Mental Health & Capacity Legislation Committee

21 July 2020, 09:00 to 12:00
Via Skype

Agenda

1. Welcome & Introductions

Sara Moseley

1.1. Apologies for Absence

Sara Moseley

1.2. Declarations of Interest

Sara Moseley

1.3. Minutes of the Meeting held on 21st February 2020

Sara Moseley

1.4 MHCHC Mins 21.02.20 - AF (03.03.20).pdf (12 pages)

1.4. Action Log following the Meeting held on 21st February 2020

Sara Moseley

1.5 Action Log.pdf (4 pages)

1.5. Chairs Action taken since the last Meeting held on 21st February 2020

2. COVID-19

2.1. Impact of COVID-19 on Reporting and Monitoring

Ian Wile

2.2. Post COVID-19 Mental Health Recovery Plan

Presentation

Annie Proctor / Ian Wile / Mark Warren

9.2 Post-Covid Board presentation Final +1.pdf (10 pages)

9.2 a Post Covid IMTP V4 - MH.pdf (24 pages)

3. Mental Capacity Act

3.1. Mental Capacity Act Monitoring Report

Ruth Walker

10.1 MCA update report July 2020.pdf (3 pages)

10.1 Appendix 1 MCA supporting info July 2020.pdf (5 pages)

10.1 Appendix 2 - IMCA Report July 2020 (2).pdf (2 pages)

3.2. The Vale and Glamorgan Local Authority Report on DoLS

Ruth Walker

4. Mental Health Act

4.1. Mental Health Act Monitoring Exception Report

Ian Wile

11.1 Mental Health Act Monitoring Exceptions Report.pdf (6 pages)

11.1 MHA Monitoring Exceptions Report - QTR 1 - WIP.pdf (42 pages)

11.1 MHA Monitoring Exceptions Report - QTR (41 pages)

4.pdf

5. Mental Health Measure

5.1. Mental Health Measure Monitoring Report including Care and Treatment Plans Update Report

Ian Wile

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

12.1 Appendix 1.pdf (6 pages)

6. Items for Noting & Information

6.1. Hospital Managers Power of Discharge Minutes

Information

Jeff Champney-Smith

13.1 POD Minutes.pdf (5 pages)

6.2. Mental Health Legislation and Governance Group Minutes

Information

Robert Kidd

13.2 Minutes of the Mental Health Legislation and Governance Group - 30-04-2020.pdf (6 pages)

7. Items for Approval / Ratification

7.1. Policy and Procedure - Section 117

Sunni Webb

14.1 Committee Template for Approval of the review of Joint Section 117 Mental Health Act 1983 Policy and Procedure.pdf (3 pages)

14.1 Cardiff and Vale UHB s117, Mental Health Act, Policy.pdf (40 pages)

14.1 Cardiff and Vale UHB s117 Joint Procedure.pdf (23 pages)

8. Any Other Business

Sara Moseley

9. Date & Time of next Committee Meeting

Tuesday 20th October 2020

09:00am - 12:00pm

Further details to be confirmed

Sara Moseley

UNCONFIRMED MINUTES OF
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
HELD ON 21 FEBRUARY 2020
NANT FAWR 1, GROUND FLOOR, WOODLANDS HOUSE, HEATH CF14 4TT

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:

Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Steve Curry	SC	Chief Operating Officer
Nicola Foreman	NF	Director of Corporate Governance
Amanda Morgan	AM	Service User
Sunni Webb	SW	Mental Health Act Manager
Dr Stuart Walker	SW	Executive Medical Director

Secretariat:

Glynis Mulford	GM	Corporate Governance Officer

Observers:

Simon McDonald		Deputy Mental Health Act Manager

Apologies:

Julia Barrell	JB	Mental Capacity Act Manager
Akmal Hanuk	AH	Independent Member, Community
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Scott McLean	SM	Director of Operations, Children & Women
Ian Wile	IW	Director of Operations, Mental Health

MHCL 20/02/001	**WELCOME AND INTRODUCTIONS** The Chair welcomed everyone to the meeting. In particular Michael Imperato, Independent Member – Legal who attended his first meeting.	**ACTION**
MHCL 20/02/002	**APOLOGIES FOR ABSENCE** Apologies for absence were noted.	
MHCL 20/02/003	**DECLARATIONS OF INTEREST** The Chair invited Committee members to declare any interests in relation to the items on the meeting agenda. The following declarations of interest were received and noted: • Sara Moseley declared an interest in the meeting as the Director of Mind Cymru, the Chair of the Crisis Care Assurance	

	Board and in relation to item 10.2 as a member of the Crisis Care Concordat and advisor of the Ministerial Advisory Board.	
MHCL 20/02/004	**MINUTES OF THE COMMITTEE HELD ON 22 OCTOBER 2019** The Committee reviewed the Minutes from the meeting held on 22 October 2019. Subject to the following amendments: • **MHCL 19/10/016** - the wording of the minutes did not relate to the Hospital Managers Powers of Discharge minutes but should be under section 2 Mental Health Legislation Governance Group minutes. • **MHCL 19/10/008 –** Independent Member – ICT asked for the question marks in the paragraph to be put into statements. **The Committee resolved that:** a) The Committee approved the minutes of the meeting held on 22 October 2019.	
MHCL 20/02/005	**ACTION LOG FOLLOWING THE LAST MEETING HELD ON 22 OCTOBER 2019** The Committee reviewed the action log and noted the following updates: **19/10/009 – Internal Audit Report – Deprivation of Liberty Safeguards (DoLS Report):** The Executive Medical Director (EMD) was asked to confirm who the Executive Lead was for the Deprivation of Liberty Safeguards (DoLS) was. The Committee was informed that the CEO had asked the Executive Nurse Director (END) to incorporate DoLS/MCA into her portfolio, with her acting as the SRO which would extend into the Mental Capacity Act. It was explained that some components of the consenting policy could still sit with the EMD. It was also explained that the medical aspects relating to consent may be addressed at another Committee. The END had asked for an external review of our DOLS processes. Independent Member – ICT asked if the Committee could have sight of the External Review on DoLS. **19/10/012 – HIW Mental Health Act Report:** This item would remain on the action log as estates were working through the concerns. This was an operational issue and would be reported through Management Executive meetings. **19/06/008 – Mental Capacity Act Monitoring Report:** The EMD stated that the action was a much broader issue and concerned the whole of mandatory training. The annual leave and study leave policies, job planning and compliance for mandatory training form part of negotiations with LMC which were ongoing.	**RW**

	The policy could not be unilaterally changed without going through due process. It was explained that clinicians found it difficult to access mandatory training on ESR. A fundamental change was required to solve the issue around training and was on the EMDs agenda. A meeting was being arranged with the team to review how it could be made more functional. The EMD stated that the action on the committee log was no longer relevant as the issue fell outside the organisation. The Chair noted that there was a discrepancy between medical staff and other staff relating to compliance. In response it was stated the figure was based on the ESR record but if people undertook MHA training in another way the data would not be recorded on ESR, therefore it was difficult to know the true compliance figure via this route. Training would be captured through the validation and appraisal process which was not centralised on ESR. It was explained that the figures were correct for training under ESR but not for training undertaken anywhere else. The Chair commented that the issue was that the Committee reviewed the figures consistently at each meeting and had expressed concern at the level of non-compliance. It would be helpful to be provided with a more composite view of the issues and to find a way of understanding the challenges. It was reiterated that there a systematic approach needed but that this would need Workforce and Organisational Development input to inform us how this could be taken forward and for the technology to be put in place. The Committee requested that the issues raised with training be reviewed at the Strategy and Delivery Committee and for any findings to be reported back to the Committee to provide assurance that the concerns were being dealt with. **The Committee resolved that:** a) The action log and verbal updates be noted	**SW – Via the S&D Committee**
MHCL 20/02/06 **MHCL 20/02/007**	**CHAIRS ACTION TAKEN SINCE LAST MEETING** No Chair's action had been taken. **PATIENT STORY** Cardiff and Vale Action for Mental Health (CVAMH) were unable to attend the meeting. A YouTube link and story outline relating to a CAMHS user would be circulated to the Committee. There was wider discussion relating to Patient Stories. The Director of Corporate Governance (DCG) confirmed that she would be looking at a systematic approach to make the	**GM**

	presentation of patient stories more robust across the Board and Committee meetings. The Chief Operating Officer asked for the story to be brought to a future meeting. The Chair asked Committee members to involve the Communications team so that the good news stories of service users could be shared within the Mental Health service.	**GM**
MHCL 20/02/008	**MENTAL CAPACITY ACT MONITORING REPORT** Comments in next agenda item. **The Committee resolved that:** (a) The Committee noted the report.	
MHCL 20/02/009	**INTERNAL AUDIT REPORT - DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)** The Medical Director introduced the report and provided the committee with the following updates: • The direction of travel had changed since the Internal Audit Report was published and now related to the Liberty Protection Standards (LPS) which are to be implemented this year. The LPS had not yet been published and the date for their implementation may be brought forward. • There was a hold on the internal audit recommendations as some of them would not be relevant after the publication of an impending Welsh Government paper. The LPS would supersede the DoLS internal audit recommendations. • The service may change within Cardiff and Vale local authorities. Thiswould be assessed once the new standards were implemented. • LPS training would be undertaken in March and an agreement put in place with both authorities as part of the MCA and DoLS meeting that previously existed. A review of the multi-stakeholder service would be undertaken which was dependent on the content of the LPS. • The Vale of Glamorgan was responsible for coordinating the training and they had also assessed the DoLS work over the last year and found that the provision of DoLS was correct. The report would be available at the next meeting. **The Committee resolved that:** (a) The Committee noted the continuing arrangements for the DoLS service.	**RW**
MHCL	**MENTAL HEALTH ACT MONITORING EXCEPTION REPORT**	

20/02/010	The Mental Health Act Manager (MHAM) presented the report and was pleased to note that there had been no unlawful detentions since July 2018 but highlighted that the percentage of inpatients was high. The recruitment of Associate Hospital Managers was currently underway and the MHAM welcomed members of the Committee to join the Group. The following comments were made: • The use of Section 136 remained an ongoing issue. This had been escalated to the Welsh Government legal team as it was important to establish when an assessment had started. Notwithstanding this the UHB had asked WG to take a view on this. The WG have confirmed that they would respond to the request. • The work with the Crisis Care Concordat allowed the UHB to work with the police to better understand some of the issues as the police were wanting to disengage with patients at an earlier pathway. • Some Health Boards had a different practice and the process undertaken in this Organisation was explained. • The local concordat group would be chaired by the Director of Operations, Mental Health from March 2020. This group fed into the National Group. • The Chair confirmed that she would put the item on the agenda for the National Group. The Chair asked for comments and questions: • The Chair raised a query relating to patients under Section 136 who were assessed and discharged. She asked whether they were followed up or signposted to other services. The (MHAM) confirmed that the information was not in the report but that the data could be built into future reports. • The Chair asked why there had been an increase in patients eligible for section 117. The MHAM advised that the increase was linked to admissions under the Eligible Section for 117. The chart for November showed an increase for Section 117 and Section 3. The data reflected this as once patients were admitted they would be added to the 117 register for aftercare. • Independent Member – ICT asked for Mental Health Compliance data for specialist CAMHS to be documented in a CAMHS specific report and asked for the date to be separated from the adult figures. • The COO confirmed that he would speak with the Independent Member – ICT outside the meeting to provide a children's section in the report. . **The Committee resolved that:** the report be noted and support given approach adopted	**SW** **SC / EB**

MHCL 20/02/011	**SECTION 135/136 PARTNERSHIP ARRANGEMENTS: POLICE MENTAL HEALTH CRISIS CONCORDAT - UPDATE** The COO introduced the report and highlighted the following system wide requirements and the MH Crisis Concordat which was relaunched in 2019. It was reported that relations and discussions had improved. The Director of Operations, Mental Health would be chairing the group from March 2020. The paper set out what the group would be covering, highlighted the gaps and what was needed going forward. The local group would report to the national group and work would be undertaken by the third sector and Local Authority. The group would feedback to the Committee how this was progressing. The Chair asked for comments and questions: The Chair explained that the Concordat was created by Welsh Government and was a partnership across agencies. The Concordat was launched in 2015 and the driving force behind the Concordat was to prevent a crisis from happening in the first instance, to provide support for those in crisis and maintain a multiagency focussed approach which included the police. With the new local leadership there would be an opportunity to reset the focus to the true purpose of the original agenda. The Chair would liaise with the Director of Operations, Mental Health to express her concerns. The Chair highlighted the work that was happening in other Health Boards which the Concordat could link in with. **The Committee resolved that:** a) The Committee noted and commented on the proposed actions.	**SM/IW**
MHCL 20/02/012	**MENTAL HEALTH MEASURE MONITORING REPORT** The Chief Operating Officer presented the report. The following comments were made: • Referrals had been rising over the last year and a reduction in numbers had been seen for mental health assessments. It was noted that the Primary Care Liaison Services were influencing the figures as numbers had fallen from 1300 to 800 • This reduction would permit the Clinical Board to ascertain the right size for the service going forward. The staff in place allowed for variation and to stay ahead of the measure. • The measure, which was combined for adults and children, fell off in January. The CAMHS contribution showed the activity levels were not great enough to influence the overall measure compliance because of the adult numbers. As the activity in CAMHS increased its influence was greater.	

	• The current position for Part 1a was over 90% compliant. Part 1b was 100% compliant. Part 2, which centred around the Care and Treatment Plan work within the Delivery Unit had decreased to 70%. It was explained that this work related to investment on a RAMP model. The measure had risen from 70% to 85% in February and would be compliant at 90% in March. Both Part 3 and 4 were compliant. The Chair invited comments and questions: • The Chair commented that early intervention showed a major effect on compliance. • If compliance could be made sustainable it would provide the ability to focus on the quality of care. • In terms of future patient stories, it would be good to understand how the joint working was being undertaken. • The COO was encouraged with the working between agencies in signposting patients to the right place. **The Committee resolved that:** a) The report be noted.	
MHCL 20/02/013	**MENTAL HEALTH MEASURE MONITORING REPORT - CAMHS** The Chief Operating Officer introduced the report and highlighted the following: • In terms of the measures the Health Board had been non-compliant since 2019 and had drifted in and out of compliance over the period. The new approach focussed on capacity to meet demand and this also worked upstream into societal and community levels. • It was expected that the UHB would be 50% compliant for Part 1 by mid-February and the latest figures suggested we were over 50% compliant and that this figure could increase to over 80% compliance by the end of February/March. This work was also aligned to the care and treatment plan. • An update from the teams would be brought to the Board and Committee with the first phase of the plan. • After the first phase of work it the plan would centre on sustainability of the service and begin to look at quality. Other work would continue to integrate the services that had been repatriated and other projects linked to the Welsh Government Delivery Unit Development. • The Committee was asked to recognise the progress that had been made and also that the team were on a journey and were moving in the right direction. Chair's comments and questions:	**SC**

Independent member - ICT asked how much of the funding was locked in as 'at risk'. The Chief Operating Office stated that some of the funding had come from the Mental Health Transformation fund and that the last monies received made a provision and requirement for CAMHS. The funding was recurrent and the services being added would be embedded into the service. Another suggestion for funds was to provide a digital solution but this was exceptionally expensive. This would be accomplished through external providers as the Health Board was unable to provide the service.

The COO confirmed that the Digital Strategy included provisions to empower patients to take control of their own access and care such and included programme's such as 'Patient Knows Best'. There was wider discussion on why CAMHS patients needed access through a digital platform.

The Chair asked what was being addressed to support and safeguard the children that were waiting. The COO said that 80% of children would have access within two weeks. The trajectory was to have an assessment and intervention within this periof and from April both would be in balance.

Independent Member – Legal confirmed that he was impressed that the Director of Operations, Children and Women plotted week by week his delivery plan to meet the demand and took assurance from this.

The Chair stated the team was to be commended as they had undertaken a phenomenal piece of work.

The Committee resolved that:

a) The report be noted and to recognise that progress had been made

MHCL 20/02/014

CARE AND TREATMENT PLANS UPDATE REPORT

The Chief Operating Officer confirmed that the report placed emphasis on training and looked at the audit on the care and treatment plans and how they could be improved. This had been sense checked and delivered by the Delivery Unit Team.

The Chair commented that the report was true to the spirit of why care and treatment plans were put in place and that this would be reflected as part of teams learning and review.

In terms of compliance for care and treatment plans in place, the overall measure was at 70%. In February this would be 85% and the trajectory for the March position was that progress would increase to 90%.

The move towards quality would be the next stage of the teams' plans and progress.. It was highlighted that the views of service users would be key to assess the impact and quality of the care and treatment plans. There would be a need to triangulate on a number of things to improve on the quality of the plans. This would be more nuanced and a number of indicators would be in place to see that improvements were being made.

The Chair asked if it was known what the general attitude was towards the care and treatment plans being part of the therapeutic process. The Chair of the Powers of Discharge Sub Committee considered that recording was the issue and the availability of the patient record was not as good as it could be. It was recognised that for young people there was still a way to go. Making the plans live documents was a work in progress. There was wider discussion on the challenges of the care and treatment plan.

The Committee resolved that:

a) The report be noted.

MHCL 20/02/015

POLICIES

1. **Department of Liaison Psychiatry Operational Policy**

Members considered the policy to be operational and therefore should have been dealt with locally. The DCG confirmed that there would be a review of the 'Policy for Policies' in future but that for now, the policy being submitted to the Committee was in line with the process.

The Committee resolved that:

a) Department of Liaison Psychiatry Operational Policy be approved.
b) the full publication of the Department of Liaison Psychiatry Operational Policy in accordance with the UHB publication scheme be approved.

2. **Approval of Review of Receipt of Applications for Detention Under the Mental Health Act 1983 Policy**

Members were informed that slight amendments had been made in line with requirements.

The Committee resolved that:

a) the Approval of Review of Receipt of Applications for Detention Under the Mental Health Act 1983 Policy be approved.

b) the full publication of Approval of Review of Receipt of Applications for Detention Under the Mental Health Act 1983 Policy in accordance with the UHB publication scheme be approved.

3. Restraint in the Care Management of Adults with Impaired Mental Capacity

As this policy related to adults there was wider discussion on a policy for under 16s and the CAMHS boundaries. Members were informed that many of the questions asked would not come to this Committee as it was outside its remit.

JB

Independent Member – ICT asked if there was any Welsh guidance for restraining children.

In regard to governance arrangements, Members were informed that the specialist service for CAMHS sat with WHSSC. Work had been undertaken with our neighbouring Health Boards and meetings had taken place with Cwm Taf where tier 4 arrangements were discussed. The COO confirmed that assurances could be provided through these aspects and that he would bring back to the next meeting the discussions undertaken regarding CAMHS.

SC

The EMD would ask The Mental Capacity Act Manager what the arrangements were for under 16s in regard to parental responsibility and how to differentiate between children and adults regarding restraint.

SW/JB

The DCG confirmed that a session on these issues would be discussed at the next Board Development day.

The Chair summarised that clarity was being sought on the following issues:

- ;
- whether there was Welsh Government guidanceon mental health restraint for under 16s,
- parental responsibility arrangements for under 16's,
- an update on discussions with Cwm Taf University Health Board in relation to CAMHS and a review of how WHSSC provides the Health Board with assurance regarding its governance arrangements.

The Committee resolved that:

a) Restraint in the Care Management of Adults with Impaired Mental Capacity Policy be approved.

b) the full publication of the Restraint in the Care Management of Adults with Impaired Mental Capacity in accordance with the UHB publication scheme be approved.

MHCL 20/02/016	**COMMITTEE ANNUAL REPORT 2019/20** The Director of Corporate Governance presented the report to the Committee and confirmed that the report provided assurance that the work undertaken during the year 2019/20 reflected the requirements set out in the Committee's Terms of Reference. **The Committee resolved that:** a) the draft Annual Report 2019/20 of the Mental Health and Capacity Legislation Committee was reviewed; and b) the Annual Report be recommended to the Board for approval.	
MHCL 20/02/017	**COMMITTEE TERMS OF REFERENCE** The Director of Corporate Governance introduced the Terms of Reference. There was wider discussion in relation to the purpose and role of the Committee and it was noted that further changes would be required. It was agreed that members would review the ToRs and feed comments back to the DCG. A date would be circulated by the DCG with the deadline for comments to be received. **The Committee resolved that:** a) the Terms of Reference 2020-21 was reviewed; b) the Terms of Reference 2020-21 be circulated to Members for further consultation and revision c) the Terms of Reference be recommended to the Board for approval at the July meeting.	NF
MHCL 20/02/018	**COMMITTEE WORKPLAN** Due to the above discussion on the Terms of Reference, it was agreed the workplan be approved subject to realignment with changes made to the Terms of Reference. **The Committee resolved that:** (a) the Workplan 2020-21 be approved subject to further review and aligned to the revised ToR (b) the Workplan be recommended for approval to the Board for use until July 2020.	
MHCL 20/02/019	**HOSPITAL MANAGERS POWER OF DISCHARGE** **The Committee resolved that:** a) The minutes of the Hospital Managers Power of Discharged be approved.	

MHCL 20/02/020	**MENTAL HEALTH LEGISLATION AND GOVERNANCE GROUP MINUTES** **The Committee resolved that:** a) The minutes of the Mental Health Legislation and Governance Group be approved.	
MHCL 20/02/021	**MENTAL HEALTH LEGISLATION RELATED ISSUES – TOGETHER FOR MENTAL HEALTH DELIVERY PLAN** The COO informed the Committee that the report addressed what relevance the plan might have on legislation for Committee purposes and that the consultation looked at whether other individuals could undertake primary mental health assessments. The plan had been considered but not a full review had not concluded. **The Committee resolved that:** a) The report be noted	
MHCL 20/02/022	**ANY OTHER URGENT BUSINESS** In regard to previous discussion on agenda item **20/02/015** - **Restraint in the Care Management of Adults with Impaired Mental Capacity**, the EMD confirmed that there was no Welsh Guidance on the restraint of patients under the age of 16 and the policy was based on the Mental Capacity Act and the associated code of practice. **COMPLETED** With regards to parental responsibility for those under 16, the Mental Capacity Act Manager would bring a more detailed summary back to the next meeting.	**JB**
MHCL 20/02/023	**DATE OF THE NEXT COMMITTEE MEETING:** Tuesday, 21 July 2020, 1.00pm Woodlands House, Heath, Cardiff CF14 4TT	

ACTION LOG
FOLLOWING MHCLC COMMITTEE MEETING
FEBRUARY 2020

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCL 19/06/011	Section 136 Partnership Arrangements	An update to be provide in six months' time	22.10.19	Ian Wile	**COMPLETED** Presented at the February 2020 meeting.
MHCL 19/10/009	Internal Audit Report – Deprivation of Liberty Safeguards (DoLS) Report	Internal Audit report would be brought back to the next Committee meeting for discussion and assurance along with confirmation of which Executive Director was responsible for DoLS.	21.02.20	Stuart Walker	**COMPLETED** Presented at the February 2020 meeting.
MHCL 19/10/009	Internal Audit Report – Deprivation of Liberty Safeguards (DoLS) Report	A request be made to Internal Audit seeking clarification on the outcome of the training section including the report being reasonable when clear issues had been identified	21.02.20	Nicola Foreman	**COMPLETED** Verbal update provided at February 2020 meeting.
MHCL 19/10/010	Mental Health Act Monitoring Exception Report	The detailed appendix would be provided at future meetings.	21.02.20	Ian Wile	**COMPLETED** Presented at the February 2020 meeting and all future meetings.
MHCL 19/10/014	Mental Health Measure Monitoring Report	Data be provided for patients under the age of 18 years.	21.02.20	Scott McLean	**COMPLETED** Presented at the February 2020 meeting.
MHCL 20/02/015 - 20/02/022	Policies – Restraint in the Care Management of Adults with	To clarify if there was any Welsh guidance for restraining children		Stuart Walker/Julia Barrell	**COMPLETED** It was clarified that there was no Welsh Guidance on the restraint of patients under the age of 16. The

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Impaired Mental Capacity				policy was based on the Mental Capacity Act and the associated Code of Practice.
MHCL 20/02/007	Patient Story	The Cardiff and Vale Action for Mental Health (CVAMH) Patient Story link and story outline to be circulated by email.	ASAP	Glynis Mulford	**COMPLETED** GM to circulate Patient Story Link and story outline by email ASAP.
MHCL 20/02/007	Patient Story	The CVAMH Patient Story to be brought to the July Committee meeting.	21.07.2020	Glynis Mulford	**COMPLETED** CVAMH Patient Story on July committee agenda. *(Agenda Item 8.1)*
Actions in Progress					
MHCL 20/02/005	Action Log – 22.10.19	To have sight of the External Review on the DoLS Terms of Reference		Ruth Walker	
MHCL 20/02/009	Internal Audit Report – Deprivation of Liberty Safeguards (DOLS)	The Vale and Glamorgan Local Authority Report on DoLS to be presented at the next meeting	21.07.2020	Ruth Walker	RW to bring the Vale of Glamorgan DoLS report to the July Committee meeting. *(Agenda Item 10.2)*
MHCL 20/02/010	Mental Health Act Monitoring Exception Report	To include a section in the Monitoring report to highlight whether patients who were assessed and discharged under section 136, had been followed up.	At all future committee meetings.	Sunni Webb	SW to incorporate follow up information in future reports.
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	Meeting/Discussion to be arranged.
MHCL 20/02/011	Section 135/136 Partnership Arrangements: Police Mental Health Crisis	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	Discussion taken place. Update to be brought by Ian Wile.

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
	Concordat - Update				
MHCL 20/02/013	Mental Health Measure Monitoring Report – CAMHS	An update on the first phase of the CAMHS - Mental Health Measure plans to be brought to a future committee meeting.	TBC	Steve Curry	An update to be brought to a future meeting.
MHCL 20/02/015	Policies – Restraint in the Care Management of Adults with Impaired Mental Capacity	To provide assurances to the Committee that WHSSC Governance arrangements relating to CAMHS were in place.		Steve Curry	
MHCL 20/02/015 - 20/02/022	Policies – Restraint in the Care Management of Adults with Impaired Mental Capacity	An update be provided on the following: 1. how to differentiate between children and adults; and 2. arrangements for parental responsibility for under 16s	21.07.20	Julia Barrell	A detailed summary would be provided at the next meeting.
MHCL 20/02/017	Committee Terms of Reference	The Director of Corporate Governance to circulate the Draft Terms of Reference for further comments and subsequent submission to the Board for approval.	21.07.20	Nicola Foreman	Circulated and Committee Development Session to be arranged to review.
MHCL 19/10/007	Patient Story	A CAMHS patient story be brought to the next Committee Meeting			This item would be brought to a future meeting.
MHCL 19/10/008	Mental Capacity Act Monitoring Report	A response to HIW be given and an update to be provided at the next Committee Meeting	21.02.20	Julia Barrell	Verbal update to be provided at February 2020 meeting.

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 19/10/014	Mental Health Measure Monitoring Report	Part 4 – Advocacy – standard to have access to an IMHA within 5 working days the report however an improvement should be seen in coming months – Update to be provided at next Committee Meeting	21.02.20	Ian Wile	To be presented at the February 2020 meeting. *(Agenda Item 12.1)*
MHCL 19/10/016	**Items for Information / Noting**	Hospital Managers Power of Discharge Minutes Clarity around arresting under section 135 / 136 be put on an agenda at National Level.		Ian Wile	Ongoing.
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.		Nicola Foreman	Ongoing.
MHCL 19/06/008 MHCL 20/02/005	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. The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee	Date to discuss at HSMB	Stuart Walker	Agreement not reached with LNC at present. Discussions are ongoing. This item would be reviewed by the S&D Committee and reported back to a future meeting.

‘Post’ Covid 19 Mental Health Recovery Plan

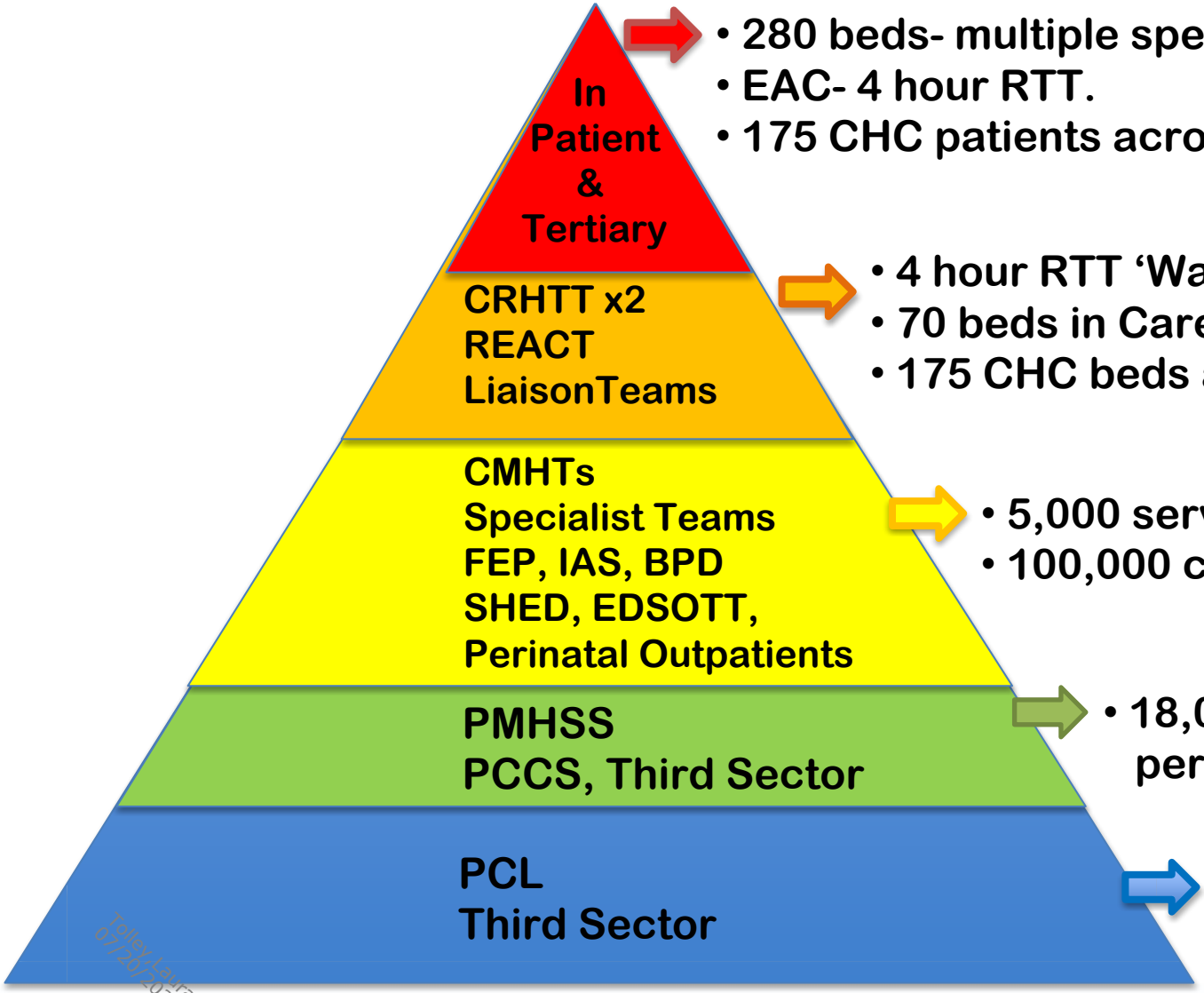
Mental Health Clinical Board

"The pandemic is opening up the fault lines

in society that were already there".

Professor Louis Appleby

Leads National Suicide Prevention Strategy For England
Directs National Confidential Inquiry into Suicide & Homicide
by people with Mental Illness

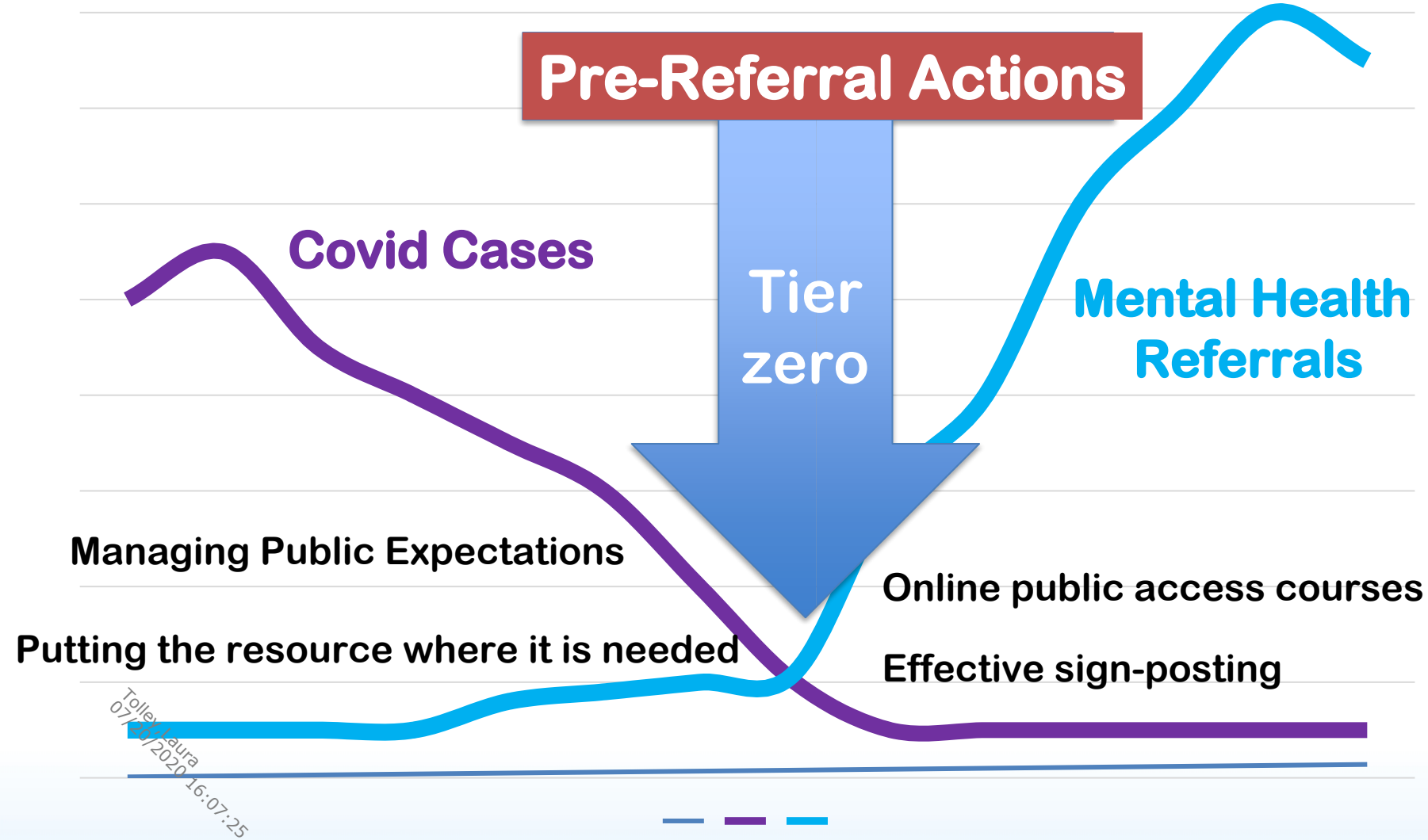


Tolley, Laura
07/20/2020 16:07:25

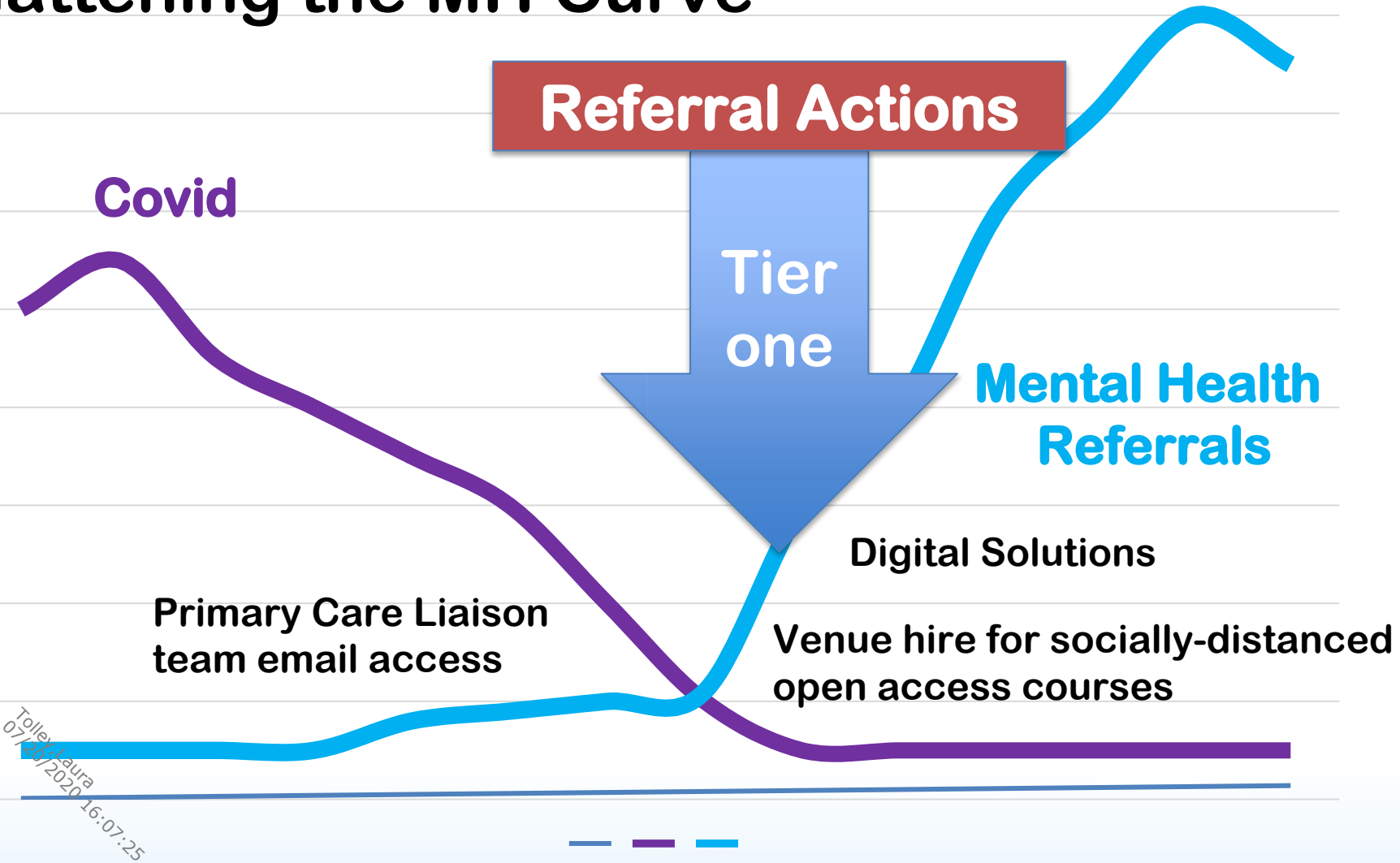
250,000 contacts per annum

We anticipate a possible post-Covid 19 Mental Health Referral Spike

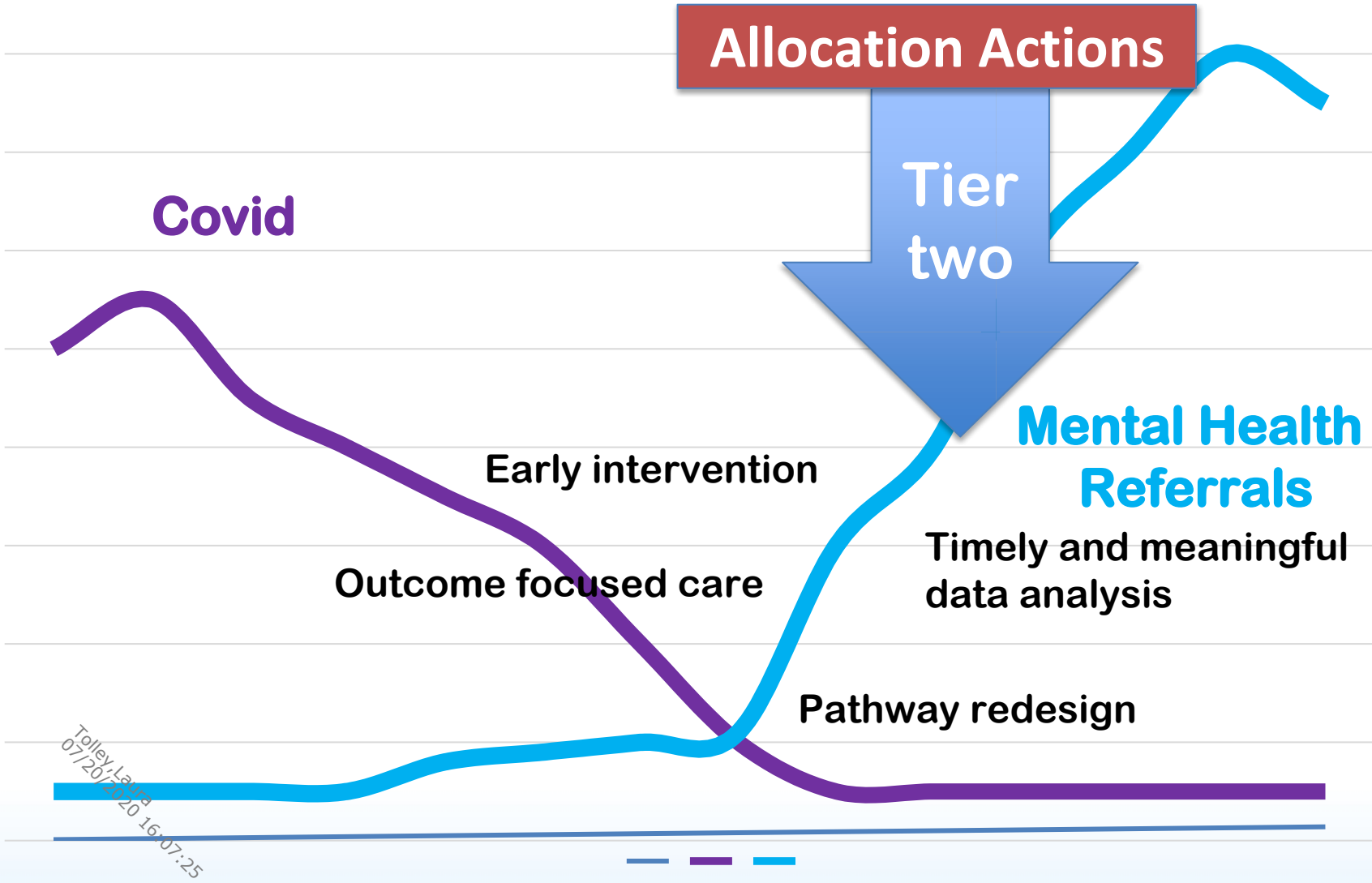
Flattening the MH Curve



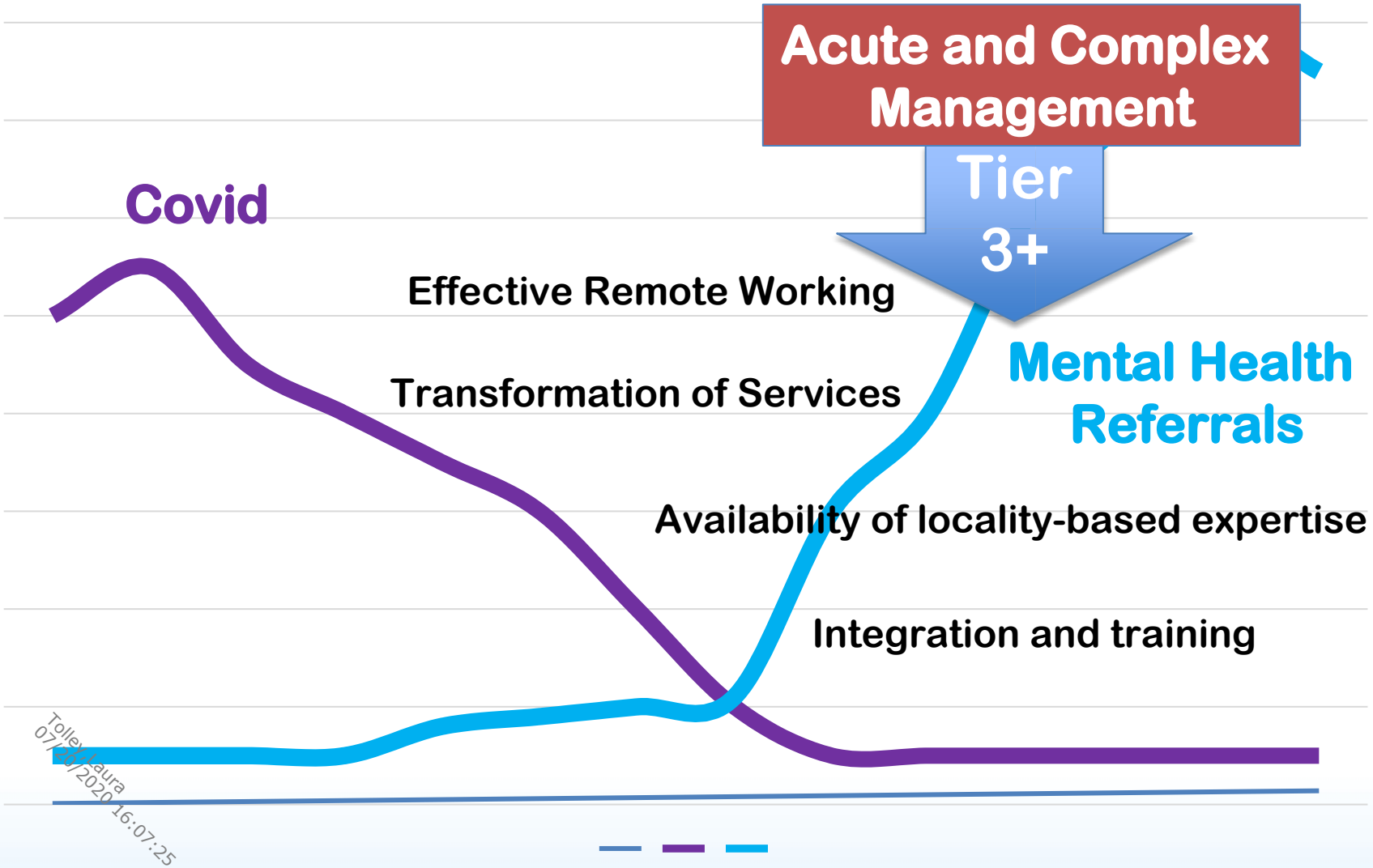
Flattening the MH Curve



Flattening the MH Curve



Flattening the MH Curve



Strategic Direction and Innovation

Open, Accountable, Accessible

3rd Sector Partnerships

Stakeholder and user involvement

Resilient Communities

Co-production & Peer recruitment

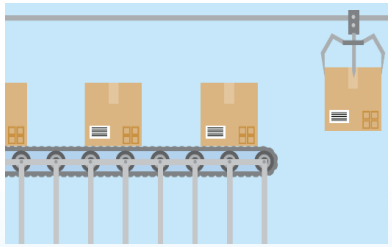
Digital access

Single Assessment

Single point of Access

Improve O/P model

Day Service Review



Caseload scrutiny

Accessible services

First time

Effective Home Working

Efficient & Effective systems

Staff & Team Resilience

Locality Working

Wiley, Laura
07/20/2020 16:07:25

ANY QUESTIONS?

Tolley, Laura
07/20/2020 16:07:25

Post - Covid '19 Mental Health Clinical Board Recovery Plan & 2020/21 - Brief IMTP

June 8

2020

As the Impact of the Covid 19 virus recedes Mental Health services are finding themselves at the forefront of a surge in demand for services – this document describes the preparations and changes the MHCB and its partners are making

Covid Recovery and Continuity Plan
Version 4 – 8th June 2020

Content

1. Context & Background

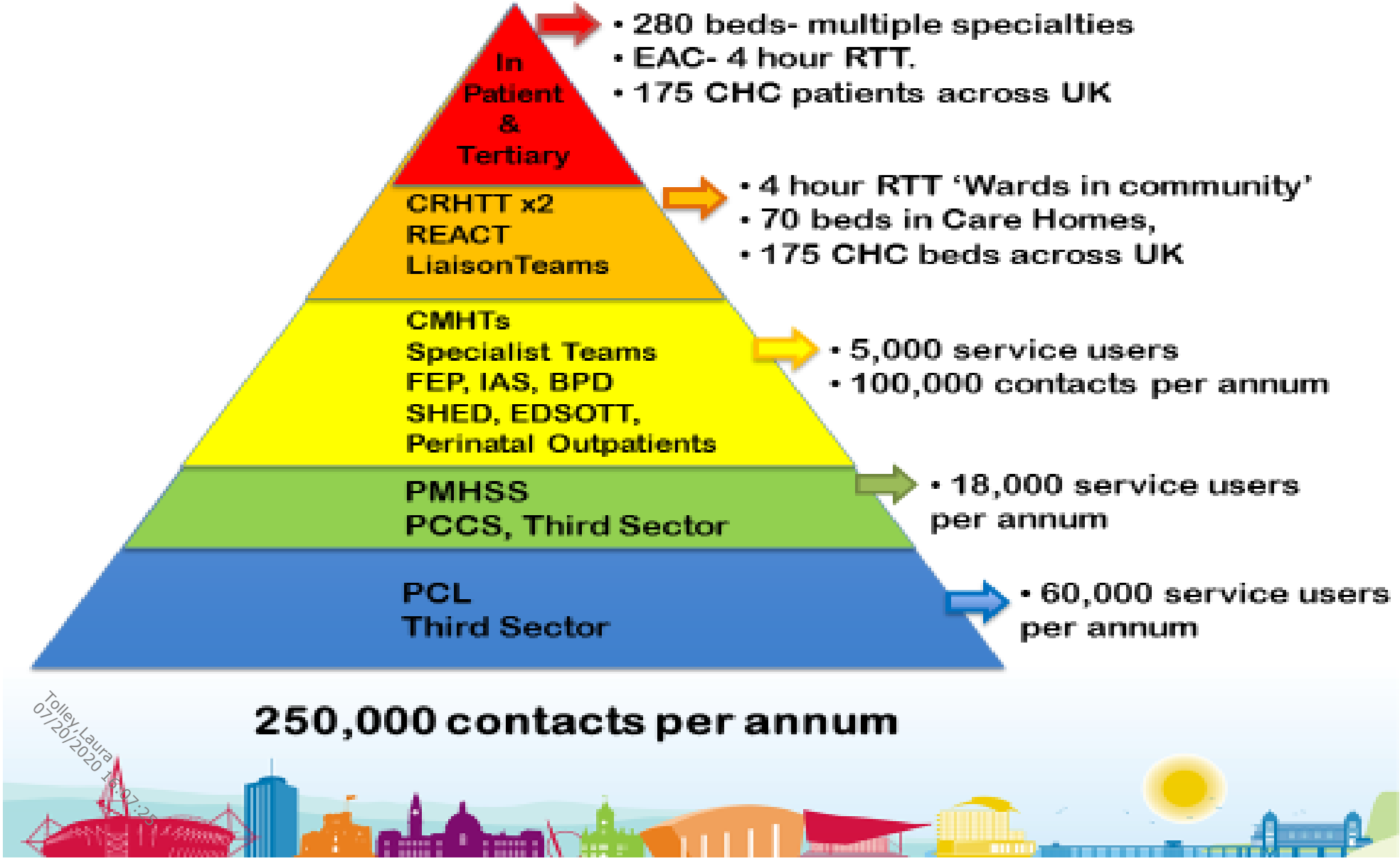
This document provides a suggested framework for the preparation of a C&V recovery/continuity plan for mental health and substance misuse for adults. This document will also be the basis of a consultation document with the Service Users and Carers within Cardiff and Vale and the Community Health Council in the coming months.

The plan will be informed by service user engagement/feedback and available research including from other countries and bespoke studies. The plan will need to be updated and adapted as the situation progresses.

It is suggested that the recovery plan consider the follow matters:

- How and when to begin transition from a Covid 19 state for services towards a new normal operation - recognising further Covid 19 peaks and associated lockdowns may be required and it might be necessary for service to flex their operating arrangements accordingly.
- The stages of recovery, from immediate actions to reinstatement of some services or repurposing staff to considering the medium and longer term
- Identifying changes (particularly innovative and or transformational) made to services during the Covid 19 crisis that should remain and how we establish whether some service models can/should be adopted quickly on an all-Wales basis and gain a consensus for doing so.
- The need to undertake demand and capacity planning which takes account of likely additional pressures on services resulting from the scaling back of services to existing service users, as well as forecasting and stratifying additional demand created as a result of the impact of the Covid 19 crisis on both previous mental health service users and the wider population. It will be important to recognise that an future surge in demand is likely to be problems with 'wellbeing' rather than mental illness per say. Therefore the importance of partnership working with service users and the third sector is of vital importance.
- Identifying available supporting information from a rapid review of the evidence, research and surveys to assist planning (e.g. from previous civil "emergencies").
- Possible solutions to allow current models to meet the likely demand for additional services – including retaining and enhancing general population approaches and self-help options

Cardiff and Vale Mental Health Services



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The strategic recovery plan will supplemented by

- The development of service-specific plans (e.g. perinatal, BPD, FEP) setting out detailed priorities, considerations and issues
- Identification of the risks to the delivery of plan and mitigating actions
- Gathering lessons learnt to inform future emergency/pandemic planning.

2. Supporting/linked work being undertaken

- Welsh Government will be undertaking a review of the Together for Mental Health 2019-22 delivery plan priorities and timescales in the light of Covid 19. The Mental Health Network and respective subgroups will also review planned work streams to assess alignment and where their work can support or be informed by the recovery plan over the next 6-12 months.
- The Welsh Government are sponsoring national research across all UHBs into the patterns of Mental Illness presentation over the coming 1-3years. This research will provide the UHB with real time updates for strategic decision making, be hosted by ABUHB and seek ethical approval vis Swansea University.
- Welsh Government to undertake a review of post pandemic and disaster literature on Mental Illness presentation for distribution to local services
- The Covid 19 Mental Health co-ordination arrangements have supported the identification, validation, preparation and publishing of a range of population mental health and wellbeing resources and on line support packages. It is intended that this work will continue to be developed in partnership with Public Heath Wales and adapted for longer term use where needed to support this recovery plan.
- A range of reviews and surveys are already underway and more are planned to assess the mental wellbeing of the general population and of existing mental health service users. It is proposed that some surveys ask more direct questions about the type of support and help needed.
- There is a regular cycle of remote engagement with Service Users/Carers and the 3rdsector

3. Principles and Ethical/Equality Framework

- All decisions patient centred
- Simplify Access
- Equity
- Dispersal of Resources
- Maintain all services albeit pared back
- Don’t re-start anything without good evidence
- All actions will be subject to EHQIA

4. Recovery Timetable

Action to recover services will need to take place in a number of phases and it may be necessary to regroup or pull back arrangements in response to the future pattern of the pandemic. This plan cannot therefore set a precise timetable but aims to give a guide to run alongside the lock-down and social distancing requirements and pandemic conditions. It will need to take account of modelling on Covid 19 infections being undertaken separately. It will also need to take account of other NHS wide service-wide changes in guidance such as on use of PPE and relaxation of visiting and leave restrictions.

The aim should be to bring services back on stream services and build capacity to cope with demand as quickly as it is safe to do so. However, the recovery plan it should provide the opportunity to assess the impact of some changes to services to enable a considered decision on whether some innovations/changes should be retained. Recovery actions could be considered in the following illustrative phases aligned with lockdown/social distancing restrictions and other conditions. It may be necessary to collapse/merge some phases according to local conditions. Although timescales/phases will ultimately need to follow the nationally determined phasing/traffic light system of recovery, the following indicative phases and timeframes may allow us to develop options for planning purposes.

Service User / Carer Comments	*Recommendation*
One of the most difficult issues to embrace during Covid-19 is uncertainty. Media speculation leads to the expectation that we, as an advanced, evolved and mature society, believe we can control events. Management of uncertainty is difficult because it also involves managing expectations and disappointment. Living with poor mental health frequently means living with uncertainty. Disappointment does not kill people but neglect does so keep us informed.	*A recommendation if possible in this context, make it clear that MH workers have, personally, felt the impact of the pandemic and this informs mental health service delivery. Make this threat an opportunity. If you are serious about involving service users in planning service delivery draw on the experiences of service users on your staff. They are not weakened by their experiences but are more powerful advocates for positive change.* *Contextualise breakdowns in service delivery over this recent period e.g. illustrating staff shortages due to illness/lockdown/bereavement/absence of transport/lack of tech competence or equipment for virtual meetings on the part of service users or staff. Draw on this knowledge and write these probabilities into future responses* *Contextualise potential spikes or second waves of the virus with this info. Tell us what you intend to do based on what has happened so far, and note both experience gained that may alleviate uncertainty in later stages. As we learn to deal with this pandemic we will apply our experience if it recurs in whatever form.* *Consider the positive outcomes of social distancing within different MH conditions, explore how this works differently for individuals. Gather data for research and better understanding of conditions and management of them. Also explore responses to mask wearing, how does that impact on service user engagement in a therapeutic setting. How has it affected interpretation of service user responses in therapeutic settings or triggers for psychotic episodes or sense of protection or isolation etc.*

PROPOSED PHASES

A. Immediate Covid Response - Soon after the confirmed disease peak (but within lock down and strict social distancing constraints) – now
B. Short Period Following some limited relaxation of lock down but with strict social distancing continuing (1-2 months: May – End of June 2020)
C. Some further relaxation of lock down but social distancing continuing (3-6 months: July – Dec 2020)
D. Ending of lock down and some social distancing measures relaxed (6-9 months: Jan 21 Onwards)
E. post vaccine availability – longer term (post 9 months: 2021 New Financial Year)

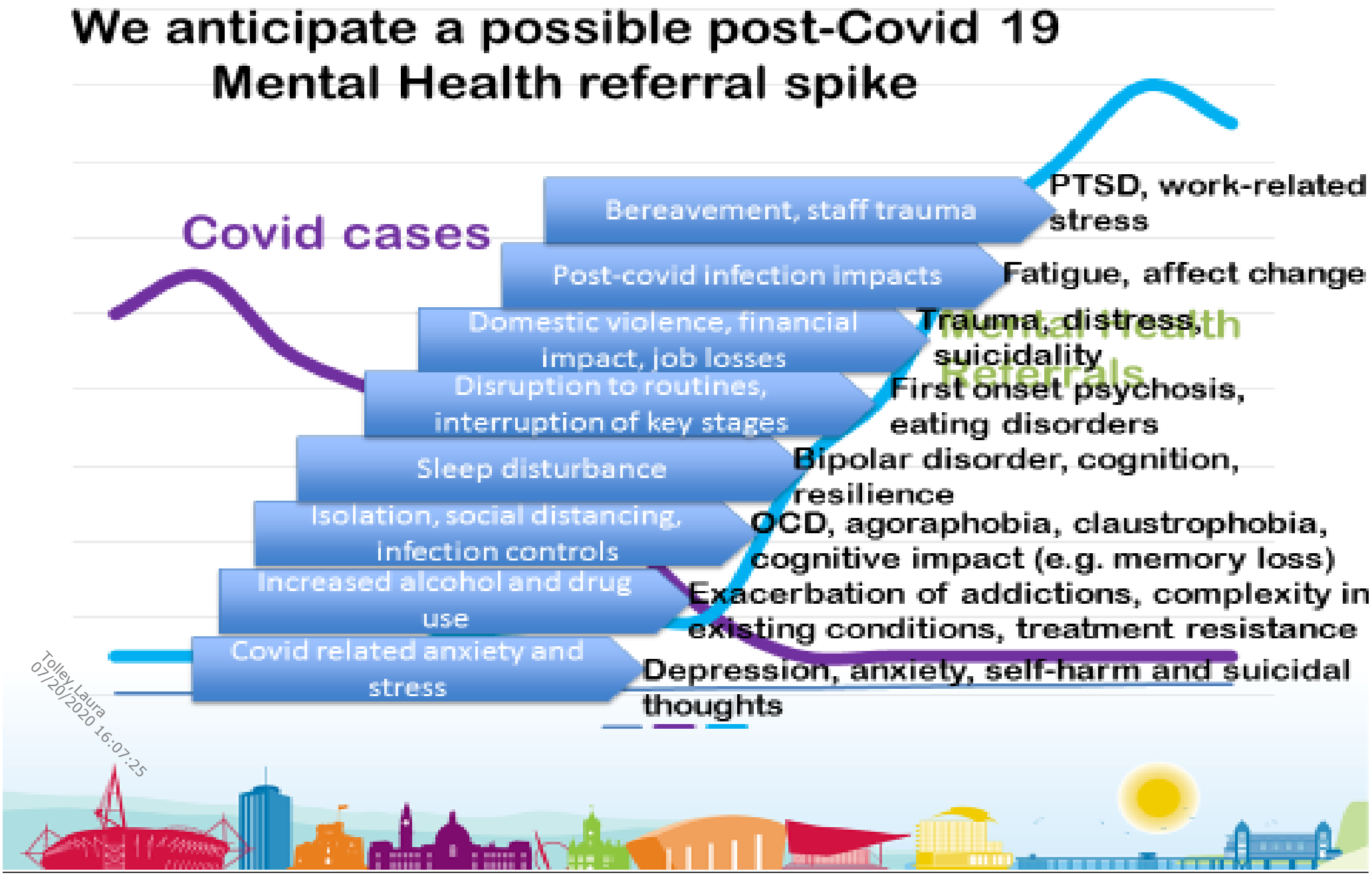
A	Soon after the confirmed disease peak (but within lock down and strict social distancing constraints) - now
Public Protection constraints / UHB Arrangements	Actions to Date
Move from CB Structure to Site Management Structure and PCIC – Site HUBs for UHW, UHL, PCIC and DHH- MH Feeding into UHL, PCIC and DHH	• MHCB to constitute new CB structure to meet twice weekly • Interviews for Deputy CBD and CD posts • Arrange representation on HUB and site meetings • Developed Medical pathway documents to 'consume own smoke' within MH – training provided for MH staff and access to medical support arranged • MHSOC Rota and 7 day Senior clinical nurse cover rota arranged • Separate Junior medical rota completed
Lock down and strict social distancing constraints continue – service saw in the first 10 days of the outbreak at the beginning of April staff losses of over 200 WTE's, cases on MHSOP wards increase to 25 in the first week, and the	Looking at all emergency changes put in place to cope with surge in acute physical care needs to identify if staff should be re-deployed to meet possible changes in demand at the front end of pathways: **Adult** • Covid Positive and Step Up/down wards established in Hafan Y Coed: PINE (11 beds) emptied of elective DTOX unit. Ward prepared and Staff team recruited and trained. Maximum of 3 CV19 patients seen on the 11 beds. • Community Staff moved to support inpatient services in a phased way: In Community services to respond to the staff losses and potential spread of the virus, all emergency referrals centralised to the crisis teams in HYC, all urgent referrals centralised to the three locality bases and routine work undertaken from the CMHT bases. Community caseloads RAG rated for complexity and risk using an RCP tool and resources allocated

dissolution of the CB structures for site hubs.	accordingly. Clozapine and Depot clinics moved to appointment system. Most routine work undertaken by phone, all emergency and urgent work undertaken face to face with PPE. • Use of Digital tech for patient contact commenced: Skype and Attend Anywhere with investment in training and equipment. • Day Hospitals Closed • Community Rehab/FORT team redeployed to CRHTT work MHSOP • 4 covid wards prepared: East 10/12 for covid positive – immobile and mobile patients respectively • East 14 established as male step down and East 16 as female step down – isolation areas established on each ward where needed. Rotas re-written regularly – additional skills training for use of syringe pump, IV and Oxygen therapy. • REACT CRHTT and CMHTs merged flexibly • Day Hospitals Closed • First Episode Psychosis P&PT • Primary Care Liaison: Consolidated both at Global Link and through Home working – moved to cover all clusters and meeting all demand from PC via phone and digital platforms – significant anxiety/depression/domestic abuse/frustration seen • PMHSS and Primary Care Counselling: Merged into a SPOE to avoid queue system for counselling. Managing demand from core team based at Hamadryad and Home working – all work undertaken by phone • The IAS have kept one office for staff to access as needed for printing of reports, letters, making confidential telephone calls etc. the rest of the IAS offices and consultations rooms etc. are being used by other services; Headroom, Midwives and tethering PC's for PC Liaison service. • Veterans NHS Wales • Therapy being delivered successfully via Skype. • Dragon's Heart Hospital • Work continuing to provide a psychological support hub for DHH. Further clarification from UHB Executives requirements needed. Possible requirement for other disciplines to join the employee wellbeing hub. Some discussions held regarding input from Liaison Psychiatry that require further dialogue with the Adult Directorate and the MH Clinical Board.

