports to the Nearest Relative at a Barring Hearing –** Clarification was sort on whether the Nearest Relative is entitled to the full Reports for a Barring Hearings given they are making the application for discharge. If a patient does not consent for this information to be shared the MHA office will not send out the Reports to them. It is entirely up to the patient whether the reports are shared. The Chair agreed to take the issue to the relevant authority to determine whether there was any legal requirement or precedent or relevant case law. **Action Chair**

4 Minutes of the last meeting held on the 28th April 2020

These were agreed as an accurate record of the meeting.

5 Matters arising

- **Coronavirus Guidance** – the Deputy Mental Health Act Manager advised that the older adult wards had restarted visiting. Visitors are given a time slot to minimise risk. As a precaution, all patients admitted to the older adult service are cared for in isolation for 14 days. Currently, because of operational difficulties, visiting on the adult wards is not permitted.

- **Relatives attendance at a hearing** – this issue had been raised in respect of a patient without capacity where a number of children had attended with differing views. Currently there is a mismatch between the advice being given under the Mental Capacity Act and the guidance within the Mental Health Act 1983 Code of

Practice for Wales Revised 2016**.** Until resolved each Hearing must make an assessment based on the following:

- If a best interest assessment been completed what was the outcome? The Panel should proceed on the basis of that outcome
- If there is no Best Interest Assessment the relatives can be invited into the Hearing at the discretion of the Panel. They should be advised that they may be excluded if they are disruptive or the Hearing could be adjourned

- At the discretion of the Panel the evidence of the family could be heard at the start of the Hearing. The meeting would then proceed with just the Nearest Relative.

The panel to make the best judgement at the time. The PoD Chair to amend the protocol to reflect this and PoD member to notify the Chair/MHA Manager if there are any issues. **Action Chair and PoD members**

- **Holding a Hearing S3 to CTO.** - If a patient's S3 is converted to a CTO but they have been informed that a S3 Renewal Hearing is to take place the Hearing will proceed. The Panel to consider whether the grounds for CTO are met. If the patient hasn't been informed there will be no Hearing.

- **Acoustics in the meeting and tribunal suites –** This is in hand and will be funded by the Covid monies. The firm supplying the acoustic Boards are now operating again. **Action Deputy MHA Manager to take forward**

- **Hearings in Welsh**- The MHA Manager requested that PoD members let her know if they can speak Welsh. If a patient asks for their Hearing in Welsh, in the absence of Welsh speakers on the PoD group, then help will be requested from neighbouring Health Boards. **Action PoD members**

- **Digital Data Protection –** Information was sent out by the Deputy Mental Health Act Manager after the last meeting. Members were asked to ensure their laptops were password protected and to let the Deputy Mental Health Act Manager know when this had been done. **Action PoD members**

- **Laptop Damage/Loss –** The Chair confirmed that in the event that a laptop provided by the Mental health Act Office was lost or stolen, or received accidental damage, then the Health Board will replace on only the first occasion for each individual PoD member.

- **Future Venue for Business Meetings** – Once it becomes possible for the PoD committee to meet in person, then venues other than Hafan Y Coed will be sought. **Action MHA Office**

6 Virtual Managers Hearings

- **Laptops** – nothing further to add

- **Protocols –** these had been updated and circulated to PoD members

- **General Discussions** – the following points/issues were raised:

  - The use of the mute facility during the Hearings
  - Chairs being aware of the need to involve all Panel Members so each member had ample opportunity to explore issues
  - Most of the difficulties seemed to have arisen because of a lack of proficiency within the Professional Team
  - The MHA Manager advised that she had accepted the opportunity to be involved in the testing of Teams with full roll-out at the end of September.
  - There was a request for a template to be developed for managers when responding to the final draft of minutes and reasons. The Chair agreed to look at this. **Action Chair**
  - There was a general reminder that Panel Members should use the “reply all” button when replying to the Chair on matters arising from the minutes or reasons. This ensures good communication between all parties. **Action PoD members**
  - A Panel member asked whether it would be possible to participate on a Hearing from a venue other than their own home. Two criteria needed to be satisfied – a suitable internet connection and confidentiality.

7 Mental Health Act Monitoring

- The activity was noted for both the Managers Hearings and the Mental Health Review Tribunal for Wales. Of note was the reduction in advocacy representation in the last quarter. The MHA Manager agreed to investigate further and discuss with the Advocacy Service Manager. **Action MHA Manager**

- The number of applications to the Mental Health Review Tribunal for Wales had fallen significantly in June. As this was a one month reduction it was greed this would be further monitored before taking to the Mental Health Legislation and Governance Group. **Action MHA Manager/Deputy Manager**

8 Concerns/compliments from Power of Discharge group Hearings

- These were noted. The Chair was unhappy with the response given to a concern regarding the CTP. PoD members were in agreement that this needed to be followed up. **Action MHA Manger**

- Further clarity was sought on the third feedback item as it appeared to be a concern rather than feedback. **Action MHA Manger**

9 Committee and Sub-Committee Feedback

There was nothing to report.

10 Training

It had been decided by the Chair and the MHA Manger not to invite Dr Cantrell to the meeting to discuss other disorders. Training would be suspended until the group was able to meet in person. It appeared unlikely that the Annual Training Event would go ahead although the MHA Manager was trying to secure the funding for an event in 2021. **Action MHA Manager**

Mr Owen informed the meeting that Prof George Kirov had published a book on ECT to counter some of the myths surrounding it. Its title is Shocked and can be found on Amazon on this link - https://www.amazon.co.uk/Shocked-Insider-stories-electroconvulsive-therapy-ebook/dp/B087NJCFS3

Currently there were no plans to hold IT training as the level of skills across the group were variable and no common area for training had emerged. However, individuals with issues can contact the Deputy Mental Health Manager.

11 Any Other Business

- **Annual Review** – Chair advised that he is going to set-up a small working group to look at how the system for annual review could be improved. Those in the PoD with expertise were welcome to be part of the group. Chair to email colleagues. **Action Chair**

- **The use of the Mental Health Act and physical health issues** – it was agreed to defer this issue to the next meeting.