B. Short Period Following some limited relaxation of lock down but with strict social distancing continuing (1-2 months – May & June 2020)

Inpatient Configuration - As the spread of the corona virus in hospital recedes, the Adult and MHSOP Directorates will be required to decide how best to use to offer its current covid 19, wards capacity. Both Directorates will need to be mindful of the potential for a second peak in the virus and how to both accommodate this possibility alongside the reinstatement of 'new normal' services'.

Demand and Capacity Modelling to support local recovery planning


We anticipate a possible post-Covid 19 Mental Health referral spike
Covid cases
Mental Health Referrals
Bereavement, staff trauma
PTSD, work-related stress
Post-covid infection impacts
Fatigue, affect change
Domestic violence, financial impact, job losses
Trauma, distress, suicidality
Disruption to routines, interruption of key stages
First onset psychosis, eating disorders
Sleep disturbance
Bipolar disorder, cognition, resilience
Isolation, social distancing, infection controls
OCD, agoraphobia, claustrophobia, cognitive impact (e.g. memory loss)
Increased alcohol and drug use
Exacerbation of addictions, complexity in existing conditions, treatment resistance
Covid related anxiety and stress
Depression, anxiety, self-harm and suicidal thoughts
Tolley, Laura
07/20/2020 16:07:25

The effective management of all health services require robust demand and capacity modelling to be regularly reviewed. Whilst in the crisis period of Covid 19 referrals to services have reduced (sometimes significantly); for some elements of the MH services, there was already a waiting list at the point of lockdown. In order to inform recovery planning to allow informed decisions on resource enhancement and redeployment, as well as risk and "expectations" management, it is important that this work begins urgently. Service leads should be asked to indicate whether they have the capacity and skills to undertake this work for all elements of their services or whether extra support is required so that this can be provided.
As a starting point, LHBs should explore:

- What are the existing waiting lists? What does the demand and capacity modelling tell us about the length of time to get back to "target" times from existing waiting lists?
- What does the fall off of referrals tell us about pent-up "normal" demand? I.e. if the usual referral rate over the "lock-down" period translated into a surge, what would that look like and how would services cope? How do we 'FLATTEN THE ANTICIPATED MENTAL HEALTH CURVE'
- Does any of the research/evidence base from a range of sources tell you about the degree and type of the Covid 19 pent-up and new demand? This should include any evidence from countries ahead in the Pandemic cycle.

Planning for additional/new demand – what information can help us?

Whilst we may be able to assess and plan for 'pent up' or delayed "normal" levels of demand and make some assessment of the needs of those with existing mental health conditions that have been exacerbated by the crisis, it will be necessary to take views and evidence from a range of sources on the nature and needs of additional demand for wellbeing and mental health support.

Information Sources:

It may be possible to stratify the possible causes and sources of information given what we know e.g. about the make-up of the employment market i.e. in Wales the Public Sector is the largest employer, with SMEs second. As part of the 4-6 week forecasting of demand Lightfoot are meeting with the MHCB shortly to offer support in thinking through this and how information is collected and used for planning purposes:

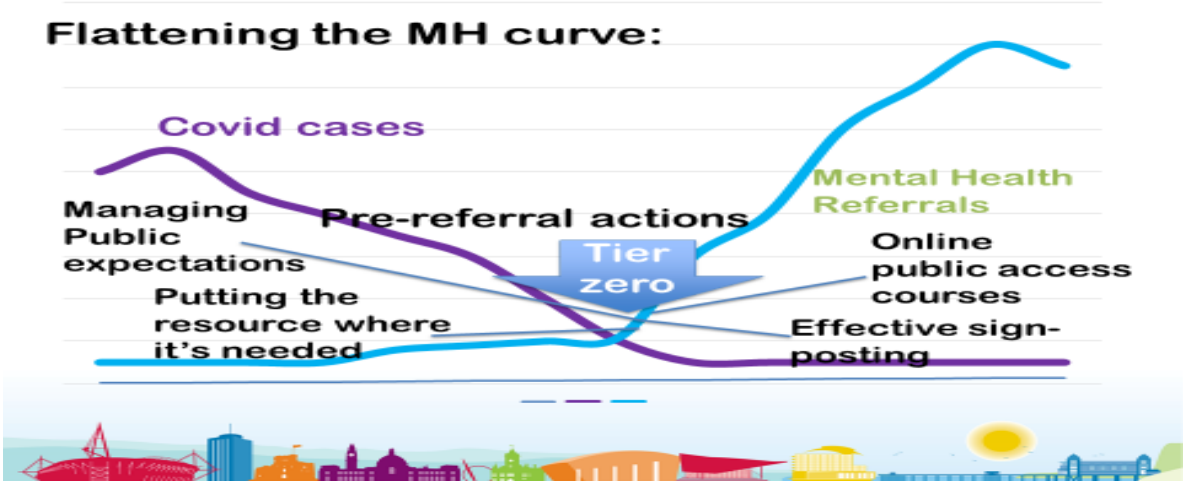
Impact	Data Source
Economic – loss of employment, bankruptcy, debt	Fed of small business DWP ESNR information

	Debt advice
Bereavement	Pattern of deaths, CALL, CRUSE and other voluntary sector sources
Domestic Abuse	Police Data / Domestic Abuse Agencies / CALL Line /
SUIs	Local and National
Local Referral Demand and needs profile	PCLT / PMHSS / PCCS / CMHTs / CRHTT /16 activity / 3rd Sector/stepiau website and other MH website hits

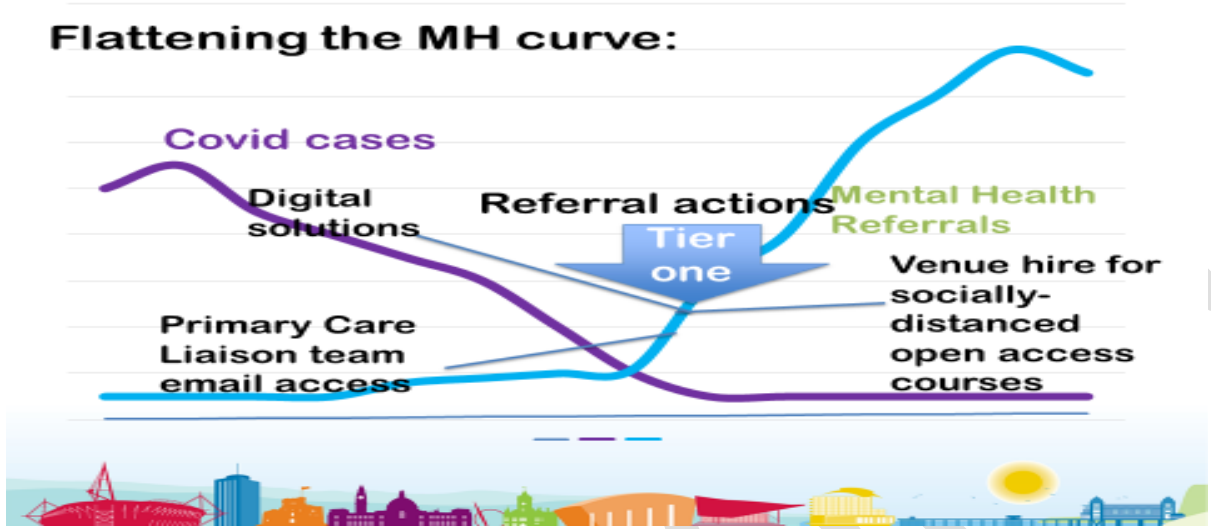
Meeting the Demand - What services should we consider planning now to enhance to mitigate the effects of Covid 19 over the recovery phases?

From early surveys and existing knowledge we can plan on the basis of a reasonable assumption that we will need to expand certain elements of MH services. In the main, this is likely to be around the lower tier services model to allow the minimum and earliest intervention possible. This response should include a wide population based approach as well some more targeted and specialist services, with a particular focus on primary care. As a starting point, the following services should be considered for early expansion:

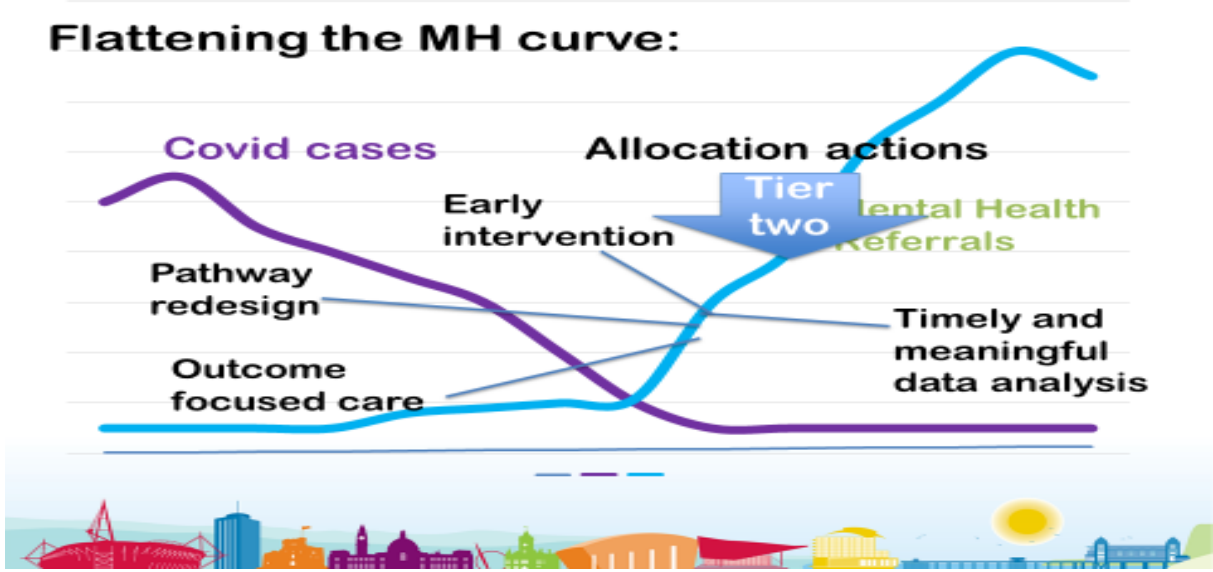
TIER 0



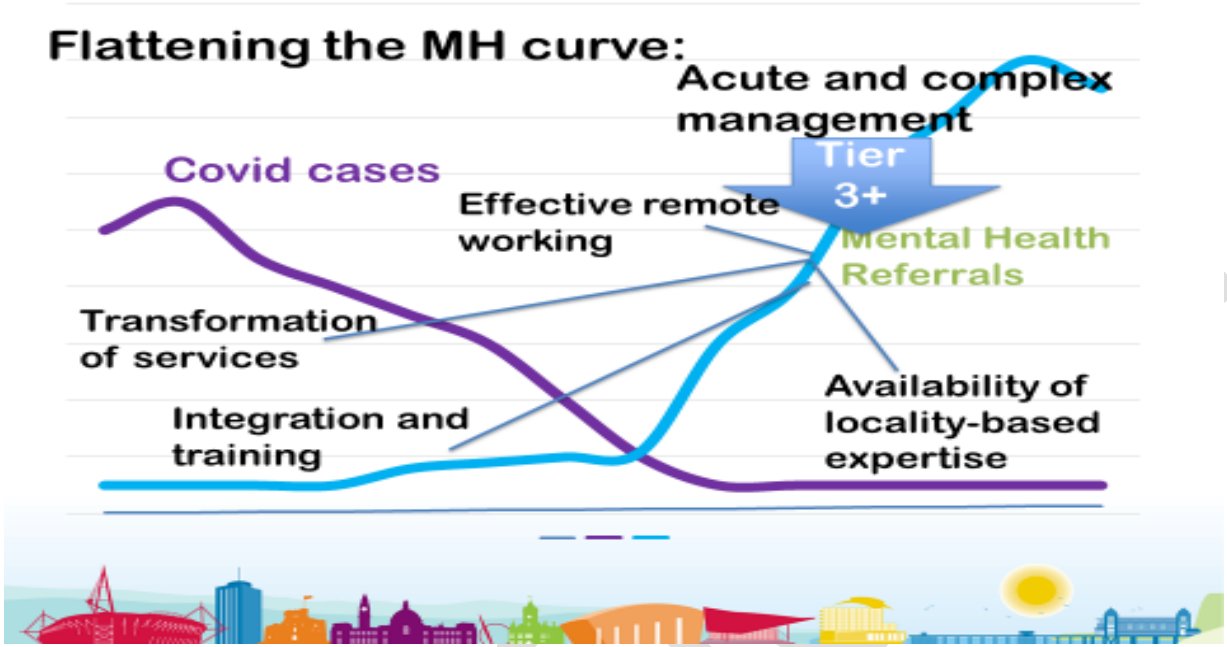
ACTIONS AT TIER 1



ACTIONS AT TIER 2



ACTIONS AT TIER 3



Demand Management preparation at Tier 0 and Tier 1

Demand Management - Community resilience and voluntary organisations Tolley, Laura 07/20/2020 16:07:25	Reduced waiting time for assessment and support Avoid medicalising healthy well-being responses to a health crisis by enabling projects to support community resilience	With the Support of Lightfoot, establish a monitoring method for real time referral activity into mental health to ensure demand is being tracked – to support decision making on resource allocation to meet the demand – May/June 2020 Primary Care Liaison team to establish a Mental Health website address to seek support - Completed P&PTs to work nationally with Jim White to establish a UK stress control pack – **Completed** To maintain all elements of the current services – albeit pared back and delivered by different methods – **complete**	The impactof the CV19 on the mental wellbeing will be seen as a Mental Illness Issue rather than community resilience. To	All P&PT DM 3rd Sector Organisations All Dir Of Ops & MH

	People in Cardiff and Vale have early as possible access to mental health support if needed to flatten a potential 'mental health curve' and prevent storing up more complex problems	For the CB to work with the National Program Director for Mental health in the WG to access a review of evidence related to post disaster mental illness presentation to inform demand management – **Completed and circulated to all partners** CB to participate in National Research to monitor MH impact over 3-5 years – **Ongoing IW Principal Lead** Review options for expanding capacity to meet need and present to Clinical Board – To include expansion of 3rd sector contracts, shifting resources and a specific Covid related service – **May/June 2020** To investigate the feasibility of a specific mental health covid helpline to divert all covid related mental health demand towards and ease pressure on generic services – the support model potentially on offer is being piloted in Pentwyn currently and offers a tiered range of interventions	enable support to get to those communities.	Research Lead Dir of Ops – Principal Investigator Dir of Ops Commissioning Lead DM s Dir of Ops

Service User / Carer Comments	*Recommendation*
Demand Information	*'interrogate the evidence base for the nature and degree of pent up demand – look at evidence from other countries ahead in the pandemic and local demographics'* *'Evidence that hitting people hardest in poverty (coronavirus: Mental Health in the pandemic, 2020) '* *'Wales faces the relative poverty rate in the UK – look to poverty experts such as the Bevan Foundation, Oxfam Cymry, WG Cross Party Group on Poverty etc.'*
Inpatients	*Were any/enough specialist beds made available for patients experiencing poor MH episodes or with existing conditions combined with Covid 19 infection, in secure conditions? With appropriately trained staff. Was this viable during peak infection? Were service users made aware of this availability? Were staff and service users adequately protected and secure?*
Outpatients	*Has the change in systems eg management of appointments engendered a sense of calm and orderliness in services or, once staff adjusted, had a different impact, both on staff and service users e.g. confusing and unsettling?* *Anecdotal feedback from non-emergency service users has been that most appointments have been organised more efficiently, therapy has been more effective and reassuring.*
Planning for Demand	*How helpful are behaviours of other nations in forming MH services, taking into consideration sociocultural factors and timescales of*

	development of the pandemic? Do we use the same data for realistic comparison across the world which makes this research valid? *Is the range of national decisions too great or variable for any useful comparison? Is there immutable evidence that any action has a positive effect of suppressing contagion whilst maintaining accessible supportive mental health provision?* *As we are still gathering data and will do so for years, current recommendations need to be elastic to adjust to responses to Covid 19 as hard (and soft) information becomes available. Current planning is speculative. We have to embrace informed uncertainty but remain flexible and reactive as the virus may remain a threat for many years. How do you define the "recovery phase" in mental health terms? Probably beyond the scope of this plan. <u>This qualification should be made clear at the beginning of the document</u>* *Service users might want reassurance that if staff are working from home (while consulting with them), can confidentiality of their information be guaranteed still? E.G. could conversations be overheard by other members of the staff's household; data storage security etc?'*

C&D. Some further relaxation of lock down but social distancing continuing (3-6 months – July – Dec 2020) & Ending of lock down and some social distancing measures relaxed (6-9 months – Jan 21 Onwards)

Post Covid recovery plan. What are the opportunities, developments and challenges ahead? Needs to be in Partnership via the TFMH Forum and SU/Carer led

Innovation	Patient Benefits	Actions and Timescales	Risks & Mitigation	Directorates Involved / Lead
1. Single locality points of access for PCCS & PMHSS via PMHSS.	Improved GP access to PCCS Reduced waiting lists in PCCS Simplify Access for Service Users Reducing clinical waits and increasing access to self-help, therapeutic groups and one to one CBT via PMHSS for PCCS referrals is likely to benefit service users accessing a range of primary care-based therapies. Meets Locality /Cluster UHB Strategic Direction	During covid to centralize all referrals into PMHSS and PCCS with PMHSS to screened and triaged at a single point of locality access - **completed** Evaluate this SPOE with support of the WG 'rapid review' process in partnership with practical Solutions company – **June & July 2020** Closely monitor referrals into these two services from pre-covid (combined 1600 pm) – whilst monitoring impact of the new PCL team on referrals into these two services. To provide capacity where required based on the hypothesis that the post covid referrals will reduce - **Ongoing**	Potential to breach the Tier 1 PMHSS Targets when referrals beging to increase – this is currently unknown with an additional possibility of a surgein MH referrals	Psychology and PTs & PCIC HUB
2. Agile/ Home working tech opportunities for staff to reduce dependency on office accommodation:	More options for Staff, Service users and carers in receiving therapeutic care and assessment. Dellcovid laptops have been very popular.. Flexibility to access Wi-Fi around different health sites has benefitted specialist services who have less need to return to base making their work more effective and has enabled better social distancing. The limited availability of netbooks has also been popular with staff. There have been some complaints about the network stability and absence of video conferencing options.	Exploration of netbook purchases for specialist services and similar pooled resource for community teams to enable better social distancing, more efficient agile working and home working options. **Ongoing**	Homeworking experience has been excellent. Only drawbacks mentioned were that there is no skype function on the computers	All via Dan Crossland Head of I&T
3. Video conferencing, digital clinical working. / video assessments and written online / silver	Psitive feedback (Zoom based Perinatal baby massage group for example) for video,. Improving the ability of teams to engage in teleconference means a different approach to how technology is purchased in the future. Positive feedback from staff groups about the use of skype in meetings to improve communication and as a future development, attending ward rounds / MDTs virtually has been positively encouraged by generic and specialist teams to	A largescale purchase of equipment for all areas of camera and headsets, monitors with integrated cameras, microphones and speakers are preferable to support roll out without exchanging desktops for laptops. Will await advice from digital lead on return from leave and develop a plan for how this can be evaluated across clinical boards. – **Ongoing during May and June 2020**	there have been reported difficulties in some areas (Psychology and Counselling) where they are awaiting early roll out of Attend Anywhere	All Directorates Dan Crossland Head of T&I

cloud & Attend anywhere	reduce unnecessary travel time and to improve regular attendance.	WG requested to undertake a 'rapid review' of the impact of digital technology for clinical work – **Accepted and to undertake June/July 2020**	The hardware to support the roll out is limited, 15 dual screens have been provide along with a limited supply of cameras and headsets and iPads.	
4. Reviews of Community Services referral pathways / OPAs & chronic condition management / RAMP / RAG Rating of Caseloads	Simplified access for GPS and Sus & Patients will be seen by the right person Reduced duplication and delay in care & Improved care for chronic mental and physical health care Clearer communication & Swift pathways of care Drugs for Dementia model works effectively Use of technology – less travel Standardise Community referral and care and treatment pathways	**Programmes of work initiated** to locate locality based services where possible such as: 7 day availability, location of Emergency referrals, a review of Outpatient efficacy and value in the context of RAMP - aim to Reduce low value OPAs attended where safe and appropriate and provide choice and alternatives with the availability to the flexible MDT – including Physical HC Regular Review of caseloads using a recognised tool such as RCP IT systems – PARIS report – solution for MHSOP	RAMP poorly understood andtoinclude training and awareness raising to all staff	Aduil and MHSOP Directorates SU and carers CHC MHCB
5. In Patients flow – identified as having uni-professional professional approach with delayed decision making and over dependency on hospital provision	Inpatient flow in adult services requiring MDT approach and regular decision making forum - with resource allocated to flow – in partnership with the CCCTeam Timely and Improved inpatient stay – reduced delays Support in a crisis Safe discharge process	Introduce regular MDT decision making opportunities into in patient flow - Re-introduce Board Rounds where appropriate – use of Grand Ward rounds : review format, length and timetable for ward rounds – **May /June 20** Increase SALT provision for Dementia wards – **Business case June 20** Clarify role and function of REACT team in MHSOP – **by July 20**		Directorate Leads MHCB
6. Review Day Services availability based on service	Improve communication Faster decision making Increased available clinical time, less travel for staff & SUs	**Establish working groups to consider where appropriate:** • 7dpw working		Directorate Leads

	user & carer need	Avoid crisis in Community Focussed treatments in day care Availability based on service user and carers needs not the services historical provision	• To support MHSOP patients as part of crisis service • CHL support in ARU • Improved flow to Grand Avenue • Respite facility • Alternative to daily REACT visits for period of time • Review Transport (Carer drivers?) • Role and function of CRU		
7.	Physical Healthcare – more blended approach particularly between MHSOP and Medicine CB	Patients can remain on MHSOP wards and not transferred out to MEAU / Medicine wards for all Physical needs. Patients cared for in familiar environment Co-morbidities cared for together Upskilling staff – helps with staff wellbeing, job satisfaction and retention Closer working with Medicine service	Physical Health Senior Nurse post filled - **complete** Training programme with LED / Medicine – **June /July** Programme for competencies (staff passport?) OOH Support Data collection around physical health changing needs R&D opportunity	Common vision for integred model with MCB	DM – MHSOP DM-Adult
8.	Complex Care Commissioning Team - Direction of travel & partnerships and decision making tools	170/80 service users in CHC OOA placements require appropriate specialist care from an MDT in a timely manner. In addition anyone with complex needs in local hospital provision requires seamless discharge. Currently this provision is patchy. Decision making currently is not based on	For the MHCB to establish development arrangements to address these long standing issues with an aim to: • Decide the MDT model of care – case management provision • Recruitment and retention to the team • Standards for service delivery • Partnership agreement over placement decision making tools	Partnership agreement inhibited due to cost implications – escalate to board partnership forum	CCCT DON DOO

Rapid Review Methodology (referred to in the Action Plan)

A specification, methodology and vehicle for these reviews is under urgent consideration but should include perspectives from both staff and service users/stakeholders as well as any available performance, outcome and financial data. Voluntary sector input will be important to this work and arrangements are underway to provide some early feedback on experiences. The WG have agreed to participate with C&V MH services to review the Primary Care SPOE and The experiences of people giving and receiving digital MH care and treatment.

We will also need to consider whether and to what extent CHCs should be engaged or informed (recognising that they have not played a part in the Covid 19 emergency changes for mental health services

Other Current Initiatives /Innovations

- Recovery College
- Open Dialogue
- SU Engagement Post /Coproduction
- BAME Accreditation
- Crisis Care Concordat
- Care Aims
- Prison Transformation
- Patient transport
- Trauma Missing Middle
- PICU Expansion
- Dual Diagnosis Action Plan
- Trial of Bodycams to reduce patient and staff injury

Service user and Carer Comments	*Recommendations*
Geographical spread; for urban and rural areas, reflecting impact on social distancing and access to services in the light of changes to business/transport etc. *Transition from existing services to "new normal" services; establish overlap/recap period ensuring continuity.* *Consider endings, beginnings and continuity of services with provision to pickup again if necessary rather than have*	*SU C encourage service users and carers to attend routine appointments again and be reassured it is safe to do so – reassure about handwashing and social distancing'* *'Agree not to pathologize normal stress responses'* *'Increase the potential of lower tier innovations'* *Cavamh on line forum is a good place to chat – low level peer resilience coaching model'* *'Organisations like Headspace and Calm offer people low priced Apps to help manage situational distress'* *Considering new channels of communications with flood of new service users who are unfamiliar with availability and means of accessing services online or phone, remotely, but not neglecting face to face engagement which may be more resource-heavy.* *Consider changes, substance misuse, accessibility to substances and opportunities to use, has there been any baked shift? This may be an area for research.*

to start new therapy all over again. *Service delivery first points of contact - how do GPs accommodate increased demand for MH services without additional training and resources ? Would the larger model of combined healthcare centres with a more developed, dedicated MH facility for initial assessments and outpatient therapeutic support, combined with wellness facilities at e.g. leisure centres improve service delivery?*	*PTSD impact statement and forecasting; assessing impact of isolation* **Perinatal care** *explore potential increase in fear of accessing healthcare because of potential infection; adding anxiety on top of anxiety - lock into service contacts on wards/teams encouraging them to consider and communicate need for regular physical health checks in safe environments for vulnerable patients. Monitor situation, with feedback loop to MH services via wards.* *Can we use this situation to instigate further training and better communication between services as a longer term objective?* *The above applies to all MH service users manifesting physical symptoms too, eg self harm, substance misuse etc. where service users may choose not to seek treatment from A&E because of fear of viral infection. By addressing these issues now we can alleviate the potential of more serious harm as physical and mental health worsens longer term. Also impacts on planning.*
In addition to Welsh Govt/C&V endorsed MH and Wellbeing activity there are abundant apps and online resources on broadcast, written and social media. In a heightened or low state, in isolation, it can be difficult to pick through what is relevant and what is potentially harmful, which are free or have hidden costs. There is an increased burden on the individual is to be well and coping, or expressing negative responses to Covid 19, with attitudes more polarised than usual. These extremes are fed by online activity and peer pressure to conform. What support is available to enable a person to pick their way through excessive "wellbeing" pressure? Is this an information/communication issue to be addressed in a wider context - mental health week, information announcements,	*Immediate and short term action: encourage the Welsh Assembly Government to publicise a message "It is understandable if you are not coping at the moment, many people are finding things difficult…" or similar … with information about how to contact people for mental health support via a centralised telephone number and online (Training and capacity, safety and security issues) Staff/volunteers, MH trained to manage calls and know where to signpost. It is crucial that volume of calls can be met supportively if this service is to be effective.* *Straying into micro managing here but persuade Welsh Govt to set up the call system… this is an opportunity to engage people who have been furloughed by providing a positive skills development opportunity and activity during this difficult time. Also potential capacity building for MH staff training or in education or peer support, to develop experience and improved service delivery in the long term; rolling a problem and meeting WAG commitment to MH service delivery to improve the overall wellbeing of the people of Wales in the longer term (even with the current challenges we are facing in this pandemic).* *<u>Research outcome</u>: this service may also contribute baseline information about state of mental wellbeing within the Vale and wider* *<u>Costs</u>: Consider approaching organisations/business wanting to publicise Corporate Social Responsibility covering their marketing at this time e.g. through Public Health Wales.* *Happy to discuss this further if you are interested but do not want to derail basic service delivery and planning.*

via policy making?	

5. RESOURCING & ENABLING FRAMEWORKS - CAPITAL INFRASTUCTURE

The following capital schemes are key enablers to support our clinical board priorities are in progress:

Major Capital or Discretionary Capital Requirements – To Be Completed

6. WORKFORCE IMPLICATIONS

To be completed

7. GOVERNANCE & DELIVERY

To be completed

8. ENGAGEMENT - Key schemes for discussion with CHC/ Public in 2020

The MHCB with Cavamh has now established a fortnightly digital meeting ongoing until further notice to maintain continuous engagement with service user and care groups. Through May and June 2020 the MHCB has been developing a health focussed plan from its directorates and clinical board as the basis of a discussion with partners to enable a whole system recovery plan from Covid 19 to develop. This has recently been shared with the Community Health Council (June 2020) to consider the service changes that will need support, consultation and engagement. Comments from the CHC, SUs and Carers are being fed directly back into this plan prior to recirculation. The Community Health Council feedback on the plan has been initially positive with a request to summarize the headlines of the changes for them and identify where support and or engagement is required.

9. Glossary of Terms

Acronym	*Description*
1. ARU	*Assessment and Recovery Unit – acute day services for older people based in UHL*
2. BAME	*Black and Minority Ethnic*
3. BPD	*Borderline Personality Disorder*

4. CA	*Care Aims*
5. CALL	*National Mental Health Call Centre*
6. CB	*Clinical Board*
7. CBD	*Clinical Board Director*
8. CCCT	*Complex Care Commissioning Team*
9. CD	*Clinical Director*
10. CHC	*Community Health Council – watchdog organisation for health services*
11. CHC	*Continuing Health Care*
12. CHL	*Care Homes Liasion – Linked to MHSOP Services*
13. CMHTs	*Community Mental Health Teams*
14. CRHTTs	*Crisis Resolution and Home Treatment Teams*
15. DETOX	*Detoxification – PINE Ward in Hafan Y Coed*
16. DHH	*Dragons Heart Hospital*
17. DOO	*Director of Operations*
18. DON	*Director of Nursing*
19. DWP	*Department of Work and Pensions*
20. EAC	*Emergency Assessment Clinic – based at Hafan Y Coed*
21. EDSOTT	*Eating Disorders Specialist Team*
22. EHQIA	*Equality Health Impact assessment*
23. FEP	*First Episode Psychosis – Headroom based at GlabalLink*
24. FORT	*Community rehabilitation team*
25. HYC	*Hafan Y Coed*
26. IAS	*Integrated Autism Services*
27. IT	*Information Technology*
28. LA	*Local Authority*
29. LED	*Learning and Education Dept*
30. MDT	*Multi-Disciplinary Team*
31. MEAU	*Medical Emergency Assessment Unit*
32. MHCB	*Mental Health Clinical Board*
33. MHSOC	*Mental Health Silver On Call*
34. OCD	*Obsessive Compulsive Disorder*
35. OD	*Open Dialogue*
36. OOHs	*Out of Hours*
37. OPAs	*Out Patient appointments*
38. PCCS	*Primary Care Counselling Service*
39. PCIC	*Primary and Intermediate Care Clinical Board*
40. PCLT	*Primary Care Liaison Team – Works out of GP practices*
41. PICU	*Psychiatric Intensive Care – based at HYC*

42. PMHSS	*Primary Mental Health Support Service – Associated with Tier 1 targets in MH*
43. PPE	*Personal Protection Equipment*
44. PTs	*Psychological Therapies*
45. PTSD	*Post Traumatic Stress Disorder*
46. RAG	*Red Amber Green – rating scale often used to assess complexity or progress against action plans*
47. RAMP	*Rapid Assessment Process – initiated to support an improved service for people with ongoing needs in cmhts*
48. RCP	*Royal College of Psychiatrists*
49. REACT	*MHSOP Equivalent of the Adult Crisis Teams*
50. RTT	*Referral To Treatment – associated with performance measures popular with NHS services*
51. SALT	*Swallow Team*
52. SHED	*Specialist Eating Disorders Team*
53. SPOE	*Single Point of Access*
54. SUIs	*Serious and Untoward Incidents*
55. TFMH	*Together for Mental Health – Welsh Strategic Plan for Mental Health*
56. UHL	*Llandough Hospital*
57. UHW	*Health Hospital*
58. WG	*Welsh Government*
59. WHSCC	*Welsh Health Specialist Commissioning Team*
60. YOD	*Young onset Dementia – team based in Barry Hospital*

Report Title:	**MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT**						
Meeting:	**Mental Health and Capacity Legislation Committee**				**Meeting Date:**	**21/7/20**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**For Information**	√
Lead Executive:	Medical Director/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 12 years. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

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

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

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

- Patients refusing treatment that they need and their refusal being taken at face value, with no assessment of their capacity to make the decision 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 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 on hold
- "Mandatory May and November" training, Senior Medical Induction and some Clinical Board Nurse Foundation Programmes – currently on hold
- Bespoke training on request
- The All-Wales MCA e-learning course is available for use on ESR

Information and advice

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

Policies and procedures

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

Additional information

Use of MCA within the UHB

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

Independent Mental Capacity Advocacy (IMCA)

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

It is disappointing that the IMCA service still, 12 years after MCA came into force, reports that clinical staff lack basic understanding of MCA – e.g. how to determine best interests. There may be a link with the low uptake of MCA training by medical staff.

Court cases involving MCA

The UHB has made applications to Court; 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 –

United Lincolnshire NHS Foundation Trust v Q [2020] EWCOP 27

This case concerned a 57-year-old woman, with profound and lifelong learning disabilities together with epilepsy. She also had impaired eyesight and was registered blind. The issue at stake was whether it was in her best interests to be given dental treatment under general anaesthetic.

A NHS Foundation Trust v MC [2020] EWCOP 33

This case was about whether it was in the best interests of a person, who lacked the mental capacity to decide for herself, to donate stem cells. A young woman aged 18, was a potential donor for her mother, who had chronic leukaemia.

ASSESSMENT

Whilst there are individual clinicians and service areas that have developed an understanding of MCA and comply with it, the position is not uniform across the UHB: there is still some way to go until MCA is embedded in clinical practice. 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 MCA, which can only be done by scutinising patients' notes.

The report of the MCA Manager (appendix one) and IMCA report (appendix two) 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:	~~Yes / No /~~ Not Applicable If "yes" please provide copy of the assessment. This will be linked to the report when published.

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION

July 2020

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/4/19 – 30/6/19	34
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

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

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

Referrals from the UHB to IMCA are as follows:

Decision/Issue	Jan – March 2019	April – June 2019	July – Sept 2019	Oct – Dec 2019	Jan – Mar 2020
Accommodation	16	12	14	16	14
Adult Safeguarding	4	0	2	1	0
Care Review	1	3	5	1	1
Serious Med T/ment	7	8	10	9	3
DoLS s.39A	0	0	1	0	0
DoLS s.39C	0	0	0	0	0
DoLS s. 39D	8	8	6	6	7
DoLS RPR	30	65	89	81	90
TOTAL	**66**	**96**	**127**	**114**	**115**

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

Whilst referrals for serious medical treatment, adult safeguarding and care reviews remain low, those for IMCA to perform the RPR function under DoLS have increased significantly. This is putting the IMCA service under strain.

3) Healthcare Inspectorate Wales (HIW) reports

HIW published three inspection reports about UHB services in the period January to June 2020 – Sam Davies Ward, Barry Hospital; Welsh Spinal Cord Injury Rehab Centre, Rookwood Hospital; and the Maternity Service, UHW. The only reference to

MCA was in relation to Sam Davies Ward, where HIW identified that staff should record the reason for applying for DoLS authorisation. However, this is not a statutory requirement under MCA.

None of the reports made mention of whether clinicians were complying with MCA regarding treatment and care.

4) Complaints from patients/carers

One complaint regarding clinicians' failure to comply with MCA was brought to the attention of the MCA Manager since the last report. However, it is very likely that there are other complaints in this period which include MCA issues.

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

The January to March 2020 Casebook has not yet been published.

6) Staff MCA training as at 30th June 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.

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	112	100	89.29
	Nursing & Midwif	1169	955	81.69
	Medical & Dental	210	74	35.24
CD&T				
	Allied Health Profs	732	576	78.69
	Nursing & Midwif	42	37	88.10
	Medical & Dental	104	43	41.35
Medicine				
	Allied Health Profs	3	2	66.67
	Nursing & Midwif	832	585	70.31
	Medical & Dental	289	62	21.45
Mental Health				
	Allied Health Profs	32	27	84.38
	Nursing & Midwif	531	385	72.50
	Medical & Dental	76	16	21.05
PCIC				
	Allied Health Profs	85	70	82.35
	Nursing & Midwif	353	272	77.05
	Medical & Dental	62	18	29.03
Specialist				
	Allied Health Profs	34	33	97.06
	Nursing & Midwif	856	635	74.18
	Medical & Dental	235	35	14.89

Surgery				
	Allied Health Profs	16	14	87.50
	Nursing & Midwif	453	330	72.85
	Medical & Dental	485	113	23.30

APPENDIX 2

Mental Health and Capacity Legislation Committee

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

IMCA referrals

Total number of referrals received from Jan 2020 – March 2020 – 115 Referrals

- Serious Medical Treatment – **3**
- Long Term Move of Accommodation (LTMA) – **14**
- Adult Safeguarding – **0**
- Care Review – **1**
- Relevant Person's Representative (RPR) – **90**
- IMCA 39d – **7**
- IMCA 39C – **0**
- IMCA 39a – **0**

Service issues/Areas of concern

- General lack of 39A, Care Review, Serious Medical Treatment and Safeguarding Referrals.

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

- Issues around DoLS –

    - DoLS authorisations backdated to time of assessment rather than dated when Supervisory Body signs authorisation
    - IMCA team receiving DoLS authorisations/RPR referrals when they have been active for weeks, or the authorisation is about to expire, or when P has already been discharged from hospital (leaves little/no time to act)
    - DoLS Team insisting RPRs attend Best Interest Meetings relating to LTMA when there are no issues and family are appropriately involved

- 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 about the best interests decision.

- Inappropriate referrals for LTMA – family involved in the care already and family has been invited to the best interests meeting.

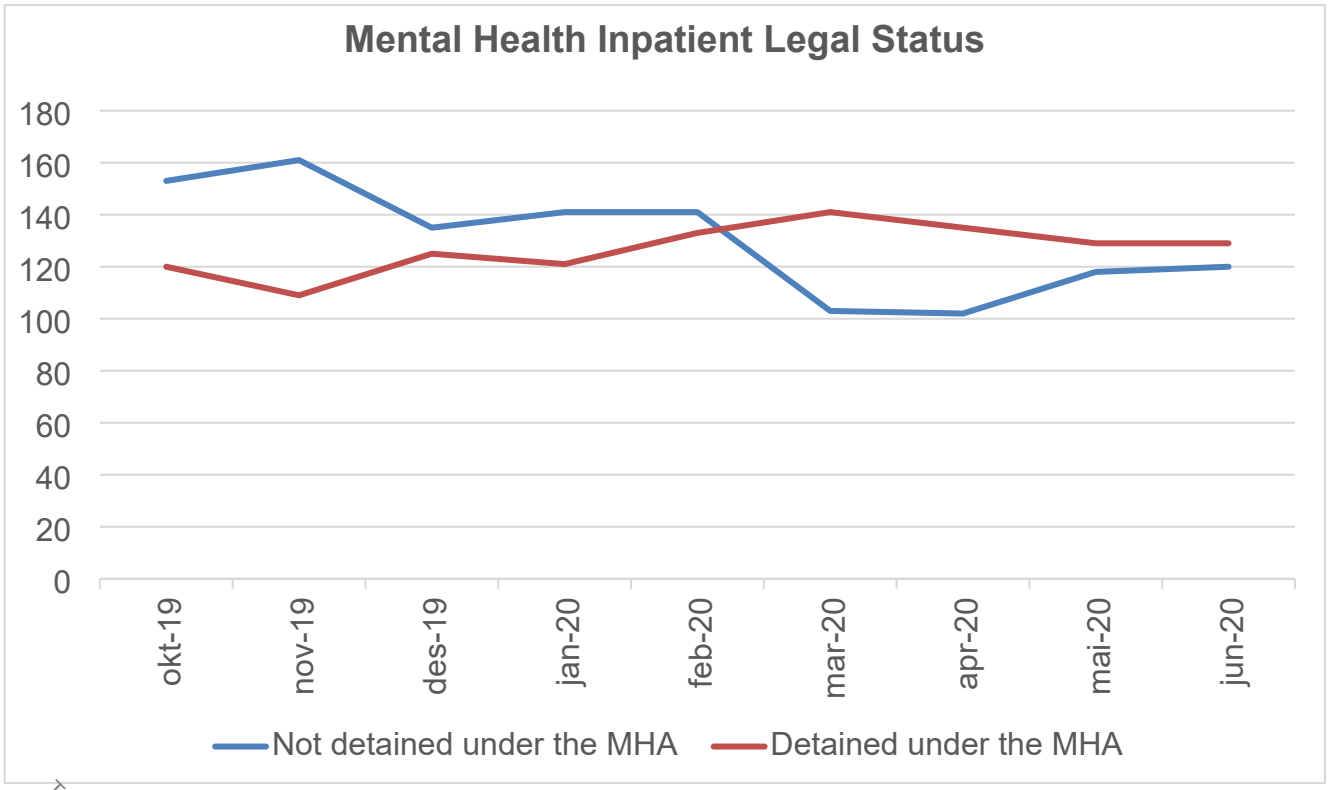
Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**21 July 2020**		
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**				**x**
Lead Executive:	**Chief Operating 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 51%.



Fundamentally defective applications for detention under Section 2, Mental Health Act 1983

During the Qtr. 4 period there were three fundamentally defective applications made by an AMHP whose period of approval had lapsed. These incidents occurred further to an oversight which took place within the Local Authority (LA) after an AMHP returned to the rota after a period of time.

The LA have reported that the incident occurred during an unexpected period of long term sick by the Consultant Social Worker DoLs/AMHP, Cardiff LA and coincided with the location of the electronic AMHP records migrating to a new data platform (Share Point). The Consultant Social Worker DoLs/AMHP, Cardiff LA has confirmed that provisions have since been put in place to ensure that records are also accessible to the Operational Manager, Cardiff LA to ensure continuity of accurate record keeping and monitoring going forward.

In addition to these in Qtr. 1, one detention was identified as invalid because the detention papers were not received on behalf of the Hospital Managers. There is a process in place to prevent these incidents occurring which has been successful up until now. However unfortunately on this occasion there is no evidence that the AMHP left instruction for nursing staff on the general site at UHW resulting in the legal documents being filed in the patients records rather than furnished to the Hospital Managers for formal receipt.

Section 5(2)
During Qtr. 1 on five occasions holding powers were invoked under s 5(2) where arrangements for a MHA assessment were not put in place in a timely manner. The purpose of this power is to prevent a patient from discharging himself from hospital before there is time to arrange for an application under s2 or s3 to be made.

On two occasions the holding power lapsed prior to a MHA assessment taking place

On one occasion the patient was not fit for assessment due to level of intoxication. The second occasion was due to the availability of an Approved Mental Health Professional (AMHP). UHB staff made several attempts to contact the Emergency Duty Team (EDT) to make the appropriate arrangements but were unable to make contact.

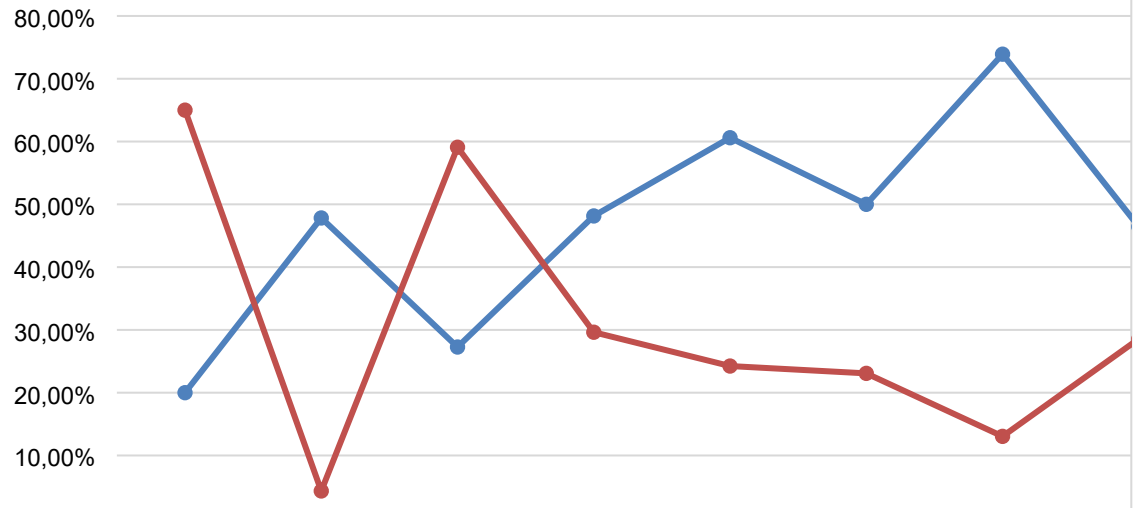
EDT confirmed that they did not have the resource to provide an AMHP to accommodate the MHA assessments. It is unlikely that MHA assessments can be supported by EDT over a weekend unless the holding power is going to lapse. EDT explained that only in these cases is it likely that the MHA assessment would be reprioritized.

The incidents described above took place over a bank holiday weekend and it has been noted that the use of s5 (2) was significantly higher than usual.

Section 136

During Qtr. 1 a significant consistent increase in cases where there reason for the use of s136 is actual self-harm has been noted. Further investigation into the reasons for this are being explored by the Mental Health Clinical Board.

s136 Officer Reason for Concern - Percentage of Total

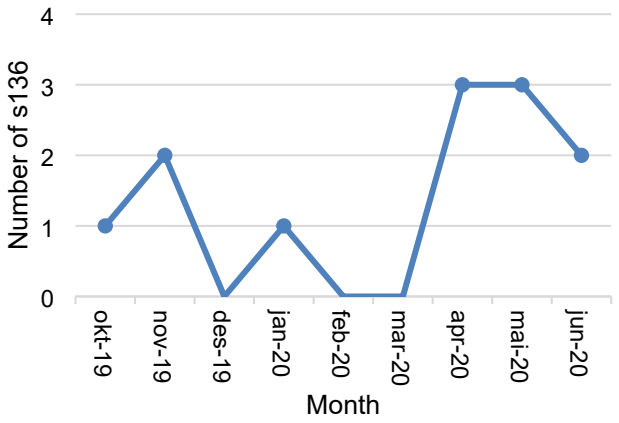


	okt-19	nov-19	des-19	jan-20	feb-20	mar-20	apr-20	ma
% Actual harm to self	20,00%	47,83%	27,27%	48,15%	60,61%	50,00%	73,91%	46,
% Risk of harm to self	65,00%	4,35%	59,09%	29,63%	24,24%	23,08%	13,04%	28,

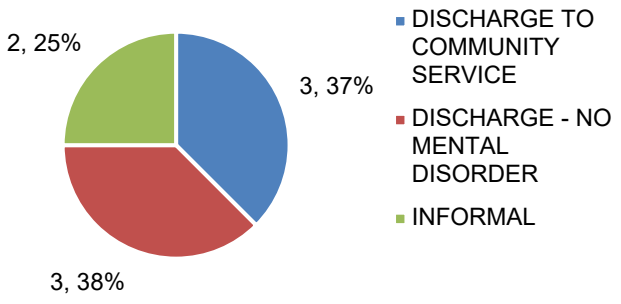
CAMHS Assessments

An increase in the number of those under 18 assessed under section 136 during Qtr. 1has been noted in comparison to previous periods. Two of these were in relation to the same patient who has previously presented on numerous occasions.

Under 18 s136 Assessments



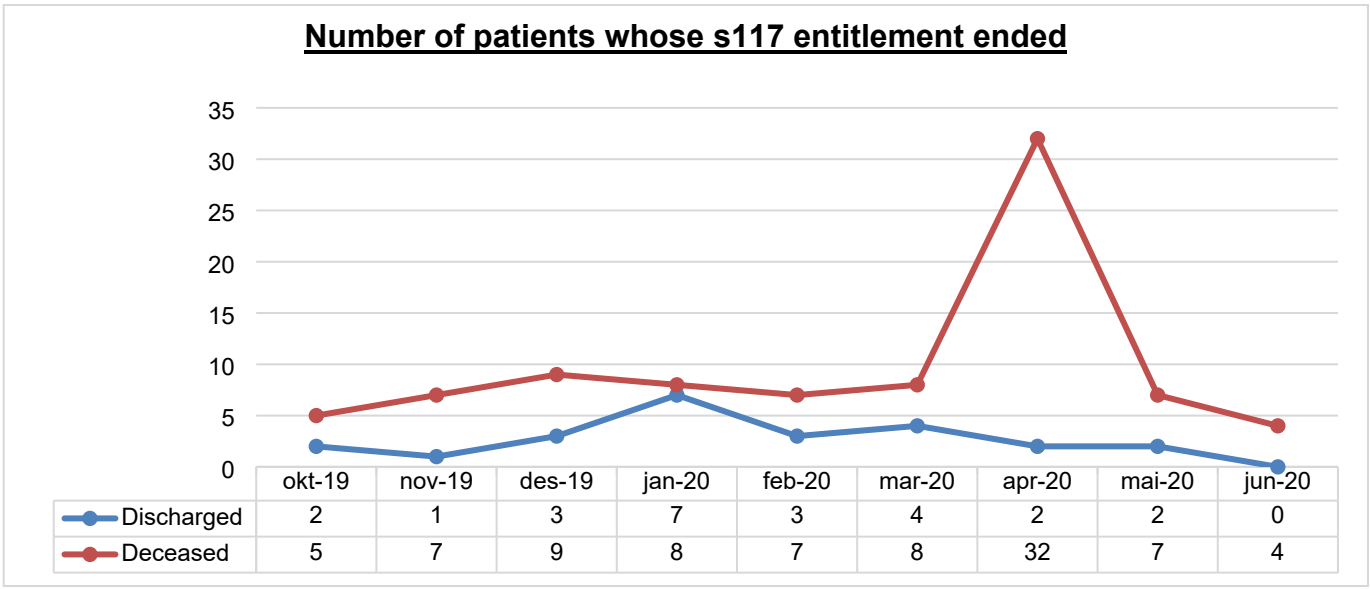
Outcome of CAMHS s136 Assessments for the period April - June 2020



Section 117

In April 2020 there was a significant increase in the ending of patients eligible to section 117 aftercare. All but two of these ended due to death. In the majority of cases the cause of death was not recorded. However further investigation identified that thirteen cases were confirmed COVID positive and two possible COVID, symptomatic but not tested. A further five cases were tested and confirmed negative. The UHB are required to report the death of a detained patient to

Healthcare Inspectorate Wales but not of those subject to section 117 aftercare.



	okt-19	nov-19	des-19	jan-20	feb-20	mar-20	apr-20	mai-20	jun-20
Discharged	2	1	3	7	3	4	2	2	0
Deceased	5	7	9	8	7	8	32	7	4

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

Fundamentally defective applications for detention under Section 2, Mental Health Act 1983

All patients detained without authority, therefore not compliant with the MHA 1983. A patients discharge must be ordered if an application is found to be fundamentally defective.

Case law has determined that the hospital are entitled to rely on the s6 (3) protection (that any application which appears to be duly made etc. may be acted upon without further proof) because the managers are entitled to rely on the AMHP's declaration. As an AMHP is treated as acting on behalf of the Local Authority the relevant council is vicariously liable for any lack of care or bad faith on the part of an AMHP. *TTM v London Borough of Hackney [2010] EWHC 1349*

The operational Manager, for both Cardiff and the Vale has reminded AMHP's of this process and its importance to prevent an incident of this kind reoccuring. In addition to the current process all AMHP's have been asked to notify the MHA Office by email when an application is made to detain under the Act. This will enable to team to follow up if papers are not received.

Section 5(2)

The incidents described above are not supportive of the best practice approach contained in the Mental Health Act 1983, Code of Practice for Wales, revised 2016 or advice contained in Mental Health Act Manual, Richard Jones, Twenty-Second Edition:

"Arrangements for an assessment to consider an application under section 2 or section 3 of the act should be put in place as soon as the report is given to the hospital managers." **18.8, Mental Health Act Code of Practice for Wales**

"As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and potential recommending doctors." **1-092, Jones, Twenty-second edition**

"Hospital managers should monitor the use of section 5, including how quickly patients are assessed for detention and discharged from the holding power." ***18*.33, Mental Health Act Code of Practice for wales**

EDT operate by priority being given to Child Protection matters first and Mental Health second if resources are stretched. Discussions are taking place with the LA in relation to the expectation that any Mental health Act matter (including s5(2)) should be dealt with as a priority if there is capacity.

Recommendation:

Fundamentally defective applications for detention under Section 2, Mental Health Act 1983

Continue to work with the Local Authority to reach an agreement fir AMHP's to notify the Mental Health Act Office when an application has been made to detain a person under the Mental Health Act to ensure that legal documents can be located if they are not received on behalf of the Hospital Managers.

Section 5(2)

Continue to work with the Local Authority to ensure that those held under section 5(2) receive a Mental Health Act assessment in good time if requested out of hours.

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

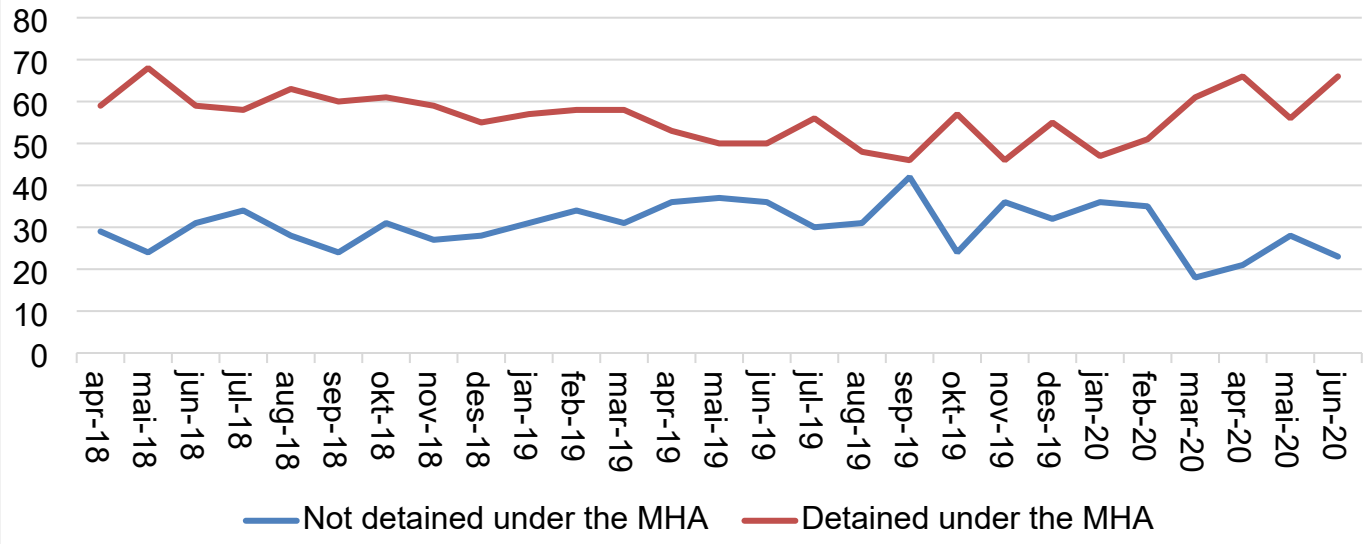
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

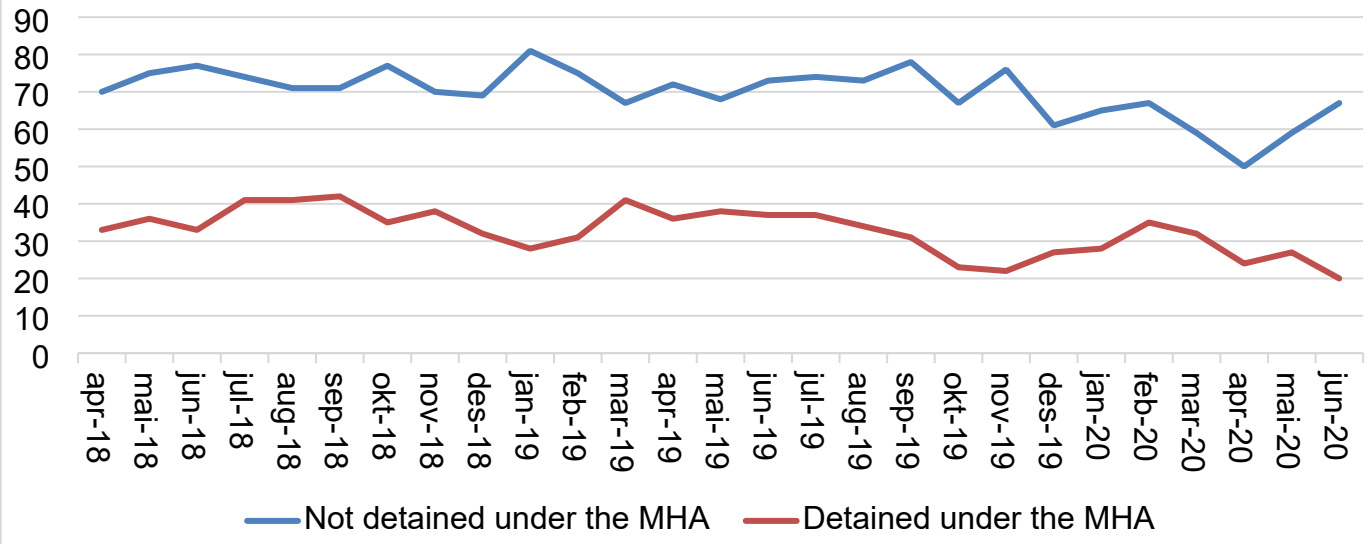
April - June 2020

	Contents	Page

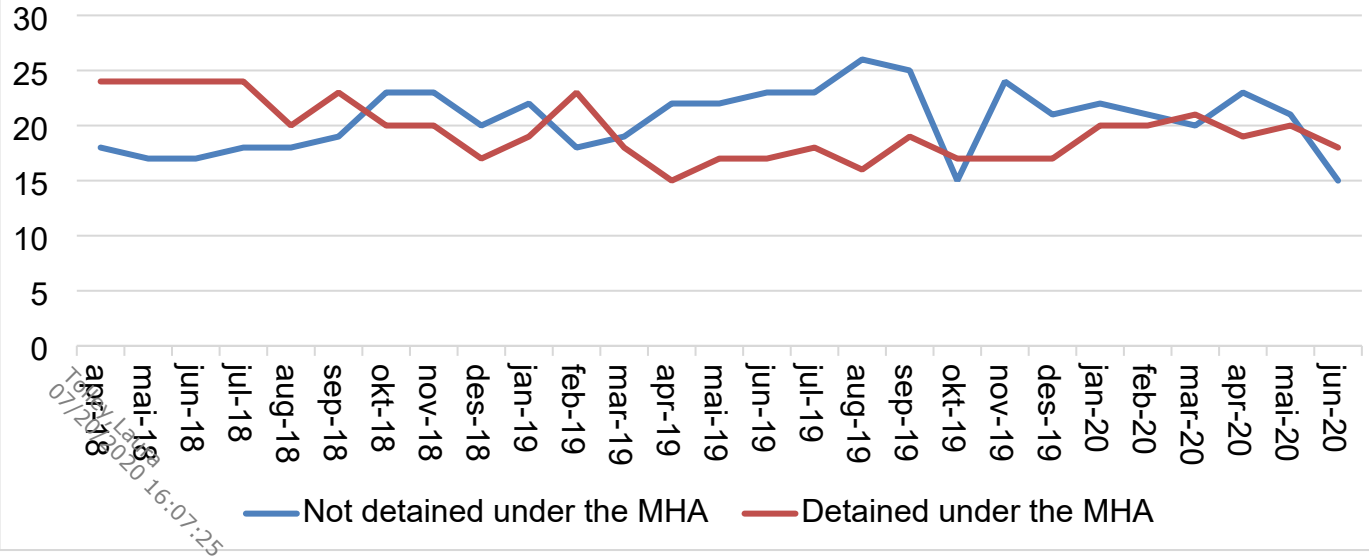
Adult Acute - Detained/Not Detained



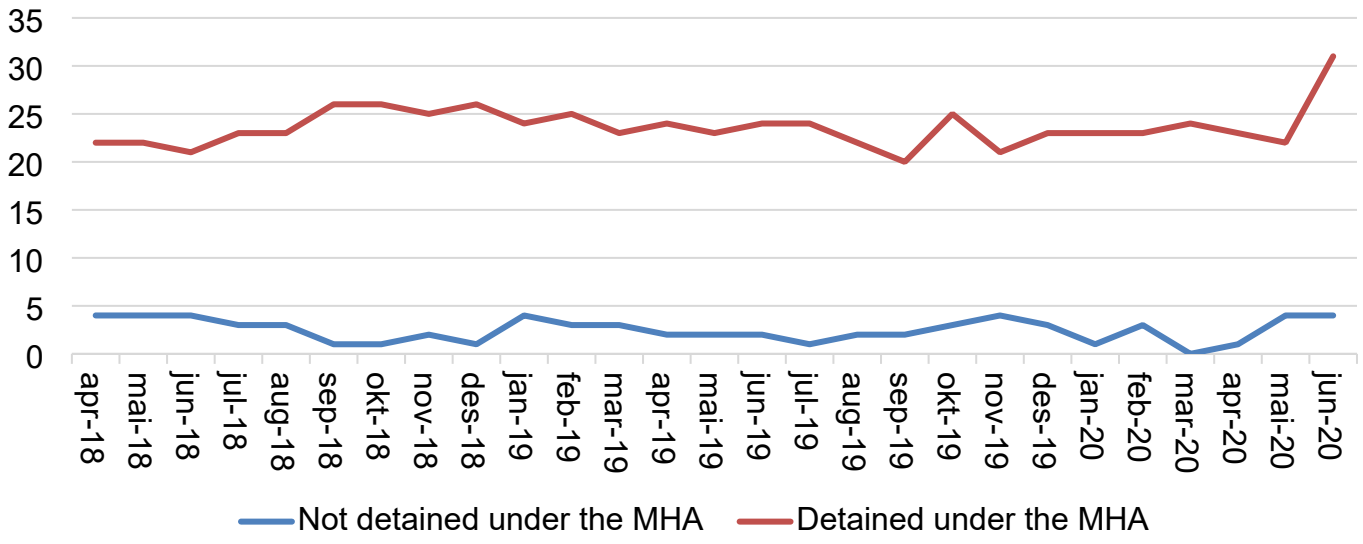
Mental Health Services for Older People - Detained/Not Detained



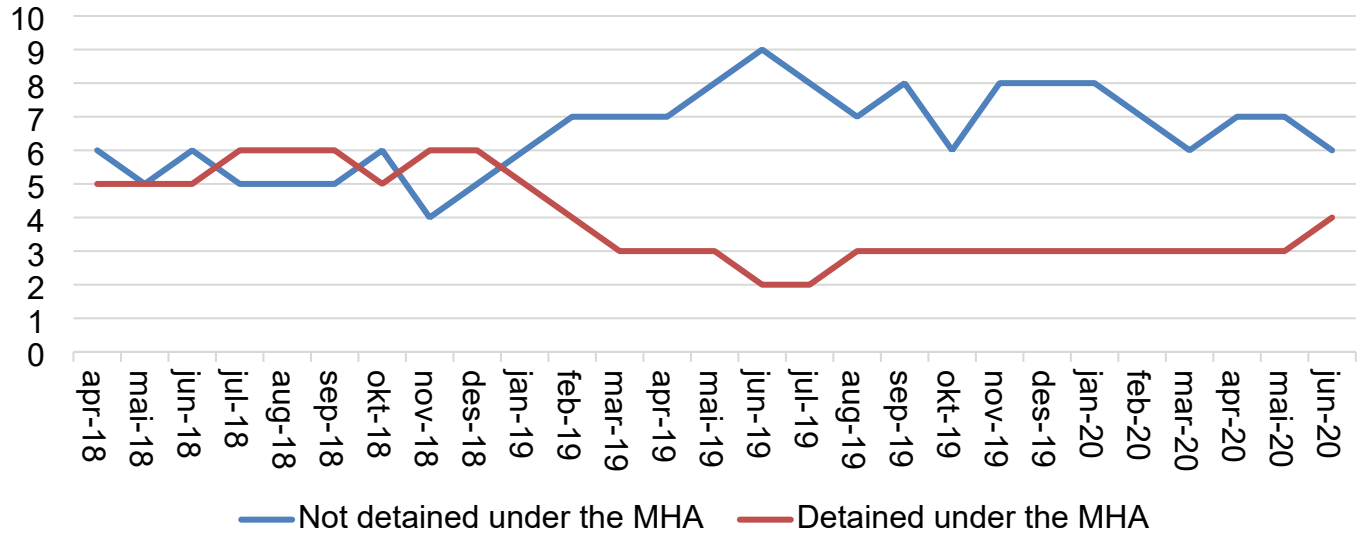
Rehabilitation - Detained/Not Detained



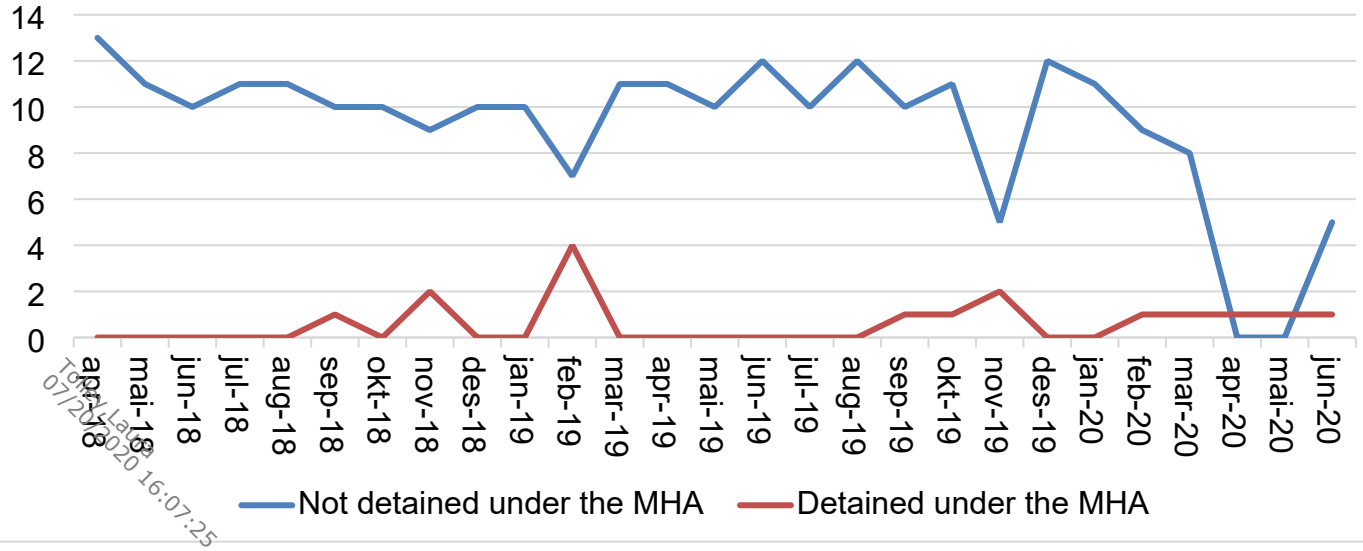
Low Secure Service - Detained/Not Detained



Neuropsychiatry - Detained/Not Detained

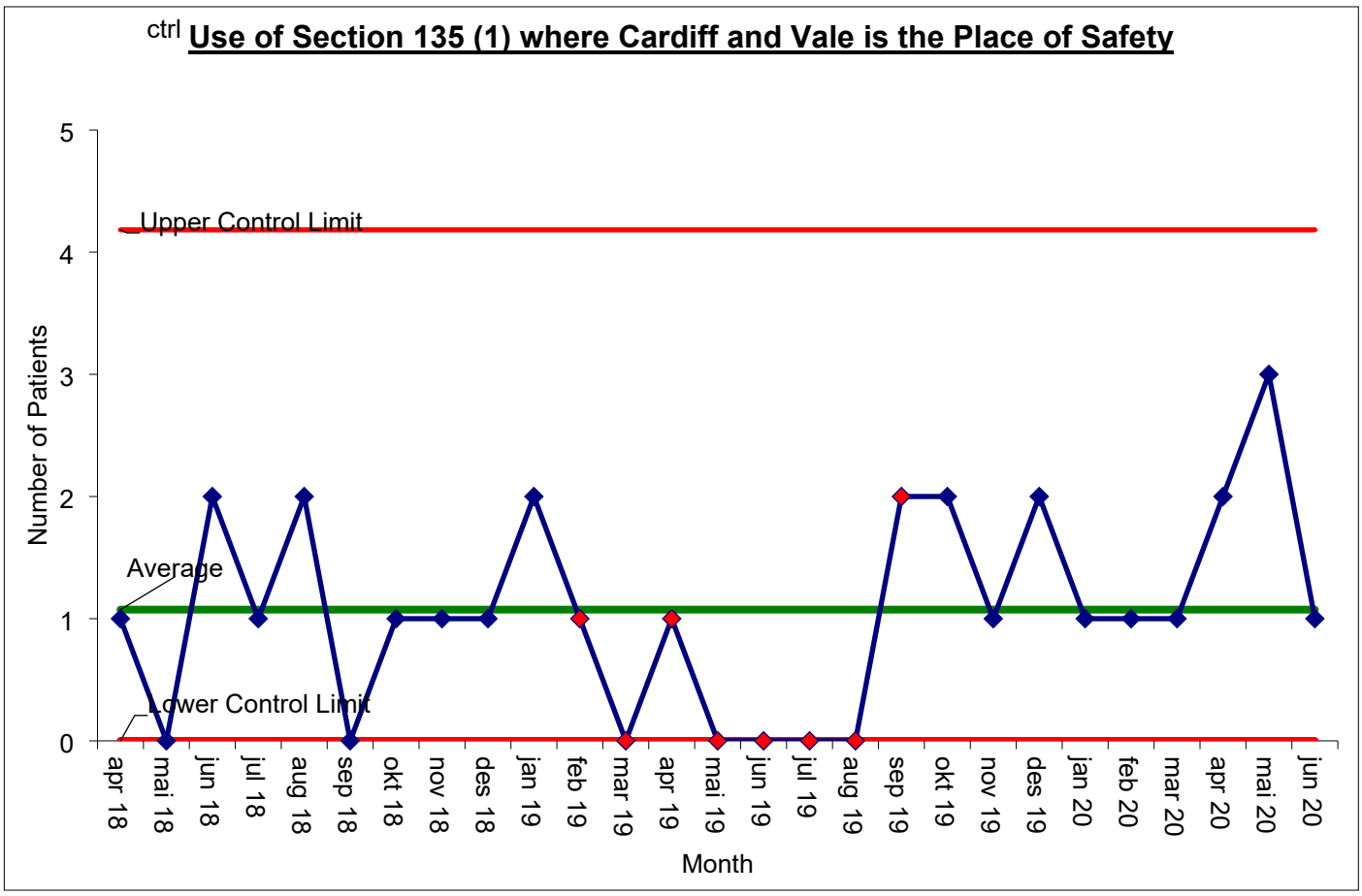


Addictions - Detained/Not Detained



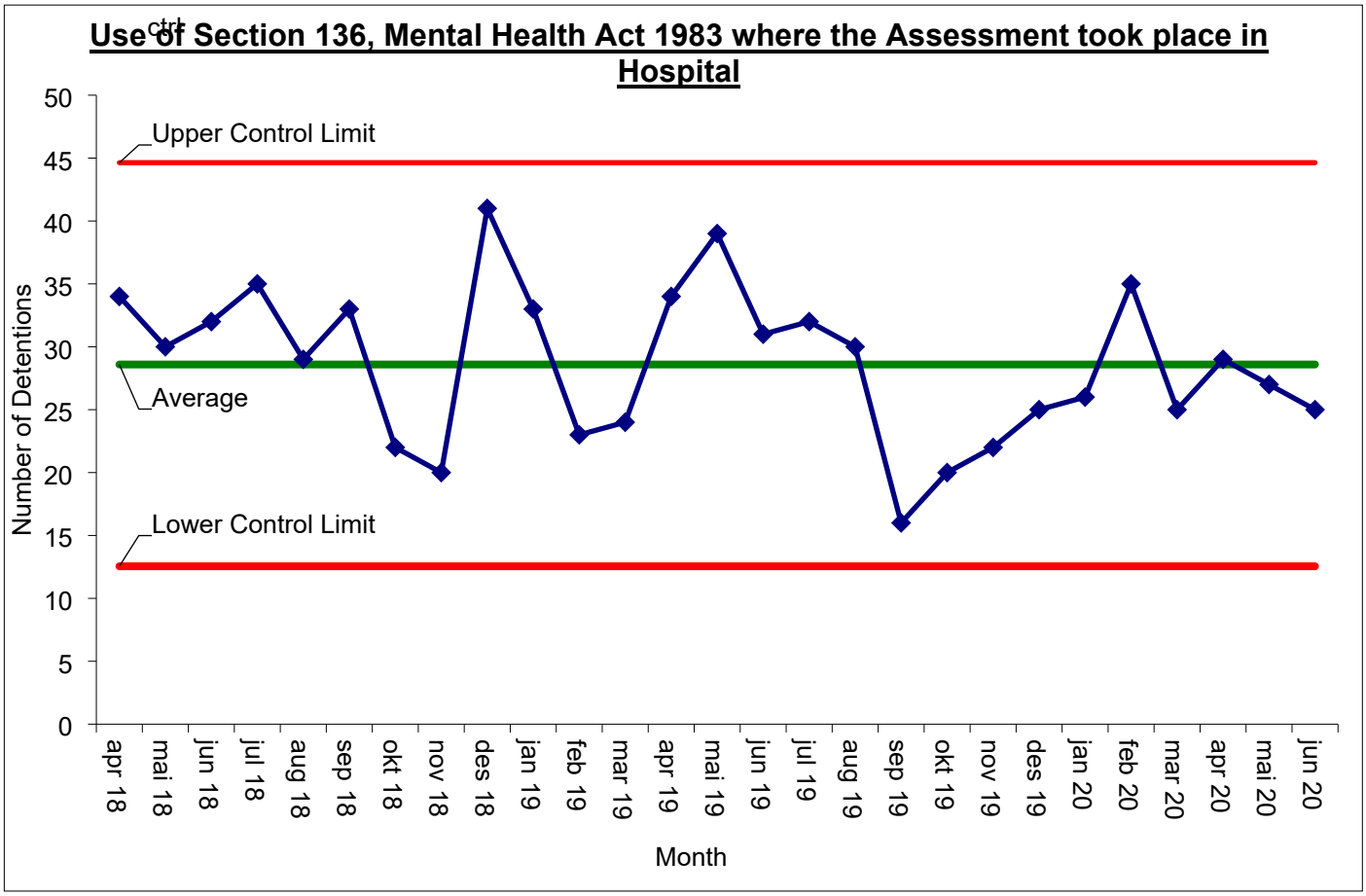
Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used on six occasions. Five patients were subsequently admitted under Section 2, and one patient discharged to Community Services.



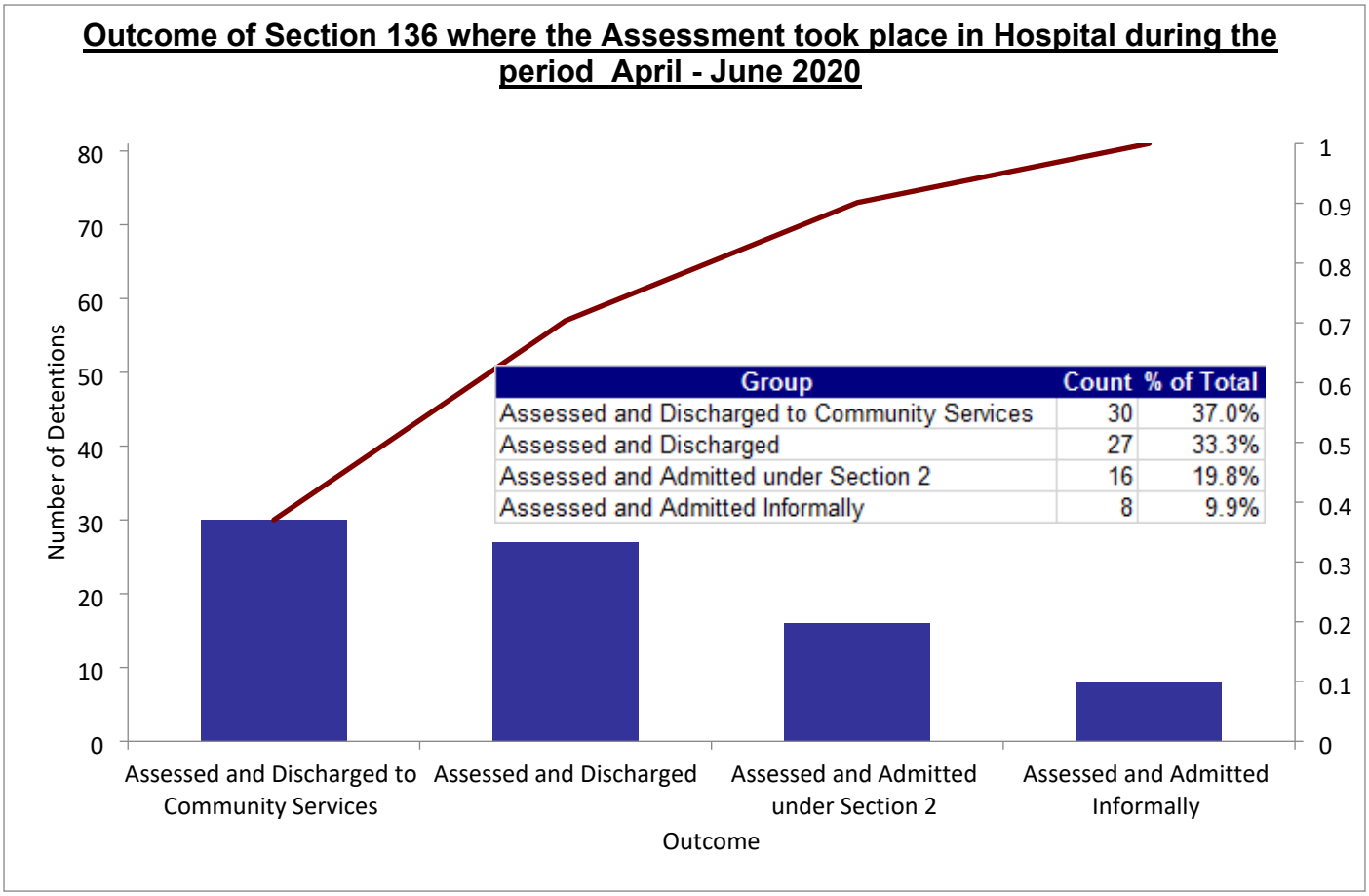
Section 135(2) powers were not used during the period.

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 81 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

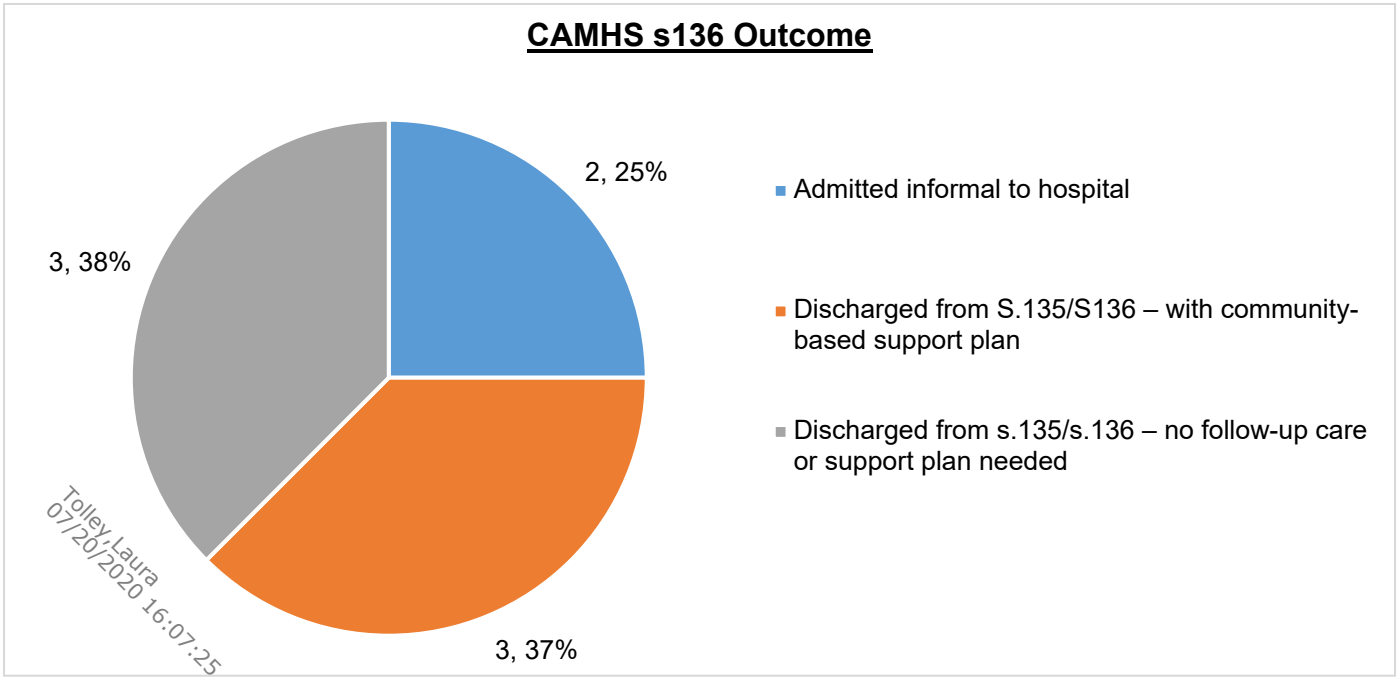
Eight of those assessments were carried out on patients under the age of 18.



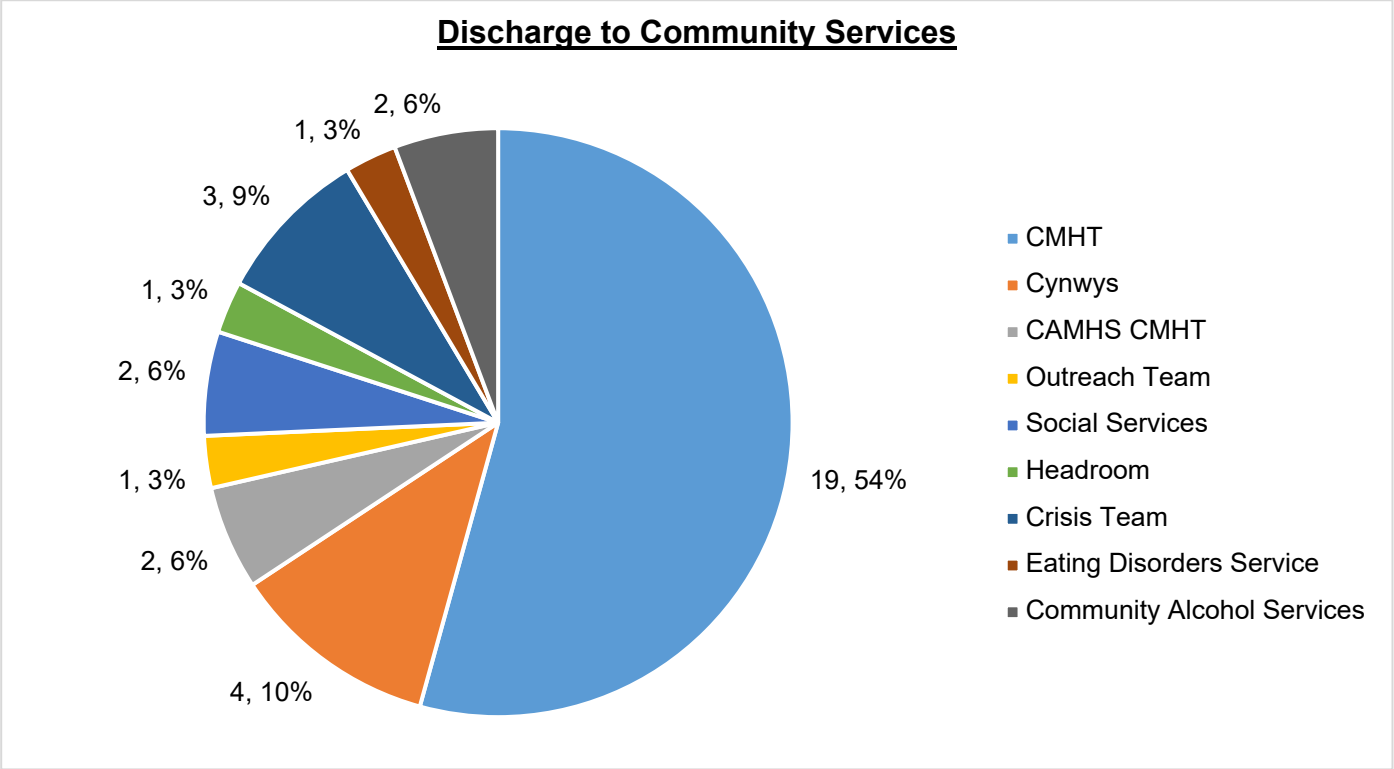
The pareto chart highlights that 70.4% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

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

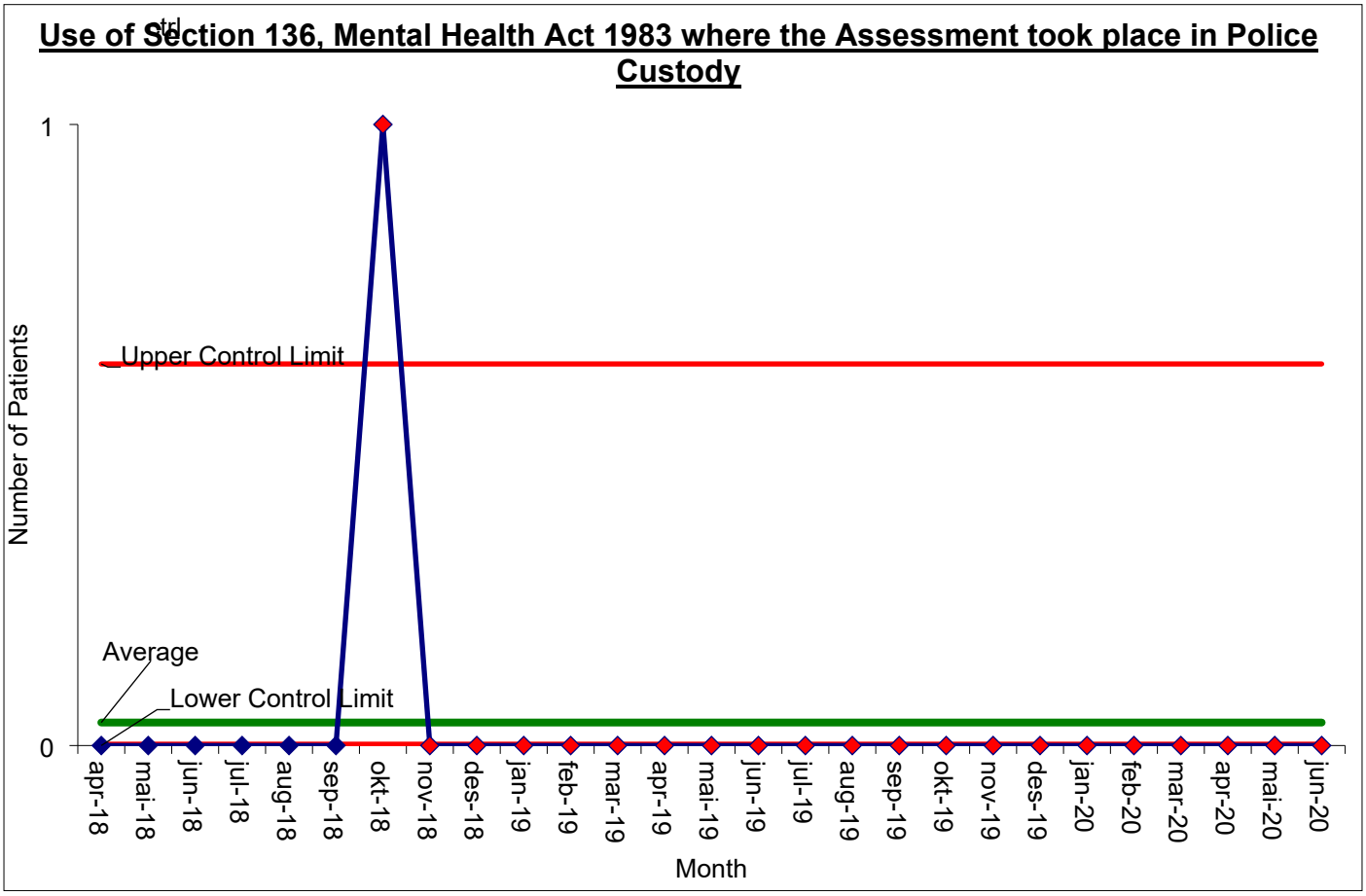
Included in the above data are the outcomes for those under 18 years of age. Those outcomes are as follows;-



The below chart is a breaksown of the referrals to Community Services as a result of a s136 assessment.

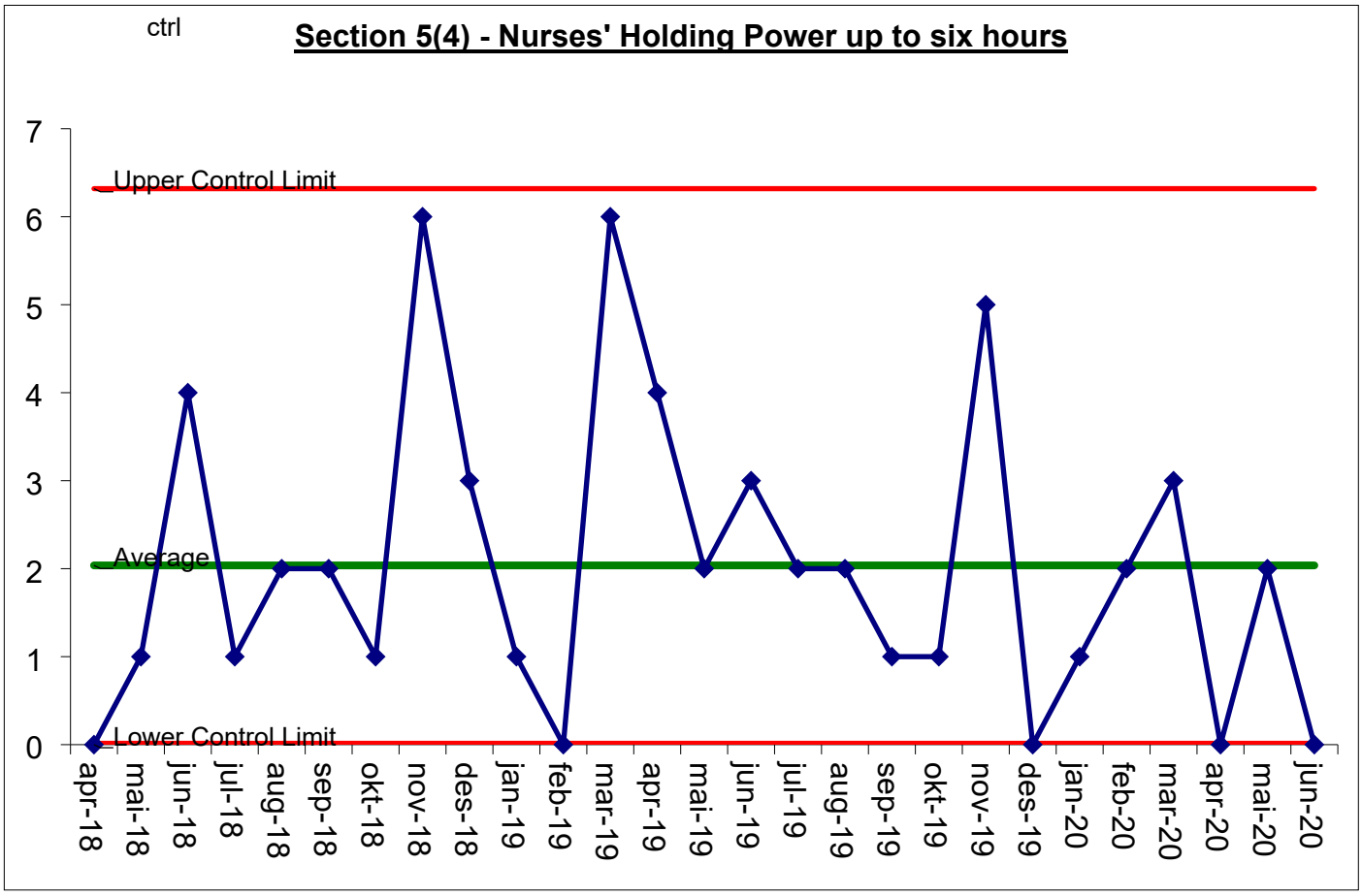


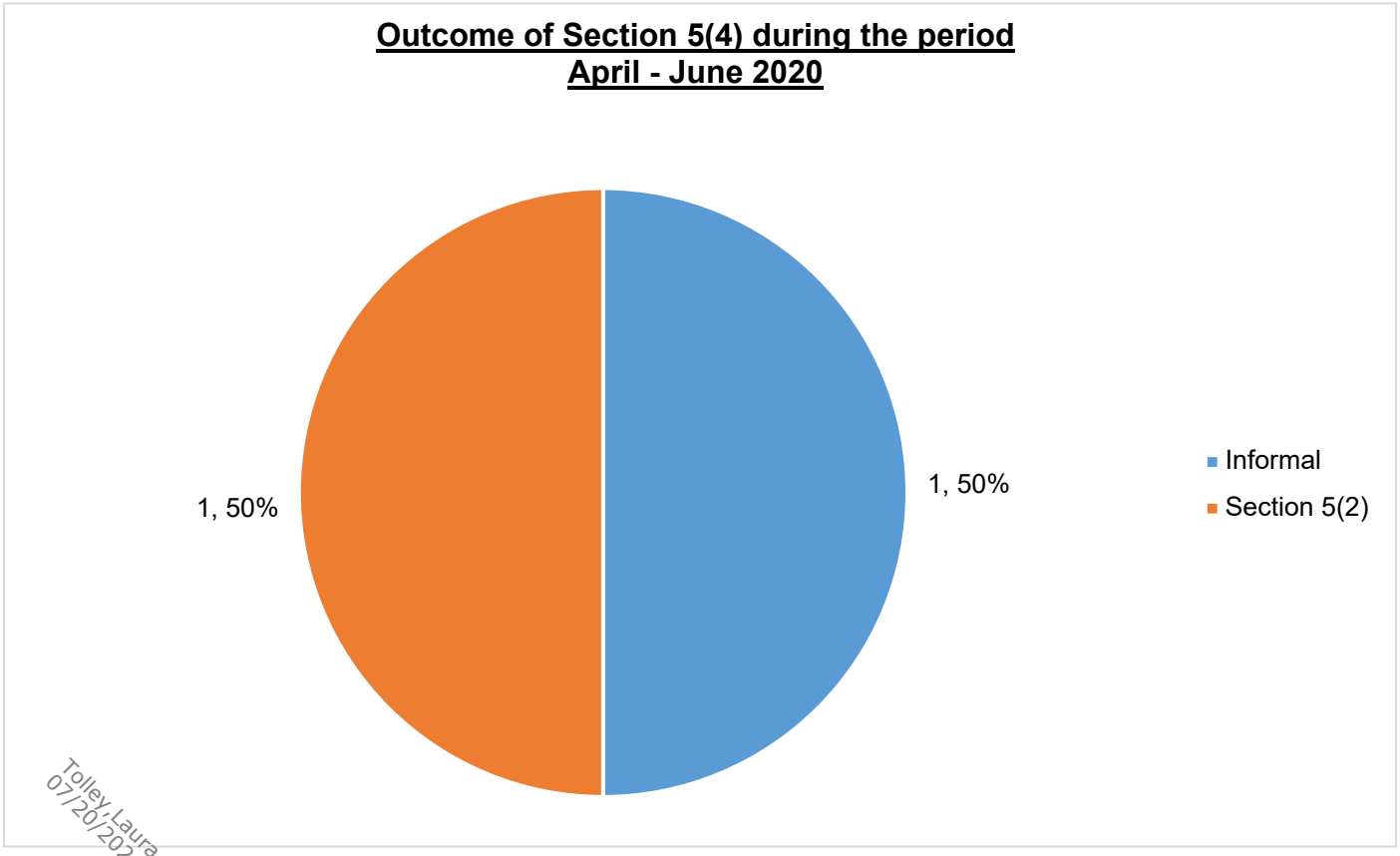
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station



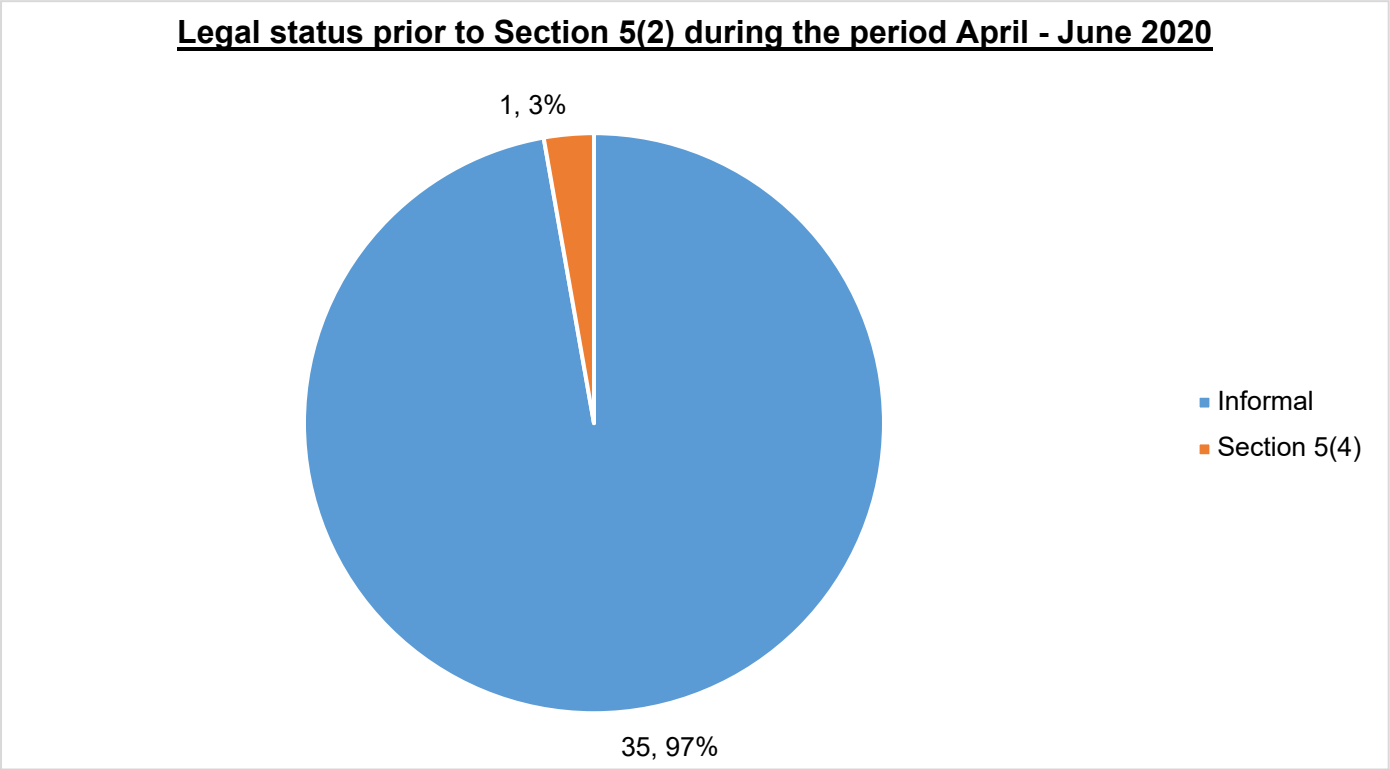
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite. However, one patient was initially taken to the Custody Suite due to the risk of violence. That patient was subsequently transferred to Hospital for assessment.

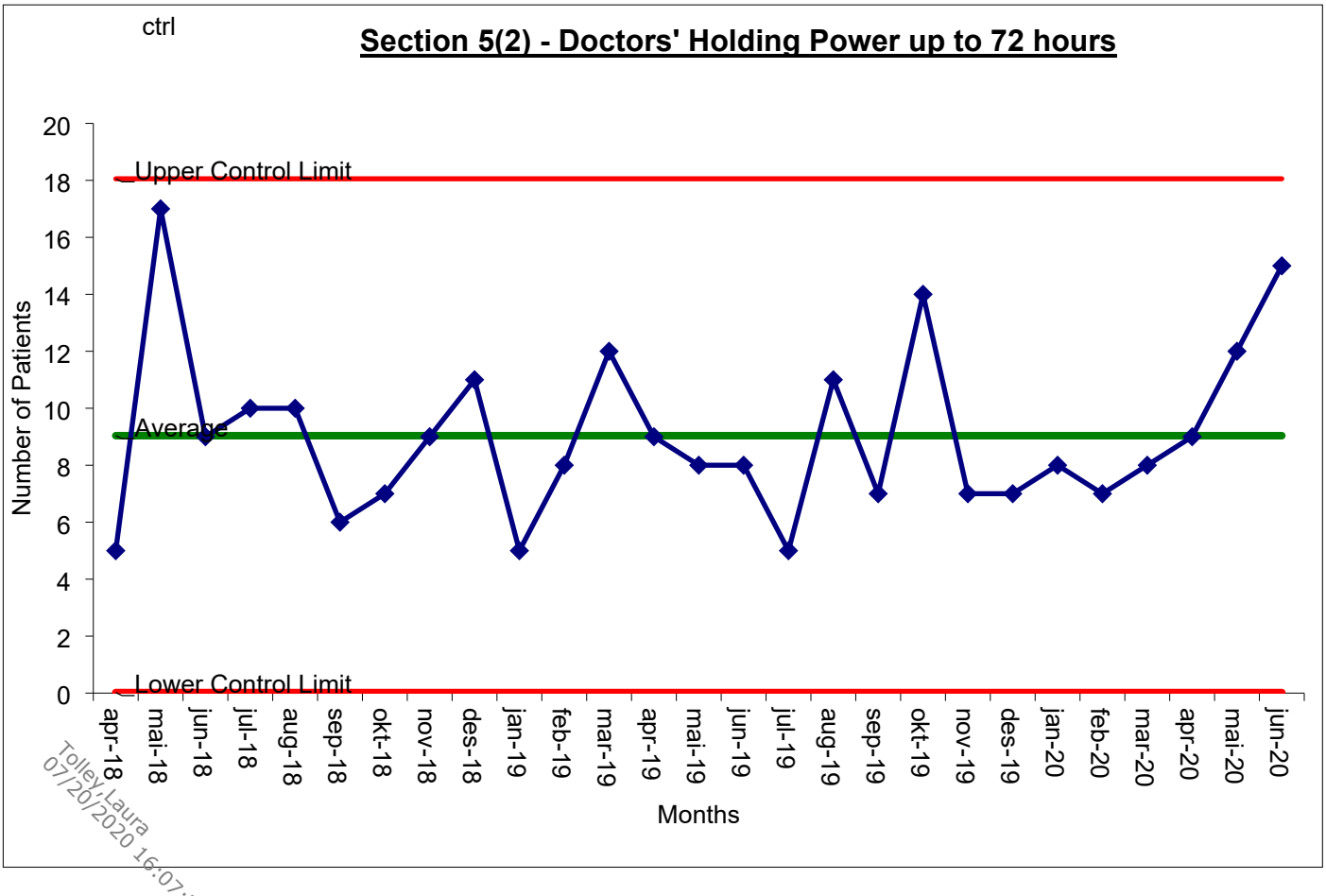
Section 5(4) - Nurses Holding Power



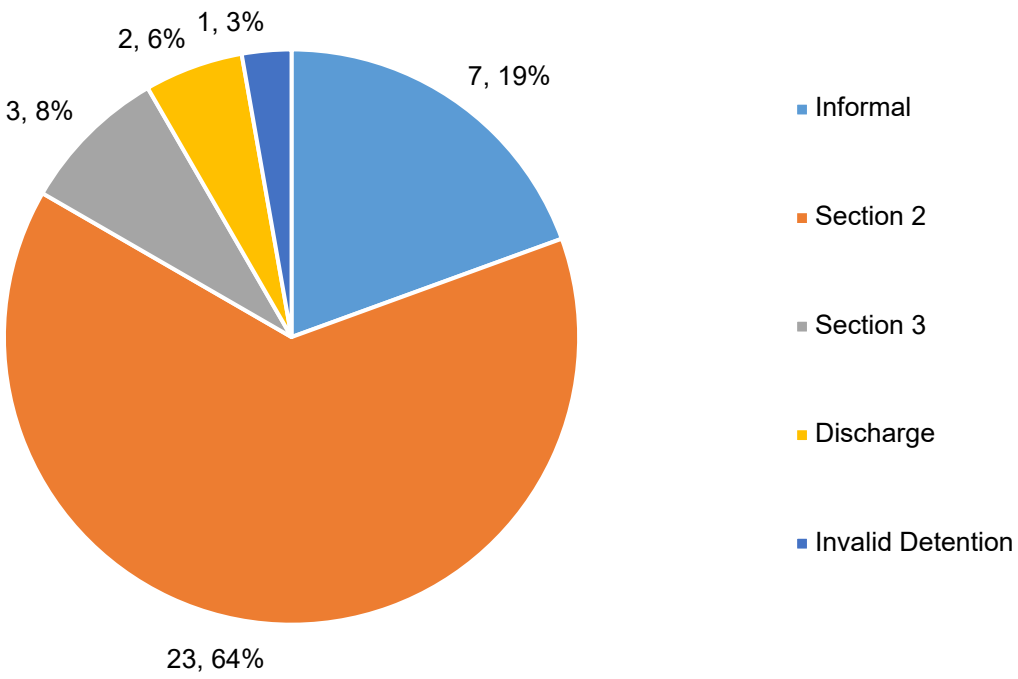


Section 5(2) - Doctors holding power

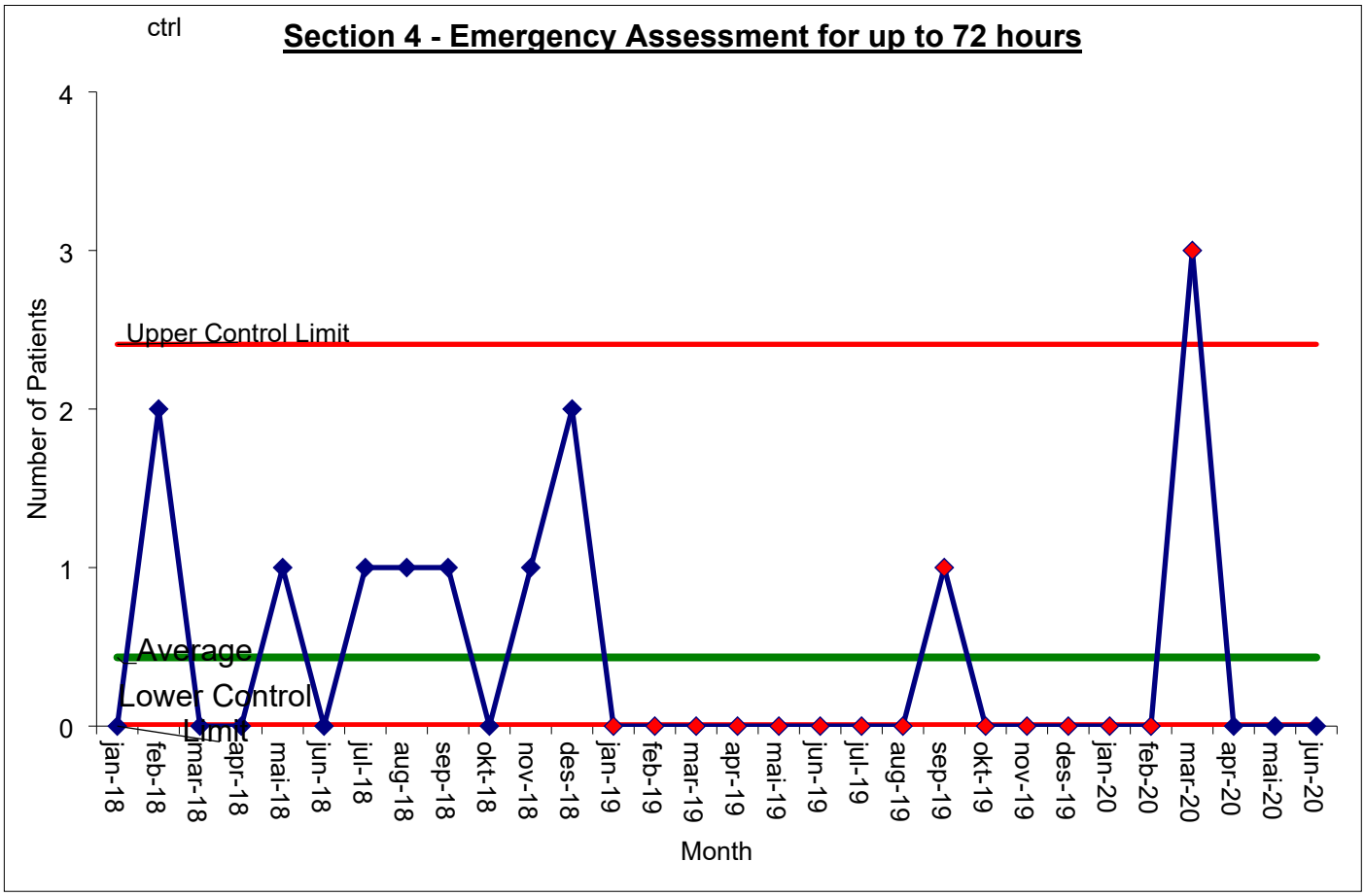




Outcome following Section 5(2) during the period April - June 2020



Section 4 - Admission for Assessment in Cases of Emergency



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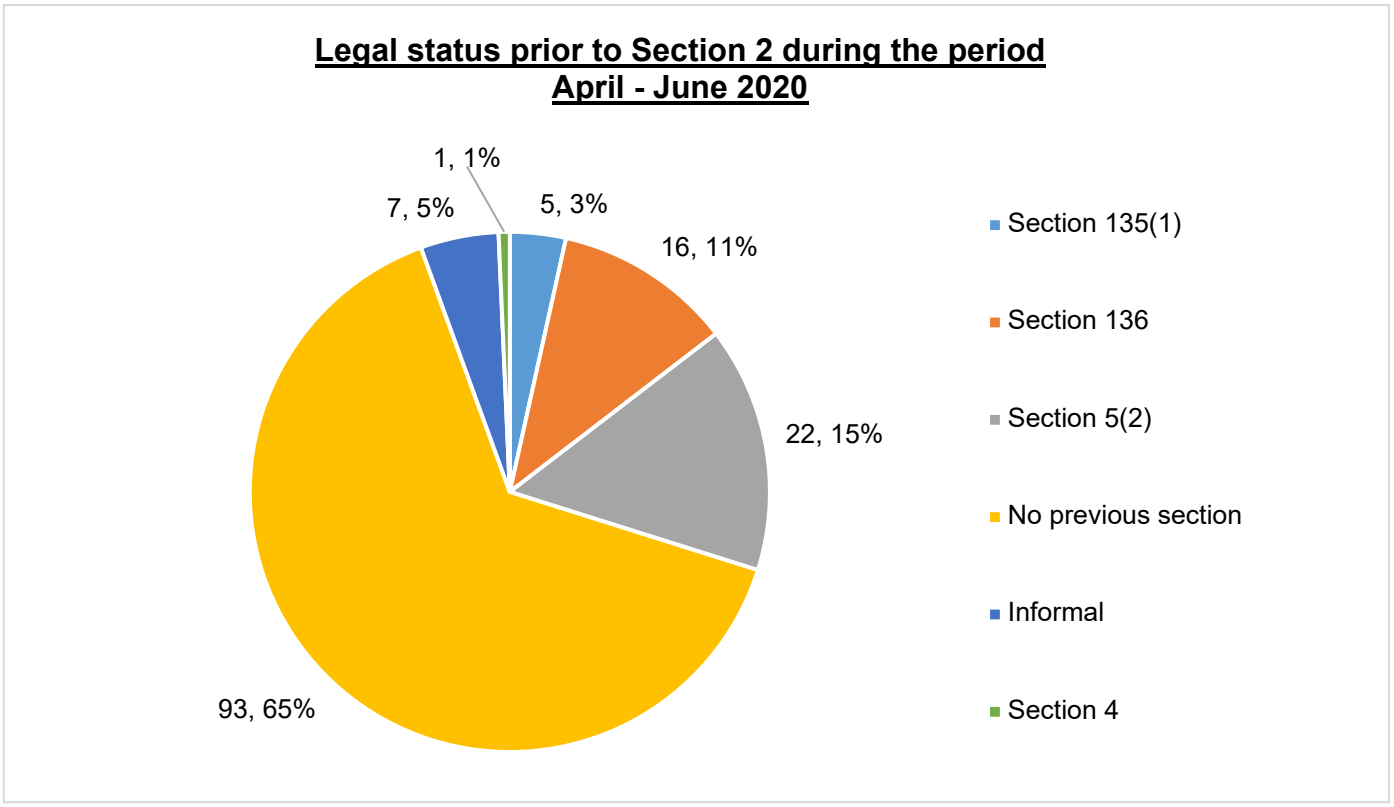
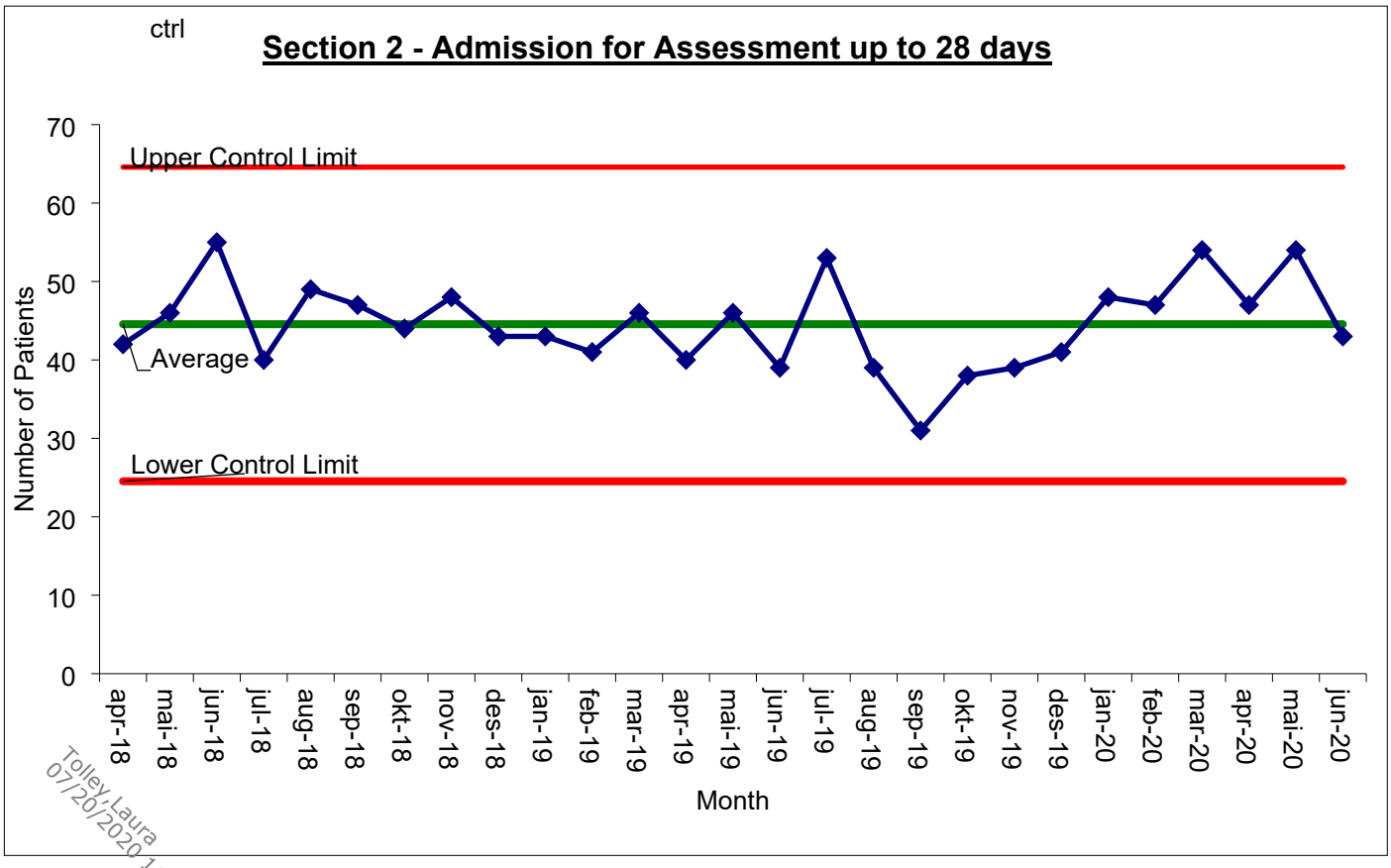
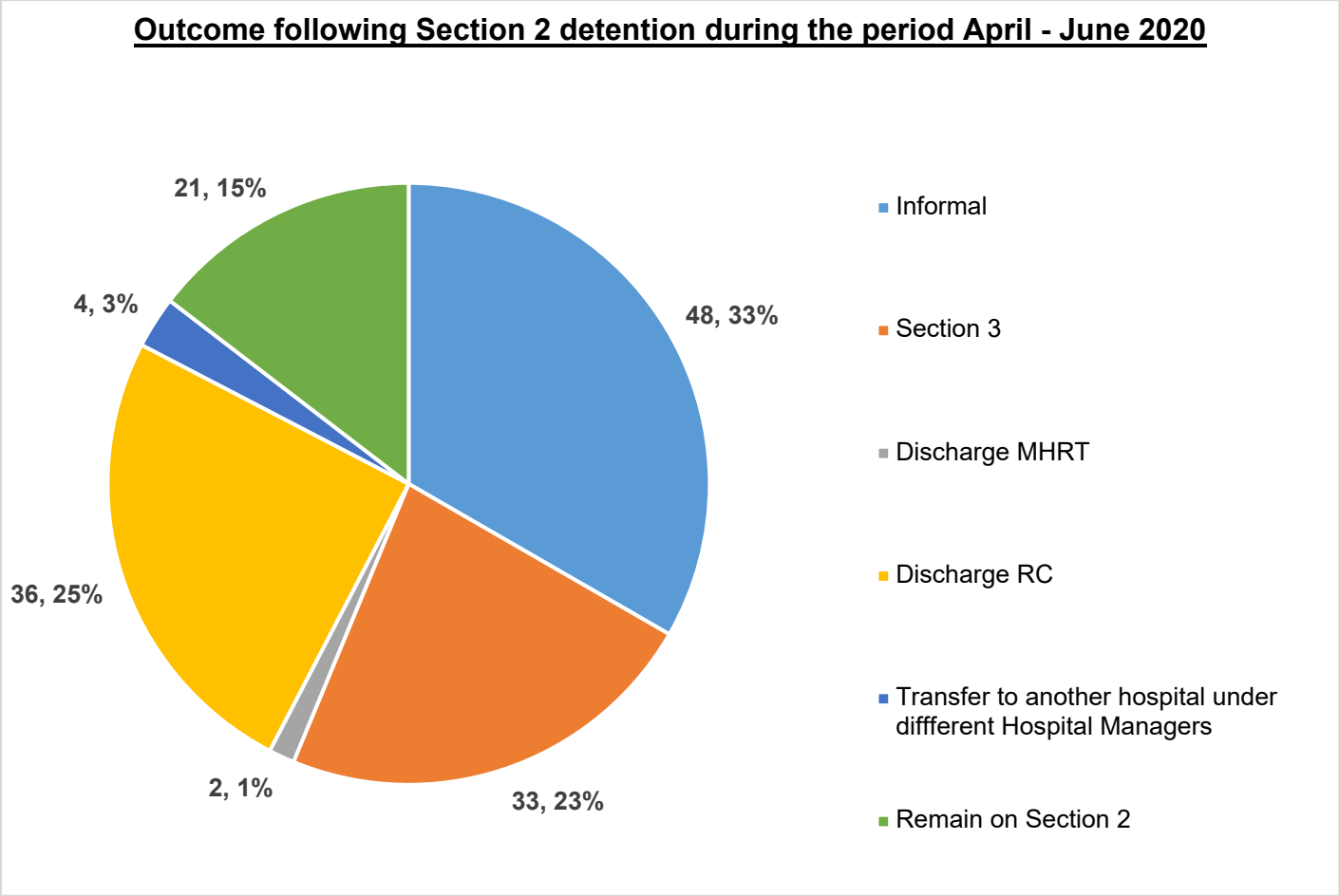
Section 2 – Admission for Assessment