There being no further business the Chair thanked everyone for their attendance and the meeting was closed.

Date of next meeting October 27th 2020

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 10th September 2020 via Skype

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Matthew Russell	Operational Manager (OM) Cardiff
Jeff Champney-Smith	Chair of the Power of Discharge Group
Jane Jones	Clinical Lead Child and Adolescent Mental Health Services
Alex Allegretto	Independent Mental Health Advocacy Manager
Mike Ivenso	Consultant Mental Health Services for Older People
Adeline Cutinha	Consultant Adult Mental Health Services
Sunni Webb	Mental Health Act Manager
Simon McDonald	Deputy Mental Health Act Manager

Apologies

Julia Barrell	Mental Capacity Act Manager
Mary Lawrence	Approved Clinician Representative
Mark Warren	Director of Nursing in Mental Health
Katie Fergus	Consultant Psychiatrist in Rehabilitation Services
Emma Powderhill	Crisis Team Leader

1 Welcome and Introductions

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

2 Apologies for Absence

Apologies were accepted and noted.

3 Minutes of meeting held on 29 April 2020

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

4 MHA Activity April – June 2020

The MHA Manager walked the group through the exceptions report. Item of note were;-

Fundamentally defective applications
There were three of these. This occurred as the AMHP who made those applications was not warranted. The OM for Cardiff has put measures in place to prevent this from occurring again.

Section 5(2)
On a bank holiday weekend there an unprecedented number of s5 (2) applications were made. Two of these lapsed. One lapsed as the patient remained too intoxicated to assess, while the other lapsed due to the lack of availability of an AMHP from the Emergency Duty Team (EDT). The Operational Manager, Cardiff LSSA confirmed that EDT will endeavour to complete all s5.2 assessments requests that they receive. S5.2 requests where the holding power elapses before day time services resume will be prioritised. It does however remain the responsibility of ward staff to ensure that EDT are informed, that they give them as much notice as they can and that they communicate the level of urgency of the request including any relevant clinical information.

The Mental Health Act Manager informed the group that nursing staff have reported difficulties contacting EDT and there had been occasions where they had refused to assess due to urgency. However once contact made subsequently and further information re: urgency provided they had assessed.

Section 136 – Harm to Self
During Qtr. 1 there was a significant increase in cases where the reason for use of s136 was Harm to Self. Health had taken this to be an increase in self

harm, but now have been informed that it's harm in general, not necessarily deliberate self-harm. The Police are clarifying this with their Officers.

Section 136 – CAMHS
An increase in CAMHS patients' s136 detentions had been noted. However, out of these a significant proportion were the same two individuals. The Chair suggested that Control Limits would help with this information to enable the at a glance ability to see if something was amiss.
ACTION – MHA Manager and Deputy MHA Manager to include Control Charts for CAMHS data in future reports.

Section 117 – Significant increase of the ending of s117 eligibly in April
It was noted that there was a 'spike' in ending s117 for the month of April. Upon investigation it was noted that all but two of those discharged from section 117 aftercare ended due to death. The bulk of these had either a positive Covid test or were Covid symptomatic.

5 Matters Arising

The use of Community Treatment Order (CTO)
It was noted that there had been a steady decline in the use of CTO. This was discussed where two actions were set to take further;-
ACTION – The Consultant for Adult and the Consultant for MHSOP to take to the Consultants Meeting meeting
ACTION – The Deputy Mental Health Act Manager to investigate any link between the use of CTO and the use of s17 leave

Voluntary Assessments
The ongoing issue around Voluntary Assessments was discussed. The Deputy MHA Manager explained that as of mid-July the electronic All Wales Monitoring Form has been put into use. This will be submitted electronically for s135, s136, VA, and Mental Capacity Act. With the advent of this form, which the police officer will complete for every occurrence where they take somebody to hospital for a MH assessment, we now have a source for this information.
ACTION – The Deputy MHA Manager to bring data to the next meeting.

Transport
The issue of conveyance has been escalated to Welsh Government level and is currently being investigated.

CAMHS RC Issue
The ongoing issue of RC responsibility for CAMHS patients detained in Cardiff and Vale Hospitals was discussed. The Clinical Lead for CAMHS confirmed that there are currently ongoing discussions on this topic, and while progress had been made a definitive solution had yet to be agreed.

Silver on Call training
No progress as yet, to be kept on the agenda

Action – Chair to continue to follow up

Guidance on remote examinations
Advice has been gained on the use of remote examinations:

"There would appear to be no reason to prevent a MHA examination being conducted via a video link or skype as this would have the potential to enable the examining doctor to both observe and attempt to interview the patient. At the end of the day, it would be up to the examining doctor to form a judgment as to whether conducting an examination in this manner would enable him or her to adequately perform their functions under s.12 of the MHA."

This issue has not come before the courts nor is there any legislation to address this issue.

Digital Signatures
The Deputy MHA Manager confirmed that we have received legal advice, and that a personal professional email account to which only the individual had access would could as a digital signature. Potentially this could be used be used to discharge a patient form detention, and is already being used for s17 leave. However the use of digital signatures for prescribed forms won't be accepted by the MHA Office at present. Due to the Covid situation other UHB's have also raised this. The issue has reached Welsh Government who are investigating options.

6 Feedback on operational issues and incidents

Covid

Hospital Manager Hearings
The Chair of the Power of Discharge Group explained that holding Hearings over Skype was going well, and some patients and professionals prefer it this way.

Tribunal Hearings
These are being held over a phone teleconference. The general consensus is that these are only just adequate. The phone call itself is expensive, and the feedback from various parties is that they feel it is not a fair Hearing.