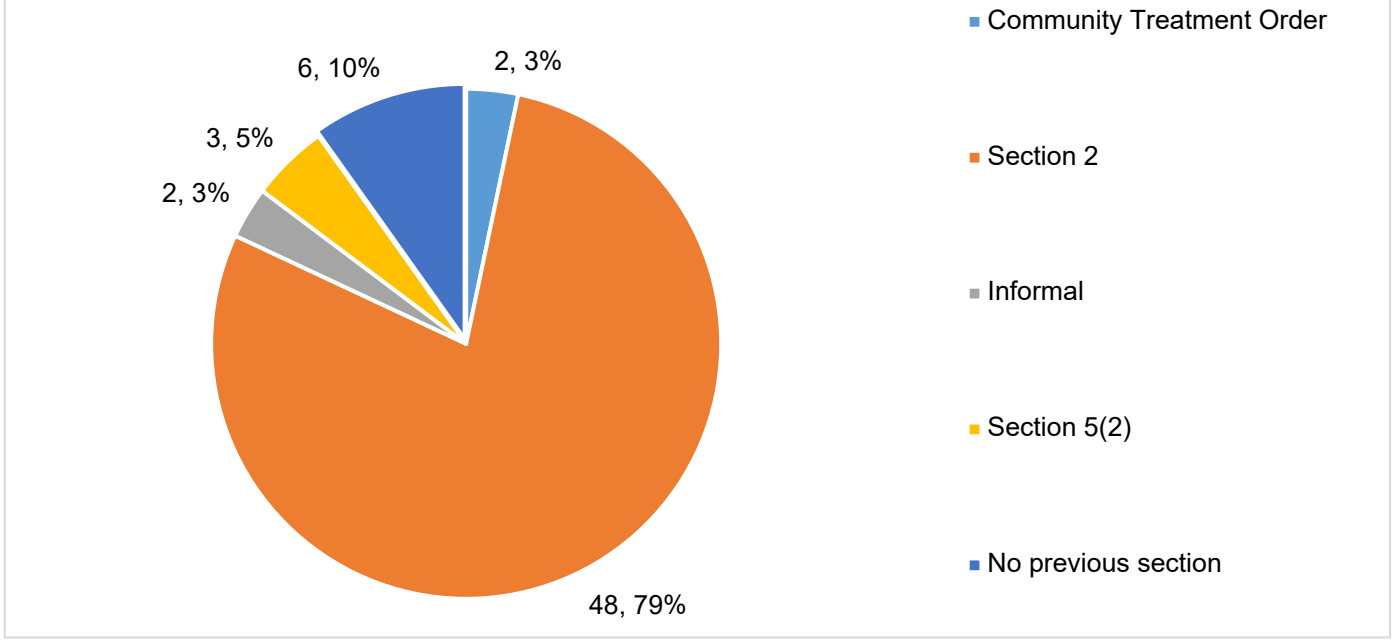
CAMHS Commissioned Inpatient Data

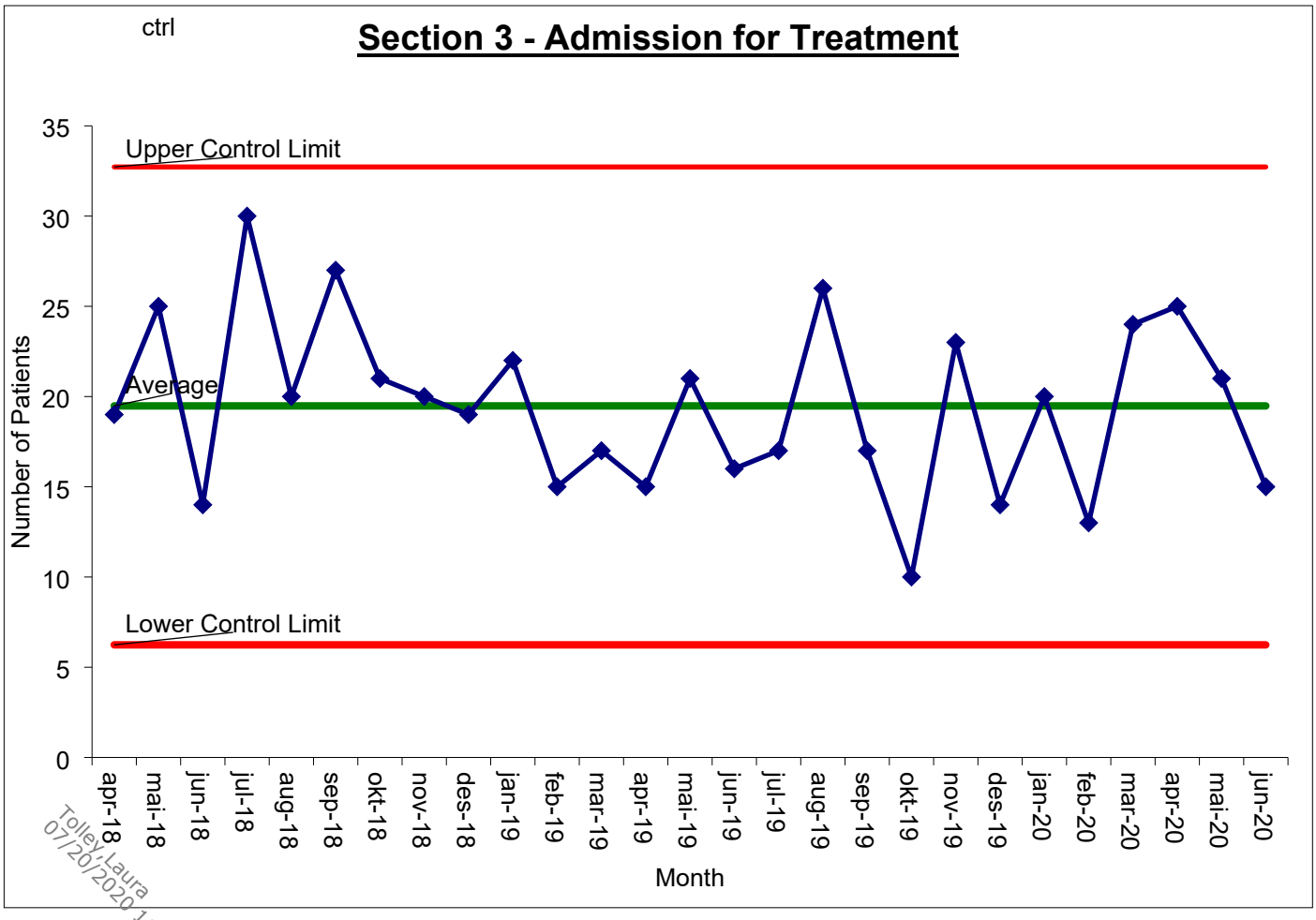
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

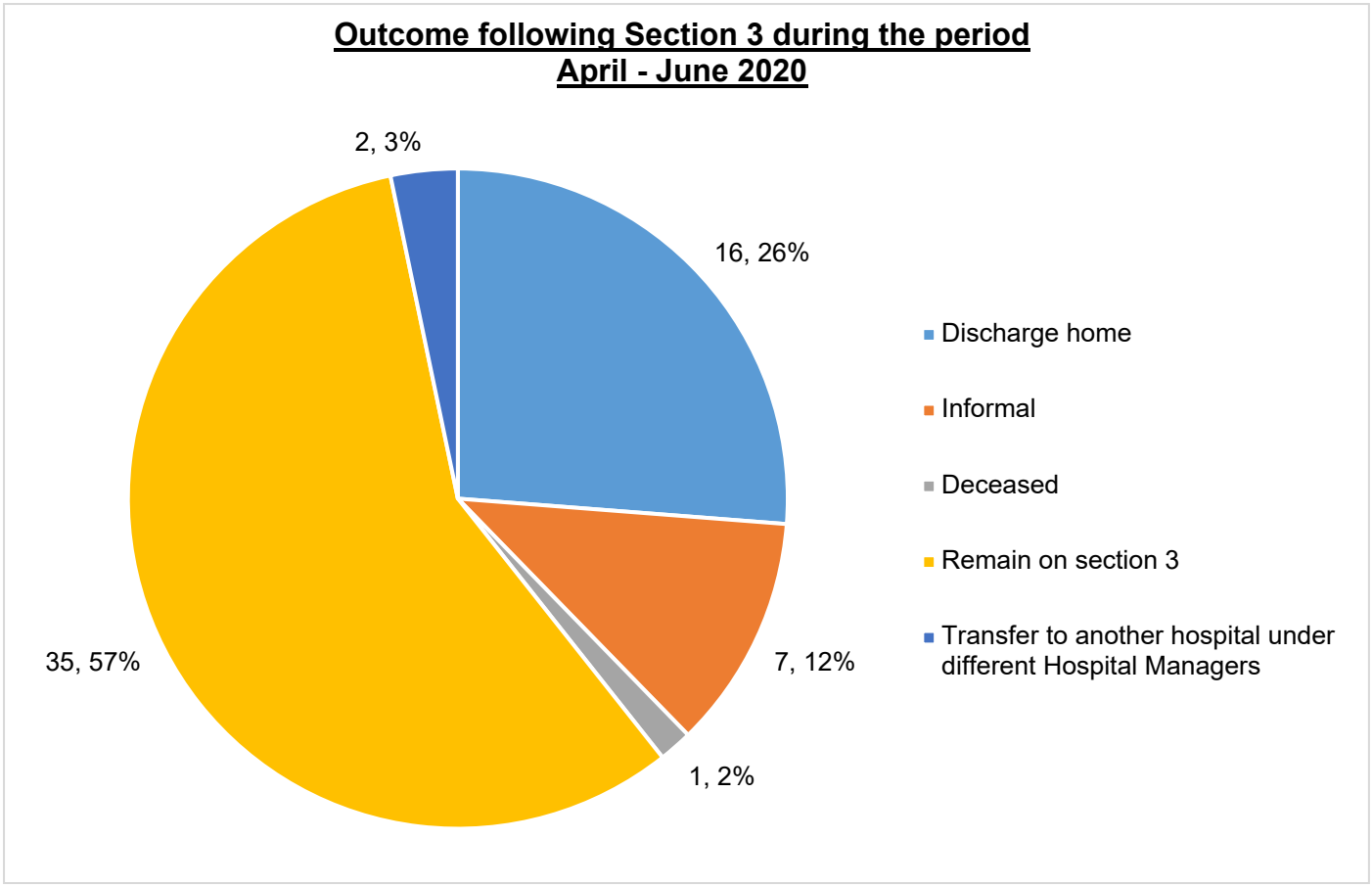
In this period there were no CAV CAMHS patients was admitted under Section.

Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period April - June 2020







CAMHS Commissioned Inpatient Data

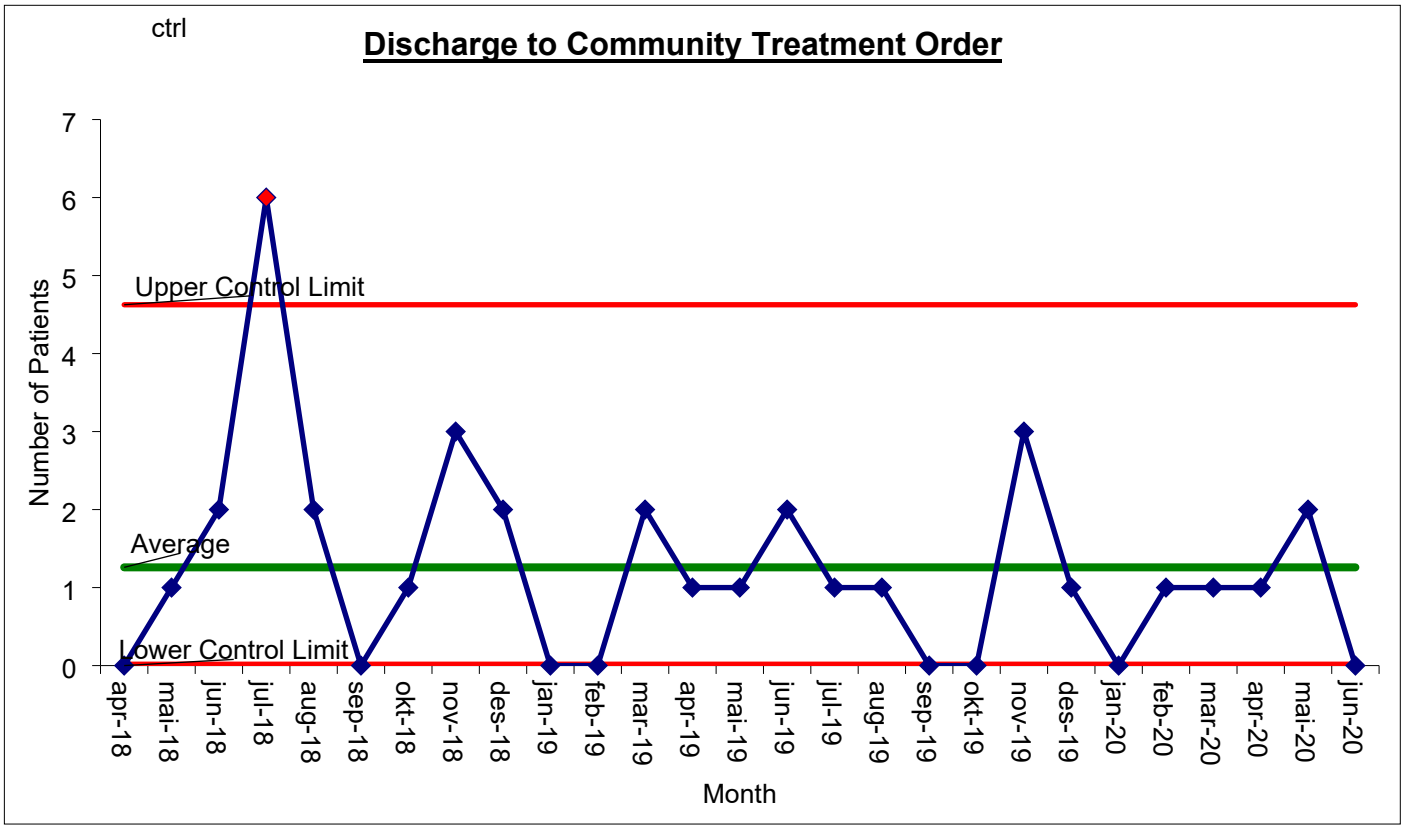
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

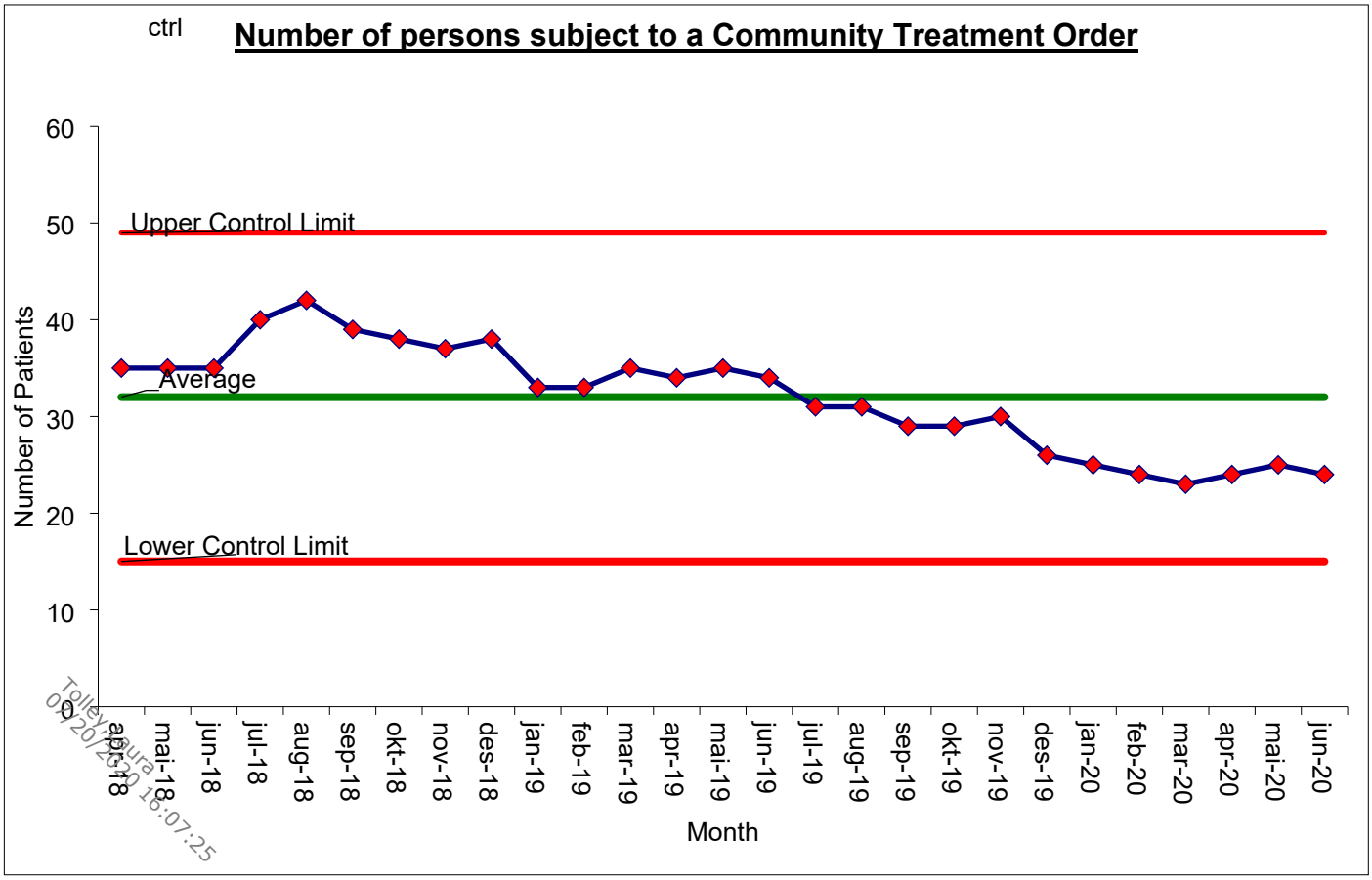
In this period there were no CAV CAMHS patients was admitted under Section.

Community Treatment Order

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

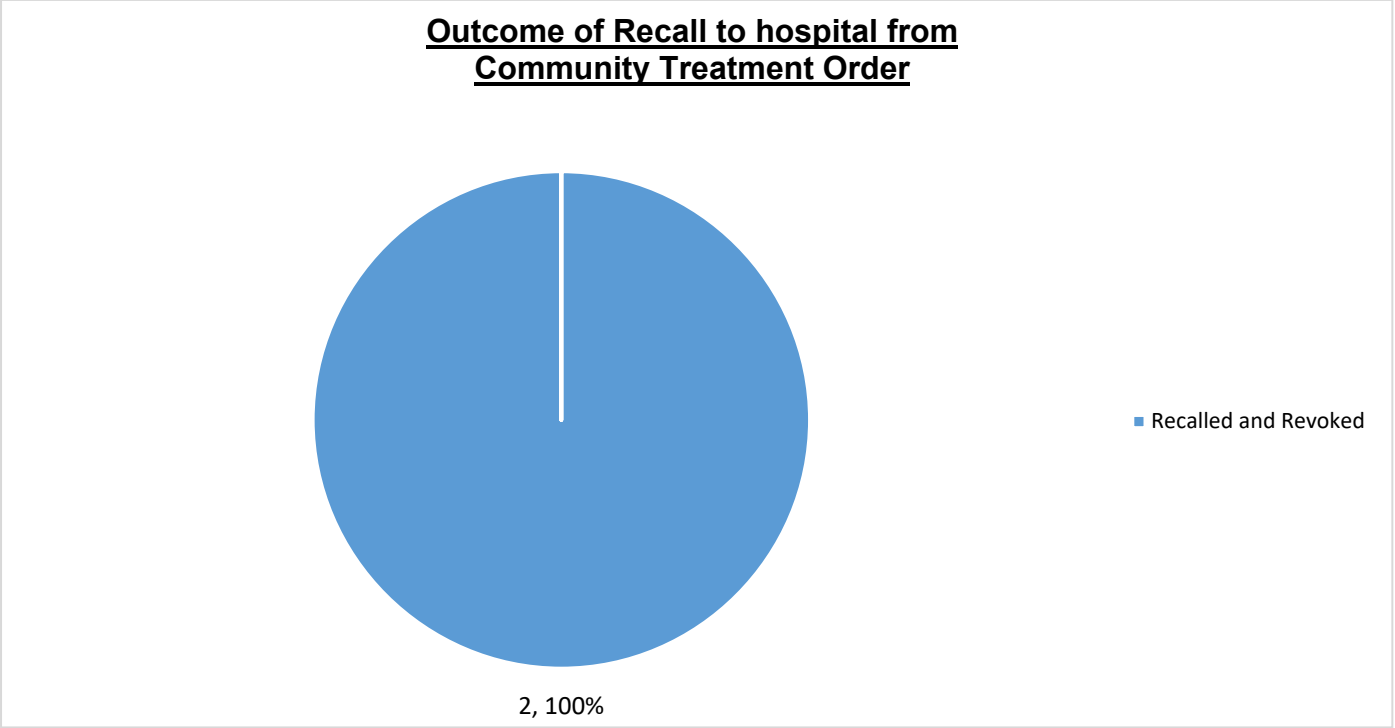
As at 30 June 2020, 24 patients were subject to a Community Treatment Order (CTO).





Recall of a community patient under Section 17E

During the period, the power of recall was used on two occasions. On both occasions the patients CTO was revoked.



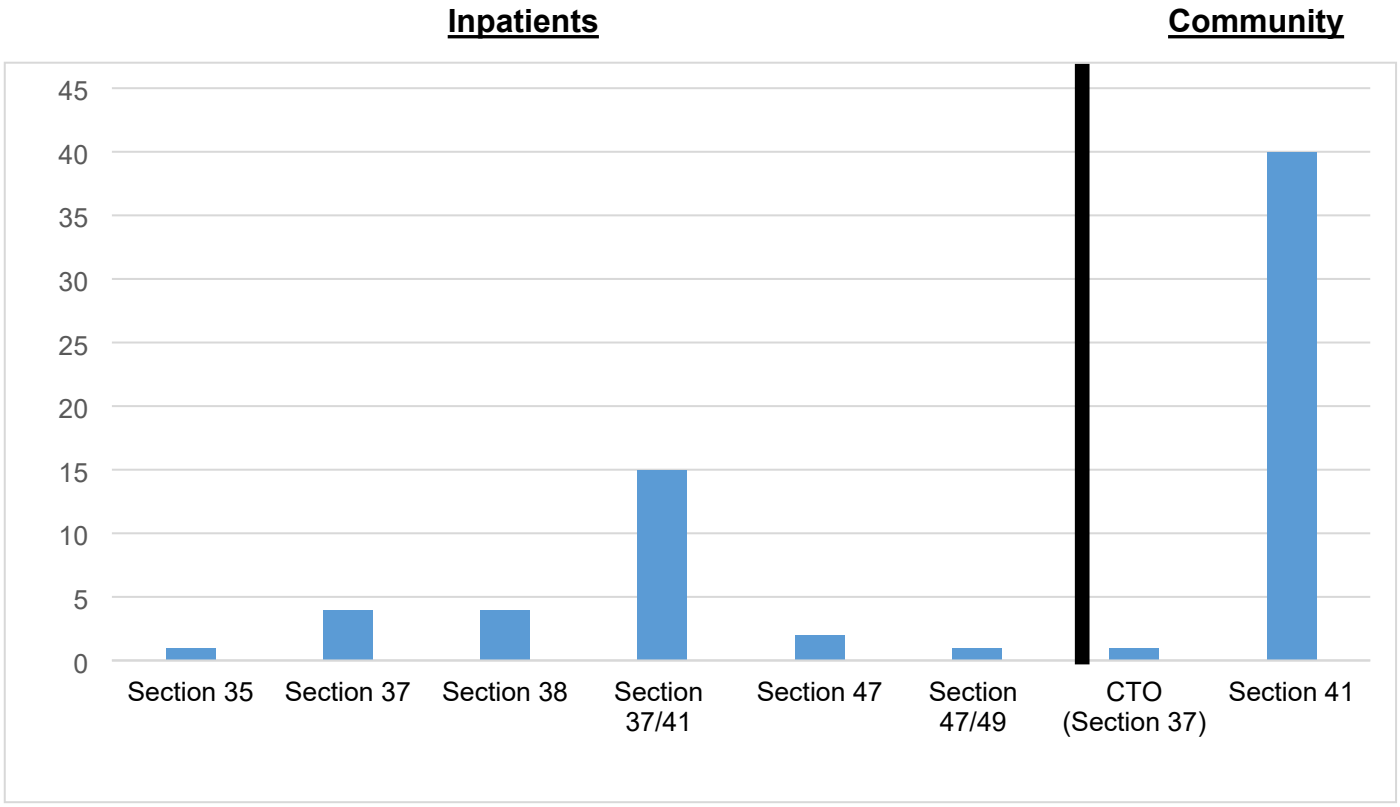
CAMHS Commissioned Inpatient Data

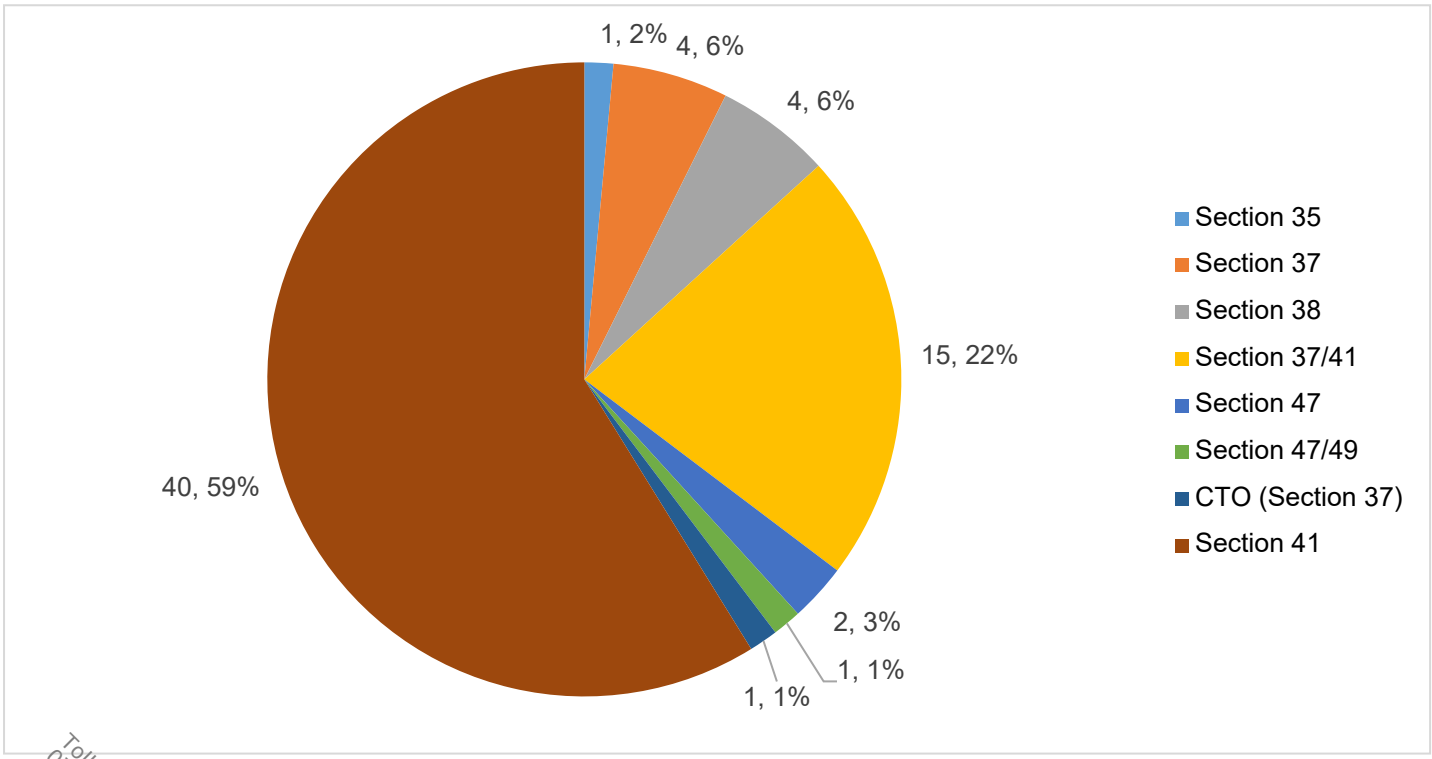
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

In this period there were was one CAMHS patient 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 June 2020





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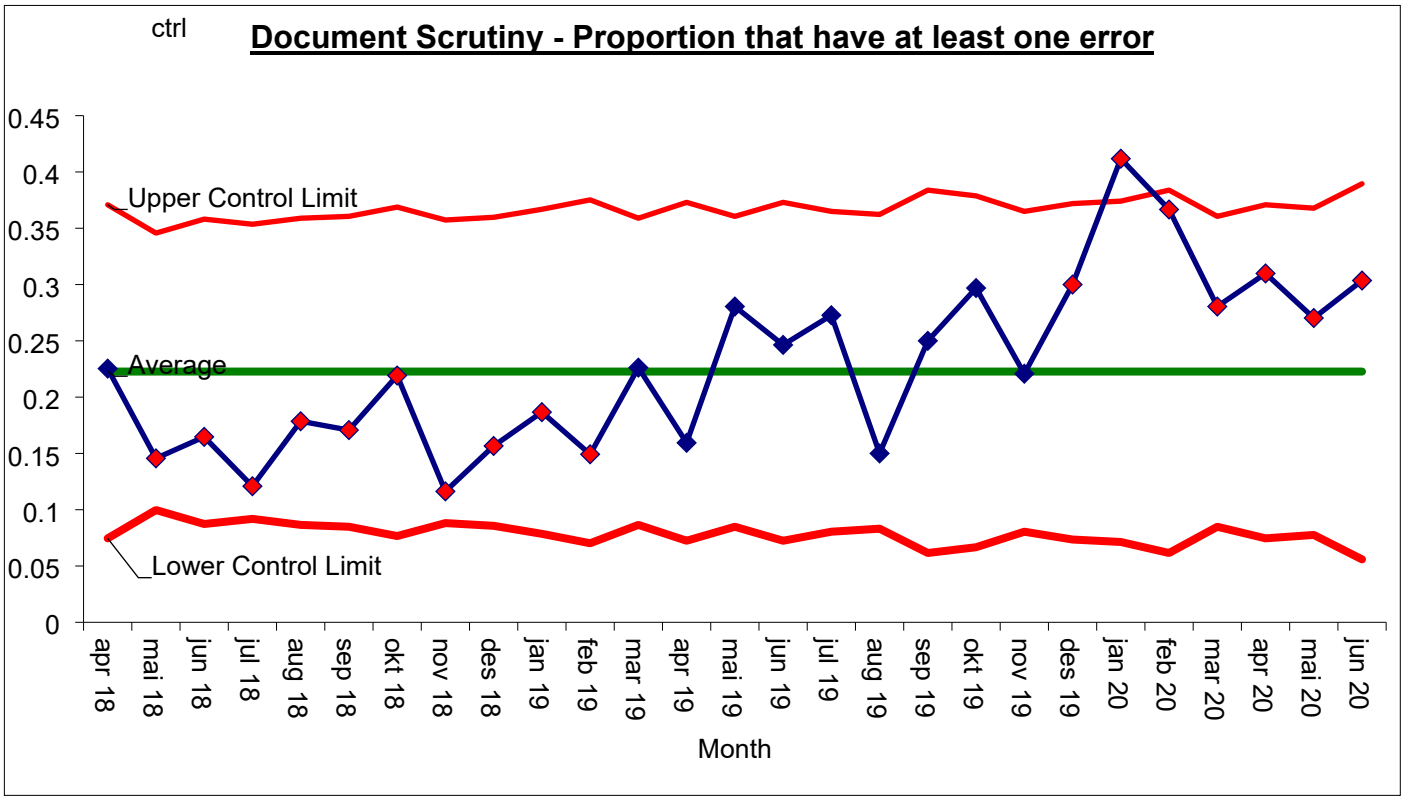
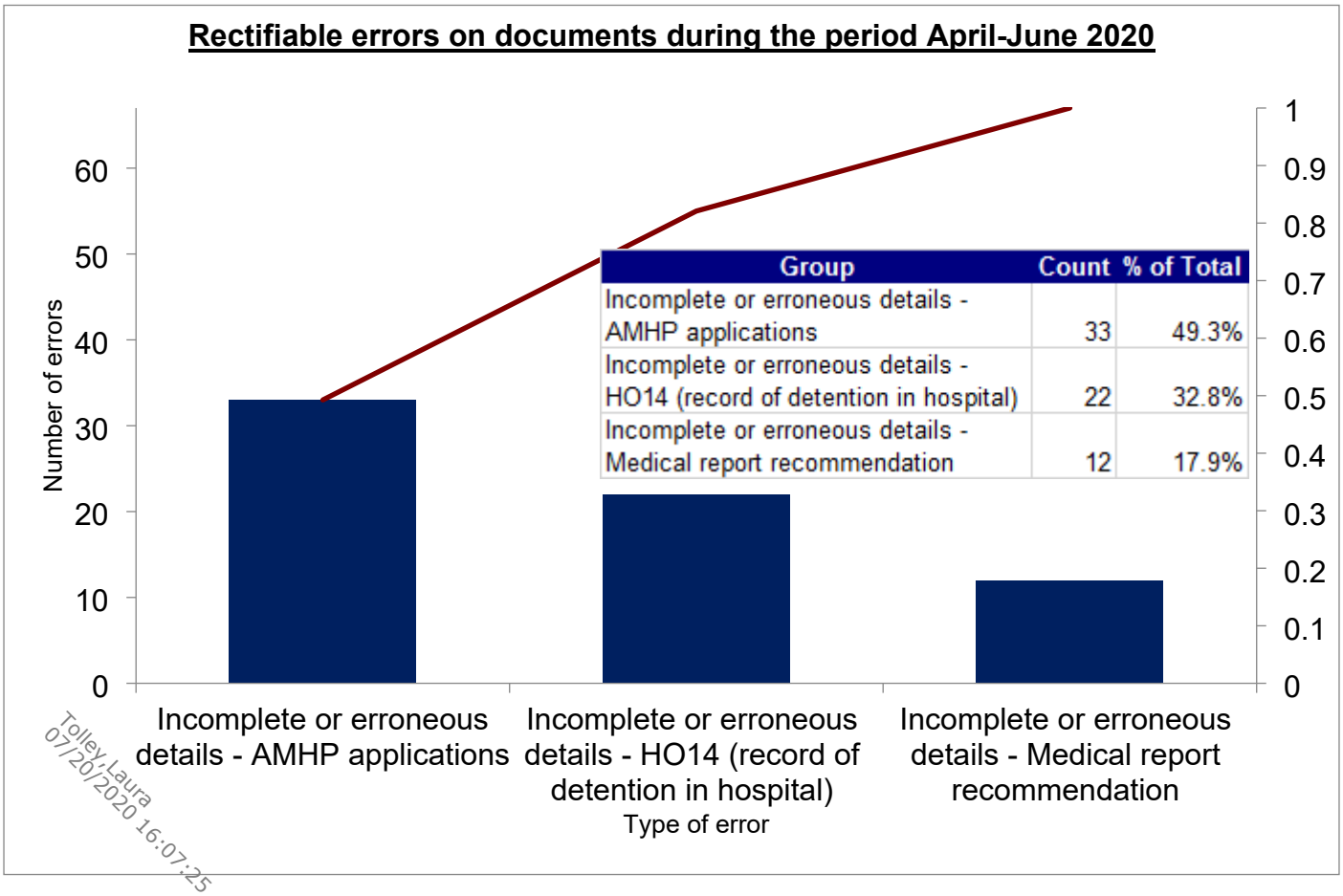
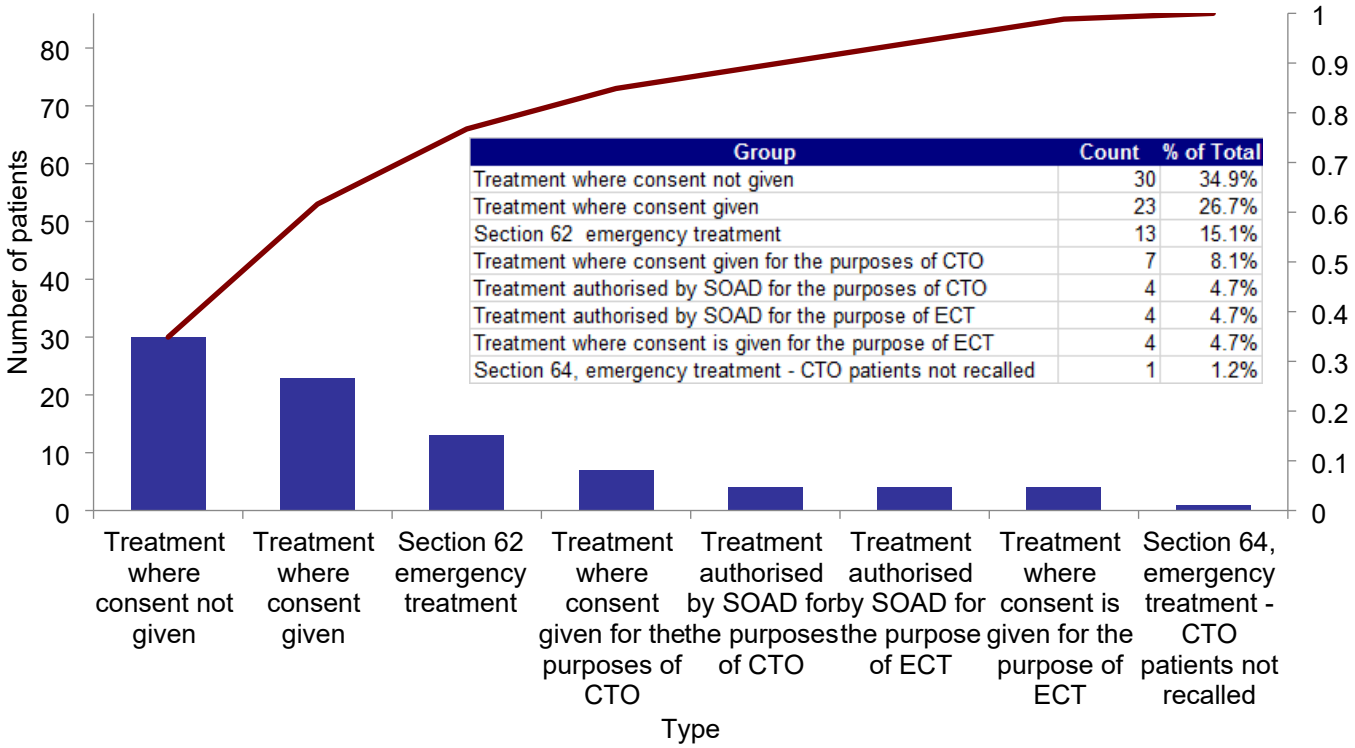
Scrutiny of documents during the period



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.



Analysis of the treatment provisions under Part 4 and Part 4A, MHA, during the period April - June 2020



Group	Count	% of Total
Treatment where consent not given	30	34.9%
Treatment where consent given	23	26.7%
Section 62 emergency treatment	13	15.1%
Treatment where consent given for the purposes of CTO	7	8.1%
Treatment authorised by SOAD for the purposes of CTO	4	4.7%
Treatment authorised by SOAD for the purpose of ECT	4	4.7%
Treatment where consent is given for the purpose of ECT	4	4.7%
Section 64, emergency treatment - CTO patients not recalled	1	1.2%

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.

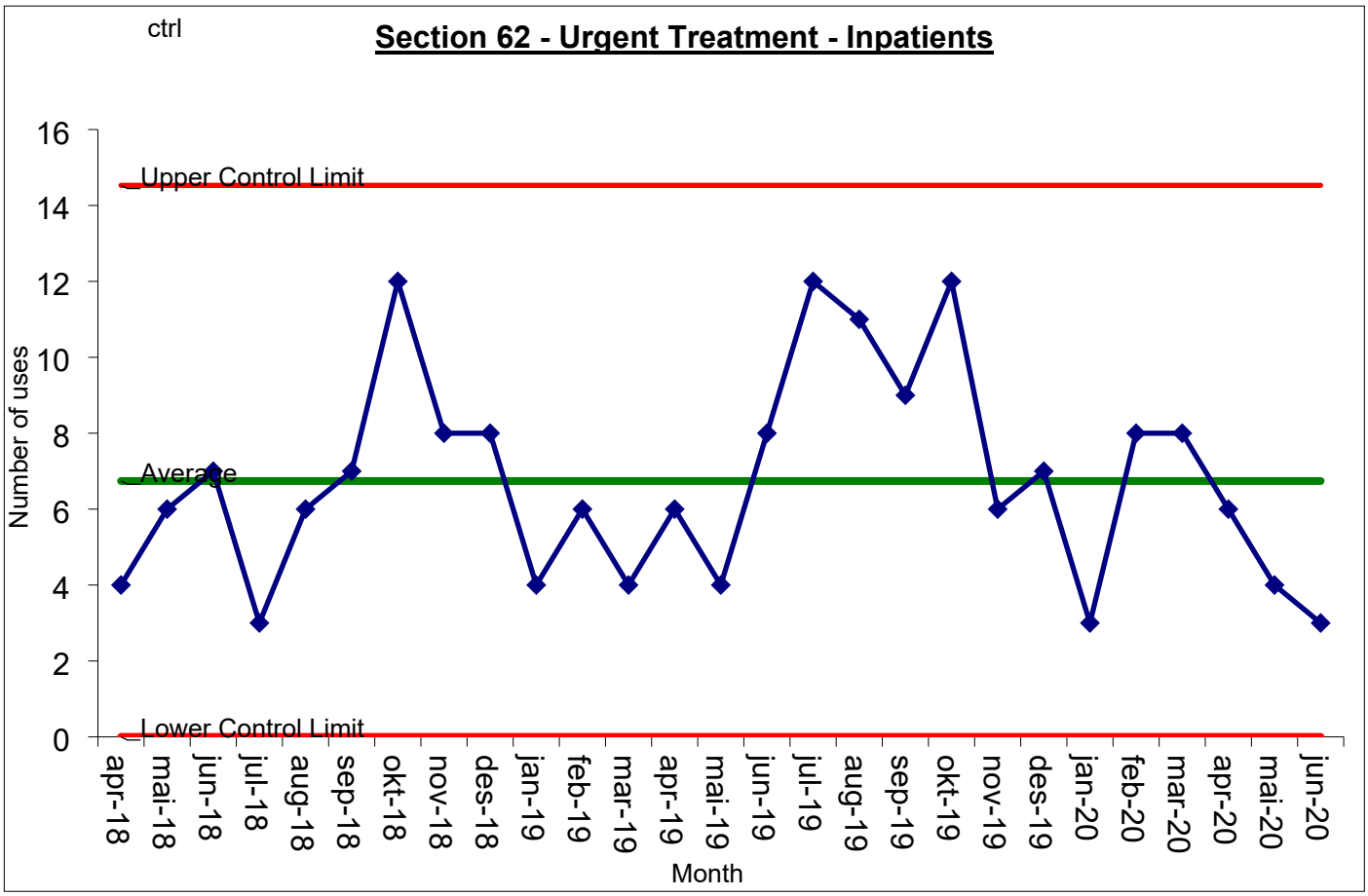
Urgent treatment is defined as treatment that is:

- 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.

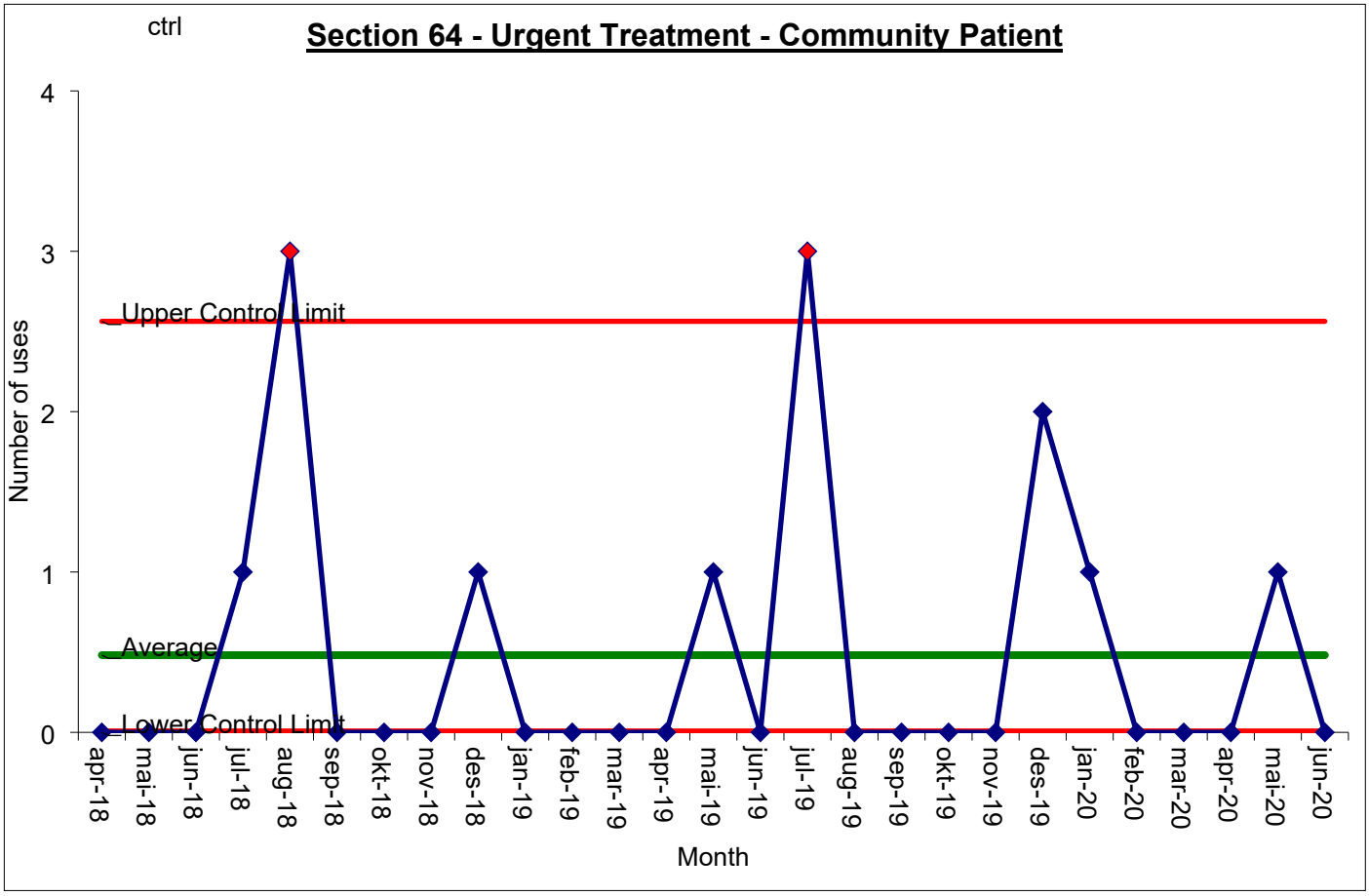
Urgent treatment can be used in any of the following instances:

- 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.



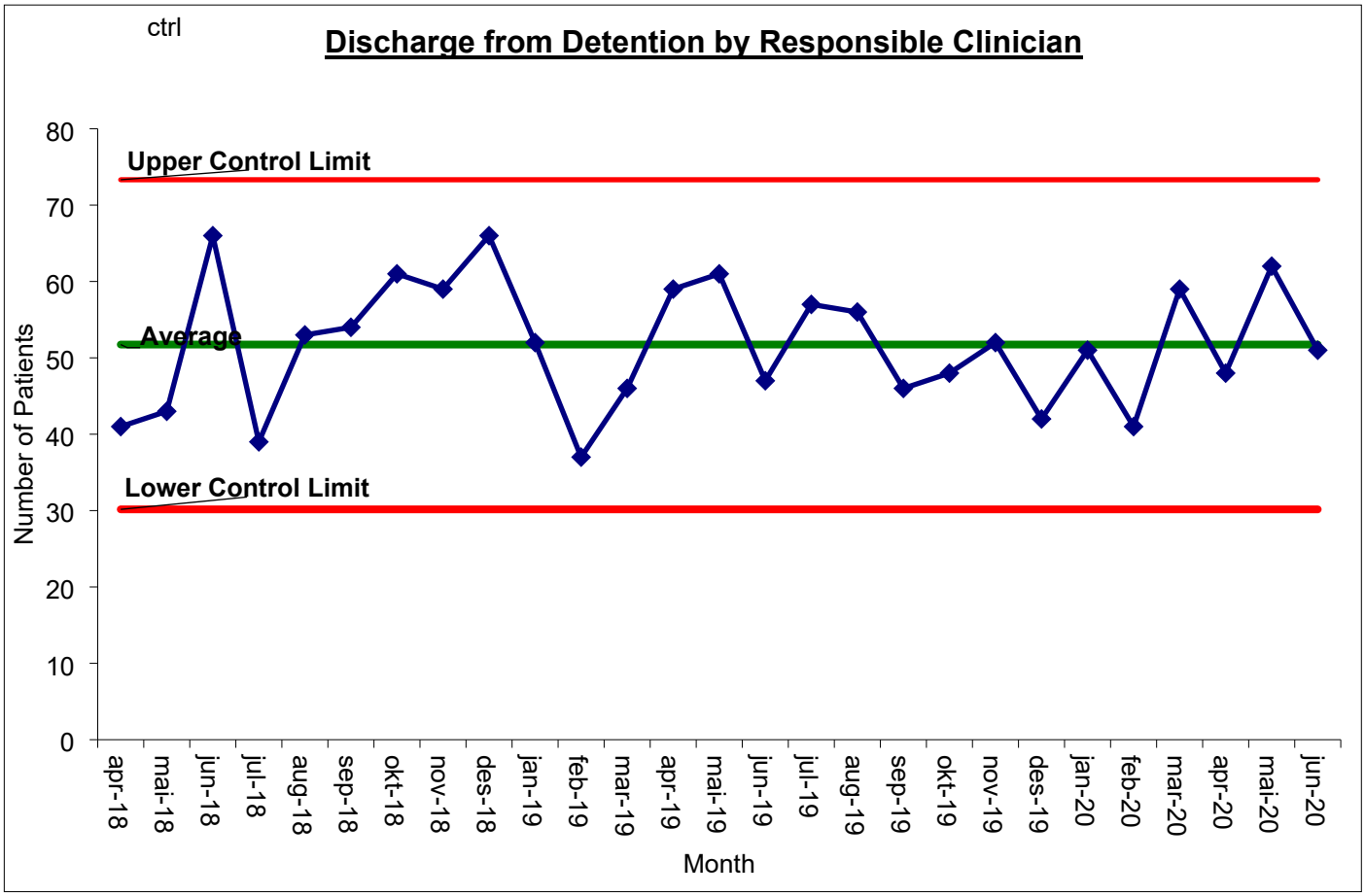
The above chart highlights that Section 62 was used on 13 occasions for the following reasons:

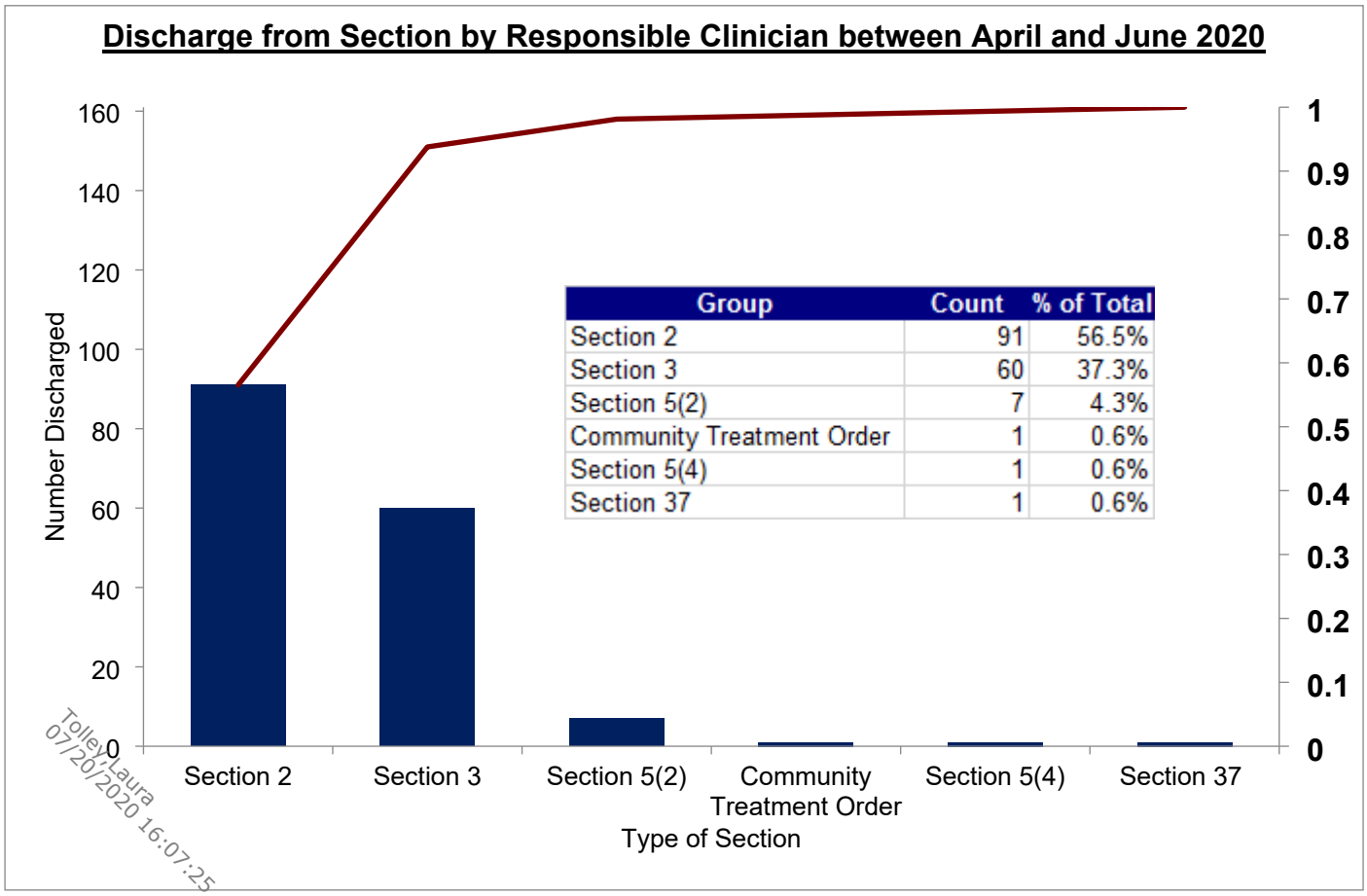
- Pending SOAD – 3 month rule x 7
- Previous certificate invalid x 1
- Pending SOAD – ECT required x 1
- Change of medication x 1
- Change to consent status x 3



The above chart highlights that Section 64 was used on one occasion during the period pending a SOAD due to a change in capacity status.

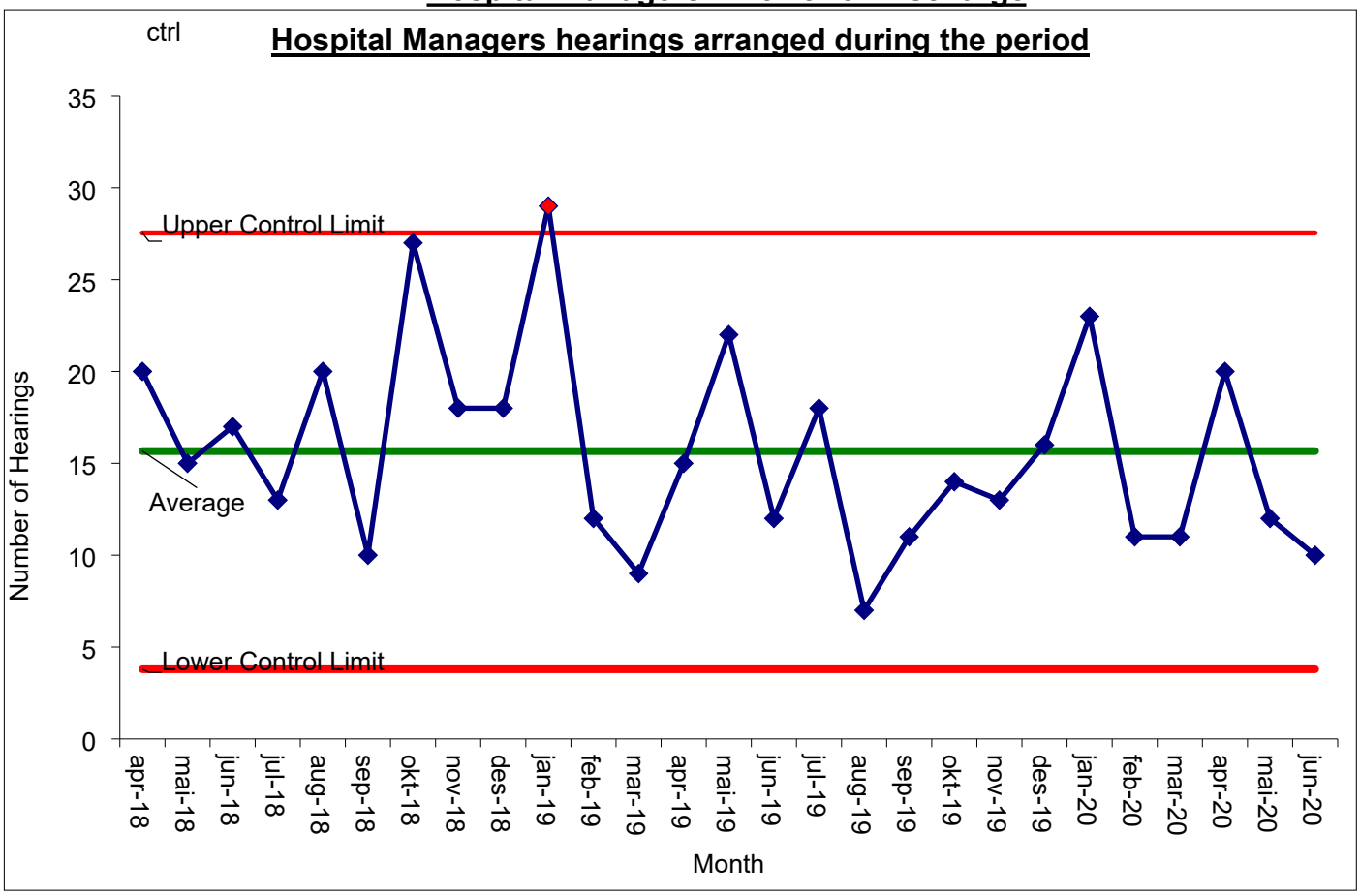
Discharge

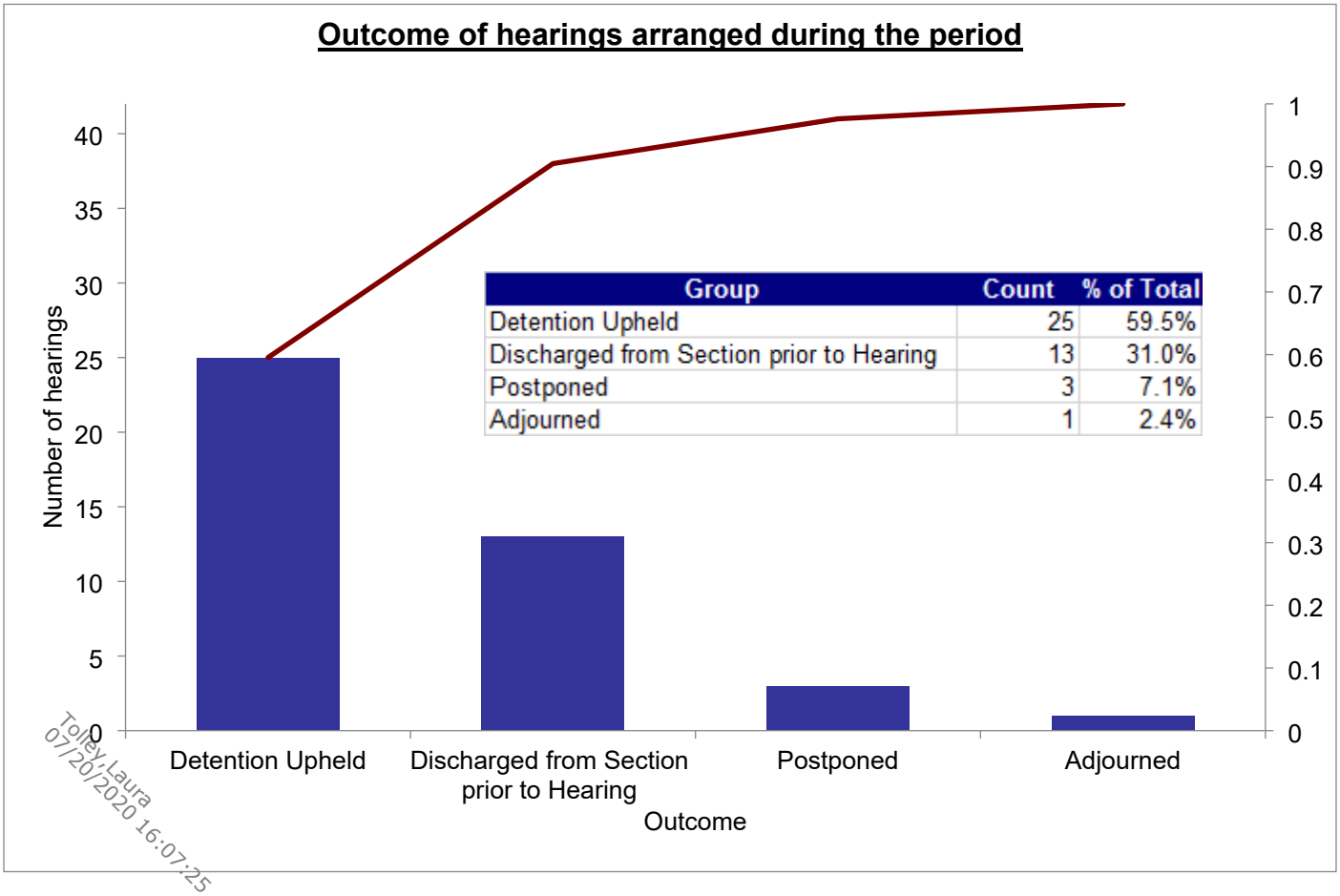




Group	Count	% of Total
Section 2	91	56.5%
Section 3	60	37.3%
Section 5(2)	7	4.3%
Community Treatment Order	1	0.6%
Section 5(4)	1	0.6%
Section 37	1	0.6%

Hospital Managers – Power of Discharge

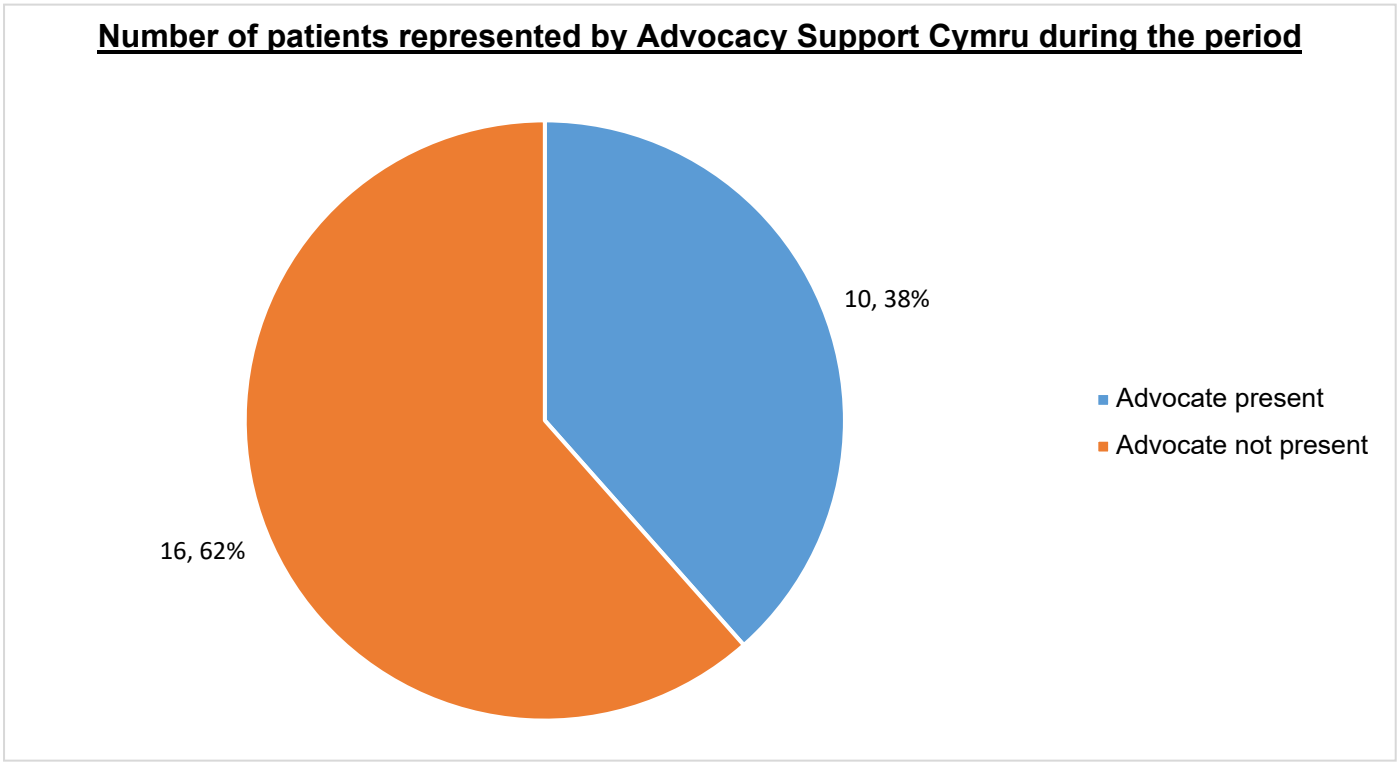


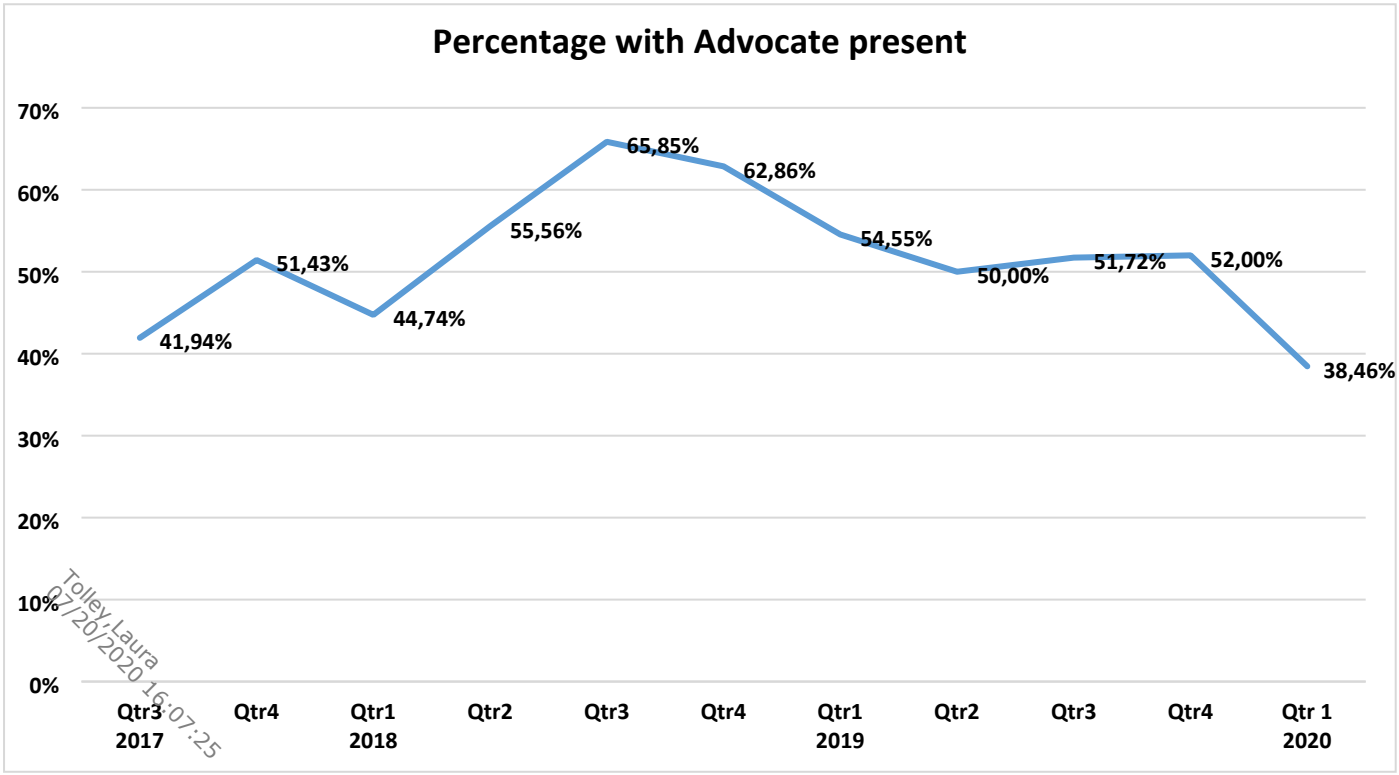


One hearing was adjourned to enable an Independent Mental Health Advocate to be present.

Three hearings were postponed for the following reasons;-

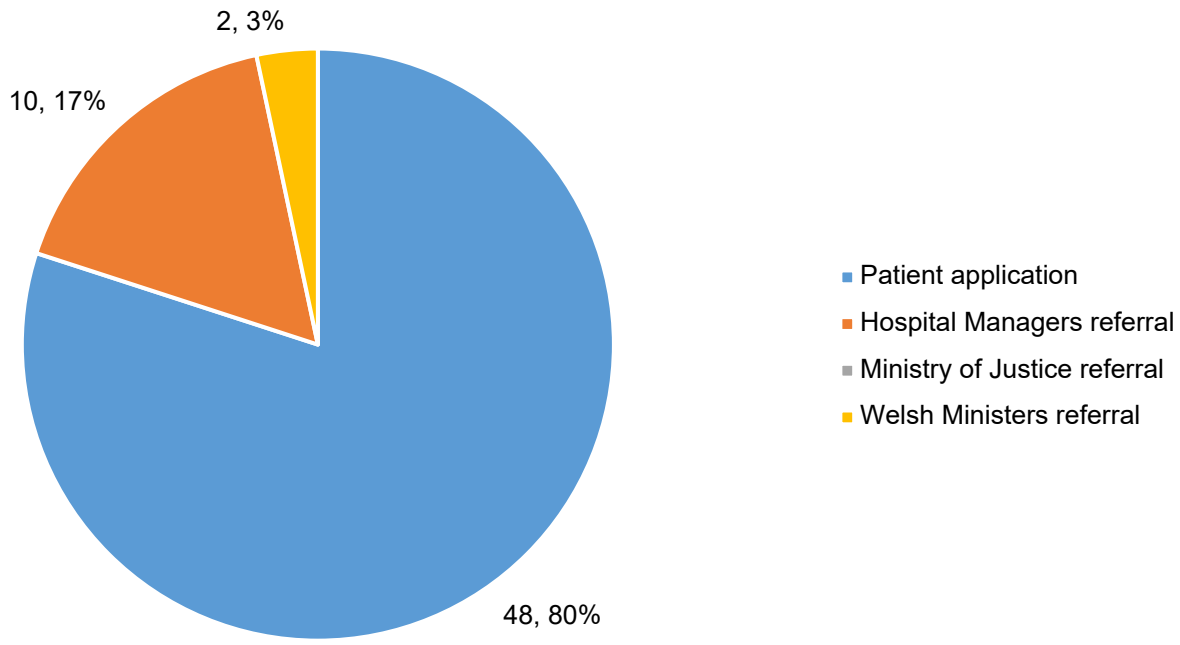
- RC unable to attend
- RC did not submit medical report or renewal document on time
- Ward unable to connect to attend the virtual hearing





Mental Health Review Tribunal (MHRT) for Wales

Source of applications to the MHRT during the period



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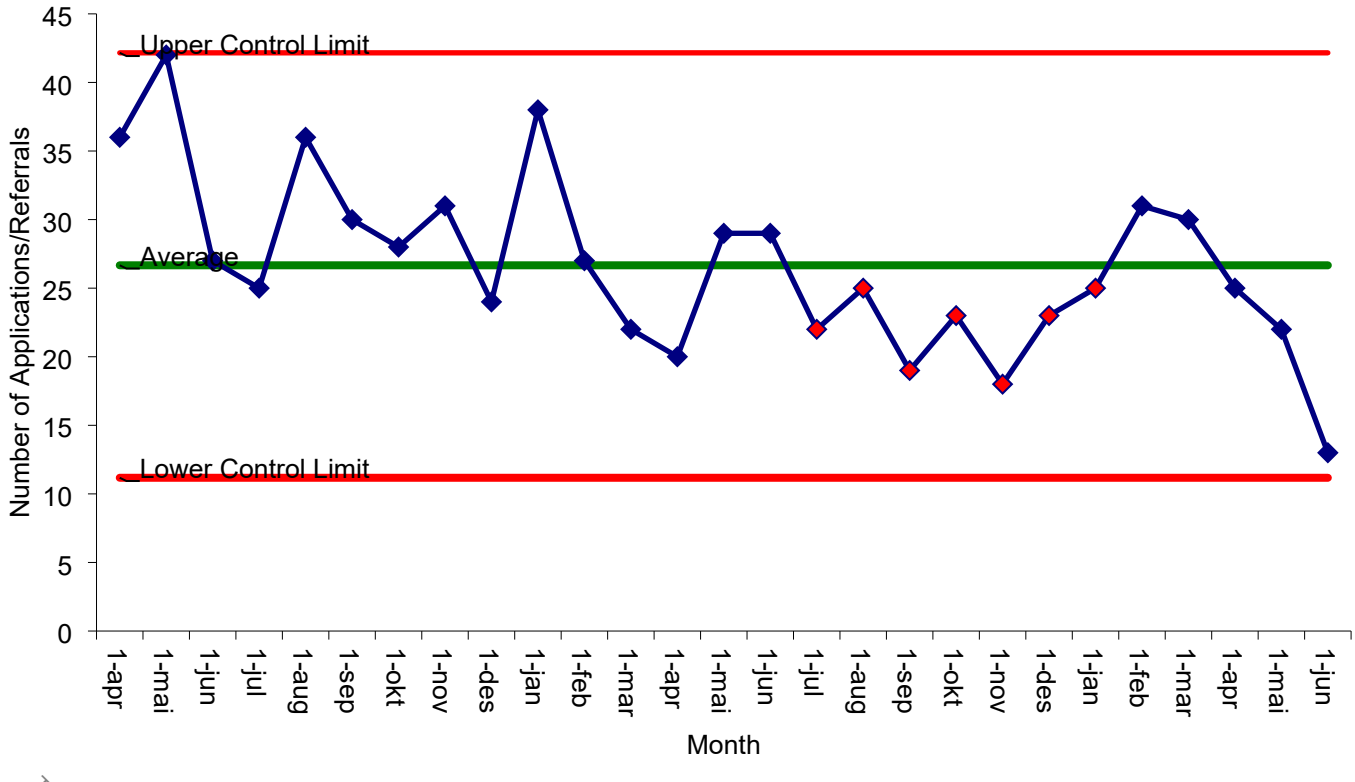
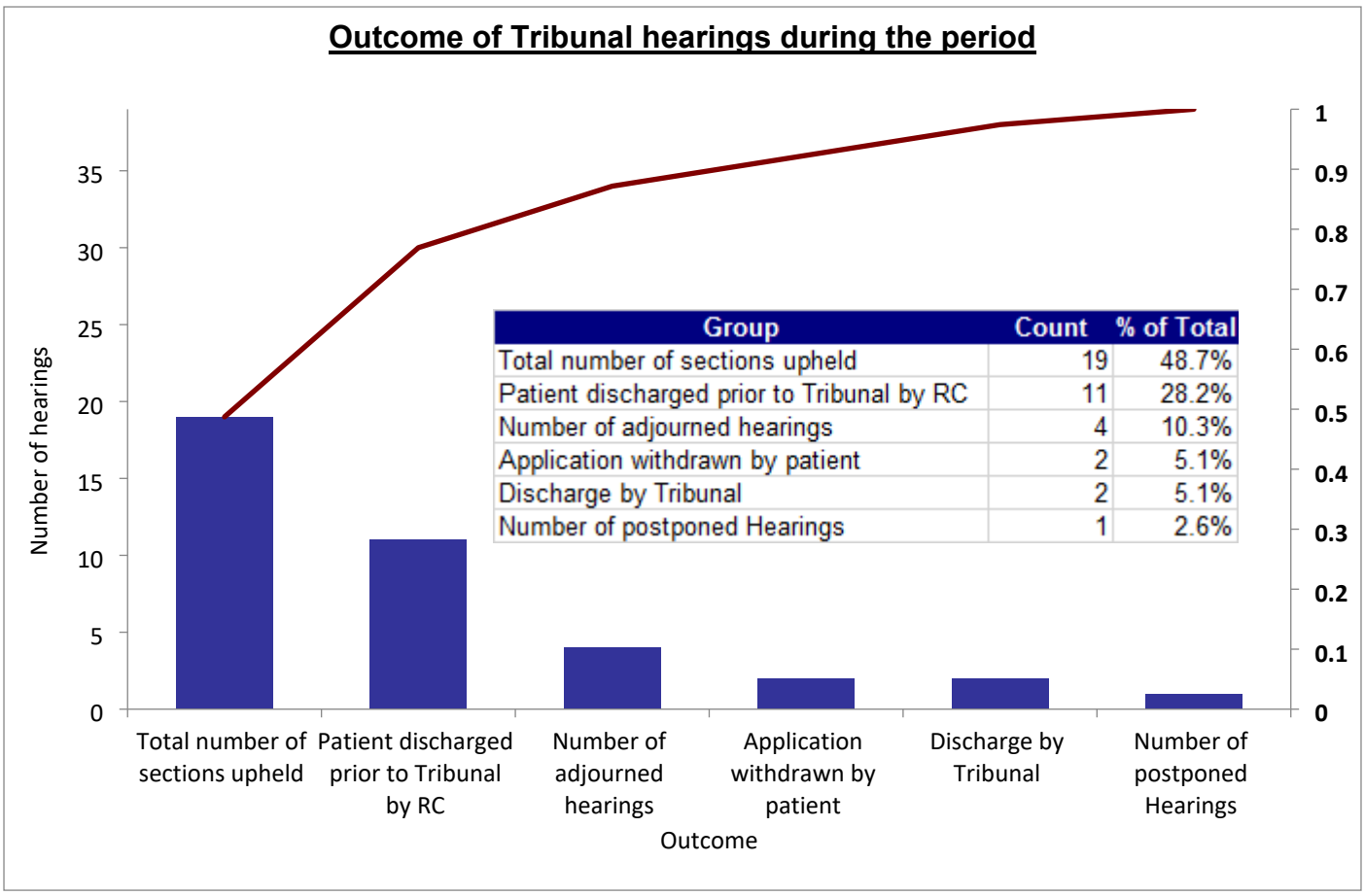
Number of MHRT applications and referrals during the period



Talley,Laura
07/20/2020 16:07:25



Group	Count	% of Total
Total number of sections upheld	19	48.7%
Patient discharged prior to Tribunal by RC	11	28.2%
Number of adjourned hearings	4	10.3%
Application withdrawn by patient	2	5.1%
Discharge by Tribunal	2	5.1%
Number of postponed Hearings	1	2.6%

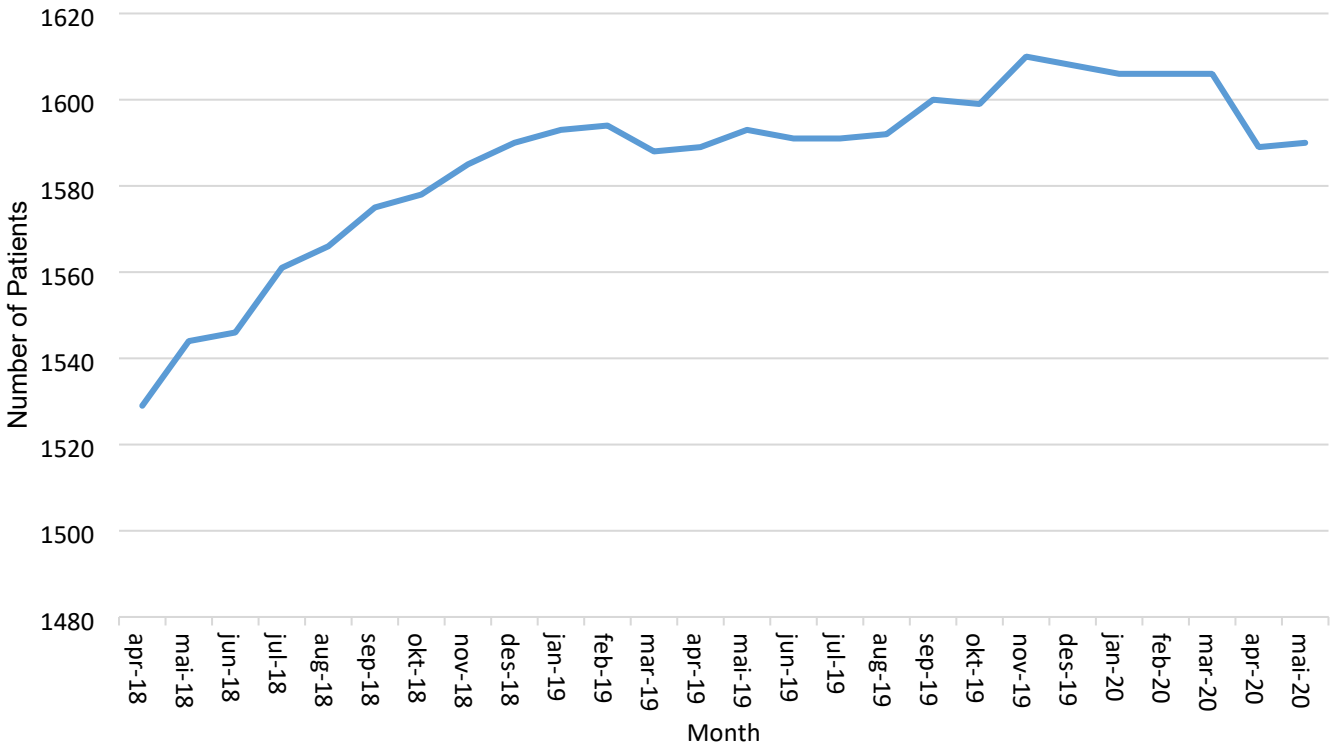
Four hearings were adjourned for the following reasons:

- One for further evidence
- On two occasions the patient changed their legal representative
- In one case the patient required more time with their legal representative to prepare for the hearing

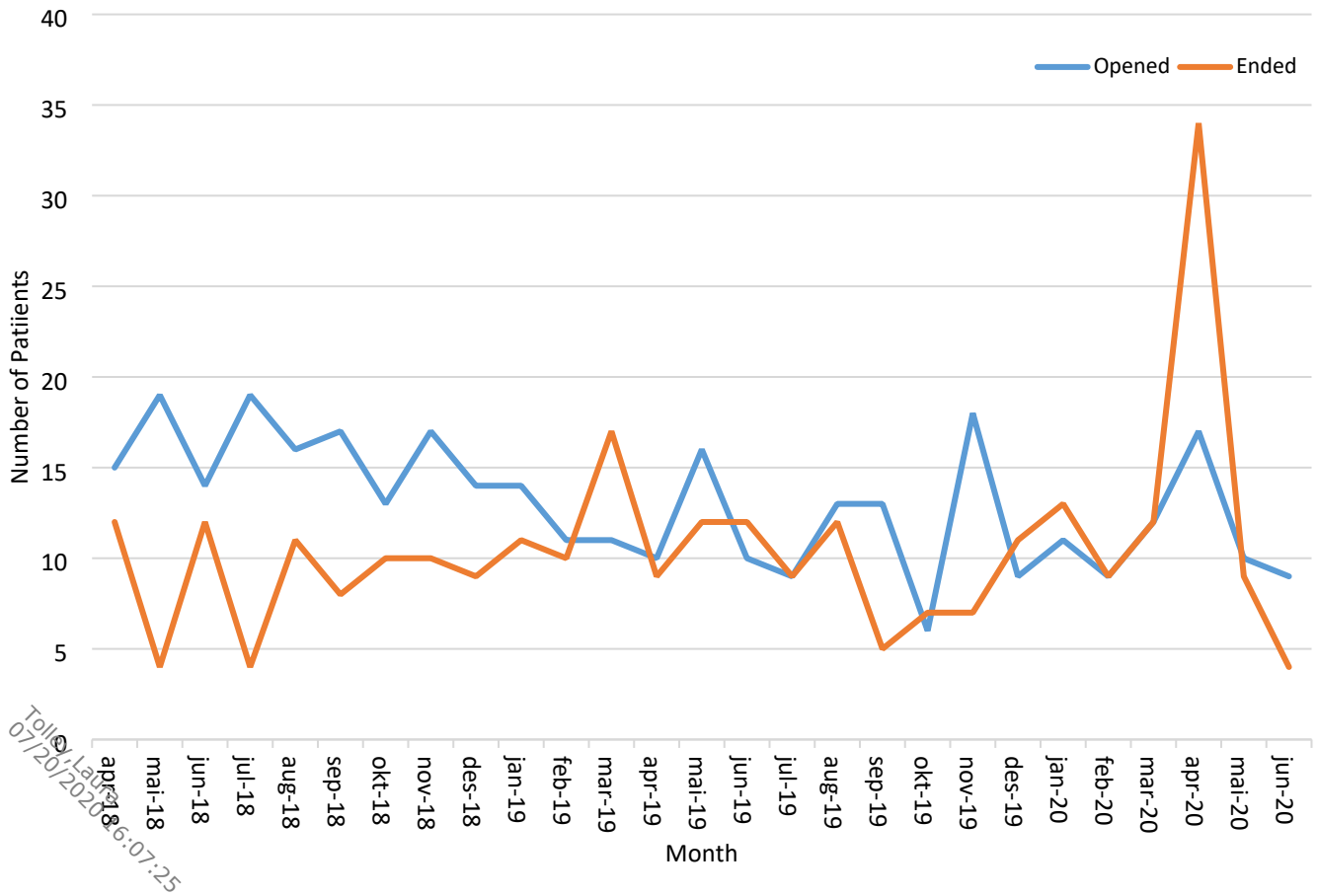
One hearing was postponed because an interpreter was required.

Section 117 Aftercare

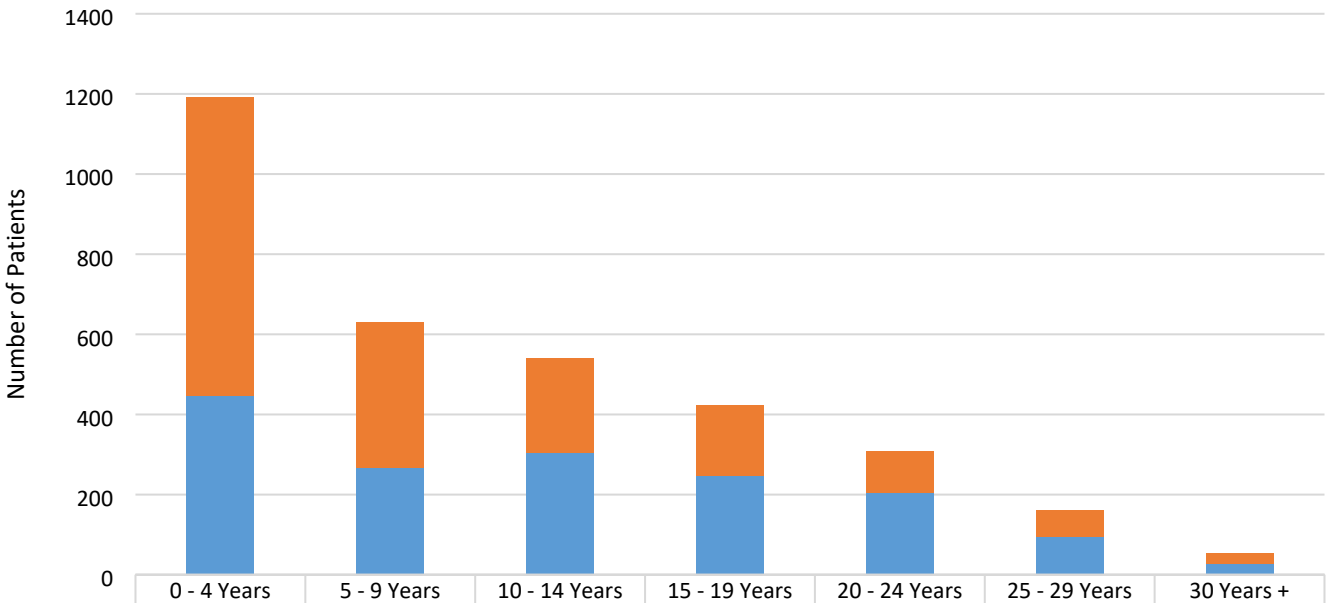
Patients eligible for Section 117 aftercare



Section 117 Activity



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	745	363	237	176	104	67	27
Ongoing	446	266	304	248	205	94	27

Timescale

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

Exclusion of visitors

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

Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- Ten patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
    - One to PICU bed
    - Four to return to their home area
    - Five to a specialist unit
    -
- Three 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:
    - One from PICU bed
    - Two to return to their home area

Death of detained patients

During the period there was one no death of a patient detained under Part 2 of the Mental Health Act. This has been reported to Healthcare Inspectorate Wales. The death was not COVID related, the patient had been tested negative.

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.

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

January to March 2020

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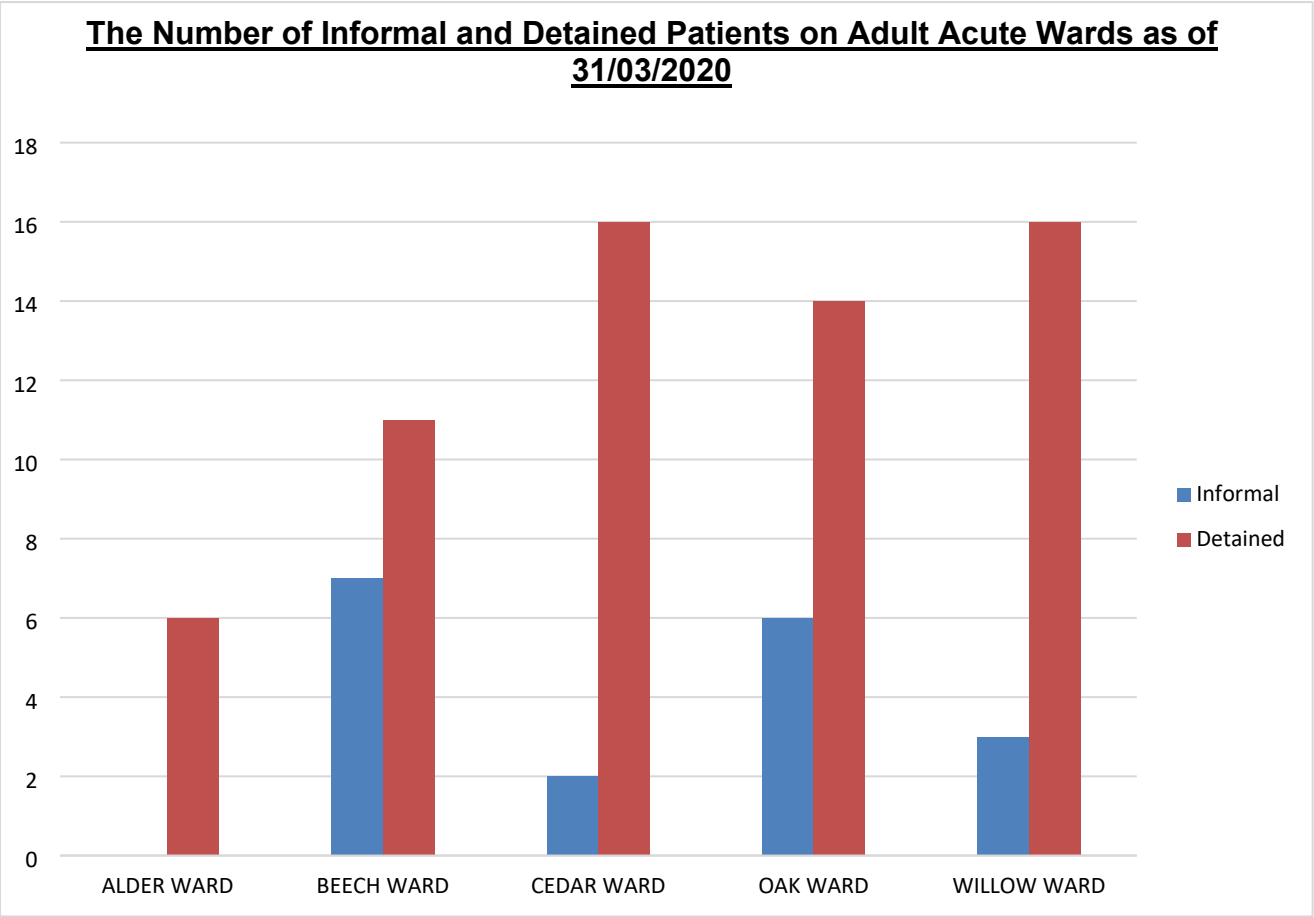
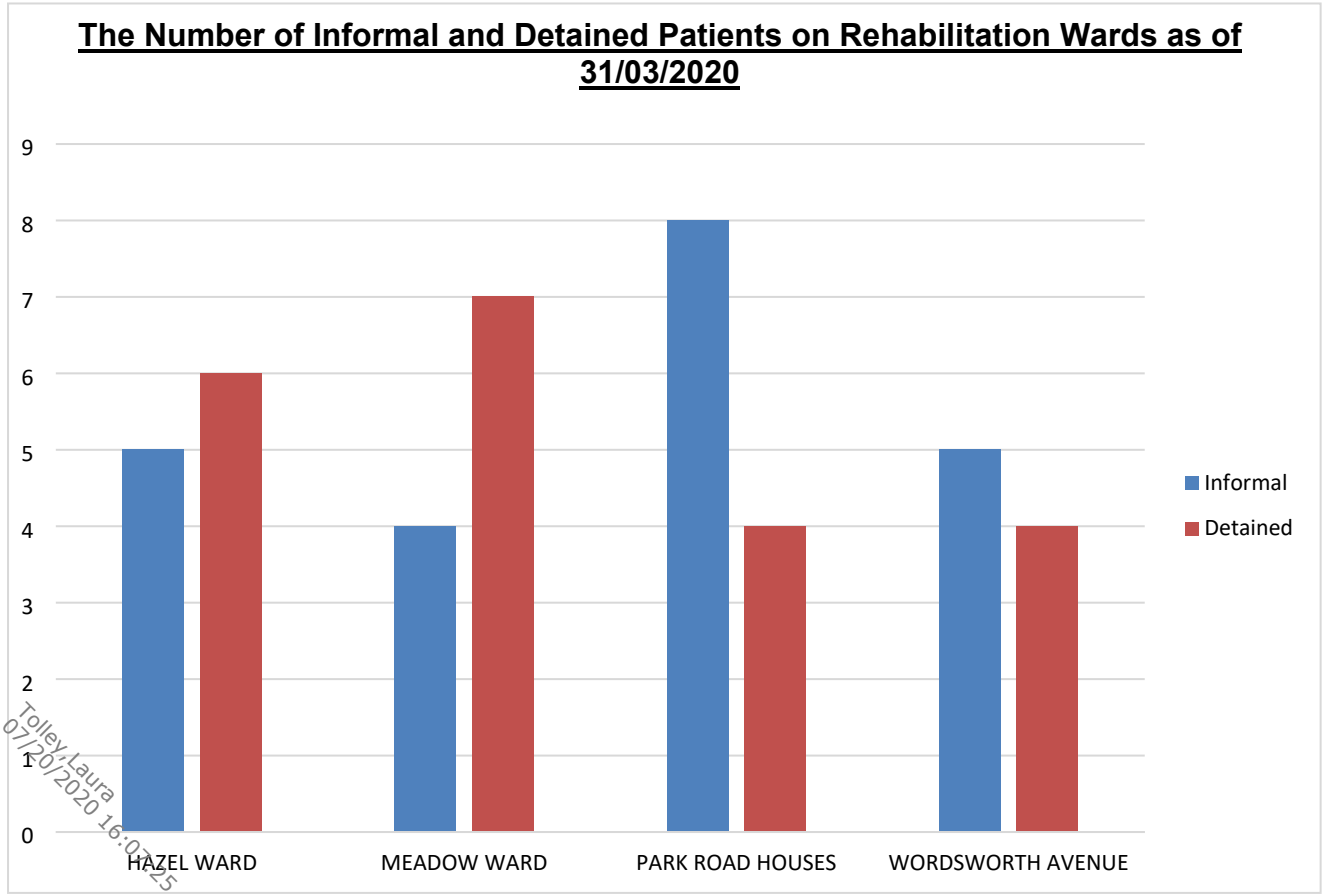
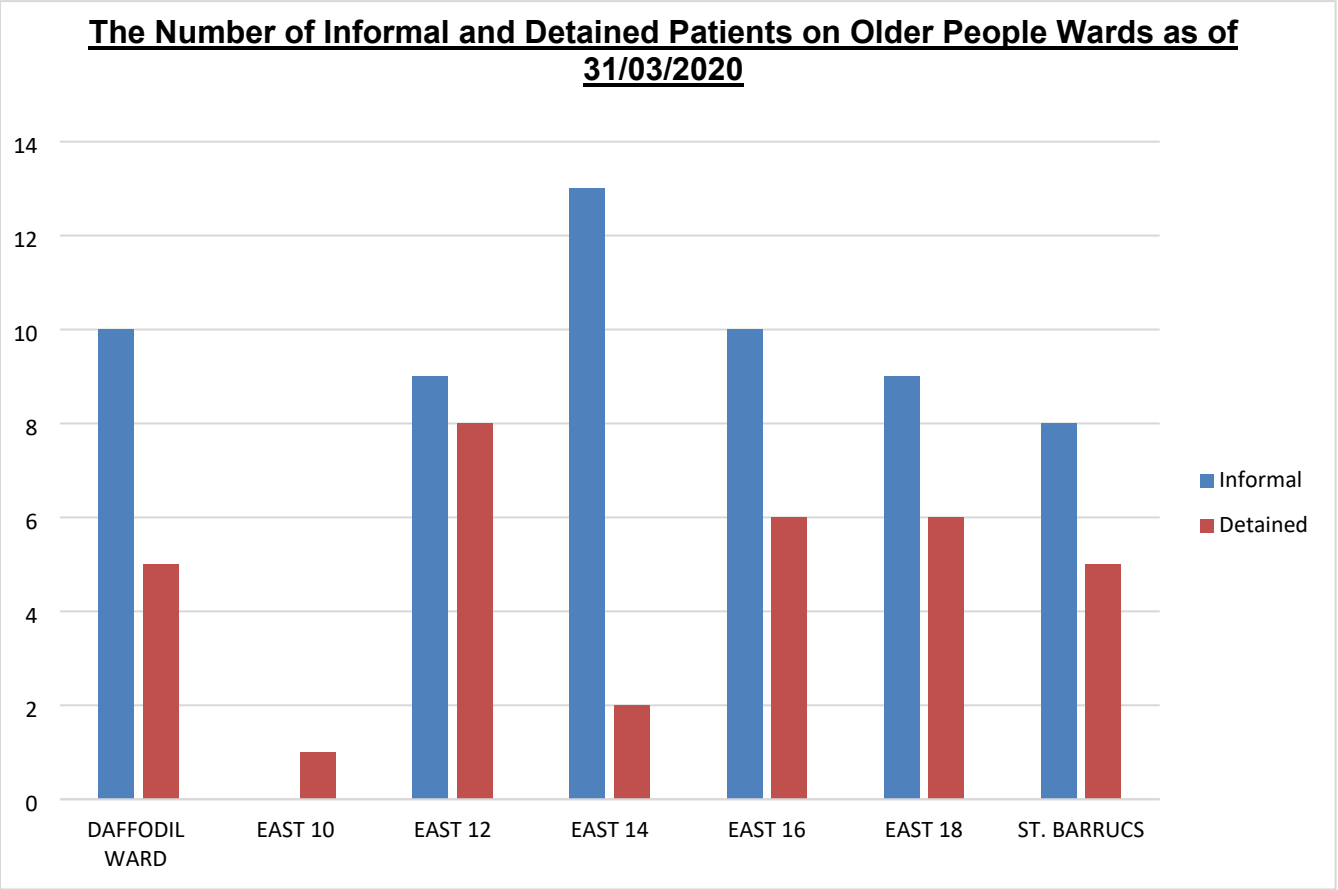
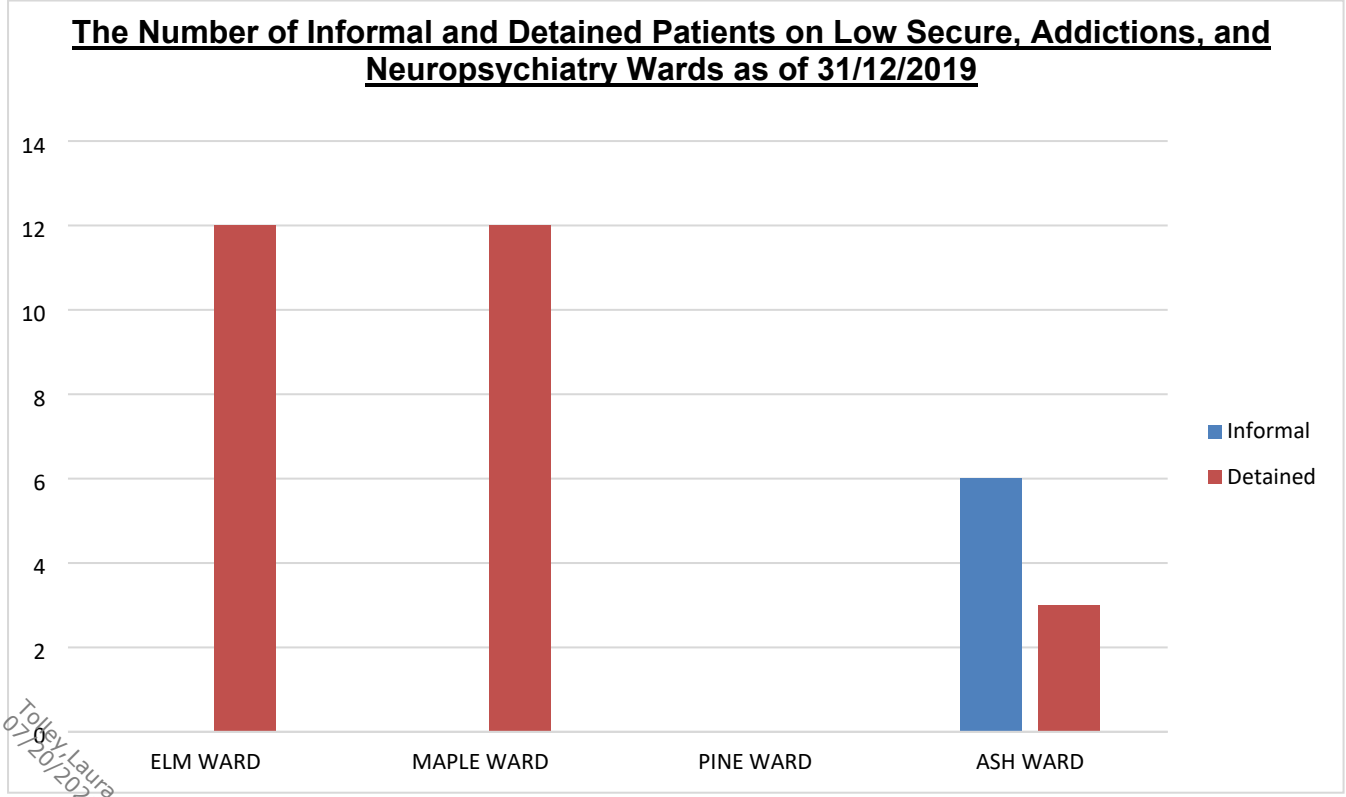




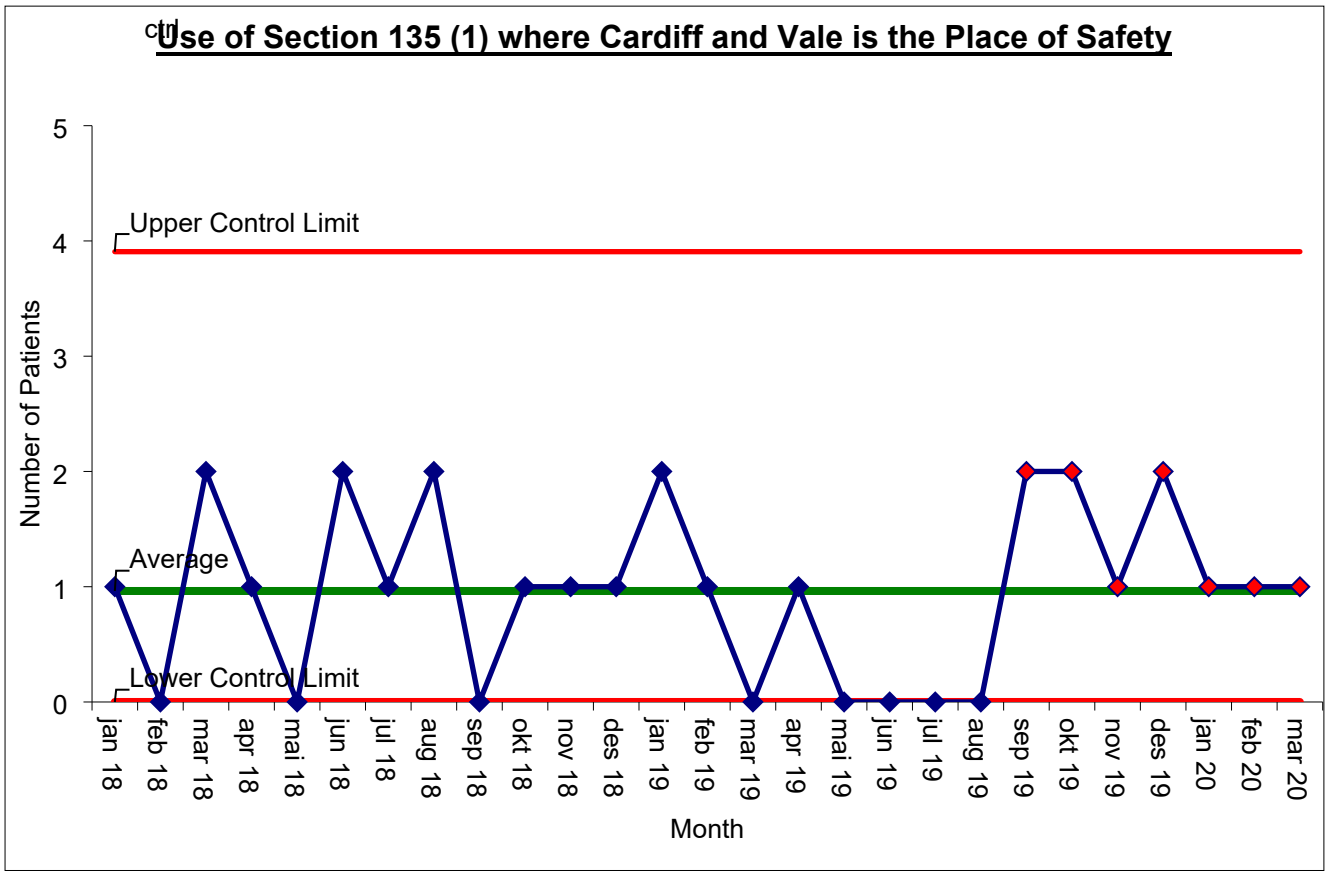




Due to the current Covid 19 pandemic that Pine Ward on 31/03/2020 was being re-configured as the dedicated Covid 19 positive Mental Health inpatients ward.

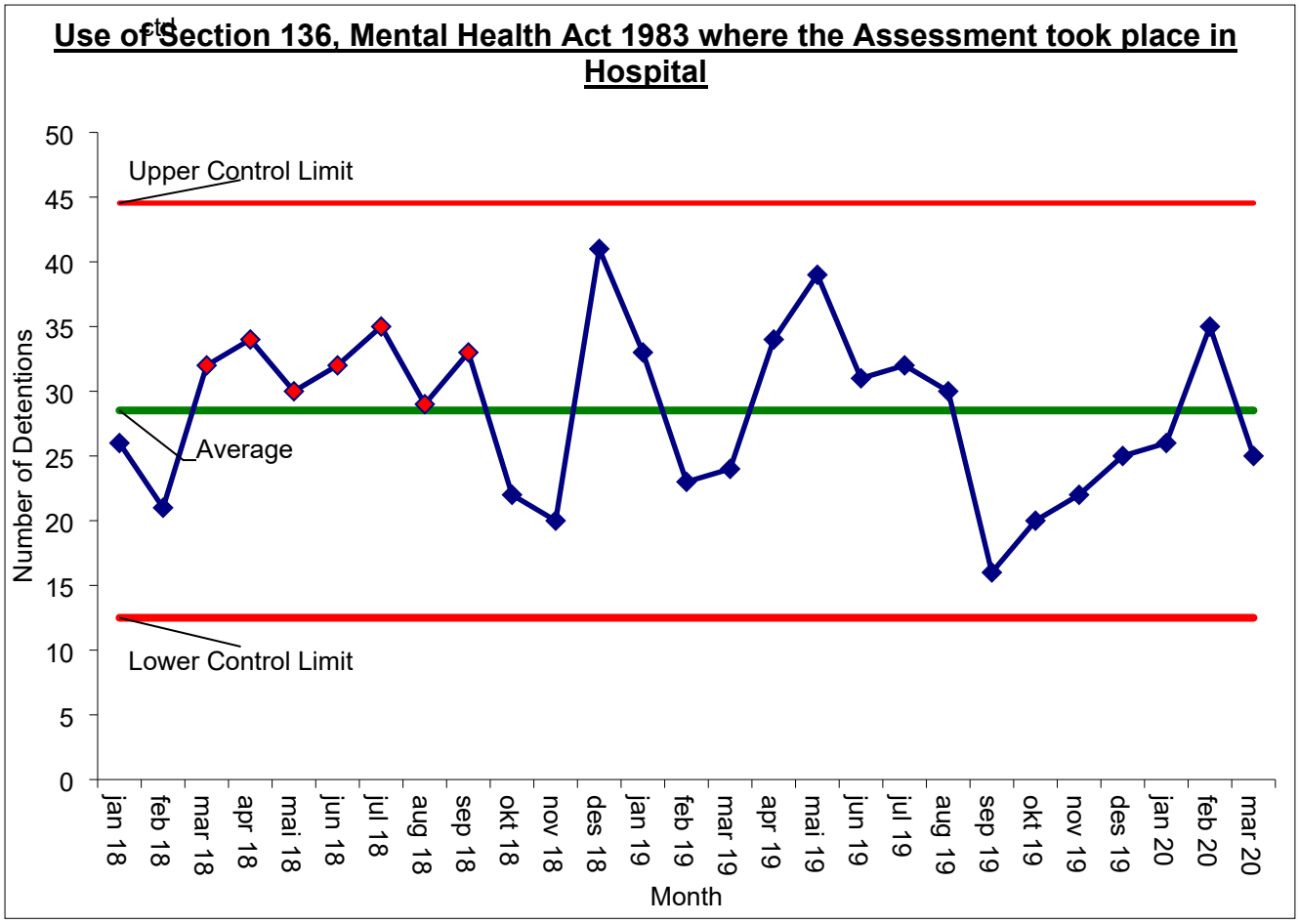
Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

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



Section 135(2) powers were used on one occaison who is detained under Section 2.

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



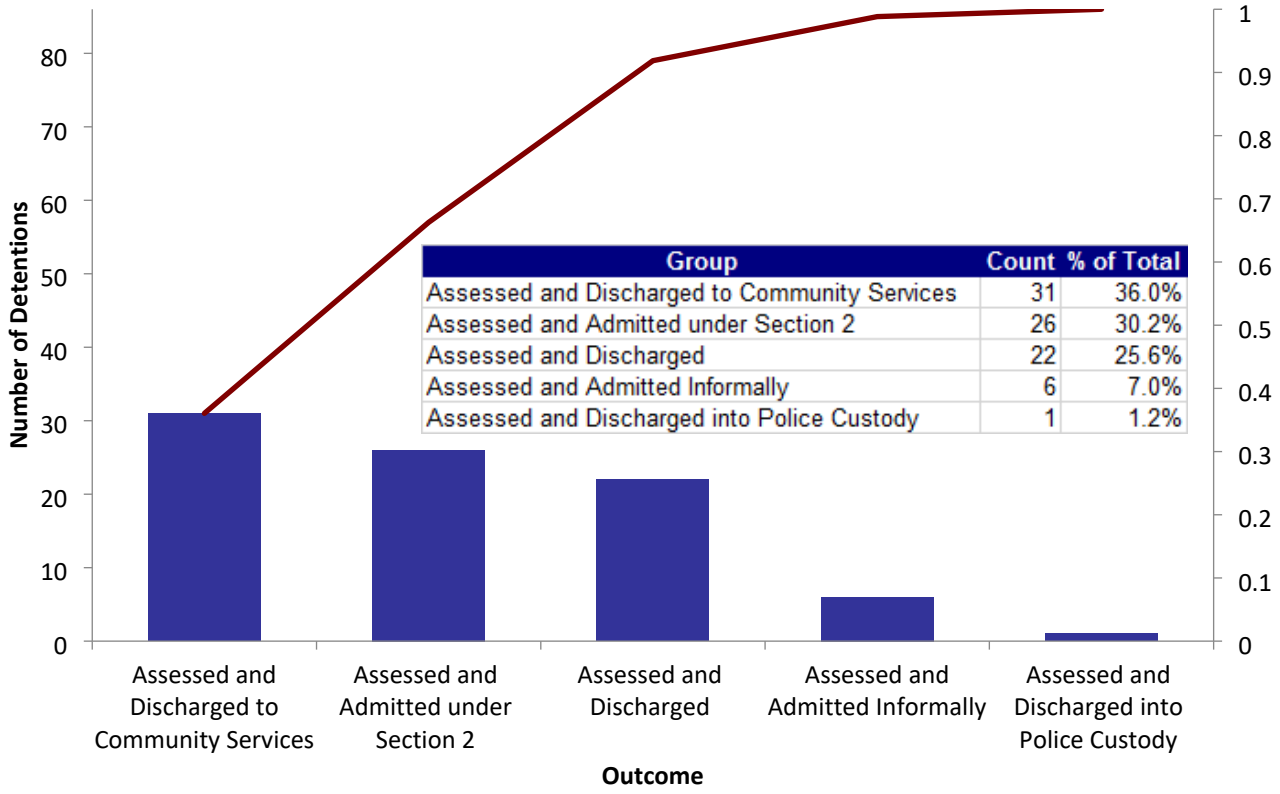
During the period a total of 86 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

CAMHS

One of those assessments was carried out on a patient under the age of 18. The outcome was as follows:

- Admitted under Section 2

Outcome of Section 136 where the Assessment took place in Hospital during the period January - March 2020



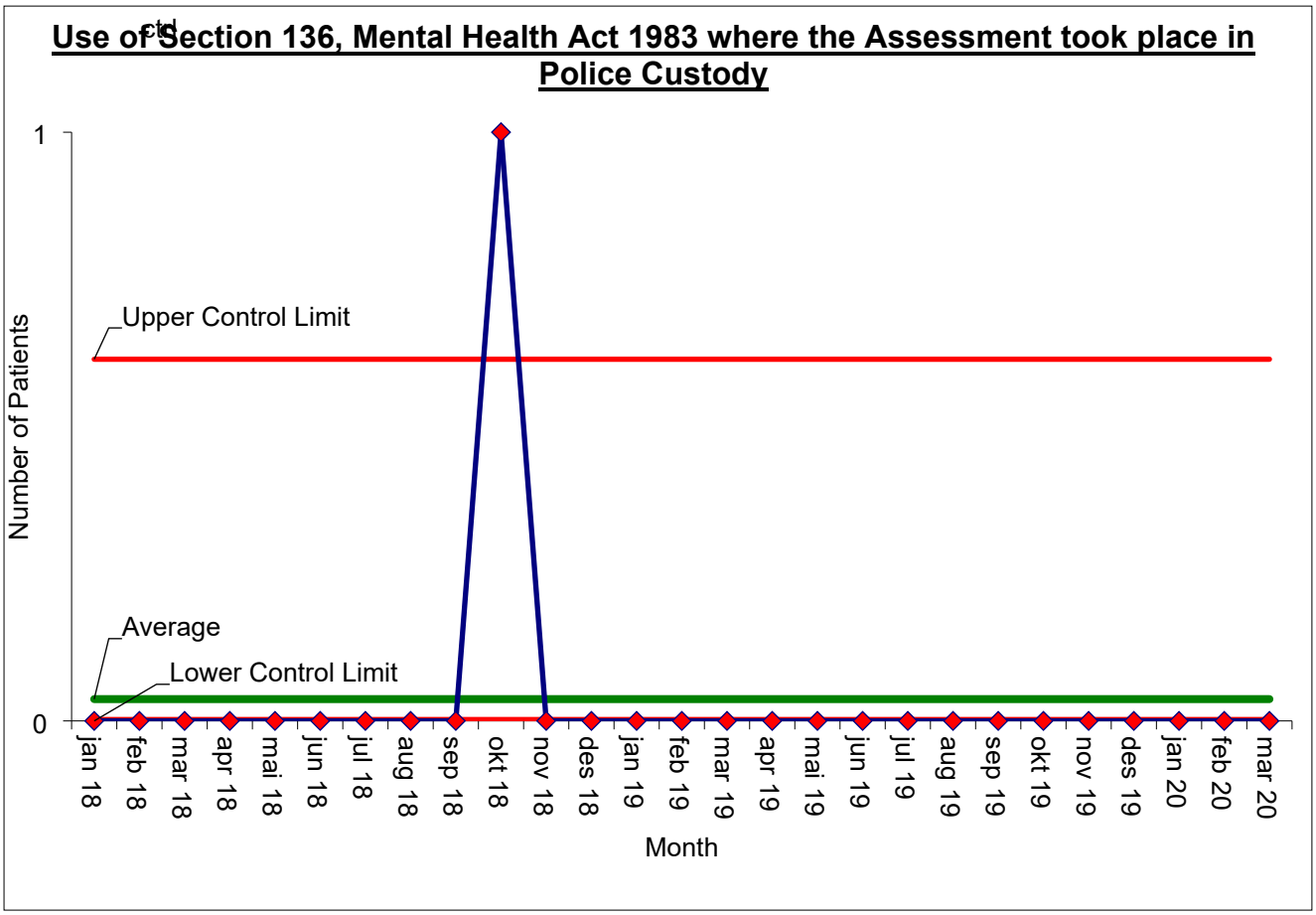
Group	Count	% of Total
Assessed and Discharged to Community Services	31	36.0%
Assessed and Admitted under Section 2	26	30.2%
Assessed and Discharged	22	25.6%
Assessed and Admitted Informally	6	7.0%
Assessed and Discharged into Police Custody	1	1.2%

The pareto chart highlights that 62.8% 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.

Two of those assessed were admitted under Section 2 to a specialist hospital under a different set of Managers.

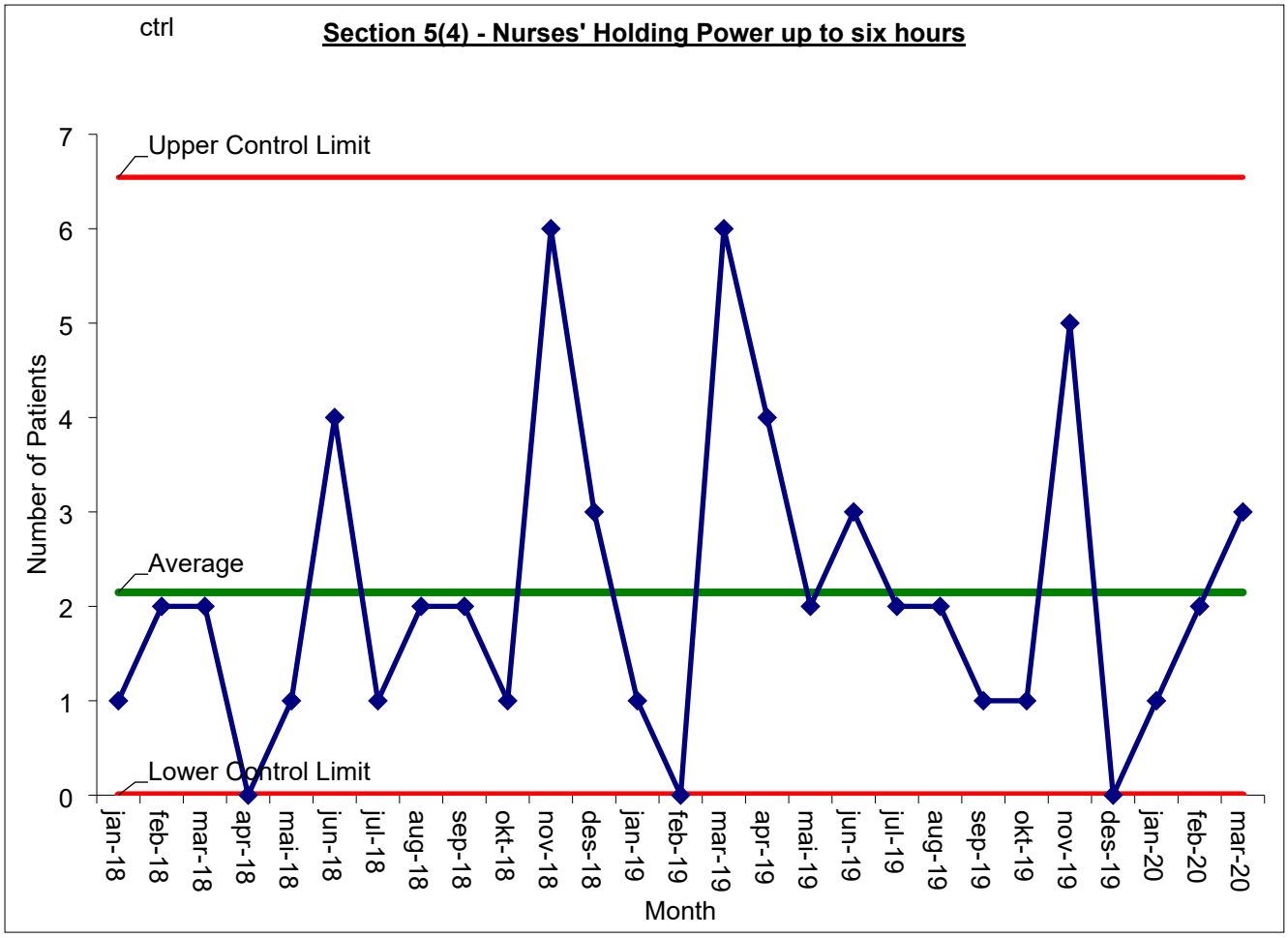
One of those assessed is a CAMHS patient who was admitted under Section and subsequently transferred to specialist hospital under a different set of Managers as soon as there was a suitable place available.