Information to detained patients
The MHA Manager explained to the group that there is a significant amount of occasions where patient Rights have not been read when they should have, including patients being discharged from section without having any form of Rights being read to them. This is something that has been taken to a senior level and is ongoing. It was also explained by the Deputy MHA Manager that the wards (and community teams) get a daily email listing which patients require their Rights to be read and for what reason. An issue had been identified that is currently being addressed where due to Covid there have

been rapid changes to which staff work on which ward. Updating the recipient list is being progressed.
ACTION – Chair to escalate to the Adult Directorate Quality and Safety Committee

AMHP Assessment in CAMHS
A detailed discussion took place about MH assessments for two specific CAMHS patients who also have learning disabilities. It was confirmed that there was no failing at the assessment level, rather there is a deficiency at a UK wide level for patients with these specific needs, especially those who would not come under the Mental Health Act.

Duty Psychiatrist
The Chair has received an email from the OM of the Vale of Glamorgan about clarity of the duties of the duty psychiatrist and their hours of work. The Chair suggested that this would be better answered in the Consultants Meeting so will get permission to pass this on.
ACTION – Chair to gain permission from OM Vale to pass the email for discussion in Consultants Meeting meeting

7 Feedback from other meetings

AMHP Forum
No meeting has taken place between MHLGG meetings

Consultants Meeting
Nothing to bring to the group from the Consultants Meeting

Power of Discharge Group
Care and Treatment Plans (CTP)
There is still the ongoing issue of the CTP being up to date. There is also an explanation from a comment about a CTP that the PoD Group are not happy with the response.
ACTION – MHA Manager to follow up of the response

Representation of a non-capacious patient
The Chair of the PoD group explained their position on having Nearest Relatives in attendance at managers' hearings where the patient does not have the capacity to consent. The advice from the MCA Manager was that if the patient could not consent, then the NR should not attend. The Chair of the PoD group went on to say that the Code of Practice states that the NR should be as involved as possible. In light of this the decision has been left to the Chair of each Managers Hearing on a case by case basis.

9 External Reviews

The MHA Manager explained that HIW have issued information in relation to their new approach using a three-tiered model of assurance and inspection

that reduces the reliance on onsite inspection activity as their primary method of gaining assurance.

Tier 1 activity will be conducted entirely offsite and will be used for a number of purposes but, at this stage, primarily where issues cannot be resolved and the risk of conducting an onsite inspection remains high. Tier 2 will introduce a combination of offsite and limited onsite activity, whilst Tier 3 will represent a more traditional onsite inspection.

HIW always reserve the right to conduct a full inspection at any time.

10 Interface MHA/MCA/DoLs:

Implementation of Liberty Protection Safeguards – April 2022

The Chair informed that full implementation of the Liberty Protection Safeguards is now expected to be by April 2022.

11 Quality indicators and audit activities

Not discussed due to time restrictions

12 Any other business

Nothing was raised

13 Date of future meetings

17 December 2020 – venue to be confirmed

Report Title:	**APPROVAL OF INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA) PROCEDURE**									
Meeting:	**Mental Health and Capacity Legislation Committee**							**Meeting Date:**	**20/10/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**			
Lead Executive:	**Executive Nurse Director**									
Report Author (Title):	Mental Capacity Act Manager, Julia.Barrell@wales.nhs.uk, Tel. 029 2183 6312									

Background and current situation:

This procedure has been in force within Cardiff and Vale University Health Board (the UHB) since 2013 and was due for review.

The procedure sets out the circumstances, under MCA, in which clinicians have a legal duty to instruct IMCA and the circumstances in which they have discretion to instruct IMCA.

BACKGROUND

The MCA makes provision for the IMCA service and the **legal duty** to instruct the IMCA service about certain decisions where patients

- aged 16 years and over lack mental capacity to make those decisions
- have no-one (apart from paid carers) whom it would be appropriate to consult with about their best interests

The decisions are: serious medical treatment and a move to, or a change in, long term accommodation. The UHB may also wish to instruct an IMCA in safeguarding adults (adult protection) cases and care reviews.

Under the Deprivation of Liberty Safeguards (DoLS) provisions, there is also a requirement for the Supervisory Body (UHB) to appoint IMCA in certain circumstances. IMCA may also be appointed as the Relevant Person's Representative.

Executive Director Opinion / Key Issues to bring to the attention of the Board / Committee:

Assurance is provided by the review of this procedure that has been undertaken to ensure that it reflects the law and assists staff to comply with it.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

The substance of the procedure has not changed and only minor amendments have been made.
Consultation on the draft procedure was undertaken with the following:

- Vulnerable Adults Risk Management Working Group;
- UHB Intranet Consultation pages – 24th August to 21st September 2020.

One suggestion was received, which was incorporated into the procedure.

The primary source for dissemination of this procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Committee is asked to:

- **APPROVE** the Independent Mental Capacity Advocacy procedure
- **APPROVE** the full publication of the Independent Mental Capacity Advocacy procedure in accordance with the UHB Publication Scheme

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term		Integration		Collaboration		Involvement	x

Equality and Health Impact Assessment Completed:	An EqHIA on the UHB Consent Policy (from which this procedure derives) was undertaken and feedback was received on the way it operates. The EqIHA found there to be no negative impact on the equalities groups and positive impact on some of the groups - age; disability; race; religion and Welsh language.

Reference Number: UHB 186 **Version Number:**3	**Date of Next Review:** **Previous Trust/LHB Reference Number:**

INDEPENDENT MENTAL CAPACITY ADVOCATE PROCEDURE (Mental Capacity Act 2005)

Introduction and Aim

This procedure explains what Independent Mental Capacity Advocates (IMCA) are and the legal duties of Cardiff and Vale University Health Board (UHB) in relation to IMCA.

The Mental Capacity Act 2005 (MCA) makes provision for the IMCA service and the **legal duty** to instruct the IMCA service about certain decisions where patients

- aged 16 years and over lack mental capacity to make those decisions
- have no-one (apart from paid carers) whom it would be appropriate to consult with about their best interests

The decisions are: serious medical treatment and a move to, or a change in, long term accommodation. The UHB may also wish to instruct an IMCA in safeguarding adults (adult protection) cases and care reviews.