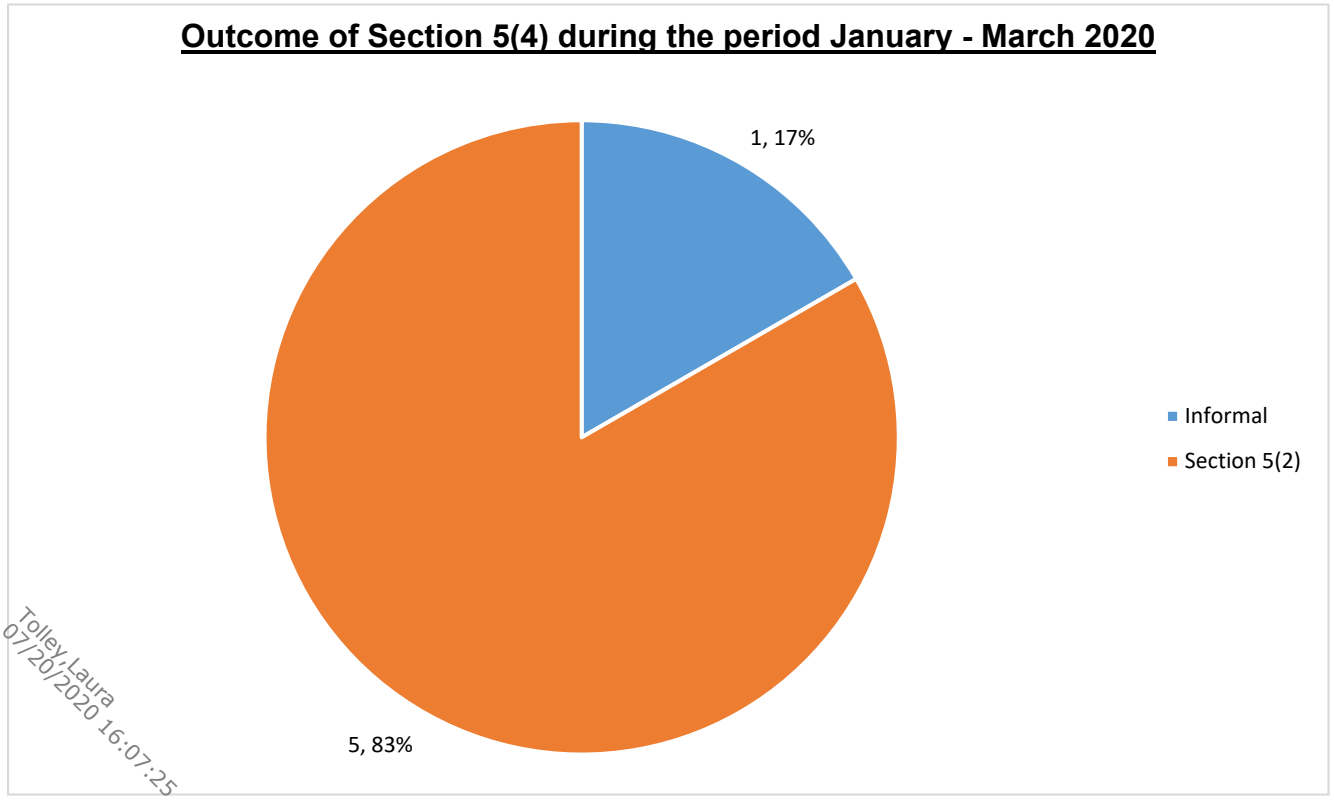
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station



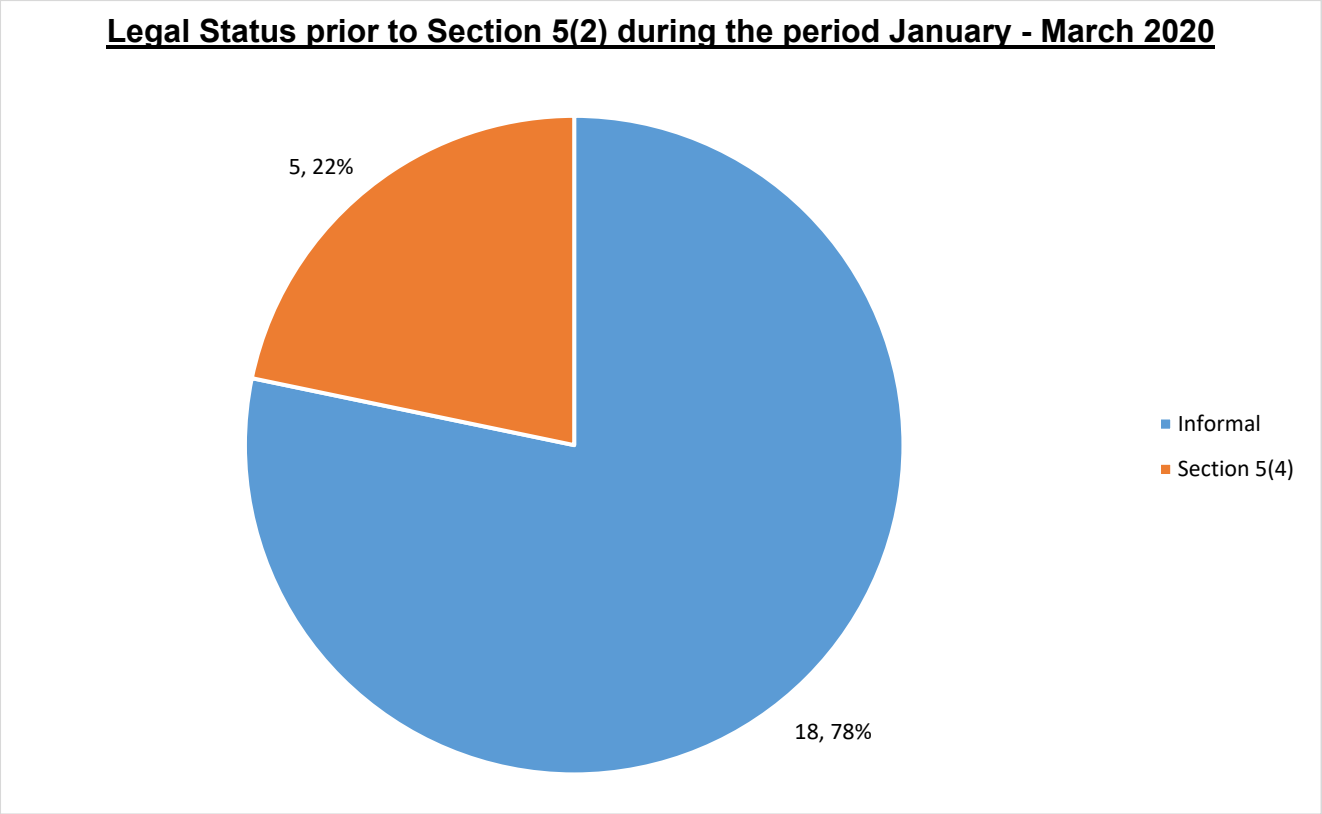
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite. However, one patient was initially taken to the Custody Suite due to the risk of violence. That patient was subsequently transferred to Hospital for assessment.

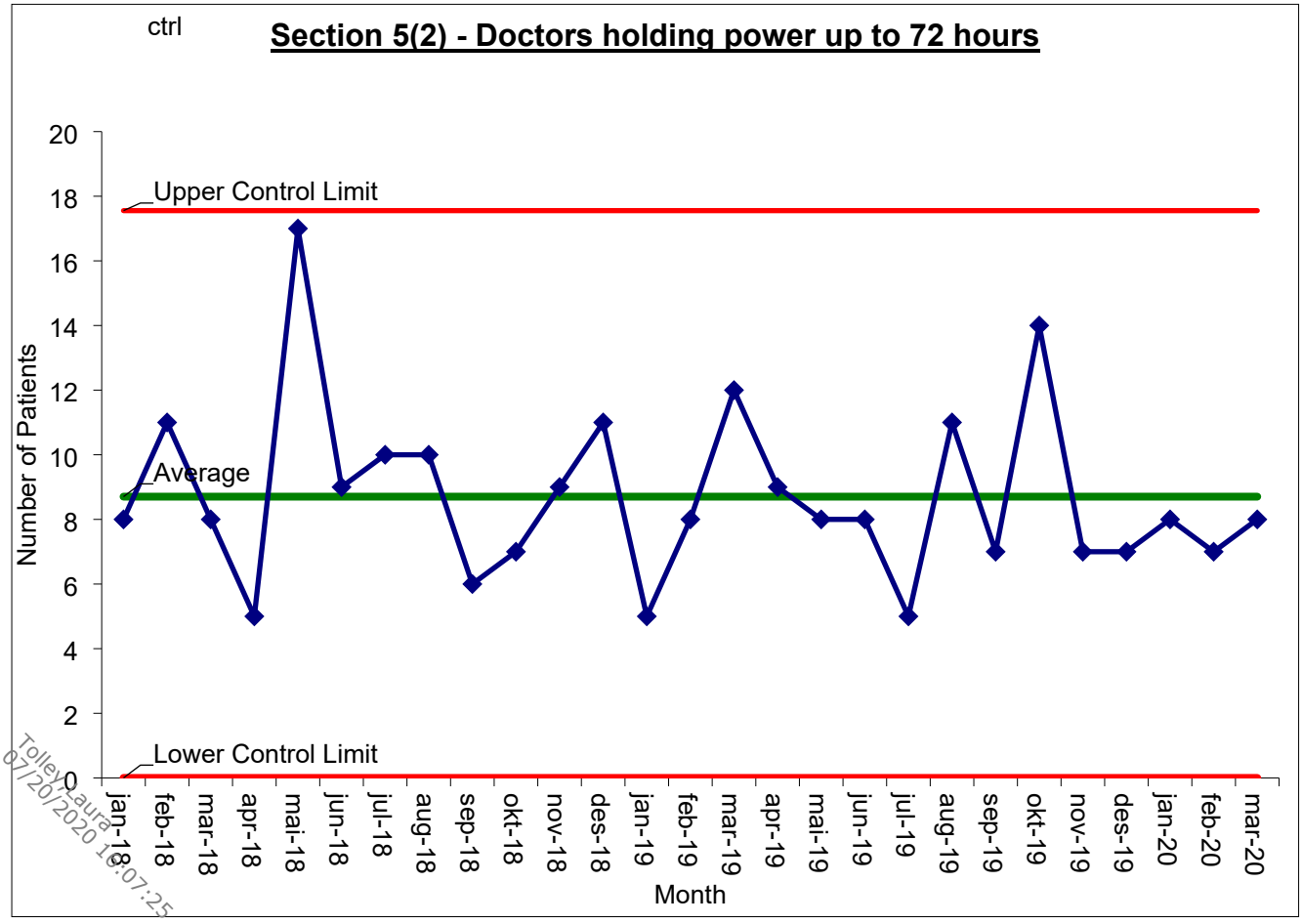
Section 5(4) - Nurses Holding Power

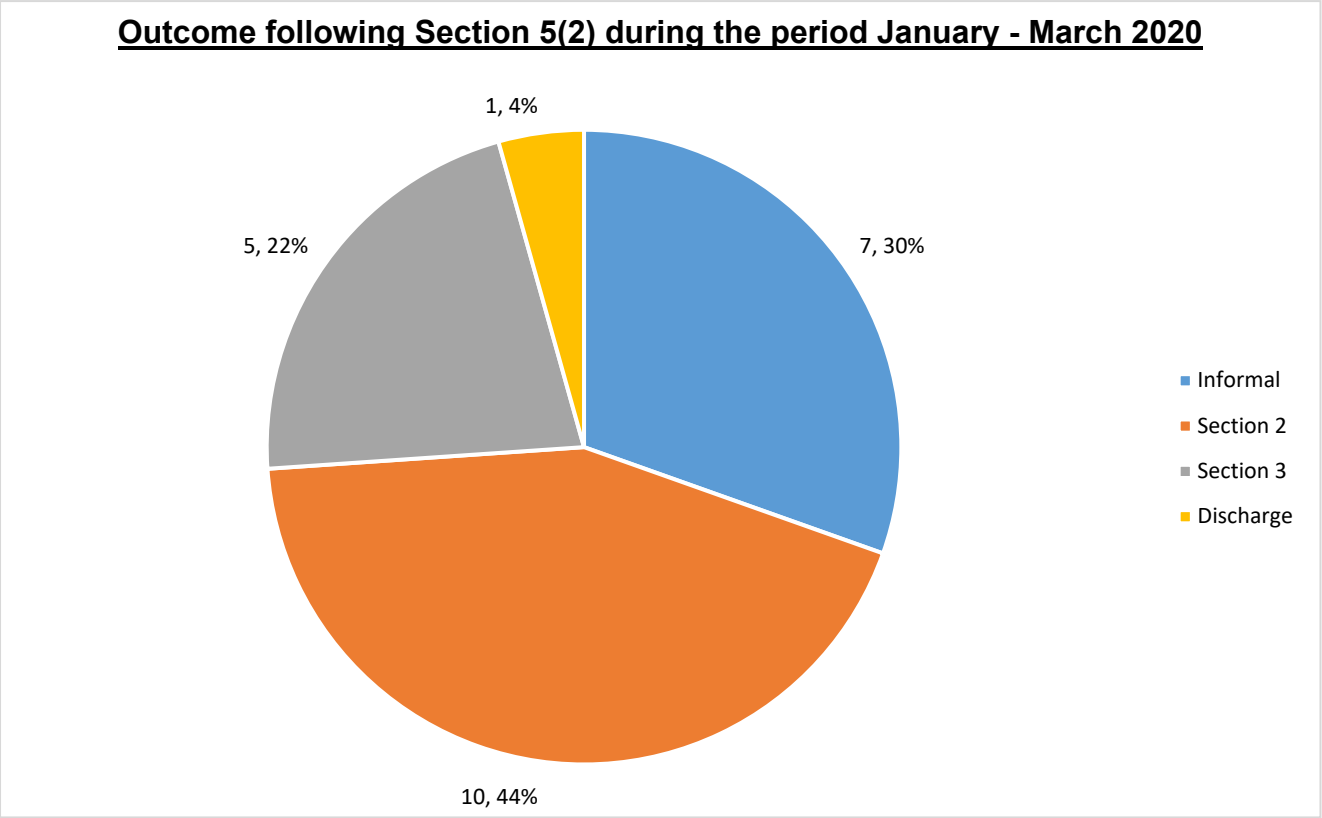




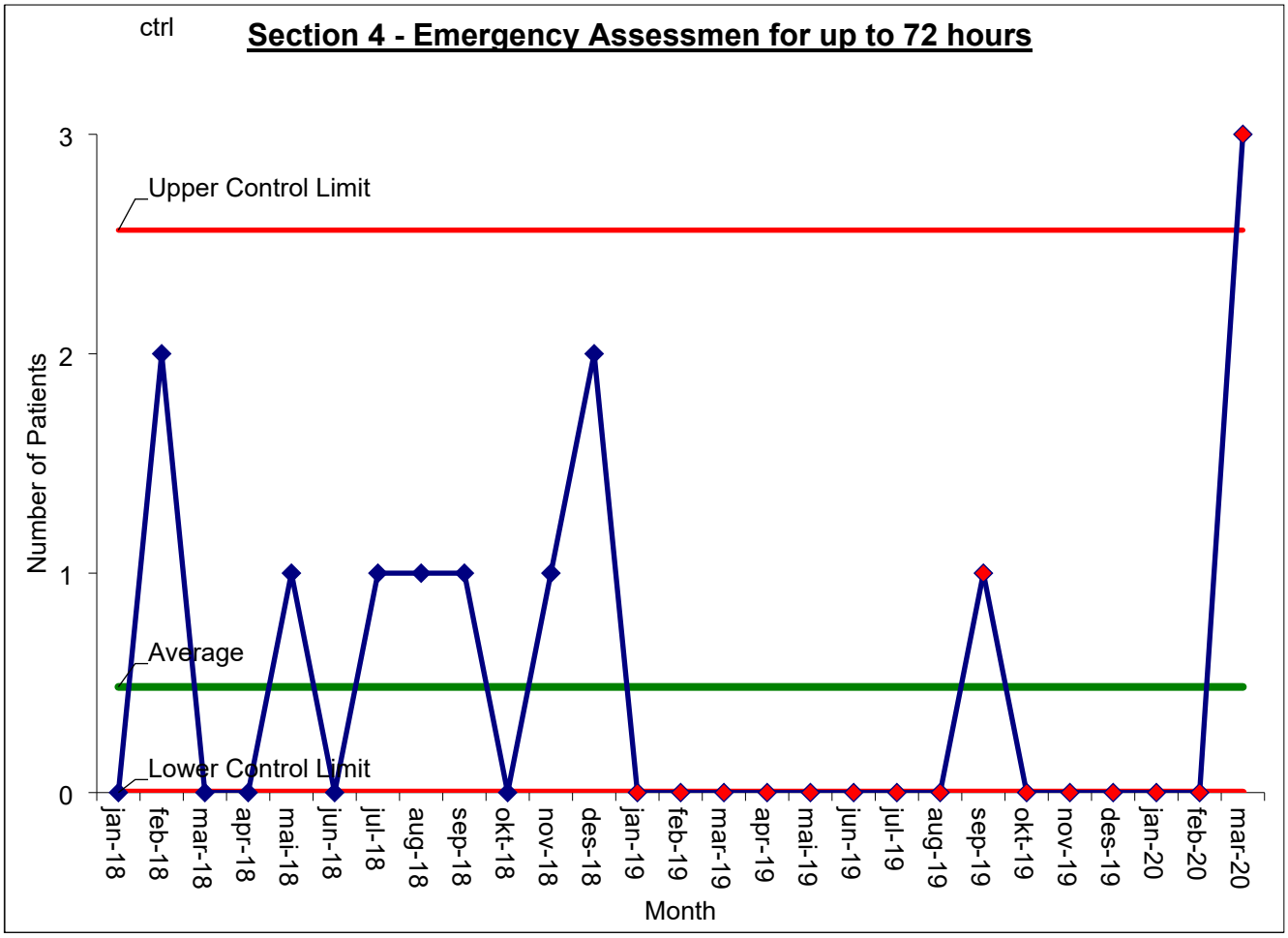
Section 5(2) - Doctors holding power





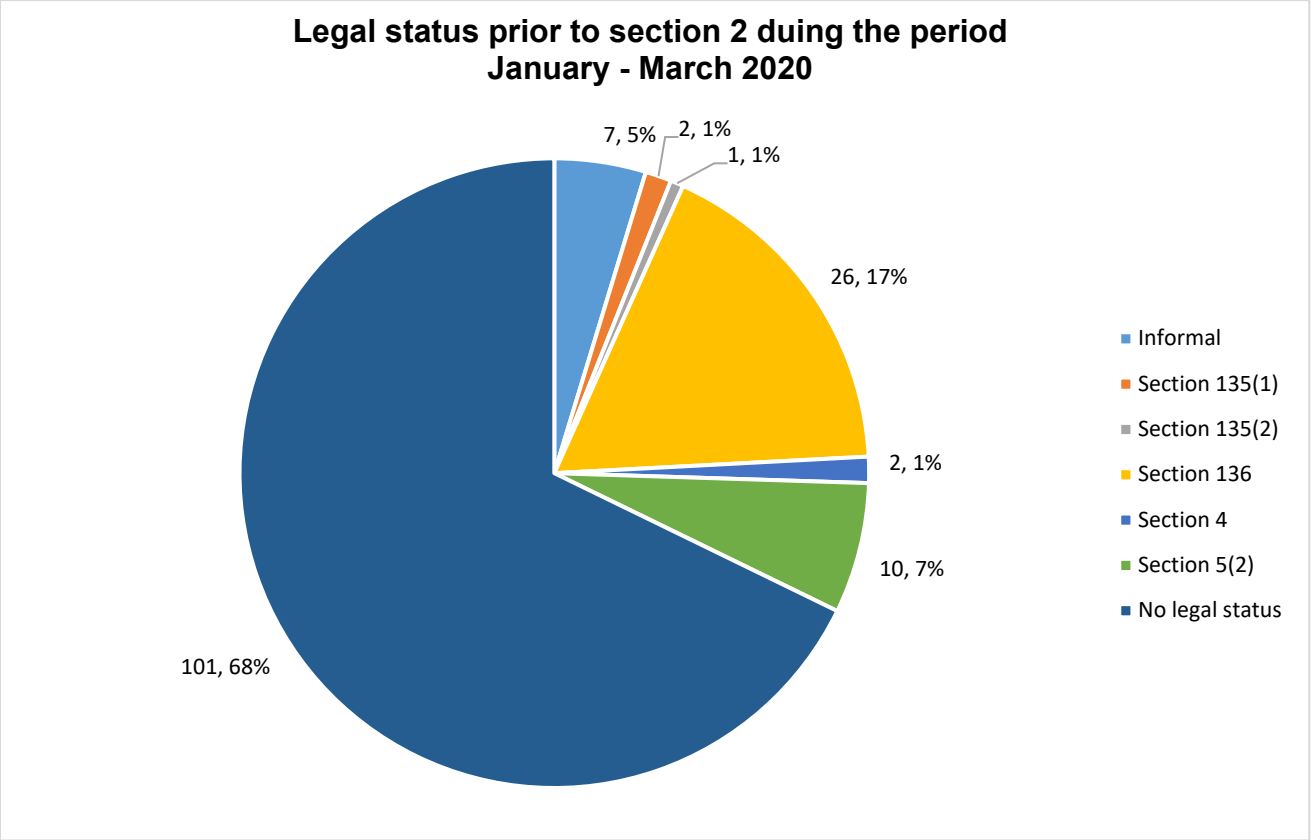


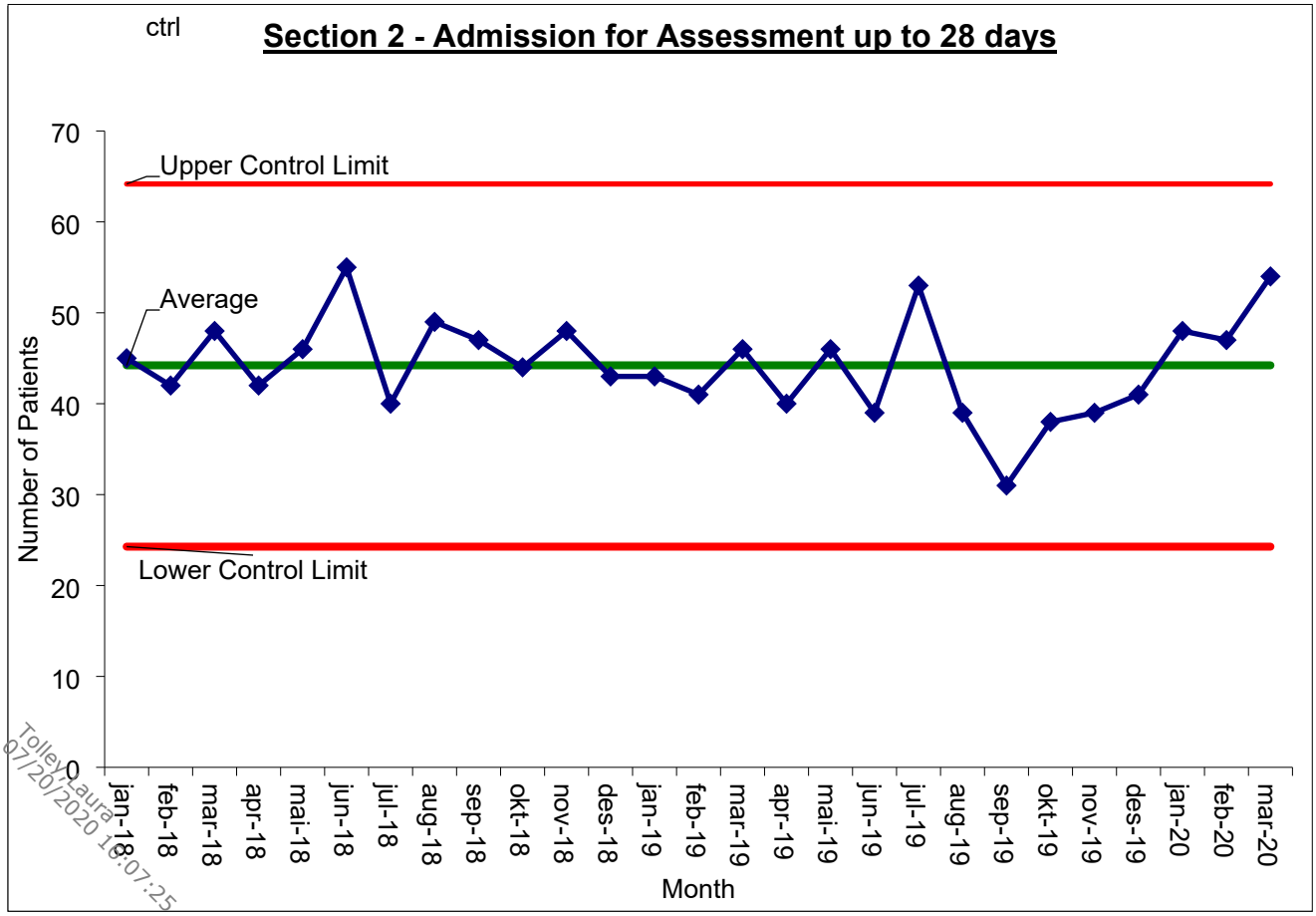
Section 4 - Admission for Assessment in Cases of Emergency

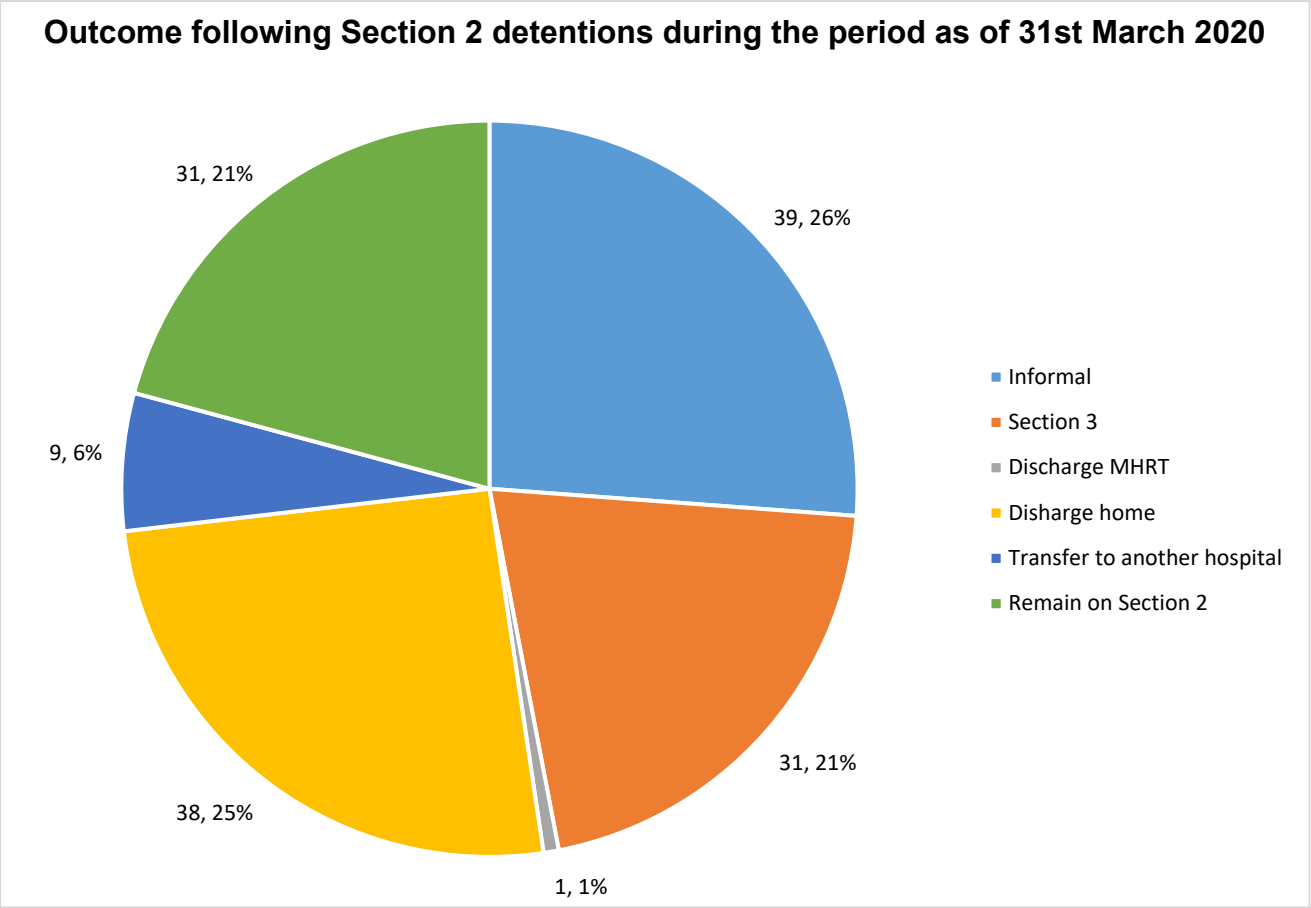


Section 4 was used on three occasions during the period due to an immediate and significant risk of mental or physical harm to the patient or others.

Section 2 – Admission for Assessment





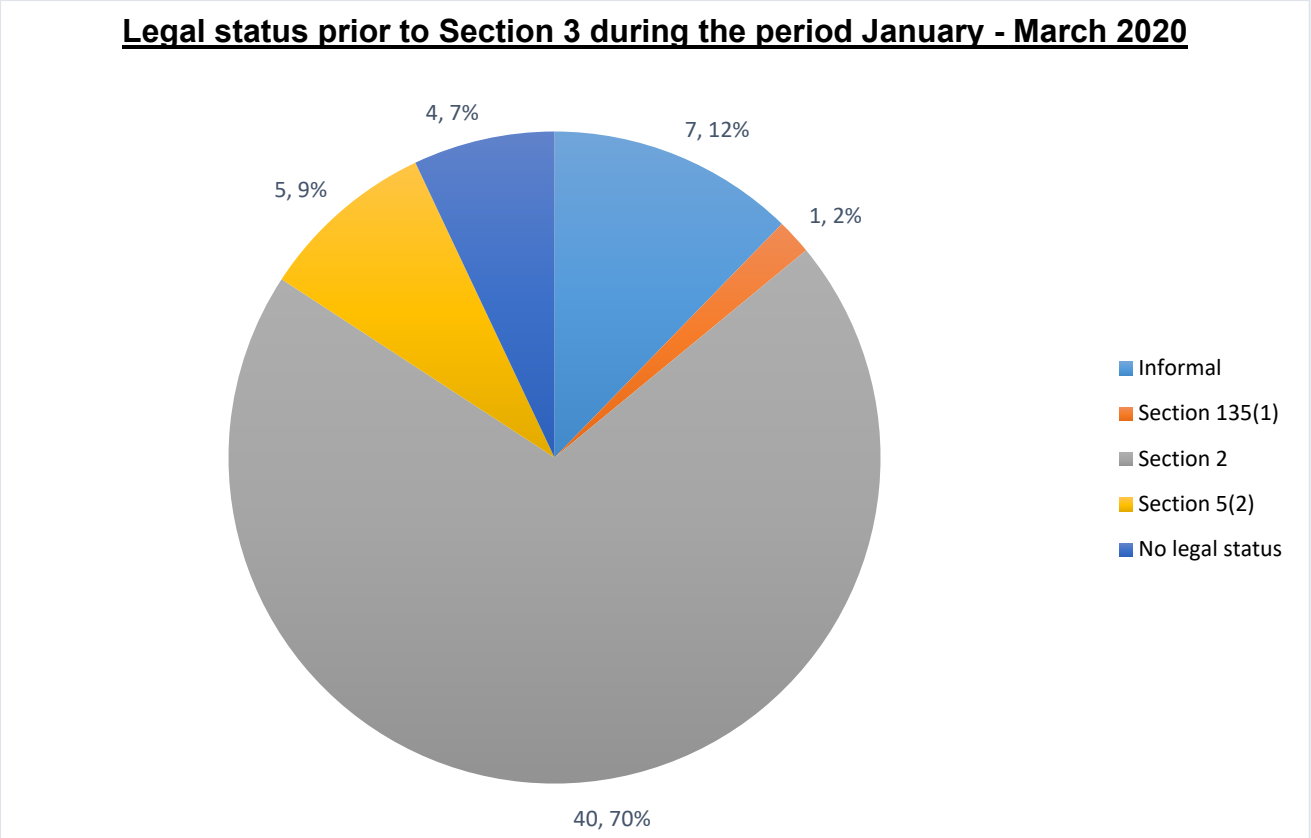


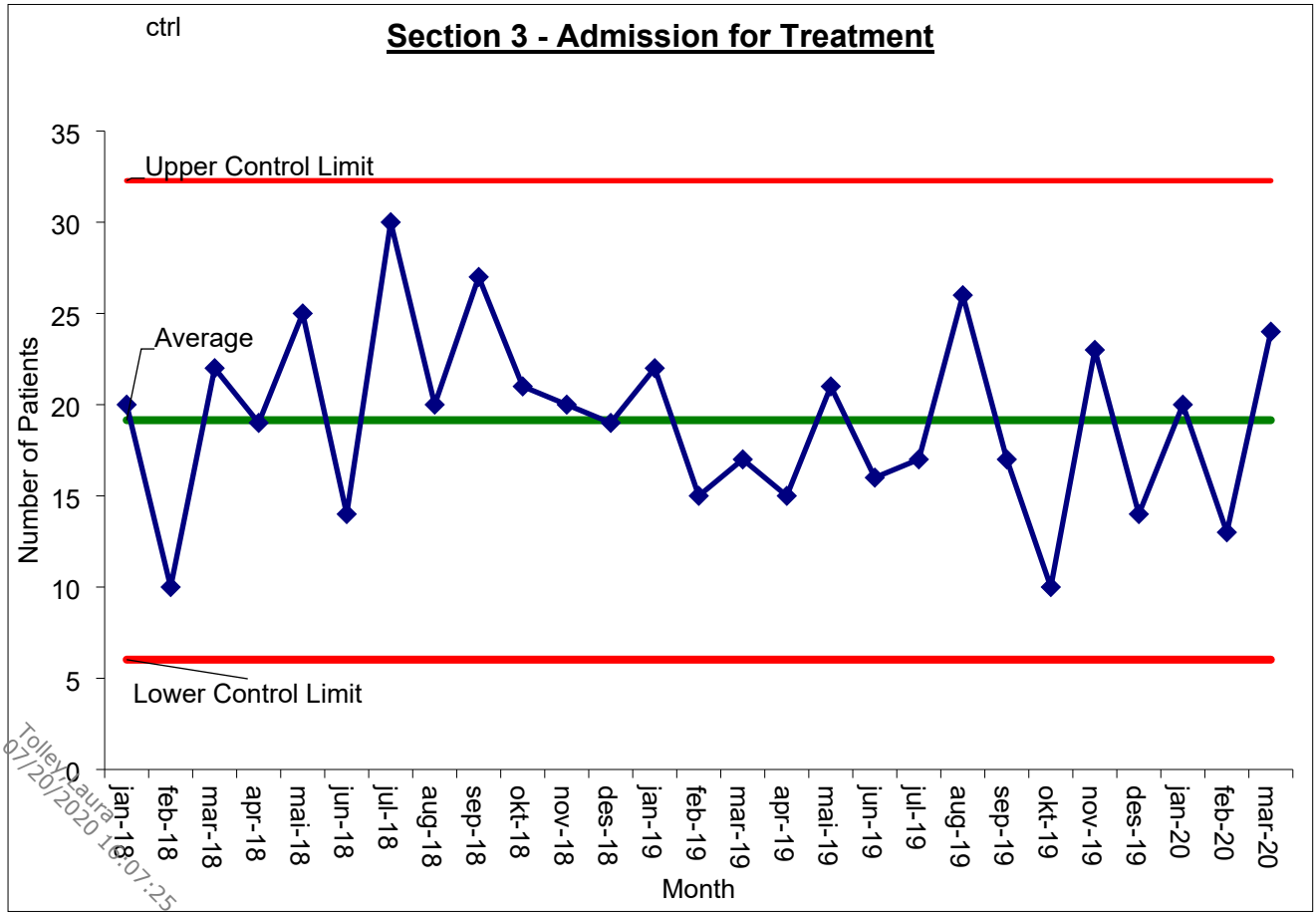
CAMHS Commissioned Inpatient Data

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

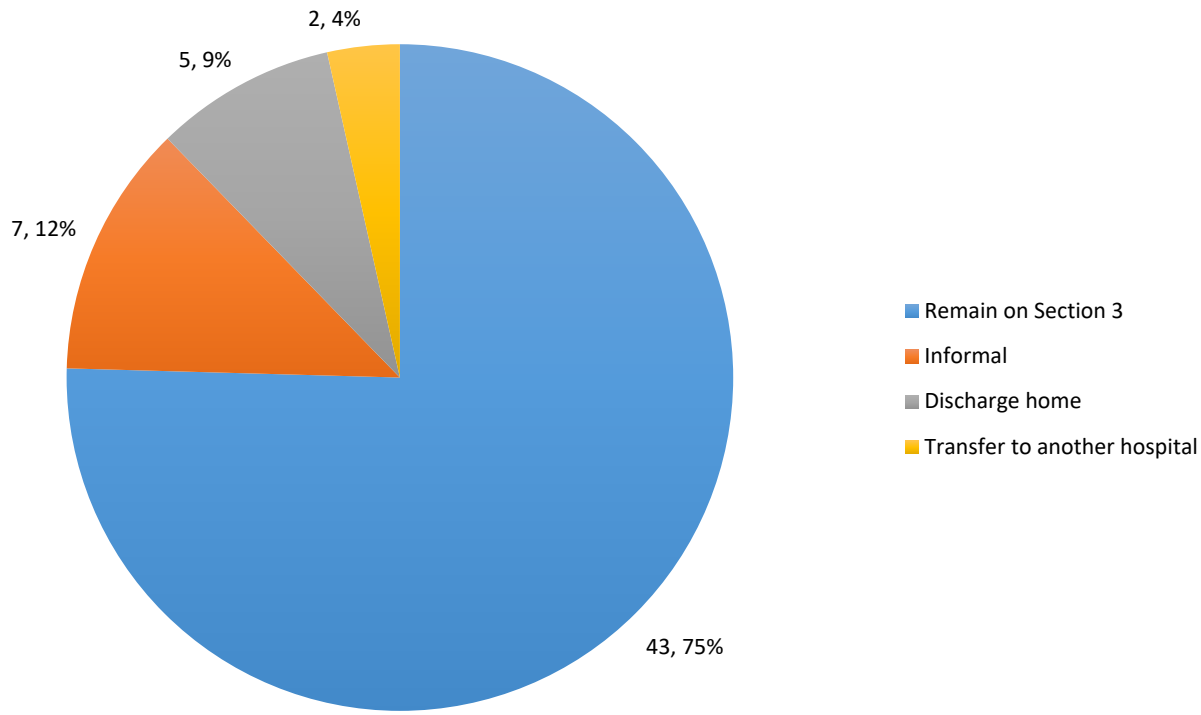
In this period one CAV CAMHS patient was admitted under Section 2, who subsequently was detained under Section 3. This individual was discharged from Section in the same period.

Section 3 – Admission for Treatment





Outcome following Section 3 detentions that were applied during the period January - March 2020 as at 31st March 2020



CAMHS Commissioned Inpatient Data

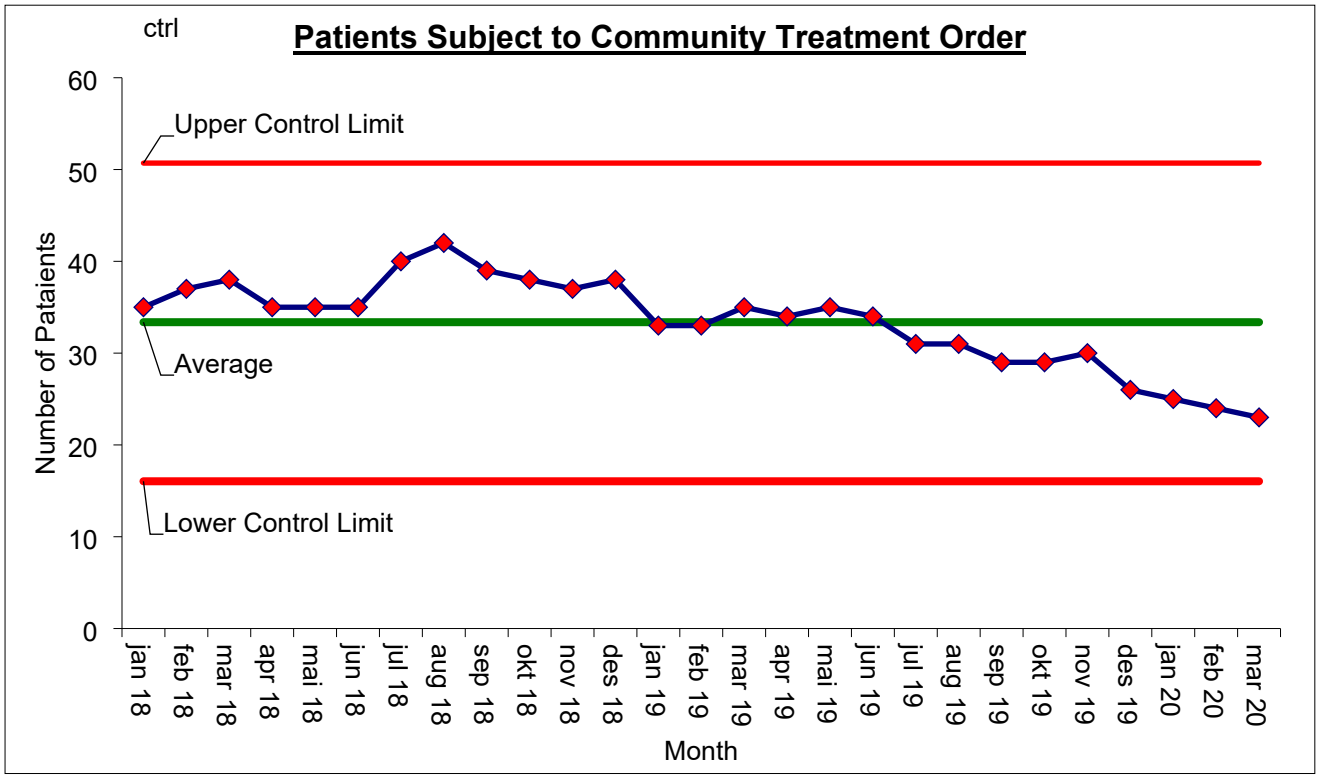
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

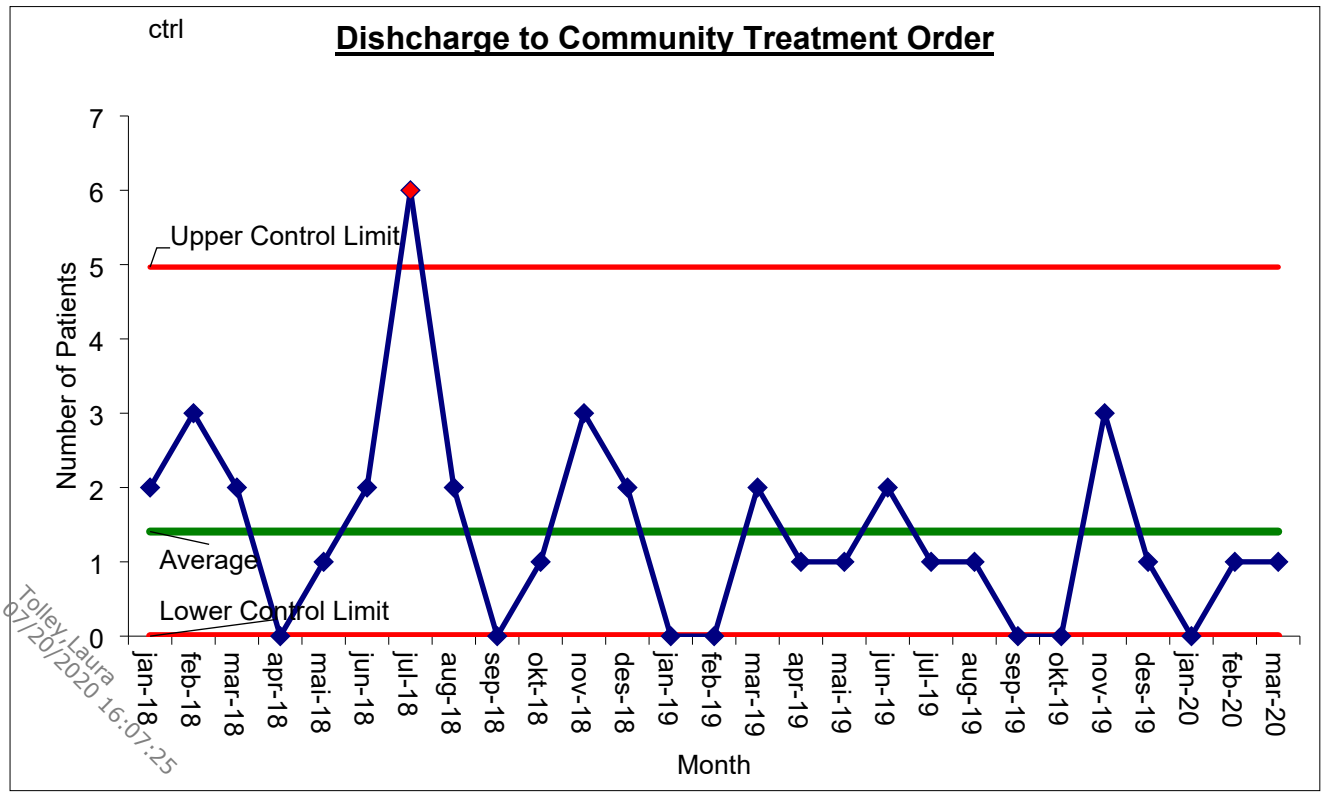
In this period one CAV CAMHS inpatient who was under Section 2, was subsequently detained under Section 3. This individual was discharged from Section in the same period.

Community Treatment Order

During the period January – March 2020, two patients were discharged to Community Treatment Order.

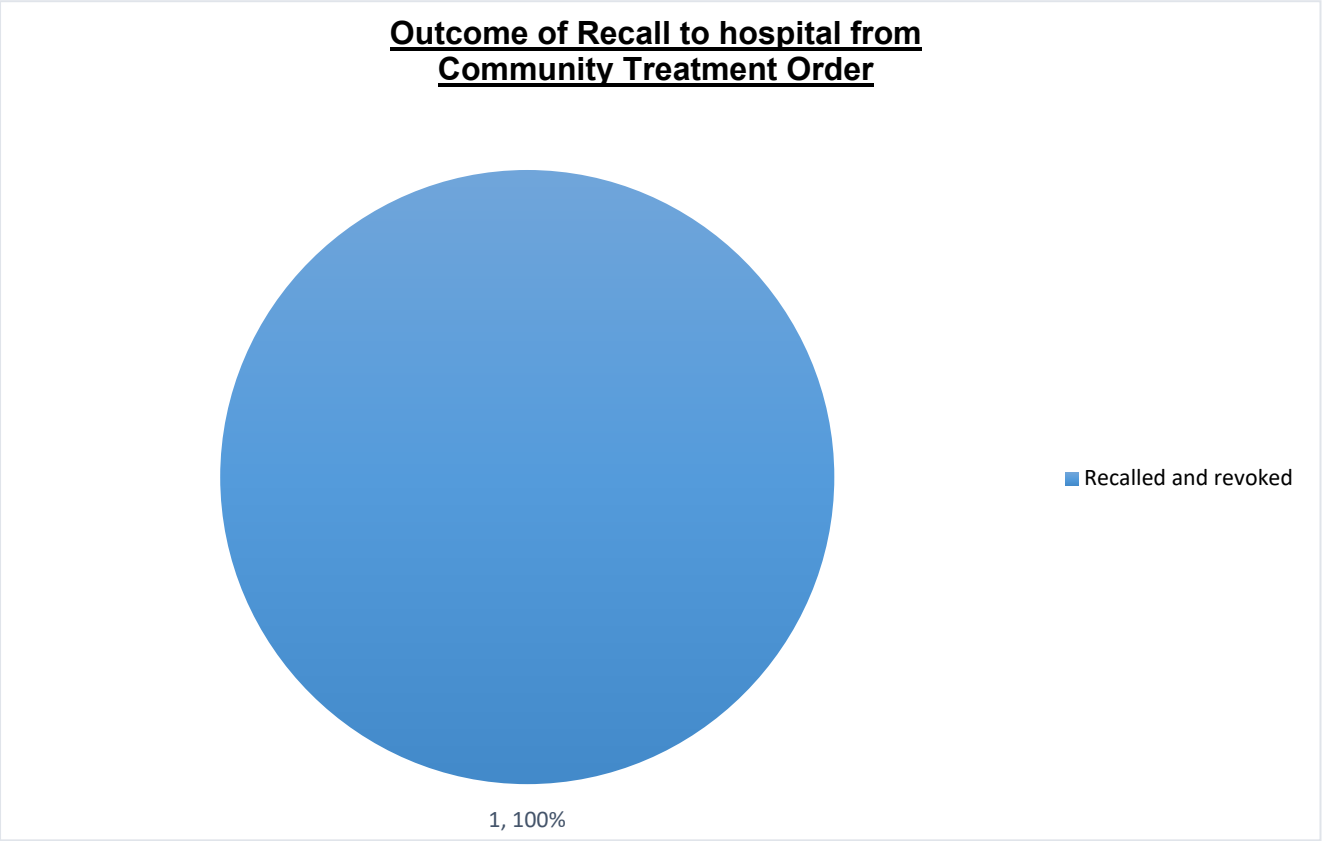
As at 31st March 2020, 23 patients were subject to a Community Treatment Order (CTO).





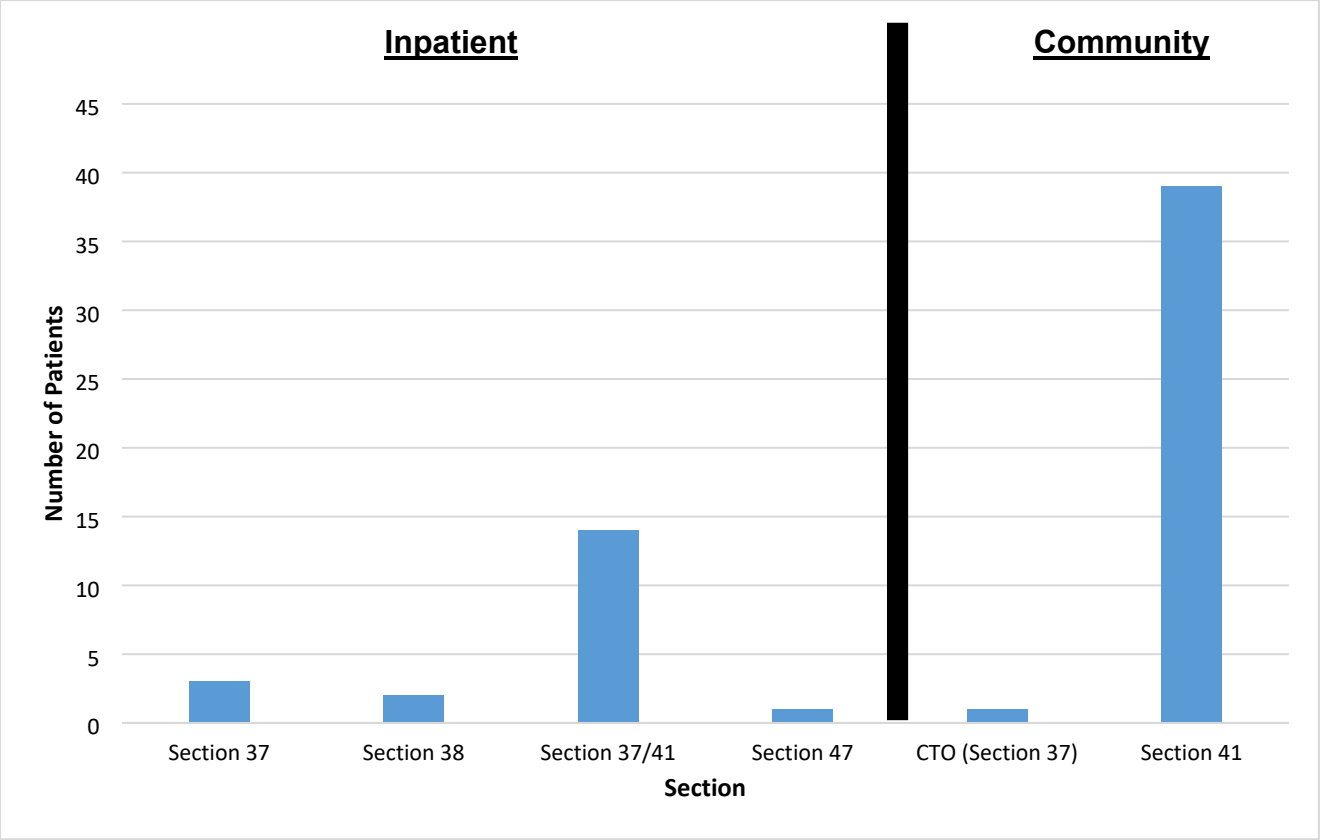
Recall of a community patient under Section 17E

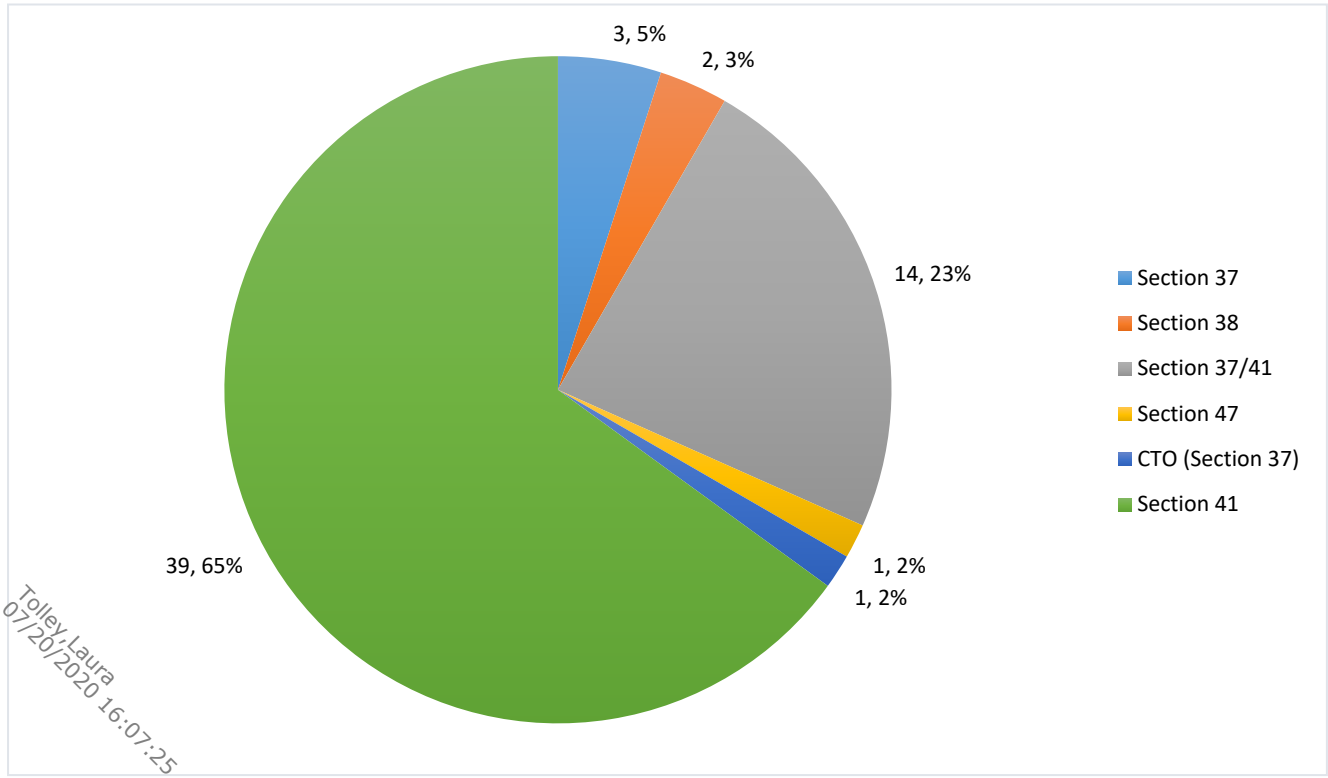
During the period, the power of recall was used on one occasion, the patient was revoked.