Under the Deprivation of Liberty Safeguards (DoLS) provisions, there is also a requirement for the Supervisory Body (UHB) to appoint IMCA in certain circumstances.

This procedure provides further information and detail in support of sections 8.50 - 8.53 (Independent Mental Capacity Advocates) of the UHB Consent to Examination or Treatment Policy.

The MCA Code of Practice states (para 10.14) that organisations should have procedures for staff regarding IMCA.

Objectives

- Adherence to this procedure means that health professionals will be acting lawfully when providing patients with impaired mental capacity with treatment and care
- The UHB will be acting lawfully with respect to the DoLS provisions

Scope

This procedure applies to all health professionals employed by the UHB, including those on honorary contracts, who make decisions about

- Providing serious medical treatment
- Admissions to and discharges from hospital
- Safeguarding adults (adult protection)

- Care reviews of patients in NHS funded accommodation

It also applies to UHB staff who undertake the duties of the Supervisory Body in accordance with the DoLS provisions.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Consent to Examination or Treatment Policy.
Documents to read alongside this Procedure	Consent to Examination or Treatment Policy (UHB 100), 2019 Mental Capacity Act 2005 Code of Practice Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	Executive Nurse Director
Author(s)	Mental Capacity Act Manager

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2	29/11/17	13/12/17	• Minor amendments – e.g. changes of word order, updating references to other documents, etc • Inclusion of para 7.3 – DoLS Relevant Person's Representative
3			• Minor amendments – e.g. changes to titles, updating references, etc

CONTENTS

1. RESPONSIBILITIES

Executive responsibility for this procedure lies with the Nurse Director.

Clinical Board Directors are responsible for ensuring that staff are aware of this procedure, how to access it and what to do if they have queries about it.

All staff who make decisions (i.e. the decision-makers) about

- Providing serious medical treatment
- Admissions to and discharges from hospital
- Safeguarding adults (adult protection))
- Care reviews of patients in NHS funded accommodation

have a responsibility to familiarise themselves with, and follow the content of, this procedure and to ensure that they remain up to date with regard to relevant legislation, case law and guidance regarding IMCA.

Staff who undertake Supervisory Body duties under DoLS are also required to comply with this procedure.

The Mental Capacity Act Manager is responsible for ensuring that this procedure is updated as necessary; that relevant training is available; and to provide information, support and training to UHB staff as required.

NOTE: Where staff are unsure about the legal aspects of IMCA in a particular case, they must seek advice from the Mental Capacity Act Manager/Patient Safety Team in the first instance. If this does not resolve the matter and legal advice is needed, staff must contact the Head of risk and Regulation in order to arrange this. Please see Appendix A for contact details.

2. RESOURCES

No extra resources are required to implement this procedure.

3. TRAINING

Specific training is not required for this procedure. However, the Mental Capacity Act Manager can provide training on this procedure, or as part of more general Mental Capacity Act training, if required.

4. IMPLEMENTATION

Clinical Board Directors are responsible for ensuring that staff who work within their Clinical Boards are familiar with and follow this procedure, where

necessary. The Mental Capacity Act Manager will provide support as required.

5. THE ROLE OF IMCA

The IMCA's role is to represent and support the person in question.

IMCAs should (this list is not exhaustive)

- Confirm that the person instructing them from the UHB has the authority to do so (i.e. is the decision-maker – the person who needs the decision made, or someone the decision maker has asked to instruct the IMCA on their behalf)
- Where possible, meet and talk to the person in question
- Discuss the person and their situation with the healthcare team and other paid staff who look after the person
- Obtain the views of anyone else who can provide information about the wishes, feelings, values and beliefs of the person in question
- Find out what, if any, alternative options there are for the person
- Where appropriate, seek a second medical opinion
- Support the patient to access the safeguards enshrined in the MCA

The IMCA must provide a report on their findings to the decision maker.

6. CIRCUMSTANCES IN WHICH AN IMCA MUST BE INSTRUCTED

6.1 Serious Medical Treatment

The UHB (in practice, the healthcare professional who needs to make the decision) has a duty to instruct an IMCA where decisions are being made about "serious medical treatment" where the person (aged 16 years and over)

- Lacks mental capacity to make the decision, and
- Has no-one, other than paid care staff, with whom it is appropriate to consult about whether the decision is in the person's best interests,

Serious medical treatment is that which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered where

- There is a fine balance between the likely benefits and the burdens and risks of a single treatment
- A decision between a choice of treatments is finely balanced

- What is proposed is likely to involve serious consequences for the patient

Serious consequences are those which could have a serious impact on the person. It could include treatments which

- Cause serious and prolonged pain, distress or side-effects
- Have potentially major consequences for the patient e.g. major surgery or stopping life-sustaining treatment
- Have a serious impact on the patient's future life choices (e.g. interventions for ovarian cancer)

Whether the treatment is "serious" will depend on the individual patient's situation and circumstances, but may include

- Cancer surgery and chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (e.g. heart, brain surgery)
- Amputation
- Treatment that involves permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy

Where an urgent decision is needed – e.g. to save the person's life - an IMCA does not need to be instructed. This reason for non-referral must be recorded. However, if serious medical treatment is required after the emergency treatment, an IMCA must be instructed.

There is no duty to instruct an IMCA if the proposed treatment is for a mental disorder and that treatment is authorized under the Mental Health Act 1983. However, if a person is subject to the Mental Health Act and the proposed treatment is for physical illness e.g. cancer, an IMCA must be instructed.

6.2 Change of Accommodation

An IMCA must be instructed where a decision is needed about a move to or a change in accommodation, arranged or provided by the NHS (including residential care that is provided under s.117 of Mental Health Act 1983)

- Where the person lacks capacity to make the decision, and
- There are no family or friends who it is appropriate to consult about the person's best interests, and
- The move is likely to be for a period of 28 days or more in hospital, or

8 weeks or more in a care home

If the person's stay is longer than was expected and so exceeds the time periods above, an IMCA must be instructed.