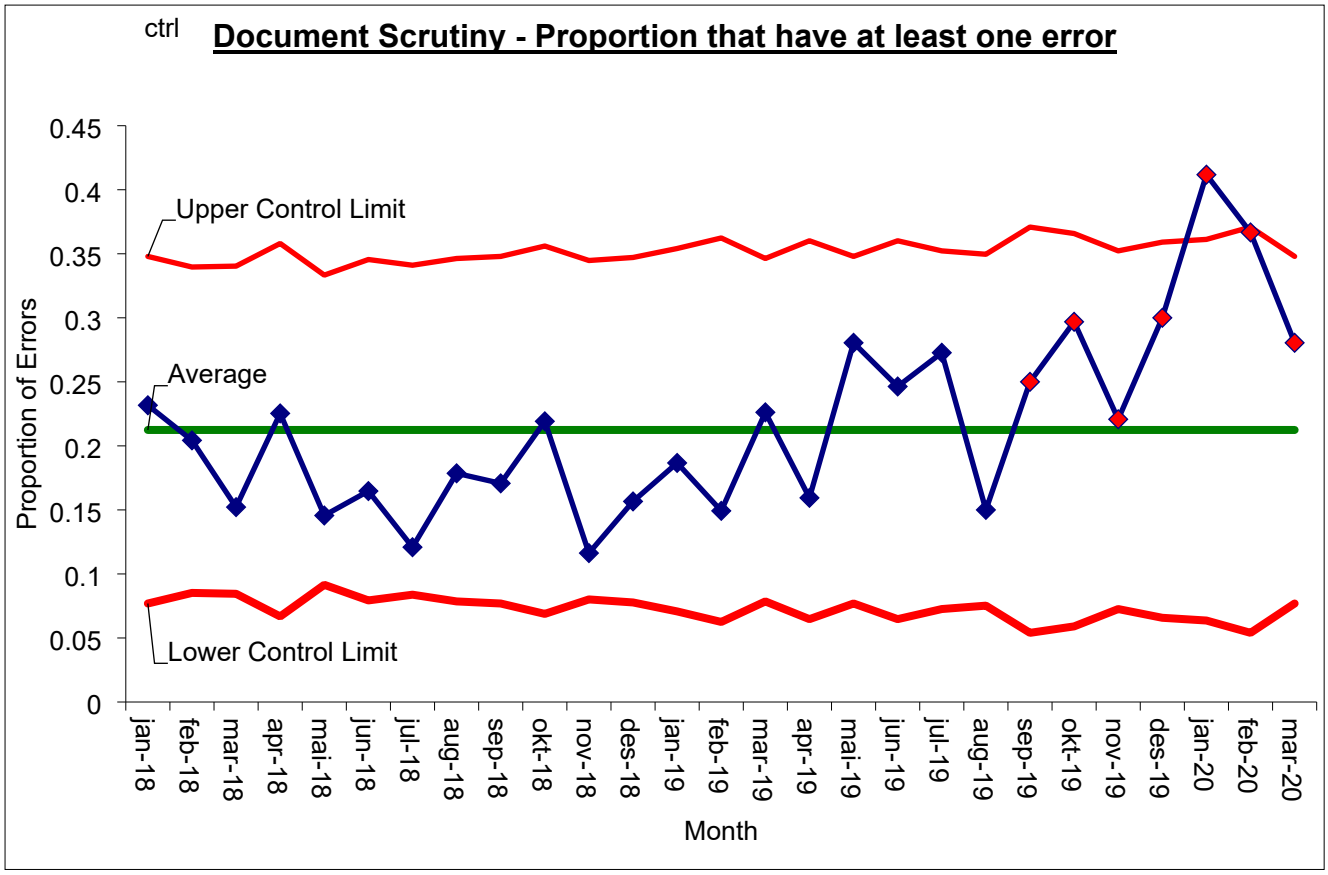
Part 3 of the Mental Health Act 1983

The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 31st March 2020



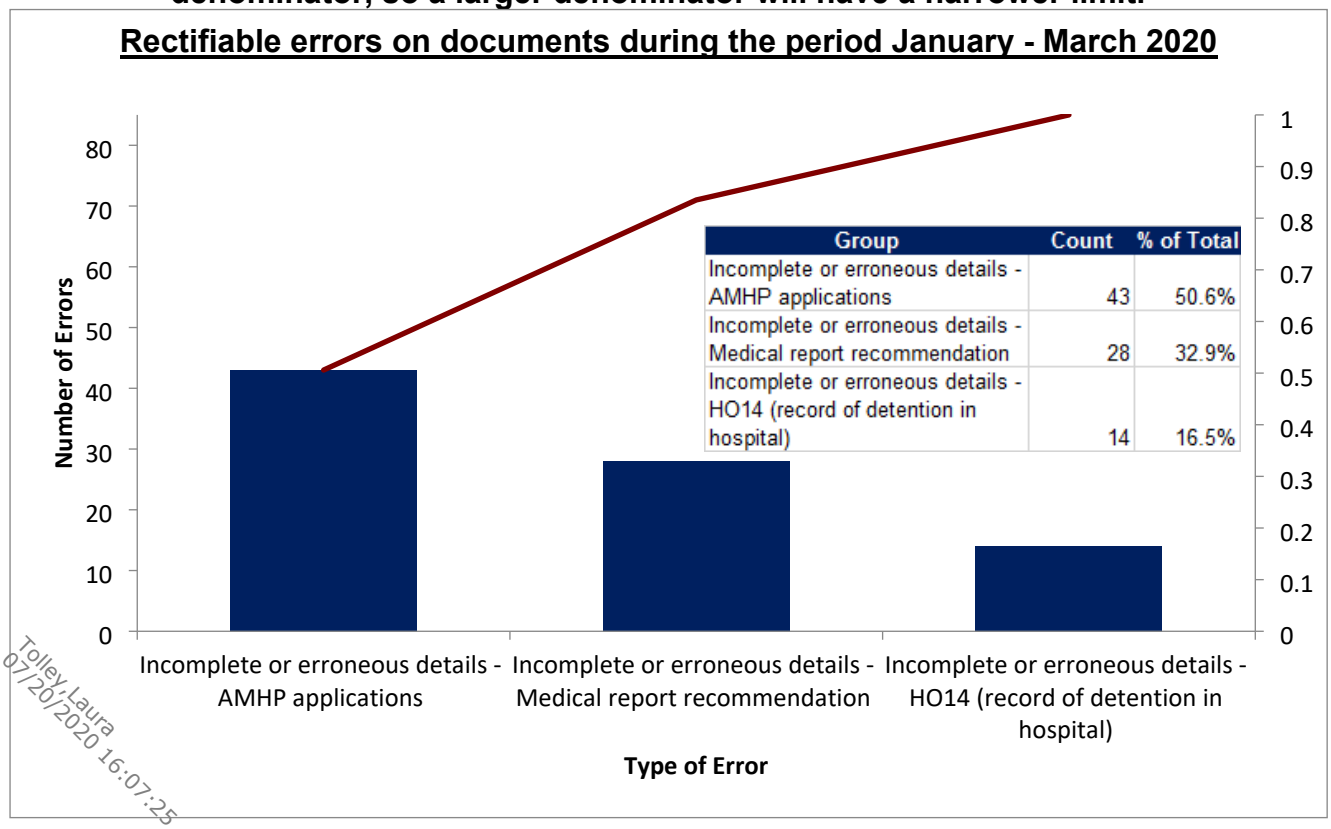


Scrutiny of documents during the period



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.

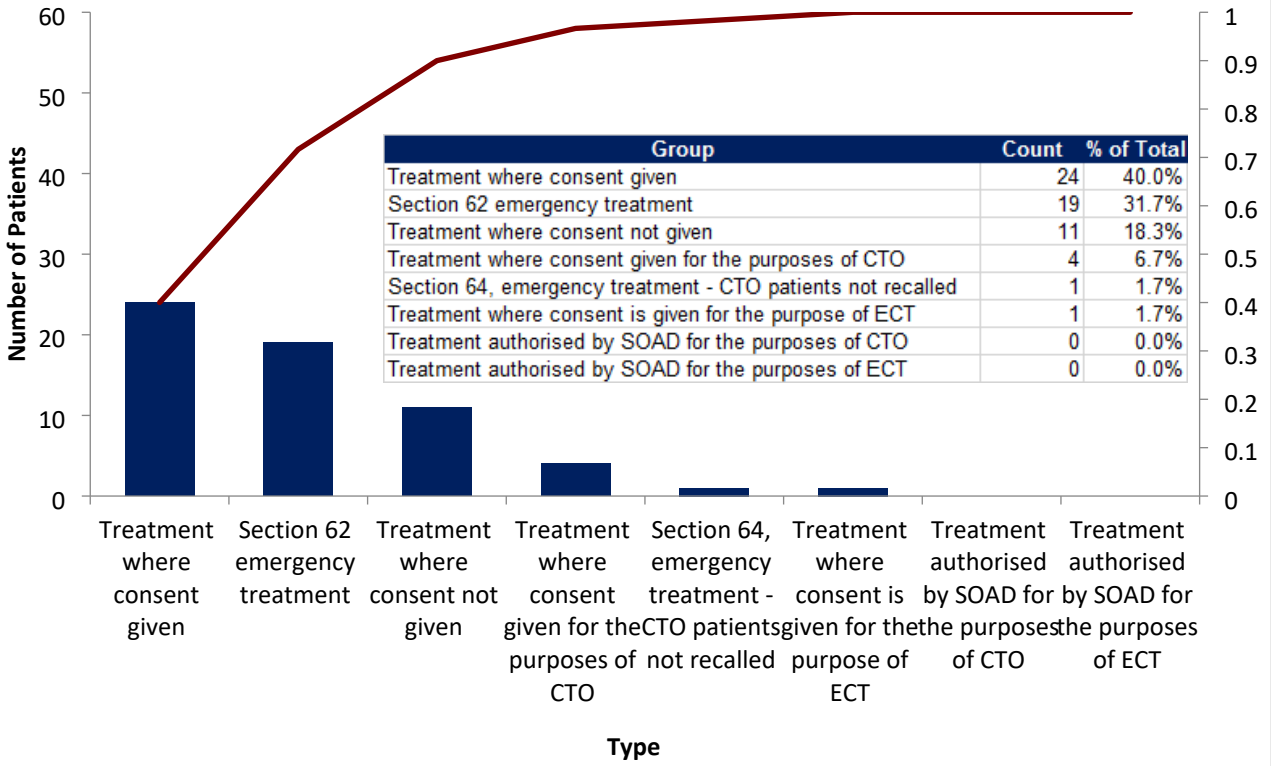
Rectifiable errors on documents during the period January - March 2020



Group	Count	% of Total
Incomplete or erroneous details - AMHP applications	43	50.6%
Incomplete or erroneous details - Medical report recommendation	28	32.9%
Incomplete or erroneous details - HO14 (record of detention in hospital)	14	16.5%

Consent to Treatment

Analysis of the treatment provisions under Part 4 and Part 4A, MHA, during the period January - March 2020



Group	Count	% of Total
Treatment where consent given	24	40.0%
Section 62 emergency treatment	19	31.7%
Treatment where consent not given	11	18.3%
Treatment where consent given for the purposes of CTO	4	6.7%
Section 64, emergency treatment - CTO patients not recalled	1	1.7%
Treatment where consent is given for the purpose of ECT	1	1.7%
Treatment authorised by SOAD for the purposes of CTO	0	0.0%
Treatment authorised by SOAD for the purposes 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.

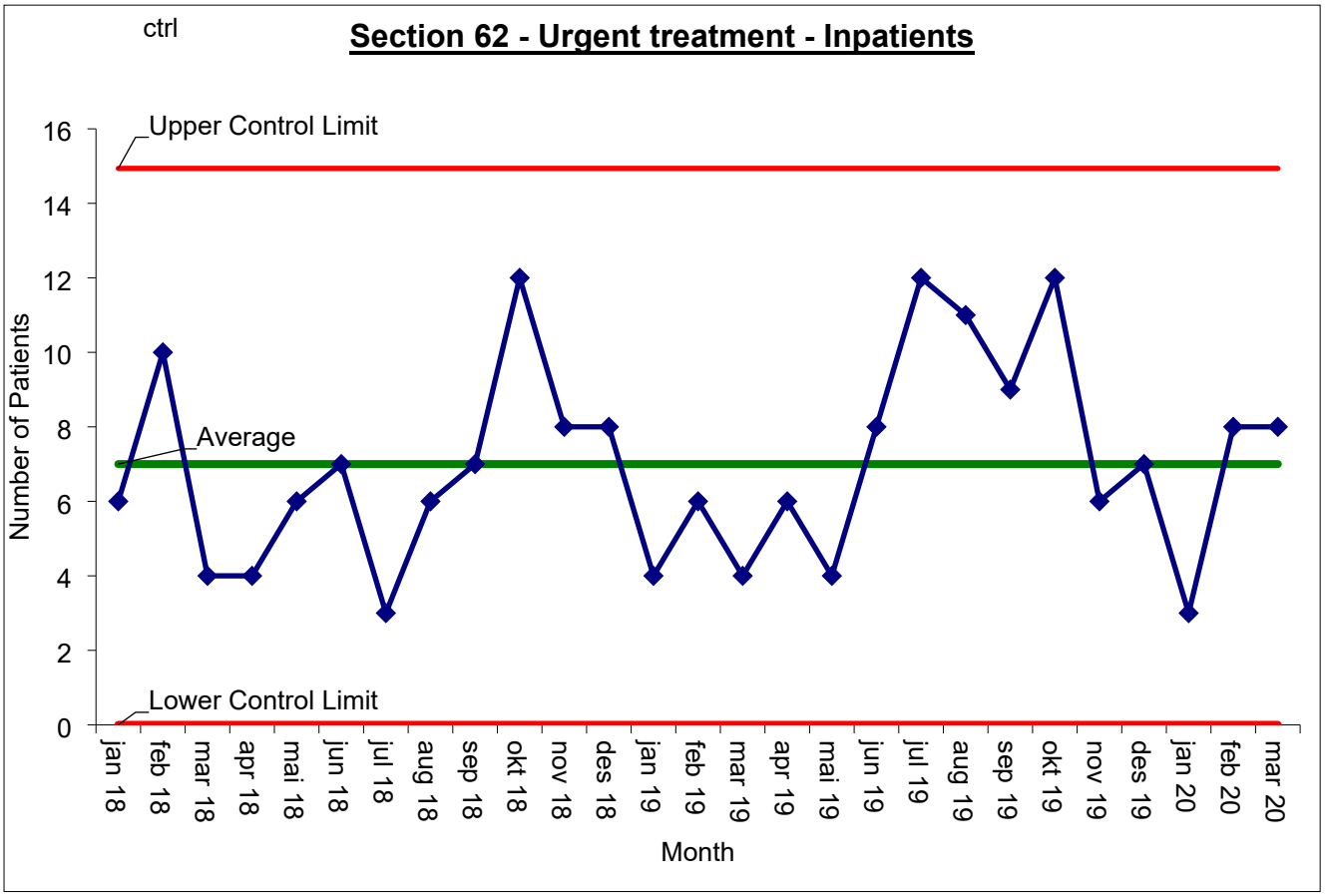
Urgent treatment is defined as treatment that is:

- 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.

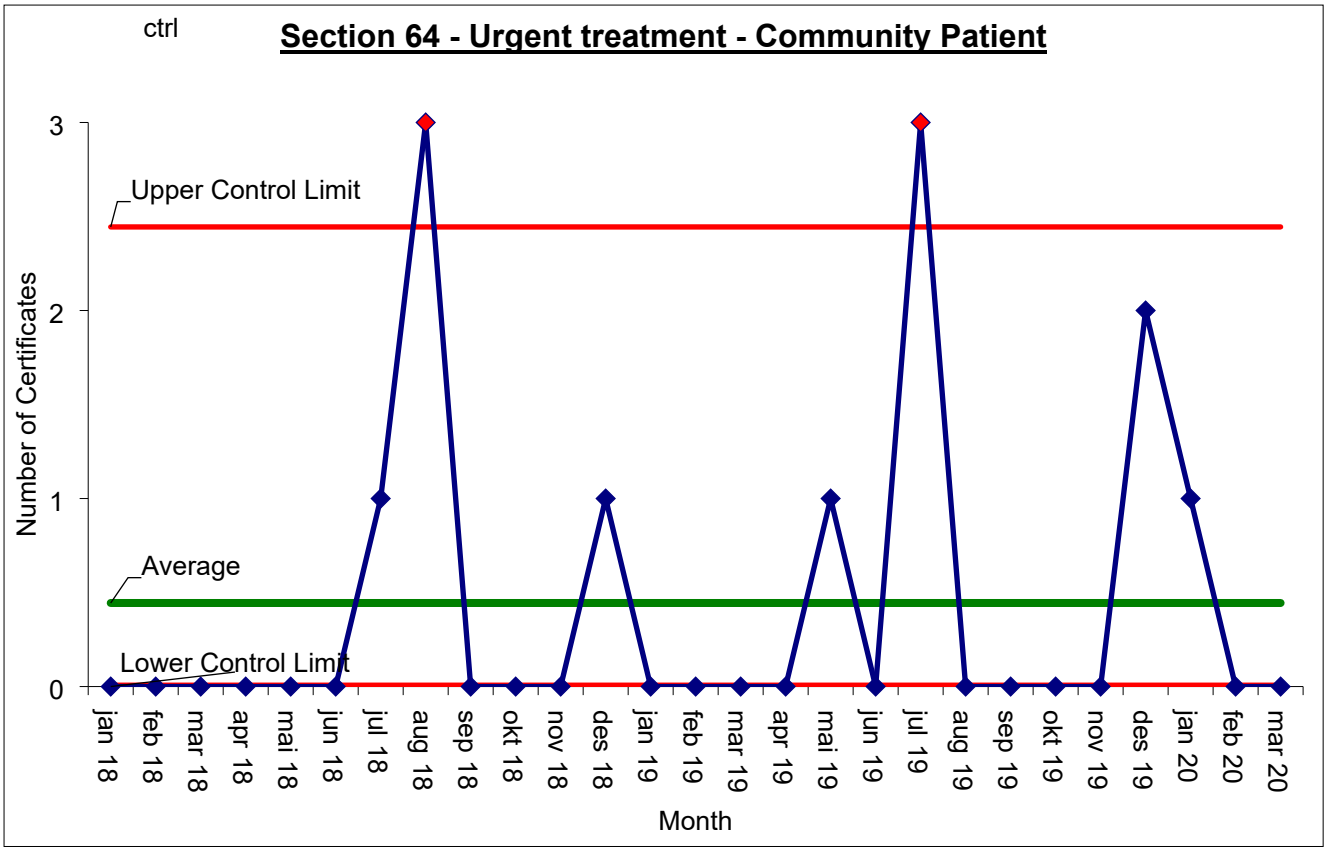
Urgent treatment can be used in any of the following instances:

- 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.



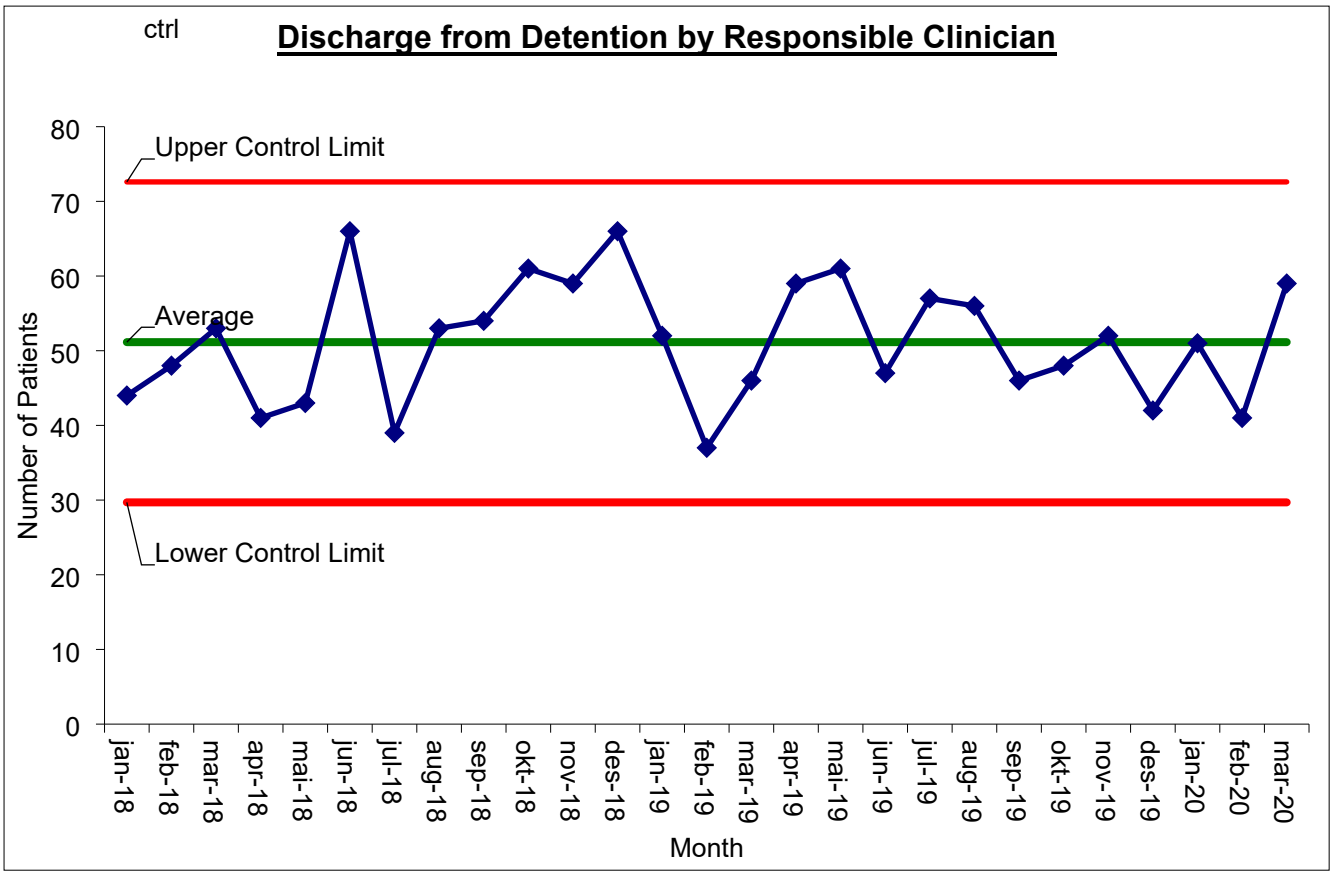
The above chart highlights that Section 62 was used on 19 occasions for the following reasons:

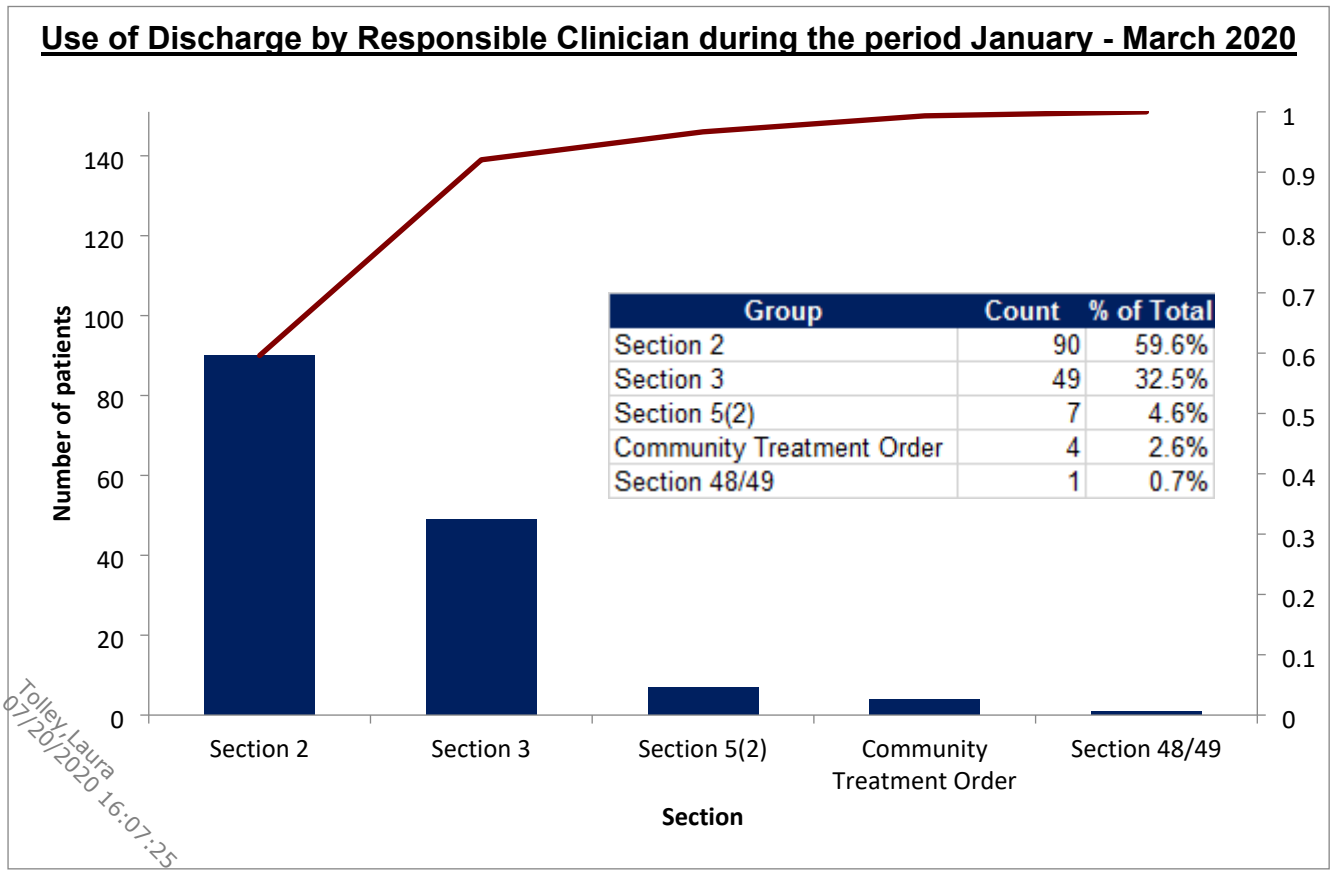
- Pending SOAD – 3 month rule x 6
- Pending SOAD, Community Treatment Order revoke x 1
- Pending SOAD – ECT required x 2
- Time limited certificate pending review by SOAD x 3
- Change of medication x 6
- Change to consent status x 1



The above chart highlights that Section 64 was used on one occasion during the period pending a SOAD subsequent to a CTO being applied – one month rule.

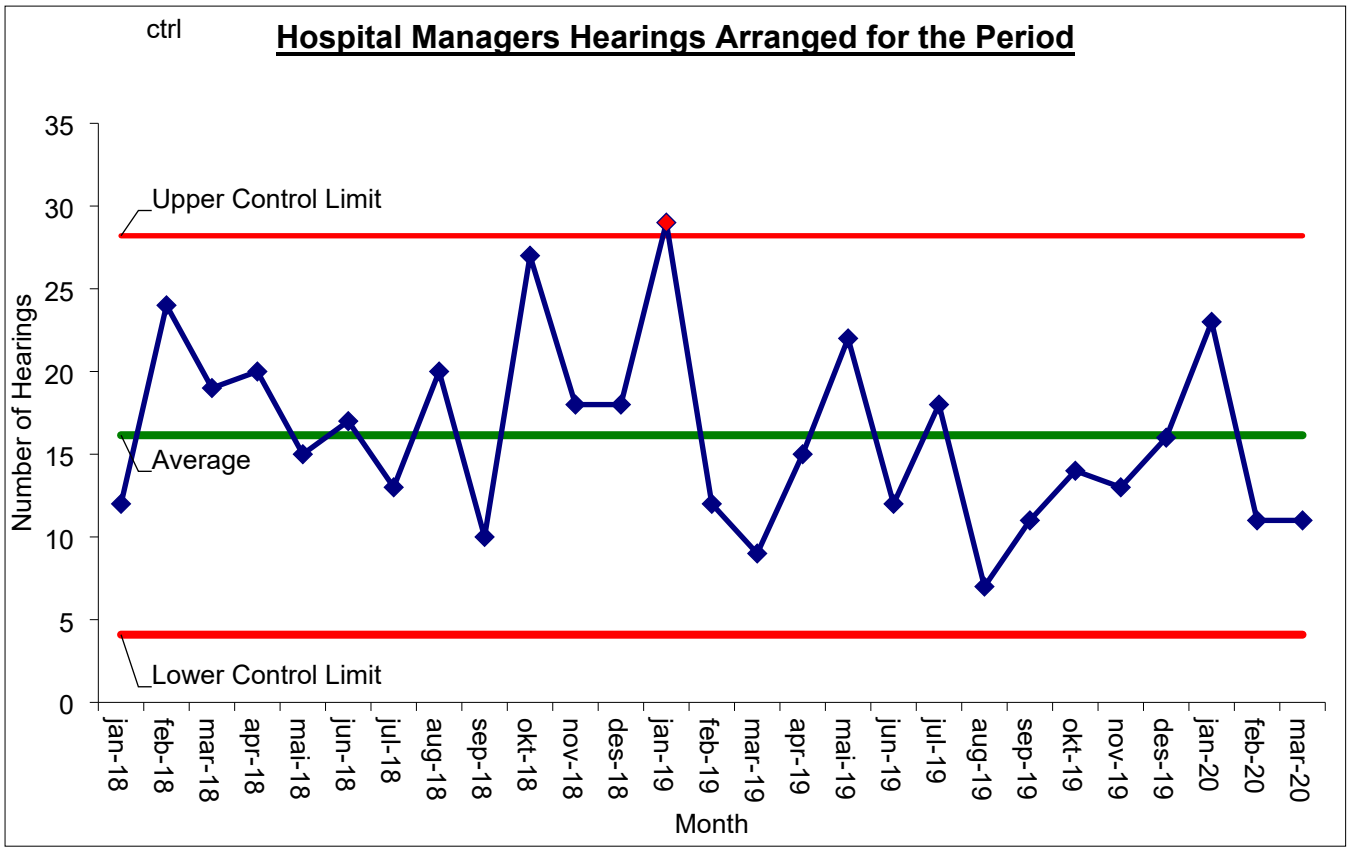
Discharge

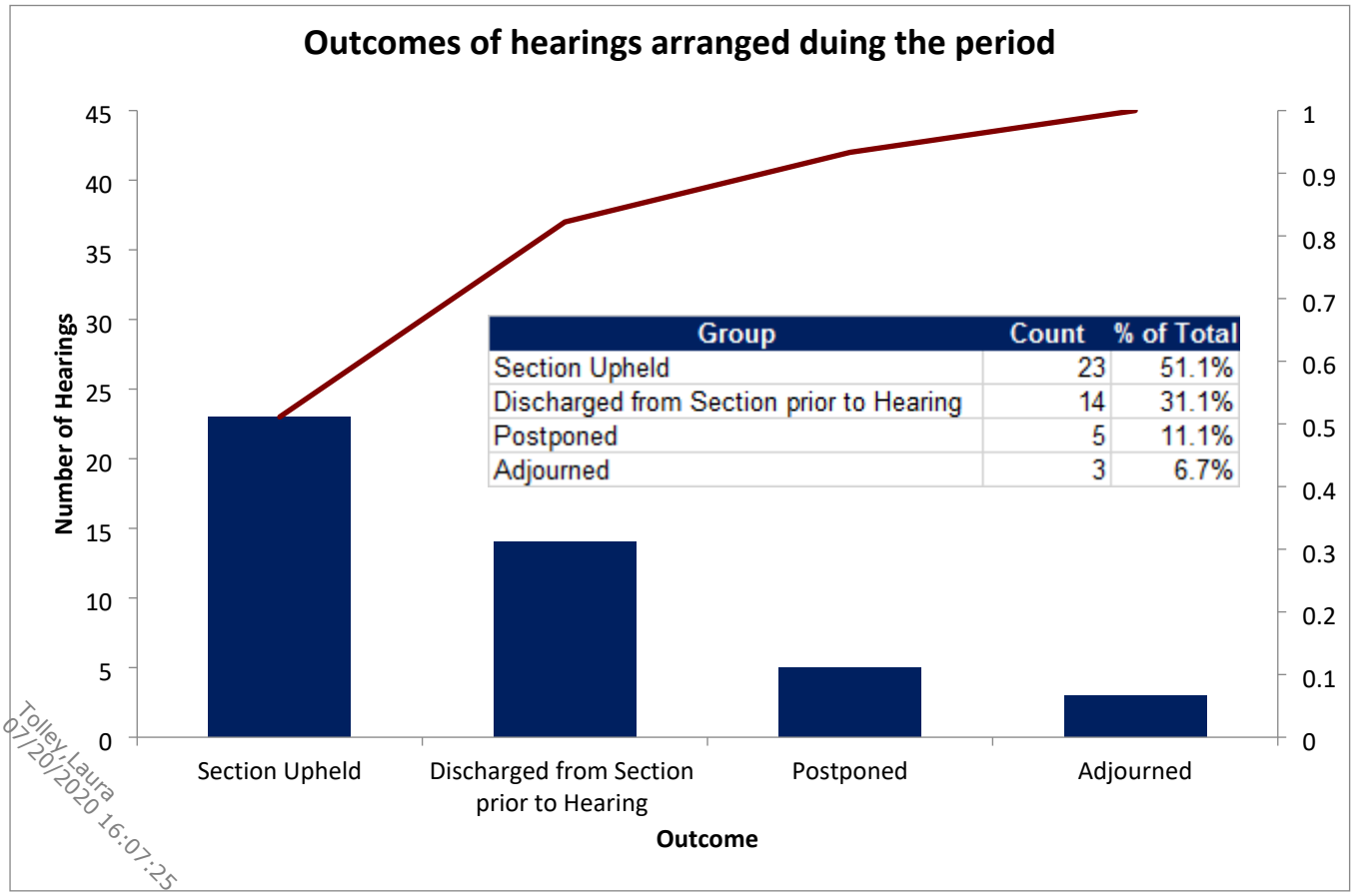




Group	Count	% of Total
Section 2	90	59.6%
Section 3	49	32.5%
Section 5(2)	7	4.6%
Community Treatment Order	4	2.6%
Section 48/49	1	0.7%

Hospital Managers – Power of Discharge





Group	Count	% of Total
Section Upheld	23	51.1%
Discharged from Section prior to Hearing	14	31.1%
Postponed	5	11.1%
Adjourned	3	6.7%

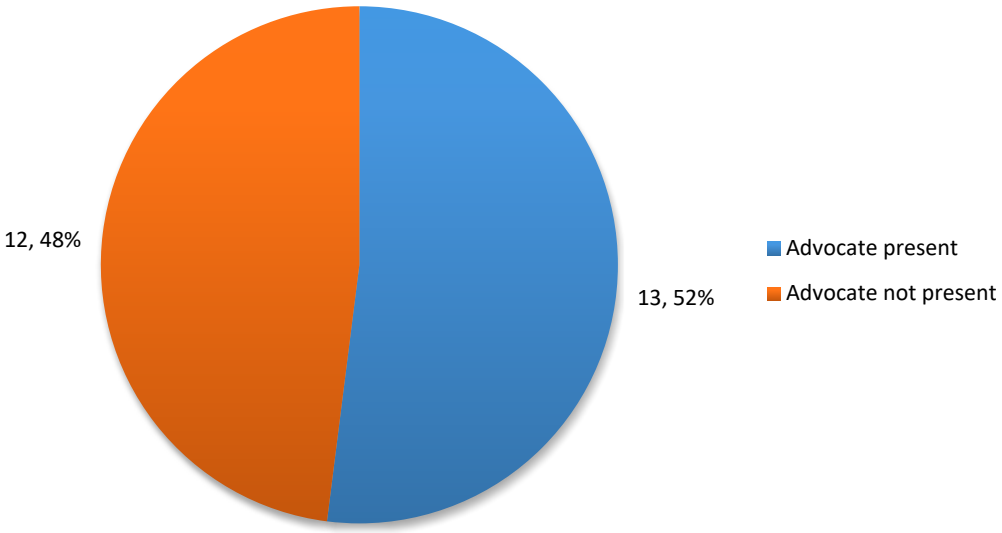
Three hearings were adjourned for the following reasons:

- On two occasions further information was required
- Ward did not provide the interpreter with the full pack of reports in preparation for the hearing.

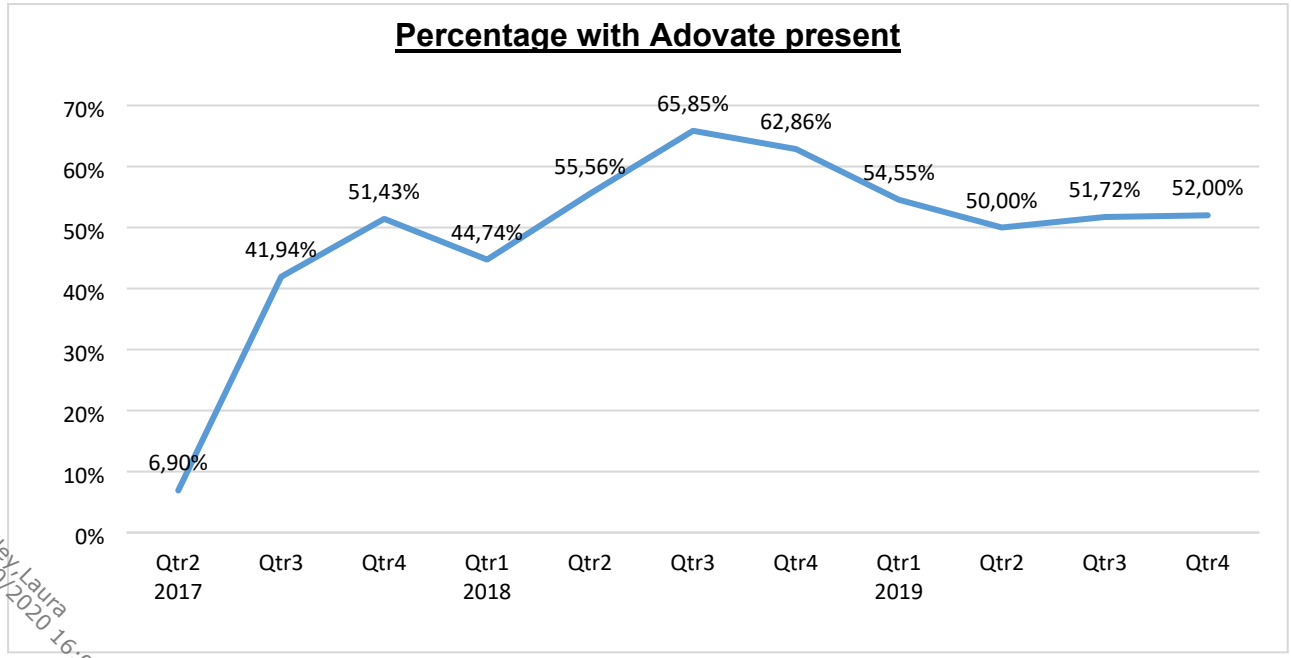
Five Hearings were postponed for the following reasons;-

- On two occasions the RC was unavailable
- To enable the Nearest Relative to attend
- RC did not submit medical report on time
- RC did not complete renewal document on time

Number of patients represnted by Advocacy Support Cymru during the period

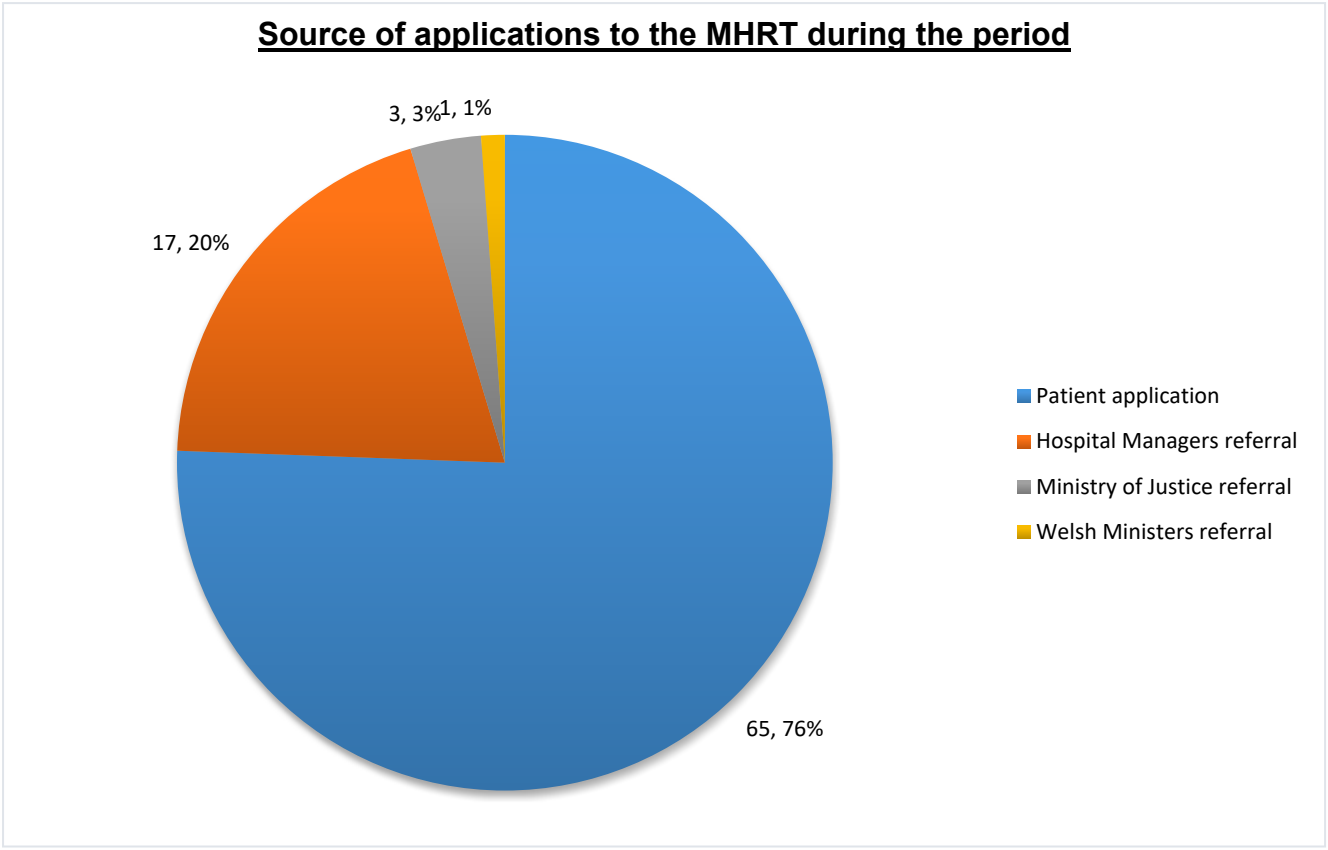


Percentage with Adovate present



Mental Health Review Tribunal (MHRT) for Wales

Source of applications to the MHRT during the period



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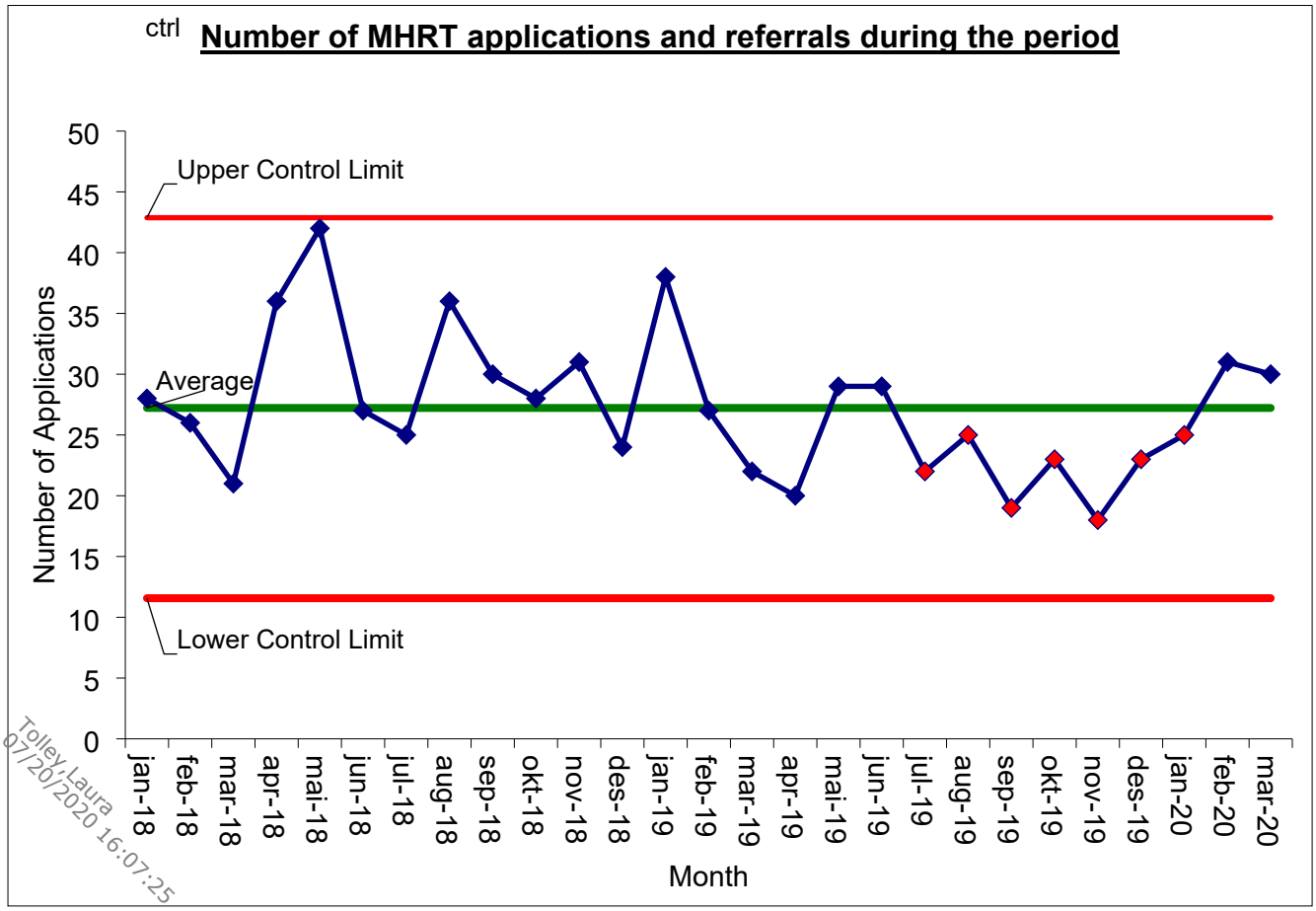
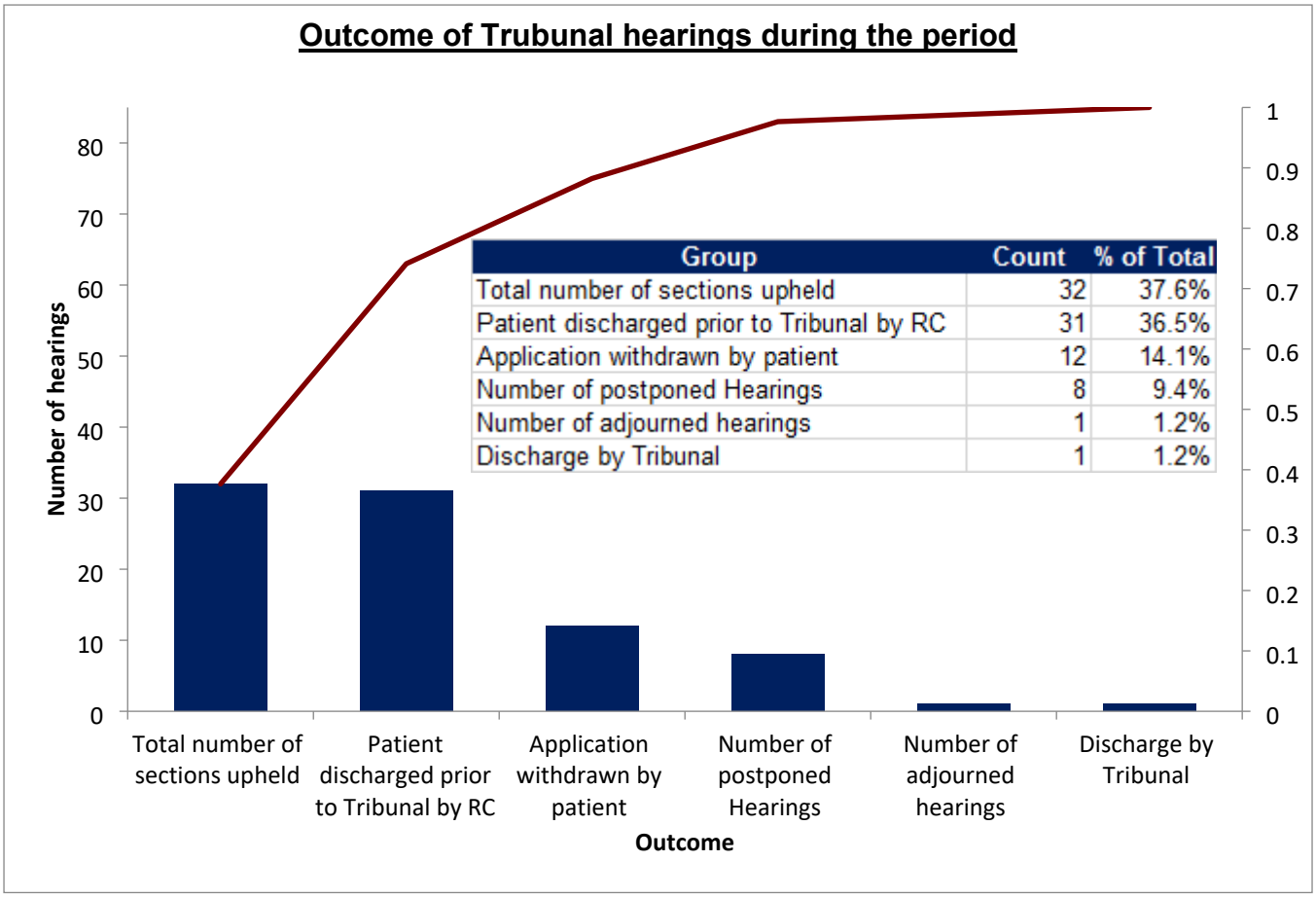
Number of MHRT applications and referrals during the period





Group	Count	% of Total
Total number of sections upheld	32	37.6%
Patient discharged prior to Tribunal by RC	31	36.5%
Application withdrawn by patient	12	14.1%
Number of postponed Hearings	8	9.4%
Number of adjourned hearings	1	1.2%
Discharge by Tribunal	1	1.2%

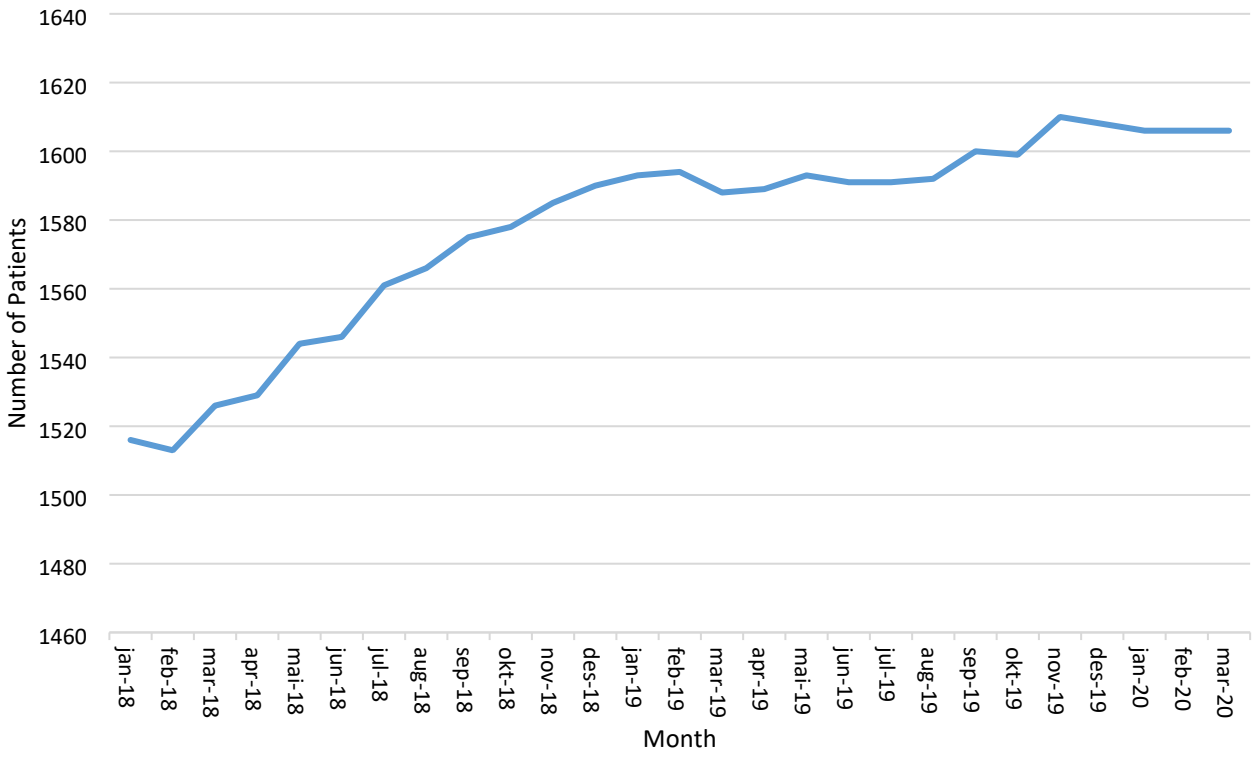
One Hearing was adjourned for further evidence.

Eight hearings were postponed during the period for the following reasons;

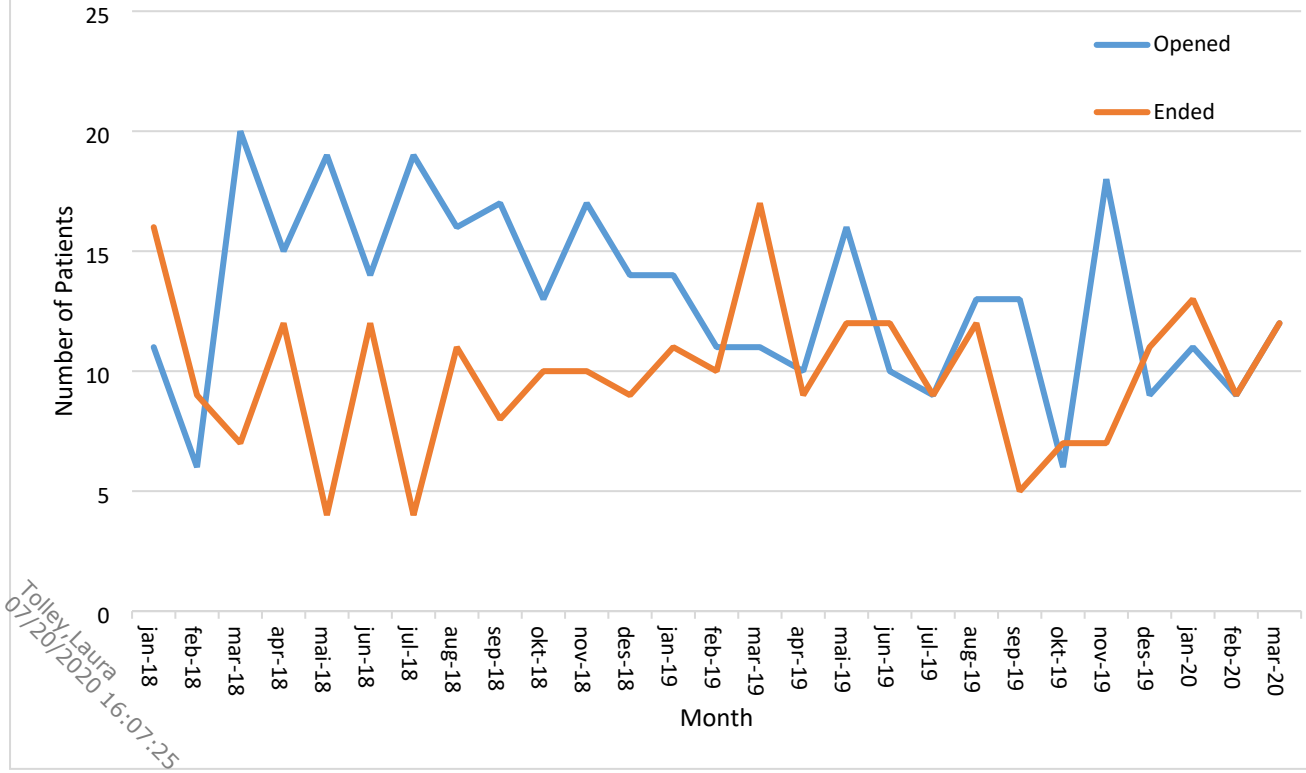
- Four due to COVID-19
- RC unavailable due to sickness
- Social Worker unavailable
- Patient too unwell to select legal representative
- Additional specialist reports required by legal representative

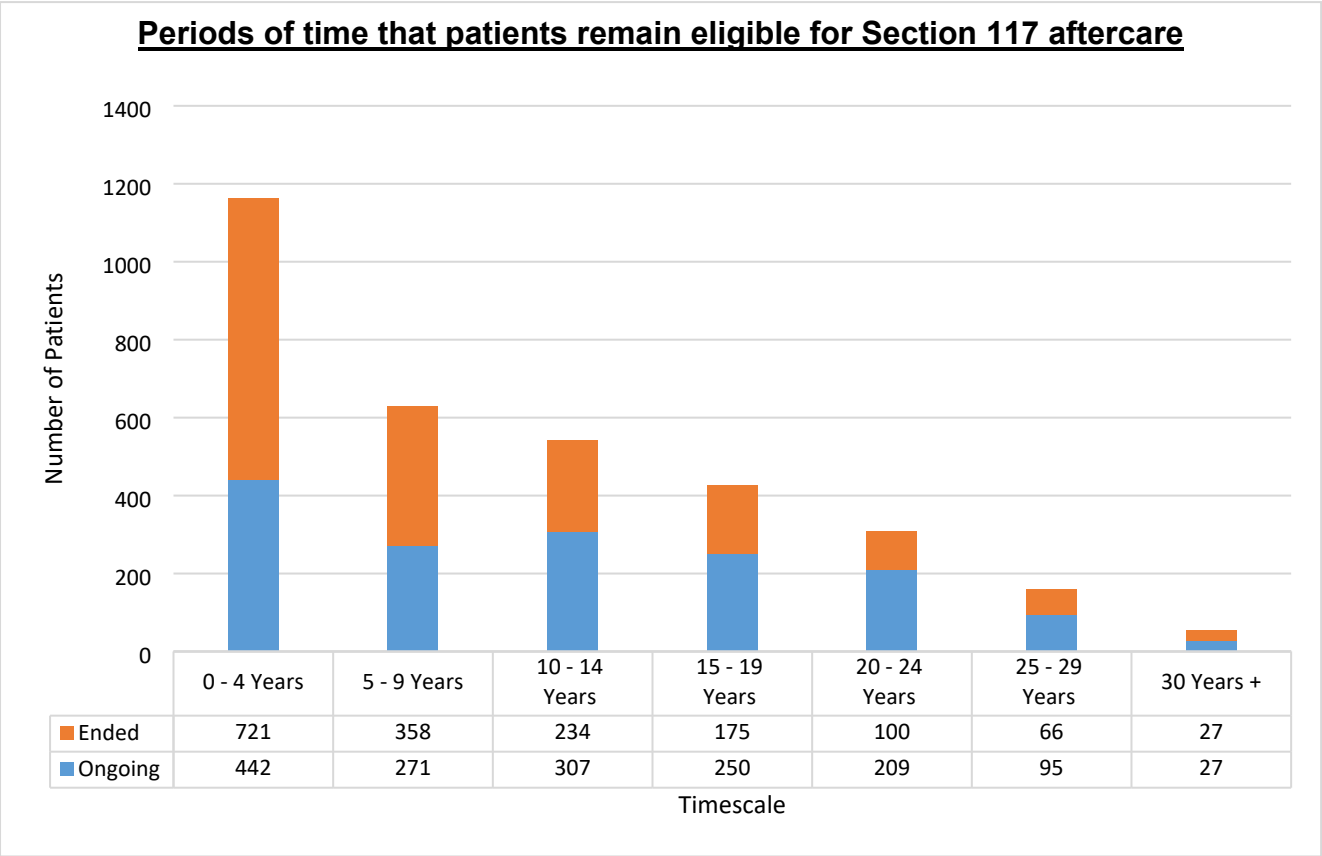
Section 117 Aftercare

Patients eligible for Section 117 aftercare



Section 117 Activity





Summary of other Mental Health Activity which took place during the period January – March 2020

Exclusion of visitors

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

Section 19 transfers to and from Cardiff and Vale UHB

During the 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:
    - Six to return to their home area.
    - One transfer to CAMHS
    - Four to PICU beds
    - One to a specialist unit
- Eight 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:
    - One transfer from CAMHS to Adult
    - One step down from specialist treatment back to home area
    - Six return to home area
- Two patients detained under Part 3 of the Mental Health Act were transferred from specialist treatment back to their home area.

Death of detained patients

During the period there were no deaths of patients subject to the Mental Health Act

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								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	**21/7/20**	
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 on a monthly basis, with reports back to the UHB Performance Monitoring Committee. In recent months the Covid 19 pandemic has ceased Welsh Government reporting therefore the Clinical Board has produced partial and unvalidated activity data for that period.

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

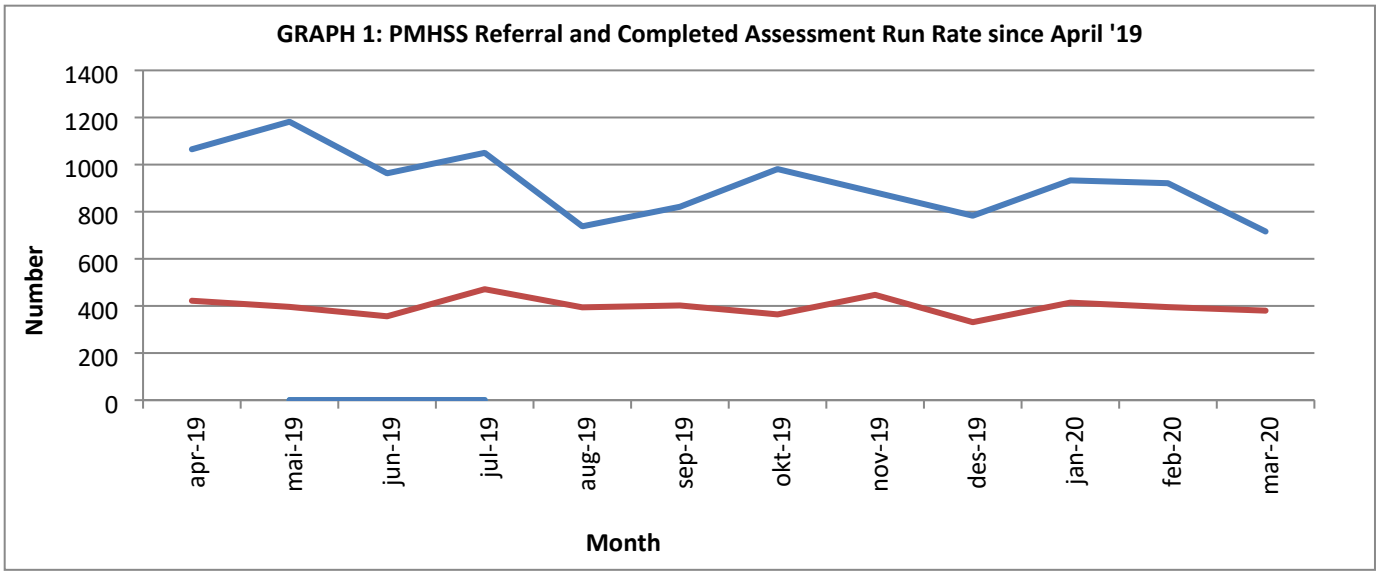
ASSESSMENT AND ASSURANCE

For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates. This reporting has been suspended during the covid 19 period and has not been reinstated at the time of this report – therefore any information provided from March 2020 has not been validated by the UHB.