If the placement or move is urgent, an IMCA need not be instructed, but the decision-maker (i.e. the person who needs the decision made) must involve an IMCA as soon as possible if the person is likely to stay in hospital longer than 28 days, or longer than 8 weeks in a care home.

6.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework for depriving a person who, because of mental disorder, is unable to consent to their accommodation in a hospital (other than under the Mental Health Act 1983) or care home in order to receive treatment and care. In certain circumstances, a person who is subject to DoLS must have an IMCA instructed for them.

An IMCA must be appointed in the following circumstances -

a) Section 39A of MCA

This applies where

- An urgent authorisation is given, or
- A standard authorisation is requested and there is not an existing authorisation in force, or
- An assessment is being undertaken to decide whether there is an unauthorised deprivation of liberty

The Managing Authority (the part of the UHB that is providing the care – i.e. the ward) must ascertain whether there is anybody, other than people engaged in providing care or treatment in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in the best interests of the person to whom the request for the authorisation relates.

If there is not, the Managing Authority must notify the Supervisory Body, and the Supervisory Body must instruct an IMCA to represent the person.

b) Section 39C of MCA

This provides for the appointment of an IMCA if the relevant person's representative's (RPR) appointment ends and the Managing Authority is satisfied that there is nobody, other than people engaged in providing care or

treatment in a professional capacity or for remuneration, whom it is appropriate to consult in determining what would be in the person's best interests. Again, the Managing Authority must notify the Supervisory Body that this is the case, and the Supervisory Body must then instruct an IMCA to represent the person.

The IMCA's role in this case comes to an end upon the appointment of a new RPR for the person.

c) Section 39D of MCA

This provides for the instruction of an IMCA by the Supervisory Body where

- The relevant person does not have a paid RPR, and
- The person themselves or their representative requests that an IMCA is instructed to help them, or
- The Supervisory Body believes that instructing an IMCA will help to ensure that the person's rights are protected.

7. CIRCUMSTANCES IN WHICH AN IMCA MAY BE INSTRUCTED

7.1 Safeguarding Adults (Adult protection)

The NHS has powers to instruct an IMCA for a person who lacks capacity where it is alleged that

- The person is being or has been abused or neglected by another person, or
- The person is abusing or has abused another person

In such cases, an IMCA can be instructed even if the person in question has family and friends who are available to be consulted about the person's best interests. The decision-maker must be satisfied that the involvement of IMCA will benefit the person.

An IMCA can only be instructed if the health care professional proposes to take, or has already taken, protective measures.

Responsibility for deciding whether an IMCA should be instructed sits with the professional leading the safeguarding investigation. They must consider whether an IMCA should be instructed for all people at risk. They must also make a decision about instructing an IMCA at both the strategy discussion/meeting and the case conference/safeguarding planning stages. Their reasons for not instructing IMCA must be recorded.

If, as a result of the safeguarding process, it is proposed that the person in question be moved to alternative accommodation and there are no family or friends who it would be appropriate to consult, an IMCA must be instructed.

7.2 Care Reviews

A healthcare professional can instruct an IMCA when

- They have arranged accommodation for the incapacitated person
- They aim to review the arrangements (as part of a care plan or otherwise)
- There are no family or friends whom it would be appropriate to consult

Reviews should relate to decisions about accommodation

- For someone who lacks capacity to make a decision about accommodation that will be provided for a continuous period of more than 12 weeks and has been arranged by the UHB
- That are not the result of an obligation under the Mental Health Act 1983

Involvement of an IMCA should be considered at each initial care review following a change of accommodation and subsequently if there is still uncertainly about the placement. An IMCA must be involved if an IMCA was involved in the initial placement.

The decision maker's reasons for not instructing IMCA must be recorded in the patient's notes.

7.3 DoLS Relevant Person's Representative (RPR)

If no-one can be found who is suitable and eligible to act as a patient's RPR under DoLS, then IMCA may be appointed.

The role of the RPR is to

- Maintain contact with the patient
- Represent and support the patient with regards to DoLS – such as, where appropriate, asking for a review of the authorisation, making a complaint, or appealing to court against the authorisation

8. WORKING WITH IMCA

The decision-maker (except where IMCA is appointed as RPR)

- Must identify those occasions where they have a duty to instruct IMCA and those situations where they have discretion to instruct an IMCA (If the decision maker is unsure about whether an IMCA should be instructed in any particular case, they should contact the IMCA office for advice (Tel: 029 2054 0444)
- Must instruct IMCA by completing the IMCA referral form - https://www.ascymru.org.uk/type-of-support/imca (scroll down the page to find the IMCA referral form link) and emailing or faxing the form to the IMCA office (details on the form)
- Must let all relevant people know when an IMCA is involved in a case
- Must record the IMCA's involvement in the case
- Must give the IMCA access to relevant medical records
- Must, on receipt of the IMCA's report, consider it in determining the best interests of the person in question
- Must record how they have taken the IMCA's report into consideration, including any reason for disagreeing with the IMCA's findings
- Must inform the IMCA of the final decision taken and the reason for it.

In the event of disagreement about the person's best interests, the decision maker and IMCA should try to settle the disagreement through discussion as soon as possible. If they cannot achieve resolution, then the matter must be dealt with through the Concerns system.

If there is no other way of resolving the dispute, an application may need to be made to the Court of Protection.

9. AUDIT

Adherence to this procedure will be monitored by a variety of processes, which may include structured and ad-hoc case note review and as part of the UHB and Clinical Board/Directorate clinical audit plan.

Related clinical audit activity which may include monitoring compliance with this procedure, will be reported to Clinical Board Quality, Safety and Experience Groups and the UHB's Mental Health and Capacity Legislation Committee.

10. DISTRIBUTION

This procedure will be made available on the UHB intranet, Clinical Portal and internet site.

11. REVIEW

This procedure will be reviewed every 3 years or sooner if appropriate.

APPENDIX A

Useful contact details

Julia Barrell, MCA Manager, Tel. 029 2183 6312

Maria Roberts, Head of Patient Safety and Quality, Tel. 029 2183 6316

Carol Evans, Assistant Director – Patient Safety and Quality, Tel. 029 2183 6331

Aaron Fowler, Head of Risk and Regulation, Tel. 029 2183 6012 (in relation to obtaining Legal Advice)

Susan Broad, DoLS Co-ordinator, Tel. 01446 704849

Report Title:	**APPROVAL OF LASTING POWER OF ATTORNEY (LPA) AND COURT APPOINTED DEPUTY (CAD) PROCEDURE**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	**20/10/2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	Mental Capacity Act Manager, Julia.Barrell@wales.nhs.uk, Tel. 029 2183 6312								

Background and current situation:

This procedure has been in force within Cardiff and Vale University Health Board (the UHB) since 2013 and was due for review.

The procedure sets out what LPAs and CADs are and how clinicians should work with them.

BACKGROUND

The Mental Capacity Act 2005 (MCA) makes provision for a person's decision-making authority with regard to property and affairs, and health and welfare to be vested in another person, either by way of a Lasting Power of Attorney (LPA) or by the appointment of a Court appointed deputy (CAD).

The procedure provides further information and detail in support of section 8 (Patients who lack capacity to give or withhold consent) of the UHB's Consent to Examination or Treatment Policy.

The aim of this procedure is to provide information and direction to Cardiff and Vale UHB staff regarding Lasting Powers of Attorney (LPA), Enduring Powers Of Attorney (EPA) and Court Appointed Deputies (CADs), so that UHB staff know how to respond appropriately and lawfully when a patient who has an attorney or deputy presents for treatment and care.

Executive Director Opinion / Key Issues to bring to the attention of the Board / Committee:

Assurance is provided by the review of this procedure that has been undertaken to ensure that it reflects the law and assists staff to comply with it.

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.)

The substance of the procedure has not changed and only minor amendments have been made.

Consultation on the draft procedure was undertaken with the following –

- Vulnerable Adults Risk Management Working Group
- UHB Intranet Consultation pages – 24th August to 21st September 2020

One minor comment was received which has been incorporated into the procedure.

The primary source for dissemination of this procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Recommendation:

The Committee is asked to:

- **APPROVE** the Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD) procedure
- **APPROVE** the full publication of the Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD) procedure in accordance with the UHB Publication Scheme

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

Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention	x	Long term		Integration		Collaboration		Involvement	x

Equality and Health Impact Assessment Completed:	An Equality and Health Impact Assessment on the UHB Consent Policy (from which this procedure derives) was undertaken and feedback was received on the way it operates. The EqHIA found there to be no negative impact on the equalities groups and positive impact on some of the groups - age; disability; race; religion and Welsh language.

Reference Number: UHB 113 **Version Number:** 3	**Date of Next Review:** **Previous Trust/LHB Reference Number:**

LASTING POWER OF ATTORNEY AND COURT APPOINTED DEPUTY PROCEDURE (MENTAL CAPACITY ACT 2005)

Introduction and Aim

The aim of this procedure is to provide information and direction to Cardiff and Vale UHB staff regarding Lasting Powers of Attorney (LPA), Enduring Powers of Attorney (EPA) and Court Appointed Deputies (CADs), so that UHB staff know how to respond appropriately and lawfully when a patient who has an attorney or deputy presents for treatment and care.

The procedure provides further information and detail in support of section 8 (Patients who lack capacity to give or withhold consent) of the UHB's Consent to Examination or Treatment Policy.

The Mental Capacity Act 2005 (MCA) makes provision for a person's decision-making authority with regard to property and affairs, and health and welfare to be vested in another person, either by way of a Lasting Power of Attorney (LPA) or by the appointment of a Court appointed deputy (CAD).

Objectives

- Adherence to this procedure means that health professionals will be acting lawfully.

Scope

This procedure applies to all of our staff in all locations, including those with honorary contracts.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Consent to Examination or Treatment Policy.
Documents to read alongside this Procedure	Mental Capacity Act 2005 Code of Practice HMSO (2005) Mental Capacity Act 2005, TSO, London Cardiff and Vale UHB Consent to Examination or Treatment Policy
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board	Executive Nurse Director

Director	
Author(s)	Mental Capacity Act Manager

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2	29/11/17	13/12/17	Revised document. Minor amendments including • Use of current UHB template • Links to examples of registered LPA and CAD documents added • Link to search the register of LPAs and CADs added • Weblinks checked References to other documents checked and amended where necessary
3			Minor amendments only – e.g. changes of titles, updated hyperlinks, etc

CONTENTS

1. DEFINITIONS

Enduring Power of Attorney (EPA):- An EPA is a legal document that deals with property and affairs – they do not cover health and welfare (see section 6).

Lasting Power of Attorney (LPA):- A LPA is a legal document that allows a person to appoint another person/persons (the attorney or donee) to make decisions that are as valid as one made by the person (the donor) (see section 7). LPAs cover either property and affairs or health and welfare.

Court Appointed Deputy (CAD):- The Court of Protection can appoint a person (a deputy) to take decisions about property, affairs, health and social care on behalf of a person who lacks mental capacity to take these decisions (see section 8).

2. RESPONSIBILITIES

Executive responsibility for this procedure lies with the Nurse Director.

Clinical Board Directors are responsible for ensuring that staff are aware of this procedure, how to access it and what to do if they have queries about it.

All staff who have contact with patients in the course of providing them with all aspects of treatment and care (including research) have a responsibility to familiarise themselves with, and follow the content of this procedure and to ensure that they remain up to date with regard to relevant legislation, case law and guidance regarding LPAs, EPAs and CADs.

The most senior health professional involved with the patient's care has specific responsibilities for working with attorneys and deputies – see section 9.

The Mental Capacity Act Manager is responsible for ensuring that this procedure is updated as necessary; that relevant training is available; and to provide information, support and training to UHB staff as required.

NOTE: Where staff are unsure about the legal aspects of LPAs, EPAs and CADs in a particular case, they must seek advice from the Mental Capacity Act Manager/Patient Safety Team in the first instance. If this does not resolve the matter and legal advice is needed, staff must contact the Head of Risk and Regulation in order to arrange this. Please see Appendix A for contact details.

3. RESOURCES

No extra resources are required to implement this procedure.

4. TRAINING

Specific training is not required for this procedure. However, the Mental Capacity Act Manager can provide training on this procedure, or as part of more general Mental Capacity Act training, if required.

5. IMPLEMENTATION

Clinical Board Directors are responsible for ensuring that staff who work within their Clinical Boards implement this procedure. The Mental Capacity Act Manager will provide support as required.

6. ENDURING POWER OF ATTORNEY (EPA)

An EPA is a document appointing a person (an 'attorney') to manage the property and financial affairs of another person (the 'donor').

If the donor becomes unable to make financial decisions, the EPA must be registered before it can be used.

New EPAs can no longer be created. However if a person made a EPA before October 2007, it can still continue to be used.

EPAs deal with property and affairs – they do not cover health and welfare.

Attorneys of EPAs must consider the Mental Capacity Act and its Code of Practice when acting on behalf of the donor.

Examples of registered EPAs can be found here - https://www.gov.uk/government/publications/enduring-power-of-attorney-valid-example

7. LASTING POWER OF ATTORNEY (LPA)

A person who is aged 18 years and over and who has mental capacity to do so may make a LPA.

A LPA is a legal document that allows a person to appoint another person/persons (the attorney or donee) to make decisions that are as valid as those made by the person (the donor).

There are two types of lasting power of attorney –

- Property and affairs (money and property)
- Health and welfare (healthcare, including consent to examination or treatment, and social care)

The donor can appoint more than one attorney. The attorneys can be appointed to act

- jointly (must always act together), or
- jointly and severally (attorneys may either act together or independently), or
- jointly in respect of some specified decisions, but severally otherwise

An attorney for a property and affairs LPA does not have authority to make health and welfare decisions (unless they are also an attorney for a health and welfare LPA). A health and welfare attorney does not have authority for property and affairs, unless they have also been appointed as a property and affairs attorney.

An LPA does not come into effect until it has been registered and stamped on each page by the Office of Public Guardian.

Attorneys of LPAs must have regard to the MCA Code of Practice and act in the person's best interests.

If it is suspected that an LPA exists but evidence cannot be gained to substantiate this, an enquiry can be made to the Office of the Public Guardian for a search of the register of attorneys - https://www.gov.uk/government/publications/search-public-guardian-registers

This is a free service.

7.1 Property and affairs LPA

Unless the donor states otherwise, once the LPA is registered, the attorney has authority to make all decisions about the donor's property and affairs even if the donor still has capacity to make the decisions for him/herself.

The attorney should allow and encourage the donor to do as much as possible for him/herself, and should only act when the donor asks them to, or when the donor loses capacity to make the decisions. If UHB staff have concerns that an attorney is acting inappropriately, they should discuss the matter with the Mental Capacity Act Manager. It may be necessary to contact the Office of the Public Guardian for advice and also notify the UHB's Safeguarding Adults Team.

The donor may, however, wish to hand over responsibility for all decisions to the attorney, even those he/she still has capacity to make.

7.2 Health and welfare LPA

LPAs can be used to appoint attorneys to make decisions about health and welfare, which can include healthcare, including medical treatment decisions

and social care. Donors can add restrictions or conditions to areas where they do not give attorneys the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare.

There are particular rules for LPAs authorising an attorney to make decisions about life-sustaining treatment (see section 7.4).

A health and welfare LPA can only be used at a time when the donor lacks capacity to make a specific decision.

When health professionals are proposing medical treatment and care or are preparing a care plan for a patient who has appointed a health and welfare attorney, they must first assess whether the donor has capacity to agree to the treatment or care plan or to parts of it. If the donor lacks mental capacity to give or withhold consent, health professionals must then consult the attorney and obtain their consent.

If a decision is needed about a health and welfare matter for which the attorney does not have authority to decide and a best interests decision needs to be made, the attorney must still be consulted, if practical and appropriate, about what they consider to be in the patient's best interests.

7.3 Restrictions on the powers of health and welfare attorneys

Attorneys do not have the right to consent to or refuse treatment in situations where:

- **the donor has capacity to make the particular healthcare decision**
  An attorney has no decision-making power if the donor can make their own treatment decisions.

- **the donor has made an advance decision to refuse the proposed treatment**
  An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after they had made an advance decision, and gave the attorney the right to consent to or refuse the treatment specified in the advance decision, the advance decision will no longer be valid and applicable. For more information about advance decisions, please refer to sections 8.14 – 8.30 of the UHB's Consent to Examination or Treatment Policy.

- **a decision relates to life-sustaining treatment**
  An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document explicitly authorises this

- **the donor is detained under the Mental Health Act**

An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act (MHA) 1983, except in the case of Electro-convulsive therapy (ECT), where the attorney may refuse consent. However, if the ECT is to be given to the patient under MHA, Section 62 (urgent treatment) the attorney has no authority to refuse.

LPAs cannot give attorneys the power to demand specific forms of medical treatment that healthcare professionals do not believe are necessary or appropriate for the donor's particular condition.

Attorneys must always follow the MCA, have regard to its Code of Practice and make decisions in the donor's best interests. If health professionals disagree with the attorney's assessment of best interests, they should discuss the case with other health professionals and/or get a formal second opinion. They should then discuss the matter further with the attorney. If they cannot settle the disagreement, they must seek legal advice. This will be arranged via the appropriate advisor within the UHB (See Appendix A). An application to the Court of Protection may be necessary.

7.4 Health and welfare LPA that authorises an attorney to make decisions about life-sustaining treatment

An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if the LPA explicitly grants this authority to the attorney.

The attorney must not be motivated by the desire to bring about the donor's death.

If there is doubt that the attorney is acting in the donor's best interests, an application can be made to the Court of Protection for a decision. While the court is coming to a decision, healthcare professionals can give life-sustaining treatment to prolong the donor's life or stop their condition getting worse.

8. COURT APPOINTED DEPUTY

The Court of Protection can appoint a person (a deputy) to take decisions about property, affairs, health and social care on behalf of a person who lacks mental capacity to take these decisions.

Deputies, like attorneys, must have regard to the MCA Code of Practice and act in the person's best interests.

Deputies cannot refuse consent for life-sustaining treatment.

If a decision is needed about a health and welfare matter for which the deputy does not have authority to decide and a best interests decision needs to be

made, the deputy must still be consulted, where practical and appropriate, about what he/she considers to be the patient's best interests.

If health professionals feel that a deputy is not acting the best interests of the patient, and they have not been able to resolve the matter with the deputy, they should contact the Office of the Public Guardian (see section 11. below).

If it is suspected that a deputyship order exists but evidence cannot be gained to substantiate this, an enquiry can be made to the Office of the Public Guardian for a search of the register –

https://www.gov.uk/government/publications/search-public-guardian-registers

8.1 Restrictions on the powers of Court Appointed Deputies

Restrictions on a Court Appointed Deputy (CAD) include –

- The CAD believes, or has reasonable grounds for believing, that the person has capacity to take the decision in question
- The CAD cannot prohibit a named person from having contact with the person with impaired capacity, nor can the CAD direct the person's responsible healthcare professional to allow a different responsible healthcare professional to take over that responsibility
- The CAD cannot overturn a decision made by an attorney acting under an LPA granted by the person before they lost capacity
- The CAD cannot refuse the provision or continuation of life-sustaining treatment for a person who lacks capacity to consent to it (only the Court can take this decision)

9. WORKING WITH AN ATTORNEY OR DEPUTY

Staff should ask patients/relatives/friends if the patient has made an LPA or have a CAD.

If staff are made aware that a patient has an attorney or deputy, particularly regarding health and welfare, this information must be reported to the most senior health professional involved in the patient's care.

The senior health professional must

- attempt to make contact with the attorney or deputy and ask to see the lasting power of attorney/court order

- satisfy themselves that the LPA is registered by inspecting the document and ensuring that it has been stamped on every page by the Office of the Public Guardian
- with the consent of the attorney, take a copy of the LPA or court order and file it in the patient's notes
- understand the powers that have been conferred on the attorney/deputy
- make arrangements to inform other health professionals involved in the patient's care that the patient has an attorney or deputy together with details of the authority the attorney/deputy has

Examples of registered LPAs can be found here - https://www.gov.uk/government/publications/lasting-power-of-attorney-valid-examples

Examples of court orders appointing a deputy can be found here - https://www.gov.uk/government/publications/deputy-court-order-valid-example

If health professionals decide to provide treatment and care to the patient, they must

- assess whether or not the patient has mental capacity to give or refuse consent to the treatment. If the patient has capacity, then the patient will make the decision
- consider whether this treatment and care falls under the authority of the attorney/deputy
- seek consent for the treatment and care from the attorney/deputy, if the attorney/deputy has the authority to take the decision. Refusal must be respected. Where appropriate (i.e. if written consent would normally be obtained from the patient if they had mental capacity to do so), complete (Consent) Form 4. If the decision does not need to be formally documented on (Consent) Form 4, ensure that the attorney/deputy's consent is recorded in the patient's notes.
- if the attorney/deputy does not have the authority to take the decision, then the health professional will need to make a best interests determination. The attorney or deputy must be consulted as part of this determination, where practical and appropriate.

10. LPAS/CADS AND ADVANCE DECISIONS TO REFUSE TREATMENT

An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after they had made an advance decision, and gave the attorney the right to consent to or refuse the treatment in question, the advance decision will no longer be valid and applicable. For more information about advance decisions, please refer to sections 8.14 – 8.30 of the Consent to Examination or Treatment Policy.

Note that neither a CAD nor the Court can overturn a valid and applicable advance decision. A CAD, therefore, has no authority to consent to treatment that is the subject of a valid and applicable advance decision.

11. DISAGREEMENT/DISPUTE WITH THE ATTORNEY/CAD

In the event that health professionals believe that an attorney or a CAD is not acting in a person's best interests, the Mental Capacity Act Manager must be informed and a decision will be made about whether advice should be sought from the Office of the Public Guardian (OPG).

In the event that an attorney of a health and welfare LPA with the authority to refuse life-sustaining treatment does refuse such treatment and health professionals do not feel that this is in the best interests of the patient, legal advice must be sought immediately (via the on-call senior manager if out-of-hours).

Information about the OPG can be found here -

http://www.justice.gov.uk/about/opg.htm

Contact details are

Office of the Public Guardian
PO Box 16185
BIRMINGHAM
B2 2WH

Tel. 0300 456 0300

Textphone - 0115 934 2778

Fax - 0870 739 5780

Mon, Tues, Thurs, Fri – 9.30am – 5.00pm
Wed – 10.00am – 5.00pm

12. AUDIT

Adherence to this procedure will be monitored by a variety of processes, including structured and ad-hoc case note review and as part of the UHB and Clinical Board/Directorate clinical audit plan.

Related clinical audit activity which may include monitoring compliance with this procedure, will be reported to Clinical Board Quality, Safety and Experience Groups and the UHB Mental Health and Capacity Legislation Committee.

13. DISTRIBUTION

This procedure will be made available on the UHB intranet, Clinical Portal and internet sites.

14. REVIEW

This procedure will be reviewed every 3 years or sooner if appropriate.

APPENDIX A

Useful contact details

Julia Barrell, MCA Manager, Tel. 029 2183 6312 (for both consent and mental capacity issues)

Maria Roberts, Head of Patient Safety and Quality, Tel. 029 2183 6316

Carol Evans, Assistant Director of Patient Safety and Quality, Tel 029 2183 6331

Aaron Fowler, Head of Risk and Regulation (in relation to obtaining Legal Advice), Tel 029 2183 6012

Out of hours legal advice/guidance in emergency situations, via the On Call Senior Manager rota