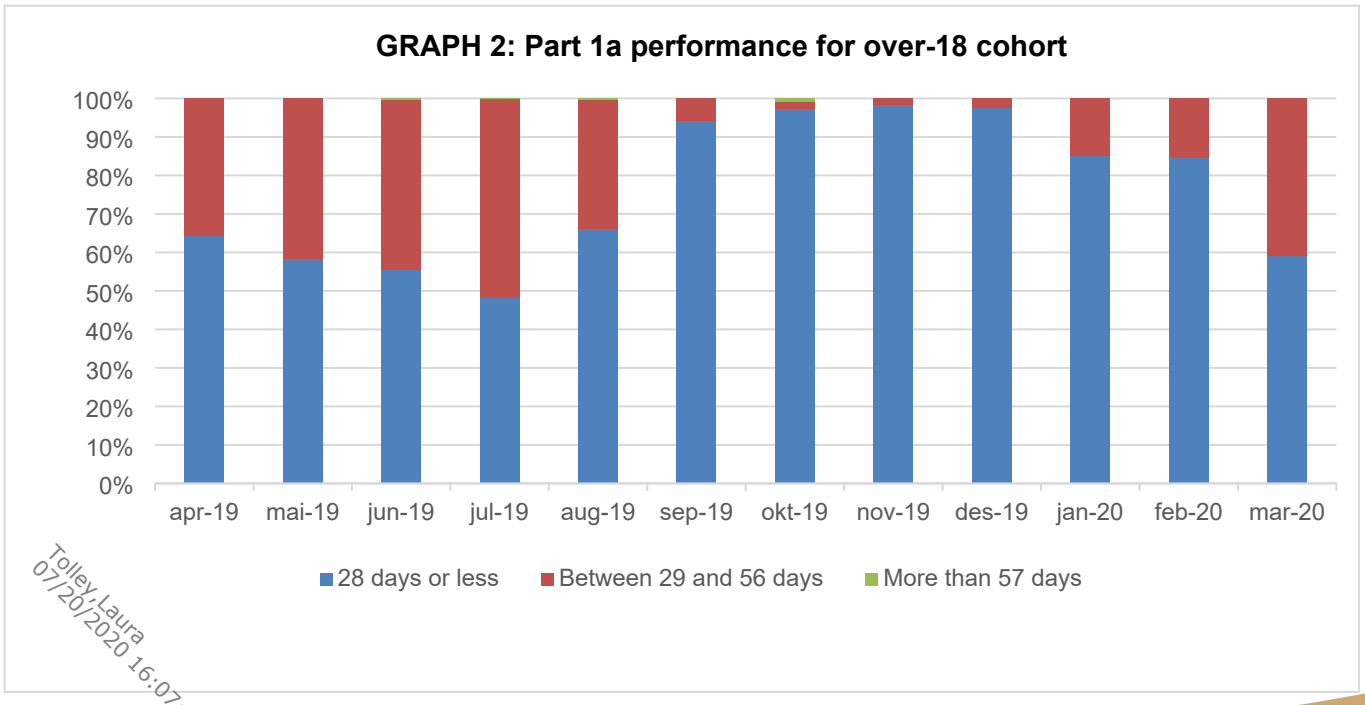
Part 1 : PMHSS

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

Referral activity this financial year has seen continuing general decrease since Month 01 onwards most likely due to the establishment of the Primary Care Liaison Service. Completed assessment rates have remained uniform looking at the financial year as a whole (See Graph 1).



Regarding the Part 1a over-18 performance, this has been compliant with the Tier 1 target from September until February 2020 (see Graph 2).



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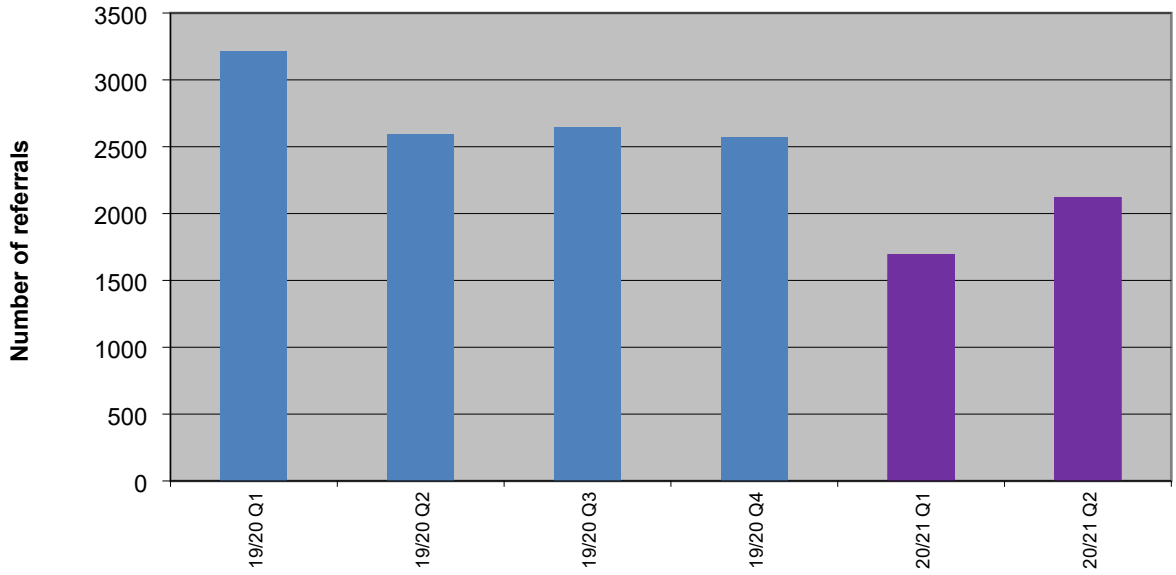
Barring huge spikes in referrals (as per October ’18) or a large loss of qualified staff (as per early ’19), we are confident we will be able to maintain this performance for the over 18 cohort into the foreseeable future.

Unfortunately such a loss of staff during March occurred due to covid19 and continued until May 2020. The performance slipped below 80% in March ostensibly as 2.0wte Band 6 members of staff were off work and others shielding. A further 1.0wte went out on Maternity Leave. At time of writing one of those vacancies has been filled, one is due to be filled in September, while the member of staff on Maternity Leave remains on leave and will be until next calendar year. This target has been compliant since May onwards as the referral numbers continued to drop.

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).

GRAPH 3: Quarterly referral run rate Qtr 1 2019/20 onwards with predicted data for Q1 and Q2 2020/21



During the Covid 19 Period - The MHCB (meaning both CYP and PMHSS) therefore regained compliance in the first week in May 2020 and will do for June and are in the high 90’s so far for July.

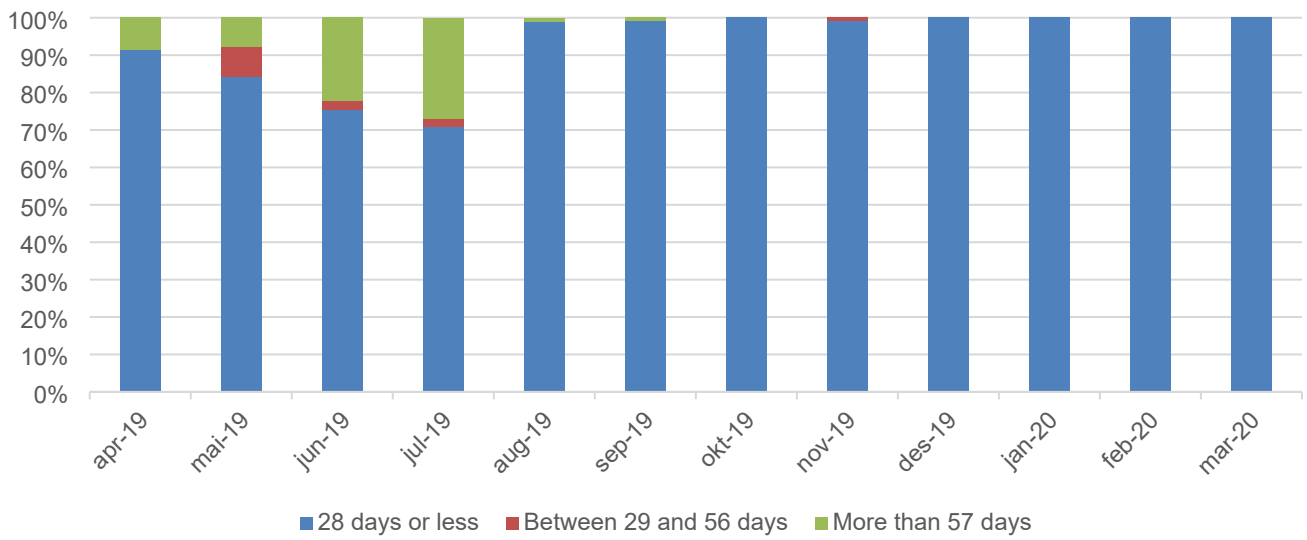
In addition to this, as we saw a significant reduction in referrals from March 2020 onwards, the MHCB took a decision to amalgamate the PMHSS and Primary Care Counselling referrals, which despite staff losses in both teams, the services were able to sustain the target and meet the demand. This decision 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.

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.

Graph 4: Part 1b Performance for over-18 cohort



Part 2 – Care and Treatment Planning

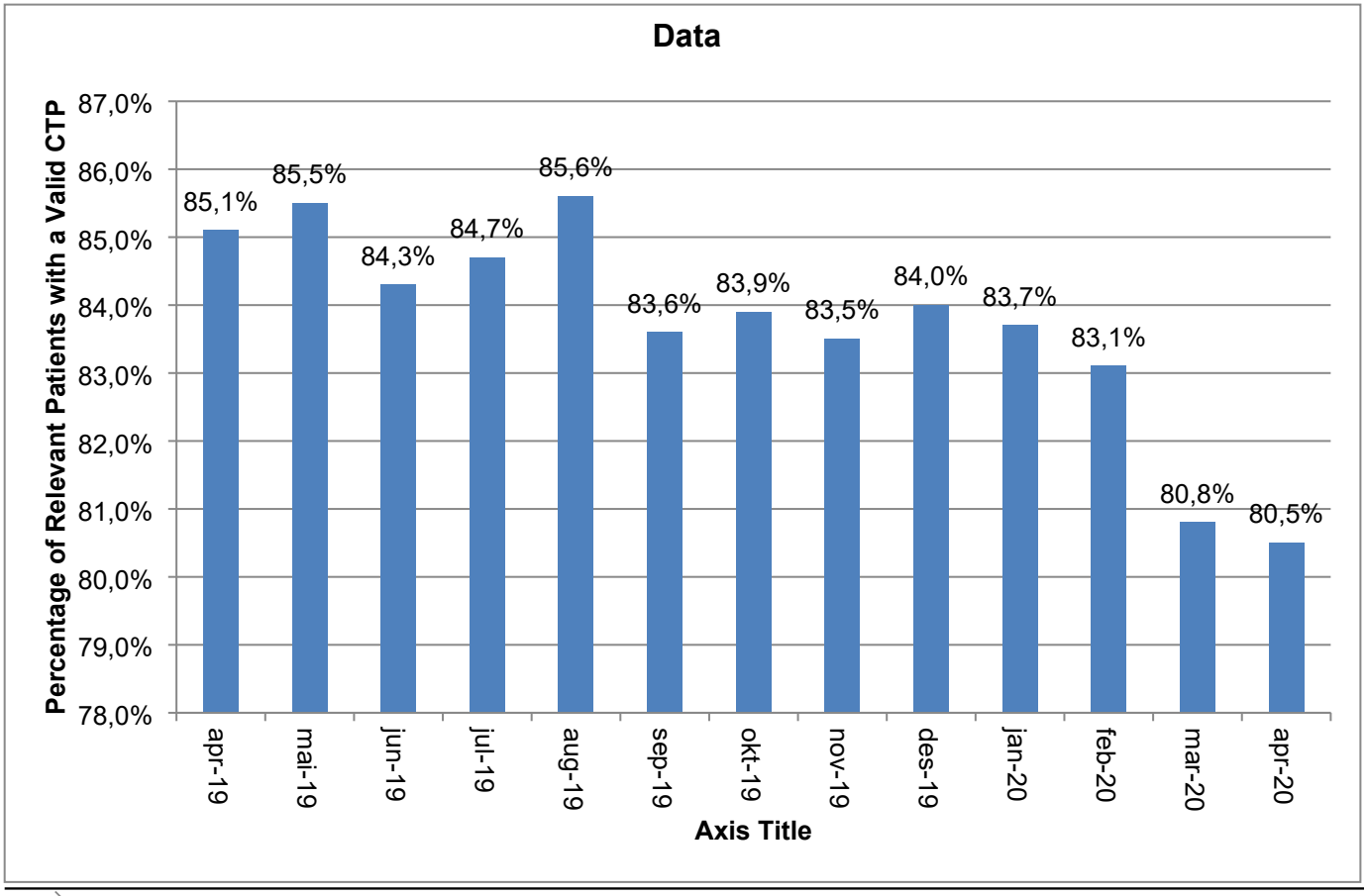
Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

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 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.

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. The Delivery Unit identified the following challenges for local and national MH services. Below are the specific recommendations by the DU which were then augmented into an action plan presented to this committee previously – (see appendix 1). This action plan was

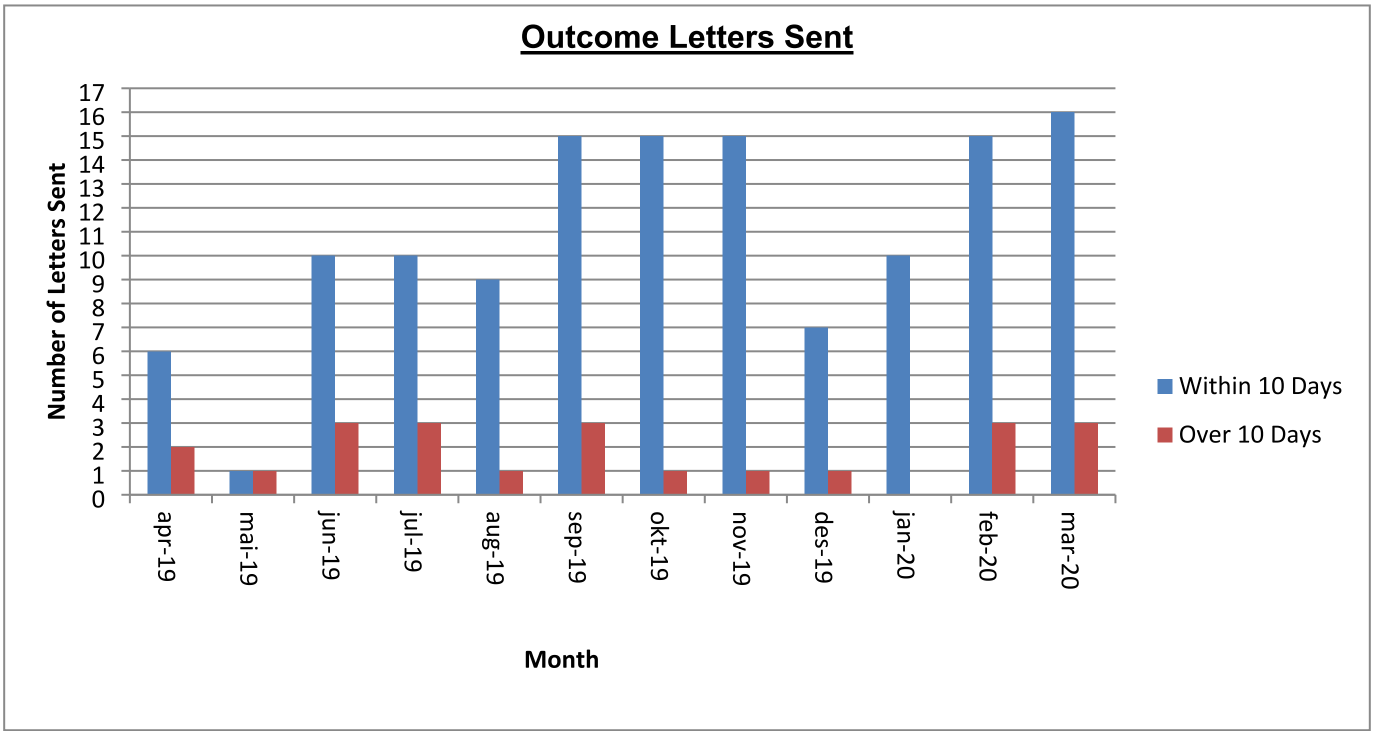
updated in January and due for an update in April 2020. This has been postponed due to the current circumstances with an update planned for August 2020.

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.



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.



In monitoring Initially the numbers seen by Cardiff and Vale were very small and manual data collection was possible. More recently in early 2019 the increase numbers require an electronic monitoring solution due to the resource required to manually collate. This has been allocated to an administrative post in the mental health act office. There is assurance that the date collection method now established is accurate but resource intensive.

The performance of the service fluctuates with steady improvement seen between September 19 and December 19 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 services 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.

Welsh Government 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.

SHAPING OUR FUTURE WELLBEING STRATEGIC OBJECTIVES RELEVANT TO THIS REPORT:

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

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

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

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

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

Appendix 1

Delivery Unit /UHB Recommendation	Action	Lead and Timescale	Review Notes
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. (Refers in the main to adult services)	Establish an education and training sub group and package which includes a guide to CTP use and development and the following characteristics: • Its use as a Therapeutic tool • Link with service user outcome measures • MDT and Multi-agency delivery • Focuses on a Pilot site in the Vale community mental health services CARE AIMS model supported as a training and clinical practice tool to meet these needs. Ensure a sufficient resource is available from the multi-agencies involved to support the rollout to at least 50% of the pilot site staff in the recently merged Vale of Glamorgan Locality Team in year 1 and 80% of MH clinical staff over 2 years. For all integrated managers and lead nurses in community and hospital settings to discuss this action plan and its contents across community and in-patient settings over the next 4 months	Ownership and lead of Action Plan overall - Ian Wile- Director of Ops – to review the action plan and its contents every 6 months – April 2019 / September 2019 / April 2020 / September 2020 Project Support - Dan Crossland – Community Transformation Lead Training and Education subgroup established – November 2018 – Chair – I wile – Director of Ops – to establish CARE AIMS Training provider and coordinate a training plan Comms regarding action plan – April – August 2019	**January 2020 – Action plan updated for the MHLC in Jan 2020 I Wile** First wave of 'Care Aims' awareness raising/training – further Care Aims training bid to the WG transitional funds approved and to be implemented from April to November 2020.

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.	Review the simplicity of documentation related to risk assessment and risk management and refine where necessary (layers of documentation have developed with the various iterations related to the use of CPA, UA and now CTP) and change/reduce where necessary Deliver Risk Assessment & WARRN training in sequence with CTP training to 75% of staff in next 2 years (90% of registered nurses within that) Audit compliance every 4 months alongside CTP audit (Delivery Unit Audit Tool) and feed-back to the steering group, MHCB Q&S Committee and report into the MHLC.	Review of Documentation between March 2019 and March 20 Cycle of training, audit tools and methods agreed – WARRN training commenced and refreshed CTP training to commence in January 2019 over 2 Year period – WARRN training Team Line management audit leads for all clinical areas in adult services to agree audit cycle and feedback method to the directorate and clinical board at least 3 times a year of the quality of risk assessments and CTPs based on the DU audit. Due in May 2019. To feed back this data to the teams for learning to take place on each audit cycle	Team of 5 part time WARRN trainers expanded to 10 who are tasked with simplifying the risk assessment and risk management documentation This team has commenced WARRN training and are on target to train 75% of staff in the required timescale. Audits currently undertaken by the Innovations Team and Integrated managers using the Audit tool originally used by the DU. Gradual improvements seen in risk assessments,

			crisis plans and relapse indicators.
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.	See training notes in no. 4 above. Continue to circulate lists of clients with 117 after-care responsibility to the integrated managers for use with MDT reviews For Community service leads to develop a process of reminding case managers of review times which could include a PARIS flagging process. Develop a caseload supervision process to regularly support practitioners with caseload management and standards of clinical practice records including CTPs. See 2 for CTP Audit Actions	Ian Wile/Sunni Webb Leads – lists go to Community Leads/Managers in Adult and MHSOP community Teams bi monthly Community Senior Nurse Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019 Community Senior Nurse Managers for MHSOP and Adult Teams Consultant Psychiatrists Psychology Leads Social Work Leads OT and Physio Leads Complete by June 2019 All above	**Completed** the necessary alterations to the Patient electronic record on PArIS – auditing on a monthly basis with slow improvements being made. Ongoing training and support provided to front line clinicians
4. Care Coordinators should ensure the inclusion of third	A draft plan is: To arrange for local third sector agencies to	This is a challenging plan with a meeting/event planned with the third sector umbrella	All community services now have

sector agencies that are providing regular and ongoing support to an individual within the assessment, planning and review processes.	those community services to have formal pathway links with the local statutory services. For relevant local third sector agencies to have a presence in Community teams. To include within the core mental health assessment a question exploring the input of any third sector support. To ensure advocacy services area available where required. Commission Cavamh to do evaluate this aspect of CTP coordination.	organization for C&V (CAVAMH) to explore a detailed and achievable action plan for this – to be the responsibility of: Ian Wile _ Director of Ops Dan Crossland – Transformation Lead Linda Newton – Cavamh lead office Integrated Managers – of CMHTs	3rd sector representation on access and referral meetings with local directories of all 3rd sector providers in community teams. Co-production lead post due to be appointed in 2020 alongside a recovery college of peer support worker trainers into MH services to promote partnership working with SUs at the centre.
5. 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	Establish a discrete resource in general adult and substance misuse services to improve Integrated working – an ANP in general adult with a significant element of the role dedicated to dual diagnosis and sessional time from a senior clinician in Substance misuse services – both roles to work collaboratively and focus on training, joint care planning MDT working and	Complete – post holder in place and improvement method agreed. ANP leading.	**Completed Actions** Duel diagnosis posts in place, and joint working between Community generic services and addictions services commenced with

issues.	accessing wider support for individuals. Also to develop a network of substance misuse liaison leads for each of the community mental health services. Mental Health and Innovation funding in 20189 secured to enhance the treatment of service users with dual diagnosis using the COMPASS model. Anticipated benefits are the availability of psychological care for those with co-morbid MH problems To seek feedback from Service Users and audit of caseloads to evaluate.	Funding secured – recruitment to commence January 2019 – Neil Jones CD adult services and Paul Sussex Senior Nurse Substance Misuse services leading.	service users spanning both areas.
MHCB Added Issue			
6. Lack of clarity over which service users in secondary care community services meet the 'relevant patient' status to ensure efforts are targeted at those most in need.	Clarify with the MDT whether cohorts of service users such as those with ADHD and those who are stable in services require and are receiving a service equivalent to secondary care. If not and the care and treatment is primary care equivalent to accommodate this until discharge is safe.	Work Commenced by Dr Neil Jones CD adult services to develop a protocol for consultation describing a step down recovery 'primary care' equivalent service within CMHT caseloads not requiring a CTP. Completion of legally scrutinized draft by May 2019 and implement through a description in the UHB Part1 'Scheme of Work' by June 2019 with a view to implement over the ensuing 12 to 18 months.	RAMP protocol now complete and ratified within the Mental Health Partners rollout commenced for the Vale and Gabalfa community services

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON 28th April 2020 Via Skype

Present:

Jeff Champney-Smith	Chair, PoD Group
Elizabeth Singer	Vice Chair, Pod Group
Teresa Goss	PoD Member
Mike Lewis	PoD Member
Sharon Dixon	PoD Member
Dr John Copley	PoD Member
Wendy Hewitt-Sayer	PoD Member
Carol Thomas	PoD Member
Mair Rawle	PoD Member
Alan Parker	PoD Member
Sarah Vetter	PoD Member
Peter Kelly	PoD Member
Mary Williams	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
Morgan Bellamy	Mental Health Act Administrator

Apologies:

Simon Williams	PoD Member
Elaine Gorvett	PoD Member
Huw Roberts	PoD Member
John Owen	PoD Member
Rashpal Singh	PoD Member
Patricia Hallett	PoD Member

1 Welcome and Introductions

The meeting was held via Skype and the Chair welcomed all to the meeting.

2 New Members and Independent Members

He introduced the two new members of the PoD group Alex Nute and Amanda Morgan. He advised the meeting that Michael Imperato, an Independent Member of the Health Board, would also be joining the PoD group.

The Chair explained the logistics of running such a meeting on Skype and requested members to use the comments box in order to attract his attention rather than talking over each other. It was agreed to observe the national one minutes silence at 11 am.

3 Members points for discussion

A PoD member raised the issue of the use of abbreviations in the reasons as these were given to the patient, it was confirmed that abbreviations should be avoided. The Chair also reminded the group of the need for formality when agreeing the contents of the minutes as these were filed in the patient's notes as a record of the Hearing.

A PoD member raised three issues and after discussion it was agreed that these would be put in writing to the Mental Health Act manager who would seek legal advice. The issues concerned:

1. The Welsh Governments coronavirus guidance on whether a Hearing could be refused
2. Whether a Hearing should proceed when, a patient was due a review, was moved from a Section 3 to a CTO.
3. The attendance of a number of relatives at Hearings when the patient lacked capacity

Action – MW to put in writing for MHA Manager to forward to WG.

4 Minutes of the last meeting held on the 21st January 2020

These were agreed as an accurate record of the meeting.

5 Matters arising not on the Agenda

There were none.

6 Matter arising on the Agenda

- **Acoustics in the meeting and tribunal suites –** foam panels had been ordered to trial in one room. The imperative at the moment was the Skype meeting rooms. If this is a success then this will be rolled out to the affected rooms.

- **Breakaway training –** this is currently on hold due to the current restrictions. In any event it is likely that PoD members will be asked to sign a disclaimer.

- **Electronic decision making –** the Chair confirmed that the protocol for this had now been circulated to all members. He reminded members that the CJSM email system must be used at all times when discussing the minutes and reasons. The Chair explained how to create a personal contact list on CJSM.

- **Concerns –** the MHA Manager confirmed that additional boxes had been added to the minutes so that each panel had the opportunity to comment on the quality of the care and treatment plan and risk assessment.

- **Hearings in Welsh –** this matter is still to be resolved.

- **Data Protection –** the most recent Health Board document was not current. The Deputy Mental Health Act Manager agreed to find information to assist PoD members. He confirmed that security software had been installed on the laptops provided. He agreed to provide information on Data Protection as soon as practicable.

- **Future Venue for Business Meetings** – it's hoped that once it becomes possible for the PoD sub-committee to meet in person the option of Global Link will still be available. However, this will be confirmed before the next meeting.

Action – Hearings in Welsh, MHA Manager
Action – data Protection, Deputy MHA Manager

7 Virtual Hearings

There was a general discussion regarding the Hearings held to date (10) via Skype. Since the rollout of laptops to the PoD members there have been no issues of drop out. Those who still required a laptop should contact MHA Manager who will arrange for one to be delivered. The use of headphones during the Hearing provides an extra level of security whilst the Hearing is in process. The MHA Manager and her team were congratulated on their tremendous work to get us to this point. Managers had the opportunity to participate in mock hearings and these will continue until all PoD members who wish to be involved feel confident and competent using Skype. For the time being the panels will continue to sit with a fourth member but this will be kept under review.

- **Laptops –** the PoD members were advised to accept all updates when requested to do so. The laptops aren't password protected and it was agreed, after discussion, that each PoD member should password protect the laptop. Please email the Mental Health manager to confirm this had been completed.

Action - All PoD Members

- **Protocols –** Members were informed that protocols have been developed and circulated and would continue as ongoing live documents to be updated as we learn from conducting virtual hearings.

- **General discussion**
  - **Liability -** An issue of insurance and personal liability was raised by one PoD member. It was agreed that this would be followed up by the MHA Office.

Action MHA Manager/Deputy Manager

  - **Delivering the outcome to the patient -** Hitherto the outcome of Skype Hearings has been conveyed to the patient via email. It was agreed that this wasn't adequate. In future, once all the evidence had

been heard the patient and professionals will be asked to leave the meeting. They will sign back into the meeting and wait in the lobby until such time as the Panel has reached their decision. The patient and professionals will be allowed back into the meeting at which point the Chair will convey the panel's decision.

The MHA Manager asked PoD members to feedback any issues to the office. So far the patients have had a positive response to the Skype Hearings.

- **Confidentiality –** as a general reminder it should be noted that the Hearings are confidential and that no one else should be in the room with either PoD members or professionals. It would be for the Chair to remind those present at the Hearing.

8 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 high percentage of discharge prior to both the Hearings and the Tribunal.

9 Concerns/compliments from Power of Discharge group Hearings

These were noted. The number of issues raised were relatively low.

10 Committee and Sub-Committee Feedback

There was nothing to report. The issue of CTP and delayed discharge, due to a shortage of supported accommodation, were still live for these committees.

11 Training

- **Other disorders**

Dr Cantrell to be invited to the next business meeting

Action - MHA Manager

- **Working with interpreters**

A suggestion was made to invite one of the interpreters who attends the Hearings so that the PoD members could get an understanding of their requirements and needs.

Action - MHA Manager

- **Annual Conference**

A decision will be made at the end of August as to whether this will go ahead.

Action - MHA Manager

12 Any Other Business

- **Healthcare Inspectorate Wales Annual Report 2018/2019**

PoD members were encourage to note the findings of HIW report via the link in the Agenda.

Action - All

- **Annual reviews**

The Chair informed the Group that the annual reviews will be going ahead and agreed to look at whether this needed to be via Skype for business or an alternative as not to tie the MHA team.

Action MHA Manager to share the self-assessment forms with the new members.

- **Microsoft Teams**

It's likely that there will be a move from Skype to Microsoft Teams imminently. Because of the nature of the business it was hoped that the MHA office would be given priority.

Action MHA Manager to follow up.

- **Fundraiser**

It was noted that this had been postponed but will be held at a later date.

There being no further business the meeting was closed.

Minutes of the Mental Health Legislation and Governance Group held at 14:00 on 29 April 2020 via Skype

Present

Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Linda Woodley	Operational Manager (OM) Vale of Glamorgan
Jeff Champney Smith	Chair of the Power of Discharge Group
Sunni Webb	Mental Health Act (MHA) Manager
Simon McDonald	Deputy Mental Health Act (MHA) Manager
Dr Mary Lawrence	Associate Specialist in Psychiatry
David Seward	Mental Health Act Coordinator
Gareth John	Consultant Social Worker- DoLs/ AMHP
Julia Barrell	Mental Capacity Act (MCA) Manager

Apologies

Adele Watkins	Paediatrics Representative
Ceri Lovell	Team Leader- CAMHS Crisis Liaison Team
Charles Janewski	Vice Chair, Cardiff and Vale University Health Board
Dr Clare Davies	Emergency Unit Consultant Representative
Dr Katie Fergus	Consultant Psychiatrist
Dr Tayyeb Tahir	Consultant Liaison Psychiatrist
Kathryn Parry	Specialist Liaison Nurse
Peter Thomas	South Wales Police
Sue Broad	Depravation of Liberty Safeguards
Simon Amphlett	Senior Nurse Manager Crisis and Liaison services
Susan Power	Lead Team Manager Emergency Duty Team
Emma Powderhill	Team Leader, South Crisis Team
Will Adams	Specialist Liaison Nurse
Fiona Pearson	Trainee Psychologist
Dr Sugandha Kumar	Consultant in Old Age Psychiatry
Ceri Martin	Emergency Unit Clinical Team Leader
Carys Williams	Emergency Unit Sister
Susan Eshel	Frequent Attender Case Load Manager
Matthew Russell	Acting Operational Manager Cardiff
Dr Michael Ivenso	Consultant in Older Persons Psychology

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 22 January 2020

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

4 MHA Activity January – March 2020

The Mental Health Act Monitoring report was discussed. There were no exceptions to discuss. It was noted that the MHA Office had found a fault with a Paris Report that has been used to get data used to compile the report. This meant that the previous reports data for the number of Active Community Treatment Orders (CTO) has been incorrect for some time. The correct data shows a clear decrease in the number of CTO for over a year.

The Deputy Mental Health Act Manager pointed out that the number of patients open to s117 had started to plateau. This is not due to a drop in new s117 eligibility or an increase of discharges, but reflects an increased death rate due to the Covid 19 pandemic.

The Mental Health Act Manager questioned the value of including information about Rectifiable Errors. As these are De Minimis errors they don't affect the validity of the documents. It was confirmed to the group that this information would still be recorded, and would be available on request if required.

Action – The Associate Specialist in Psychiatry will take the CTO data to the Consultants meeting to find out if there is a conscious effort to reduce the use of CTO and if so the reasons for this.

Action – The Deputy Mental Health Act Manager to investigate a possible correlation between the use of CTO and s17 leave, to see if s17 has risen whilst CTO has dropped.

5 Matters Arising

Recording/reporting VA's – The issue of people brought to hospital by the Police for a Voluntary Mental Health Assessment was discussed. Due to the current pandemic situation very little has progressed since the last meeting.

Action – The Deputy MHA Manager to continue to investigate the recording of VA

Silver on Call (SoC) training – Not discussed due to the relevant people not being in attendance.

Action – Chair to carry SoC training forward

Transport/booking transport – Both the Consultant Social Worker and Operational Manager (OM) Vale of Glamorgan explained that this issue has been ongoing for the last two years. They confirmed that this is still a significant issue and expressed a wish for this to be taken forward.

Concerns were raised in relation to the UHB fulfilling their legal obligation and reference was made to chapter 17, Mental Health Act 1983, Code of Practice for Wales, revised 2016.

First and foremost it is for the individual and the need to maintain their dignity and limit the distress to them. Being transported in a timely and appropriate manner is a key part of this. It is also for the protection and preservation of AMHP staff.

Lack of resource provided by the UHB has made it difficult to resolve this issue. The Consultant Social Worker explained that whilst the Local Authority appreciate the cost implications of providing a robust transport service to the UHB, they also incur similar costs to meet their legal obligations to provide Approved Mental Health Professionals. Recent costs to train 4 AMHP's was approximately 100k, which include time away from front line duties and provision of practice assessors and so on. It is not merely the cost of the course fees.

It was suggested that this now be considered as an agenda item for the Mental Health and Capacity Legislation Committee to enable progress to be made.

Action – Chair to escalate the issue of transport forward

CAMHS RC issue – The Chair confirmed that this issue is ongoing and that there have been discussions at a high level, but the pandemic has pushed this down the priorities list.

Action – The Associate Specialist in Psychiatry to take to the Consultants meeting

Crisis Attendance – Not discussed due to the relevant people not being in attendance.

Availability of AMHP's – The Consultant Social Worker informed the group that Cardiff Local Authority have put four staff members forward for AMHP training. The Operational Manager (OM) Vale of Glamorgan informed the group that the Vale Local Authority are hoping to put forward three staff members, two of which are from Mental Health Services for Older People.

6 Feedback on Operational Issues and Incidents

Mental Health Act Manager Hearings over Skype – The Chair of the Power of Discharge Group informed the group that the Manager Hearings have been taking place over Skype with 11 completed so far and that he is very pleased with the system so far. There have been connection issues identified with those using Apple devices, IPhone, IPad, and desktop. Due to this laptops have been acquired and are being distributed to the Power of Discharge members. The Associate Specialist in Psychiatry stated that it is working well for her, and has an unintended benefit in that it allows her to carry on with other work whilst waiting for the outcome.

Mental Health Act Review Tribunals by Telephone Conference – The Mental Health Act Manager informed the group of the method that MHRT Hearings whilst working wasn't ideal. One of the issues is the availability on each ward of a private room with a telephone.

Remote Examination – The group were informed that legal advice has been obtained about the remote examination of patients via systems such as Skype. The advice is that this can be completed provided that the person completing the examination is happy to do so. The Operational Manager (OM) Vale of Glamorgan informed the group that there is good guidance on assessments that are not face to face.

Action – The Mental Health Act Manager to disseminate the legal advice

Action – Operational Manager (OM) Vale of Glamorgan to share the guidance with the group

Digital Signatures – The Mental Health Act Manager informed the group that legal advice had been obtained on the use of digital signatures on MHA paperwork, which would enable professionals to complete tasks remotely and let them minimise contact with other persons. The Deputy Mental Health Act Manager explained that the use of a profession email address that only that professional was able to send email from (NHS email, LA email) would count as an Advanced Digital Signature, so would be enough to sign the paperwork. This is something that is being actively investigated and developed due to the current pandemic.

Action – The Deputy Mental Health Act Manager to progress

Datix Incident Reporting – The Chair explained that this is something that he still has on his agenda but has been unable to follow up completely due to issues relating to the current pandemic. After the last meeting there have been 4 incidents reported;-

- Unlawful detention due to AMHP warrant lapse
- Legal document lost in post – no copies retained by ward

Action – The Chair to take forward

Section 135 Process – The Operational Manager (OM) Vale of Glamorgan informed the group that there had been changes to the process to obtain s135 warrants due to the current pandemic and that the changes known about had been passed to the MHA Office.

7 Feedback from other meetings

Consultant Meeting

Assessment Numbers – The Associate Specialist in Psychiatry explained that assessment numbers are starting to rise. The belief is that patients are trying not to contact services so as not to over burden them in this current pandemic. This in turn means that by the time they seek help they are more ill than they would have been if contacted earlier.

AMHP Forum

Teams Replacing Skype – The group were informed that Vale Local Authority had moved to Teams from Skype, and that Cardiff Local Authority were in the same process. The UHB has imminent plans to do the same. The Deputy Mental Health Act Manager has tested interoperability between the systems and found no issues.

Private Ambulance for Covid-19 Positive Patients – The Consultant Social Worker requested clarification that if they needed transport for a patient who is Covid-19 positive that they were able to do this. It was confirmed that this has been agreed.

Action – The Mental Health Act Manager to distribute the email containing the agreement

Assessment Numbers – The Operational Manager (OM) Vale of Glamorgan informed the group that The Jan – April assessment numbers vary from the previous year, 64 in 2019 to 48 in 2020. This now seems to be increasing. Personal Protective Equipment has been in good supply so this isn't a factor.

Health Staff in the AMHP Role – The Operational Manager (OM) Vale of Glamorgan reiterated that any health staff who wished to become an AMHP would be more than welcome. It was decided that whilst this is a good idea in principle, the current pandemic would take priority. This is to be re-visited at a later date.

8 Power of Discharge Group

New Members – The Chair of the Power of Discharge Group informed the group that there have recently been two new Members appointed, and that it is looking likely that one of the independent members of the board will also be appointed.

Comments, Compliments, and Feedback – The Chair Power of Discharge Group explained that the most commented items remain to be around Care and Treatment Plans and Risk Assessments. The Mental Health Act Manager explained that there had been an increase in compliments from the panel back to the professionals involved. When this happens the compliment is sent to the individual and their manager.

9 External Reviews

No external Reviews have been carried out since the last meeting.

10 Interface MHA/MCA/DoLs

Liberty Protection Safeguards – The Mental Capacity Act (MCA) Manager informed the group that it is looking increasingly likely that the Liberty Protection Safeguards were going to be delayed due to the current climate.

Court of Protection Service – The (Chair) Consultant Forensic Clinical Psychologist informed the group that the Court of Protection Service is running significantly slower than normal due to the current pandemic.

11 Quality Indicators and audit activities

Not progressed as this is a lower priority than work needed for the current pandemic.

12 Any other business

Family Members' Attendance at Manager Hearings – The Chair of the Power of Discharge Group informed the group of a situation in a Managers Hearing where several members of the patients family attended, and the patient themselves did not have the

capacity to agree or disagree to this. The group agreed with the opinion of the Power and Discharge Group, who had recently discussed this. The decision is ultimately down to the Chair of the panel, where the best interests of the patient are taken into account.

Using the Mental Health Act to Treat Diabetes – The Mental Capacity Act (MCA) Manager informed the group that there is recent case law on treating diabetes under the Mental Health Act. See link below:

https://www.bailii.org/ew/cases/EWHC/Fam/2020/574.html

Early Retirement – The Consultant Social Worker informed the group that he is taking early retirement, and therefore this will be his last Mental Health Legislation and Governance Group Meeting. He was thanked by the group for all of his valuable input and expertise that he has provided, and wished him well.

13 Date of future meetings

To be held in the Seminar Room, Hafan Y Coed at 14:00hrs;

22 July 2020
28 October 2020
27 January 2021

Report Title:	**APPROVAL OF REVIEW OF JOINT SECTION 117, MENTAL HEALTH ACT, 1983, POLICY AND PROCEDURE**								
Meeting:	**Mental Health & Capacity Legislation Committee**						**Meeting Date:**	**21 July 2020**	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	**Chief Operating Officer**								
Report Author (Title):	**Mental Health Clinical Board Director of Operations**								

Background and current situation:

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

This policy and procedure sets out the requirements for provision of aftercare to eligible patients who cease to be detained and leave hospital. This includes patients granted leave of absence under section 17 and patients subject to community treatment orders (CTOs). It applies to people of all ages, including children.

Local authorities and local health boards have a joint responsibility to provide or commission mental health after-care services.

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

This policy and procedure has been reviewed to ensure statutory requirements under the Mental Health Act 1983 are met.

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

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

- The document was added to the Policy Consultation pages on the intranet between 10 December 2019 and 07 January 2020;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality, Safety and Experience Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Local Authority Legal Team

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

The primary source for dissemination of this document 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.

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

ASSURANCE is provided by consultation with:

- All Wales Mental Health Act Administrators Policy Group
- Mental Health Policy Group
- Mental Health Quality and Safety Sub Committee
- Internet consultation
- Approval by Local Authority Legal Team

Recommendation:

The Board is asked to:

APPROVE the Review of the Joint Section 117, Mental Health Act, 1983, Policy and Procedure **and**
APPROVE the full publication of the Joint Section 117, Mental Health Act 1983, Policy and 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	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:	Yes – included with the Joint section 117, Mental Health Act 1983, Policy document. *If "yes" please provide copy of the assessment. This will be linked to the report when published.*

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

Section 5(2) Doctors' Holding Power Policy
Mental Health Act, 1983

Policy Statement

Cardiff & Vale University Health Board, Cardiff County Council, and the Vale of Glamorgan Council as partner agencies are committed to providing appropriate aftercare services to eligible patients according to need as set out in section 117 of the Mental Health Act 1983.

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering and assessing the needs of individuals eligible to section 117 aftercare.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of section 117 aftercare.

Practitioners must be fully aware of the diverse needs of the patient when considering the use of section 117 aftercare and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

To set out the requirements for provision of aftercare under section 117 of the Mental Health Act 1983 to the practitioners and agencies involved in the management of patients eligible to section 117 aftercare**.**

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

Supporting Procedures and Written Control Documents

This Policy and the Joint Procedure on Section 117, Mental Health Act 1983 describe the following with regard to section 117 aftercare:

- The purpose of section 117 aftercare
- The process for assessing the suitability for the use section 117 aftercare
- The duties of the practitioners and agencies involved in the management of patients eligible to section 117 aftercare

Other supporting documents are:

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

Scope

This policy is applicable to employees within all Mental Health inpatient settings, community settings and general hospital settings, including those with honorary contracts responsible for considering and assessing the needs of individuals eligible to section 117 aftercare.

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

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

Director	

Disclaimer

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

Summary of reviews/amendments

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

Equality & Health Impact Assessment for

Section 117, Mental Health Act 1983, Policy

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	SECTION 117, MENTAL HEALTH ACT 1983, POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure doctors' are aware of their individual and collective responsibilities when considering and assessing individuals eligible to section 117 aftercare. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering and assessing individuals eligible to section 117 aftercare.

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

		sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives

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

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

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

		The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all individuals are provided with treatment and care within the legal framework of the Mental health Act 1983.. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no

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

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

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

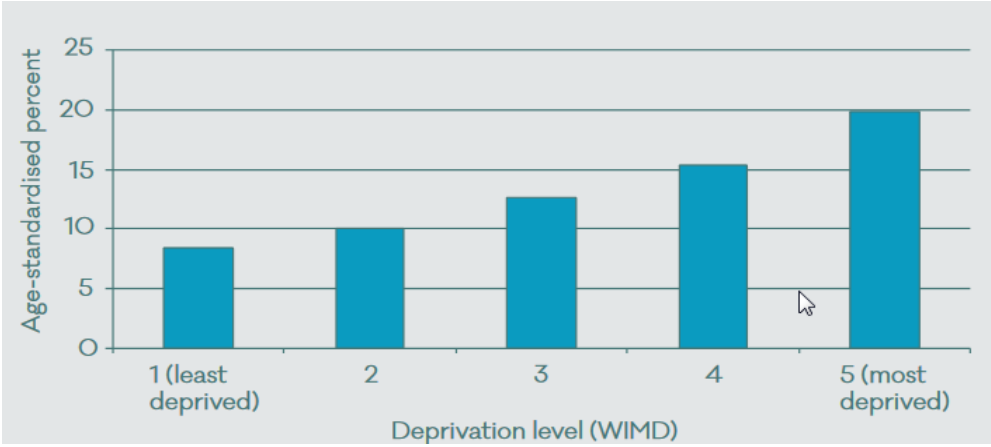
		factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian,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

		The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website. Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found

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

have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



Findings from the 2015 survey found, that there was poorer mental health in more deprived areas. The percentage of adults that reported currently being treated for any mental health condition by area deprivation showed 8 per cent in the least deprived fifth in receipt of mental health treatment which rose steadily with higher levels of deprivation to 20 per cent in the most deprived fifth.

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with

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

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

		Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental

		health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf The duty to provide or to arrange to provide after-care services applies to patients irrespective of their country of origin. There would be little or no impact in respect of race but there is a negative bearing on some who have an immigration or asylum. This section does not appear in the list of provisions set out in Sch. 3 to the Nationality, Immigration and Asylum Act 2002 which has the effect of preventing local authorities from providing support under the provisions listed in the Schedule to certain categories of refugees and asylum seekers.

It may be difficult to deliver a care and treatment plan to gypsies and travellers who move around from area to area; however, they do have the option to decline s.117 services, as do all other relevant patients.

Prisoners

10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%.

26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody.

Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.

49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression.

46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide.

http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth

		Information in relation to multiple protected characteristics - Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The section 117 policy applies to eligible individuals with needs which require mental health services after discharge from hospital. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out as the Mental Health Act 1983 and associated legislation allows.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- <https://www.rdash.nhs.uk/wp-content/uploads/2014/04/S-132-Providing-Legal-Rights-v11.pdf> accessed 13 August 2019 <https://www.google.com/search?ei=maxSXbvgHM-W8gLXkJ7ABg&q=s117+policy+with+eqia&oq=s117+policy+with+eqia&gs_l=psy-ab.3...5363.7344..7528...1.0..1.409.1595.8j0j1j1j1.....0....1..gws-wiz.....0i71j0i22i30j33i160.BDpPr09FfPI&ved=0ahUKEwj7kKOR7P_jAhVPi1wKHVeIB2gQ4dUDCAo&uact=5> accessed 13 August 2019 EqIA Section 117 Policy Nov 17 v2 fina - accessed 13 August 2019

Action Plan for Mitigation / Improvement and Implementation

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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A Hospital managers should maintain and monitor a register of all individuals eligible to section 117 aftercare and ensure that individuals are reviewed within the statutory timeframes.

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

Joint Procedure on Section 117,
Mental Health Act, 1983

Introduction and Aim

This document supports the Section 117, Mental Health Act, 1983 Policy.

Cardiff & Vale University Health Board, Cardiff County Council, and the Vale of Glamorgan Council as partner agencies are committed to providing appropriate aftercare services to eligible patients according to need as set out in section 117 of the Mental Health Act 1983.

To ensure staff are aware of their individual and collective responsibilities to those eligible to receive section 117 aftercare.

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983.

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

Objectives

To set out the requirements for provision of after-care services under section 117 of the Mental Health Act 1983 to the residents and patients of the partner agencies.

This procedure describes the following with regard to section 117 aftercare:

- The purpose of section 117 aftercare
- The process for eligibility for section 117 aftercare
- The duties of the practitioners and agencies involved in the management of patients eligible to receive section 117 aftercare

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are providing aftercare services under Section 117.

Scope

This procedure is applicable UHB wide and to employees of Cardiff and the Vale of Glamorgan Council with a duty to provide aftercare services under section 117 of the Mental Health Act 1983.

Equality and Health	There is potential for both positive and negative impact. The

Impact Assessment	procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read alongside this Procedure	• Mental Health Act 1983 • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • The Equality Act 2010 • Mental Health (Wales) Measure 2010
Approved by	Pending – Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Chief Operating Officer*
Author(s)	*Mental Health Act Manager*

Disclaimer

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

Summary of reviews/amendments

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

CONTENTS

1 INTRODUCTION

1.1 This procedure sets out to describe the process of using s117 aftercare. It also gives guidance on the duties of the practitioners involved in the management of those patients eligible to receive such aftercare.

1.2 s117 provides a statutory framework and imposes an enforceable joint duty on the relevant health and social services authority to provide aftercare services for certain categories of mentally disordered patients who have ceased to be detained and leave hospital (or prison having spent part of their sentence detained in hospital).

1.3 The fact that the duty is a joint one does not mean that the costs incurred in providing services under this section should be shared between the authorities irrespective of the nature of the service being provided. The duty is joint in the sense that authorities must collaborate and plan together when providing, or arranging to provide services that come within the scope of their health or social care responsibilities.

2 PROCEDURE STATEMENT

2.1 Cardiff and Vale University Health Board and Cardiff and Vale of Glamorgan Councils are committed to ensuring, through this procedure, that individuals who are subject to s117 of the MHA 1983 (s117) receive care in line with the principles set out within the MHA Code of Practice. The primary purposes of s117, as defined in s117 (5), are as follows:

- **To meet the need arising from the individual's mental disorder**
- **Reduce the risk of deterioration**
- **To minimise the need for repeated admissions.**

2.2 It is the intention of this procedure to articulate a clear process by which care planning in the context of s117 should be undertaken to deliver these objectives.

2.3 It is the intention of this procedure to ensure that s117 status is reviewed in a timely fashion and that all decisions in respect of this are clearly documented.

2.4 Patients and their carers/representatives, where appropriate, are seen as equal partners through this process. Individuals will be eligible for the help and assistance of Independent Mental Health Advocates or Independent Mental Capacity Advocates as appropriate.

3 PURPOSE

3.1 The objective of this procedure is to set out the policy requirements for provision of after-care services under s117 of the MHA 1983 to the residents of Cardiff and the Vale of Glamorgan.

3.2 This document aims to lay out a clear framework for the Health and Social Care services in Cardiff and the Vale of Glamorgan to utilise when delivering statutory aftercare to people who are entitled to those services under s117.

3.3 All staff should be familiar with the relevant sections in the Mental Health Act 1983 (the Act) and the Code of Practice for Wales, Revised 2016.

3.4 This document aims to give staff an understanding of their responsibilities with respect to planning, providing, reviewing and ending aftercare services and will ensure that the Local Social Services Authorities and Health Boards involved, work together to discharge their responsibilities under the Act.

4 SCOPE

4.1 The procedure is relevant for all Approved Mental Health Professionals; qualified and registered staff of Cardiff and Vale University Health Board and Cardiff and Vale of Glamorgan Councils who are required to assess, plan and deliver aftercare services.

5 LEGAL CONTEXT

5.1 Local Social Services Authorities (LSSAs) and Local Health Boards (LHBs) have a statutory duty to provide, in cooperation with relevant voluntary organisations, aftercare services for any person to whom s117 applies.

5.4 The Mental Health Act 1983, Code of Practice for Wales, Revised 2016 requires there to be a policy developed on a multiagency basis involving Local Authorities[1]

5.5 s117 **only** applies to the following circumstances and individuals:

- Patients who have detained in a psychiatric hospital under Section 3 MHA (compulsory admission to hospital for treatment);
- Patients who have been admitted under an order made under Section 37 MHA (detention in psychiatric hospital under a court order);

[1] Mental Health Act 1983, Code of Practice for Wales, Revised 2016, 265

- Patients who have been transferred to a psychiatric hospital from prison or remand centre (including those on remand, detained in prison under the civil law or held under immigration legislation) in pursuance of a transfer direction under Section 45A, 47 MHA and Section 48 MHA who cease to be detained and Leave hospital (whether or not immediately after the detention has ended).

5.6 In addition s117 applies to:

- Those patients subject to Guardianship where he/she has previously been detained under Section 3; 37; 45A, 47 and 48 MHA and discharged from one of these and where the Aftercare plan included a requirement of Guardianship (Section 7 MHA);

- Patients, detained under Section 3; 37; 45A, 47 and 48 MHA, who are given leave of absence under Section 17 MHA, as part of the preparation of a post-discharge aftercare plan, and where that care plan is based on jointly assessed and agreed health and social care needs;

- Patients detained under Section 3; 37; 45A, 47 and 48 MHA, who are made subject to a Community Treatment Order (CTO) under Section 17A MHA;

- Patients who have been assessed as requiring live-in residential accommodation or to receive other non-residential community care services as a condition of leave under Section 17 MHA and/or s117 MHA.

5.7 Aftercare under s117 is to be provided until such time as the Local Social Services Authority and LHB are **jointly satisfied** that the person concerned is no longer in need of statutory after-care. This is achieved through Care Co-ordination with systematic, high quality assessment, review and discharge arrangements.

5.8 Health Service Circular HSC 2000/003 and Local Authority Circular LAC 2000(3) states that:

- ***'Social services and health authorities should establish jointly agreed local policies on providing S117 MHA after-care. Policies should set out clearly the criteria for deciding which services fall under S117 MHA and which authorities should finance them. The S117 MHA Aftercare plan should indicate which service is provided as part of the plan. After-care provision under S117 MHA does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when after-care provided under S117 MHA should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in deciding when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted'***

6 MANDATORY PROCEDURES

6.1 The s117 statutory duty arises at the point of discharge but aftercare bodies must ensure that appropriate planning takes place as soon as possible.

6.2 s117 aftercare planning meetings must be documented fully within the patient's electronic record under clinical information, using the appropriate review form.

6.3. Patients who are subject to s117 and receiving community services should be offered an Independent Mental Health Advocate (IMHA) to support them at reviews by the Care Coordinator.

6.4 Decision to end s117 can only happen with the agreement of both the responsible LSSA and the LHB (see section – Ending Section 117 Aftercare). Any such decision **must** be recorded in writing in line with this policy using the proforma contained in appendix 1.

6.5 Aftercare services **should not** be automatically discharged from s117 solely on the basis of any of the following:

- The patient has been discharged from the care of specialist mental health services
- An arbitrary period has passed since the care was first provided
- The patient is deprived of their liberty under the Mental Capacity Act (MCA)
- The patient is no longer on a CTO or section 17[2].

6.6 Aftercare **must** be provided and extends to when a patient's Responsible Clinician (RC) authorises s17 leave of absence, the patient is discharged on to a CTO and upon discharge from hospital[3].

6.7 Services required to meet a patients mental health needs are provided by the LSSA and the LHB who are jointly responsible to commission aftercare under s117[4].

6.9 The duty to provide s117 aftercare is not broken by the patient's subsequent re-admission to hospital, even if detained under the Act, though the responsible authorities may change.

[2] Welsh Government, Mental health Act 1983, *Code of Practice for Wales, Revised 2016*; Para 33.20
[3] Welsh Government, Mental health Act 1983, *Code of Practice for Wales, Revised 2016*; Para 33.2
[4] Welsh Government, Mental health Act 1983, *Code of Practice for Wales, Revised 2016*; Para 33.6

7 THE PURPOSE OF AFTERCARE

7.1 s117 (6)(a)(b) sets out the purpose of after-care services:

- Meet a need arising from or related to the person's mental disorder; and
- Reduce the risk of a deterioration of the person's mental condition (and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).

8 CHILDREN SUBJECT TO S117 AFTERCARE

8.1 Children who are subject to s117 are cared for clinically under the CAMHS service; Cardiff and Vale ULHB will maintain a list of children subject to s117. Reviews will be organised by CAMHS at appropriate intervals. Children's services, if involved, should be invited and attend reviews along with other partner agencies involved in the child's care.

8.2 Children subject to s117 will be transitioned to adult mental health services for their 18th birthday. A well planned, comprehensive handover will be arranged with all agencies involved. Where a child is known to require Adult Mental Health Services, they should be referred to the appropriate Adult CMHT at age 16. Transition cases will be held under a separate PARIS list by the CMHT, with joint working with adult services to be arranged at age 17 and 6 months. It is essential that CAMHS and the relevant Local Authority social services team communicate and share relevant information in order that safe, seamless multi-disciplinary care is provided.

8.3 Where a looked-after child is the subject of a care order, the local authority responsible for providing accommodation for the child will be the authority which is designated by the Court at the time the care order is made. The chid is therefore "ordinary resident" in the Local Authority area responsible for the funding of the placement and if eligible for s117 aftercare, from the placing Local Authority.

8.4 The Local Authorities for both Cardiff & Vale of Glamorgan will assist in the recording of eligible s117's by ensuring they notify the Cardiff and Vale ULHB Mental Health Act office of all detentions eligible for s117 aftercare by forwarding copies of the section papers to the Mental Health Act Office in a timely manner.

8.5 If the child/Young Person is discharged from s117 aftercare prior to requiring Adult Mental Health Services it is the responsibility of CAMHS to ensure the Mental Health Act Office are notified.

9 SCOPE OF AFTERCARE

9.1 Aftercare services could include a combination of health and social care services to ensure that issues relating to an individual's mental health needs and social care needs are met through the appropriate professionals.

9.2 The provision of accommodation in and of itself is not considered to be a s117 aftercare need unless there is a clear connection between the need and the mental disorder.

Relevant cases

- See R v Mayor & Burgess of the London Borough Camden [2013] *"basic or pure or ordinary accommodation"* does not come within the concept of aftercare services
  - Consistent with definition that ordinary accommodation meets a basic human need that applies to all individuals; it is not one which either arises from or is related to the person's mental disorder.
  - Receiving an aftercare service, such as residential care, for mental health needs prior to admission to hospital does not mean that service cannot be an *"aftercare service"* for purposes of this section. The person could not be charged for the accommodation on returning from hospital even if charged prior to the admission.

- R v Mayor & Burgess of the London Borough Camden [2013] – claim that specialist accommodation came within scope failed because the need arose from a brain injury which occurred after discharge.

9.3 If need for residential care arises from physical disability which requires full time support for daily living needs, the fact of continuing to suffer from the symptoms of a mental disorder does not bring residential care within the scope of this section[5].

10 CARERS

10.1 Although the duty to provide aftercare begins when the patient leaves hospital, the planning of aftercare should start whilst the patient is in hospital. Local Health Boards and Local Authorities should take reasonable steps, in consultation with the patient, their family or carer, care coordinator and other members of the multidisciplinary team, to identify appropriate aftercare services for the patient in good time for their eventual discharge from hospital, or release from prison[6].

[5] *Report by Health Services Ombudsman and Local Government Ombudsman*
[6] Welsh Government, Mental health Act 1983, *Code of Practice for Wales, Revised 2016*; Para 33.8

10.2 Carers and parents can be important members of the care delivery team, even in certain circumstances where their involvement is not requested by the patient. Part 2 of the Mental Health (Wales) Measure 2010 (the Measure) requires care coordinators to take all practicable steps to consult with parents and any carer(s) who may have a caring relationship with the patient during the preparation or review of the care plan. Consultation may go ahead even if the patient has indicated that they do not wish for the carer to be consulted, provided that due consideration has been given to the patient's wishes[7].

11 ASSESSMENT

11.1 The planning and implementation of Aftercare services should be completed using the existing processes contained in Part 2 of the Measure[8].

11.2 Aftercare arrangements should be recorded in the care and treatment plan. It is recommended that meeting the requirements to regularly review care plans are combined to reduce the need for multiple meetings[9].

11.3 All care plans must include specific detail of which services are to be provided under s117.

12 PLANNING OF SECTION 117 AFTERCARE

12.1 Failure to implement discharge planning arrangements within *'a reasonable time'* is in breach of Article 5 of the European Convention on Human Rights, and therefore in breach of the 1998 Human Rights Act. Health and Social Care Staff responsible for discharge planning need to ensure that the reasons for any delay are well documented and evidenced. Discharging remains a joint responsibility between the LHB and the LSSA.

12.2 Within the framework of the Care and Treatment Planning (CTP), a written care plan, based on a full assessment of the patient's needs, and which specifies s117 after-care arrangements, must be in place before:

- Discharge from hospital
- A period of s17 leave - except for short periods of leave, when "a less comprehensive review may suffice, but the arrangements for the patient's care should still be properly recorded" Any period of leave which includes an overnight stay necessitates a full after-care plan.

[7] Welsh Government, *Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010* ; Para 4.20
[8] Welsh Government, *Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010* ; Para 2.1 – 2.21
[9] Welsh Government, *Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010* ; Para's 6.23, 6.24

- A Mental Health Review Tribunal for Wales or hospital managers' hearing. The hospital managers must ensure that Health Board and the Local Authorities are aware of the hearing so that they are able to consider after-care arrangements in all cases; however this is particularly important when discharge is a strong possibility and appropriate after-care is a key factor in the decision.

12.3 The responsible clinician (RC) will ensure that the patient's after-care needs have been fully assessed. The s117 after-care plan should normally be formulated at a multi-disciplinary CTP meeting; this meeting will also identify the care co-ordinator (if not already identified). The Code of Practice for Wales contains detailed guidance about the people who should be involved in this process and the considerations to be taken into account.

12.4 A s117 register is to be kept and maintained by the Mental Health Act Department, Hafan Y Coed, University Hospital Llandough. All residents who are eligible for s117 aftercare, whether or not they receive such services should be on the register. The Mental Health Act Team are responsible for keeping the s117 register up to date and must be informed by the patients care co-ordinator of any significant changes:

- the date s117 after-care ends, or
- if responsibility for s117 after-care is transferred to another authority

12.5 The care plan must clearly identify the interventions that are related to s117 entitlement and those that are not.

13 REVIEW OF SECTION 117 AFTERCARE

13.1 The Care Coordinator will arrange an initial review of the Care Plan within an appropriate timescale (to be determined on a case by case basis according to need and standard practice). Care Plans for patients receiving after-care under s117 should be as often as required but once every twelve months as a statutory minimum, within the CTP process.

13.2 This meeting may include the following people:

- The patient, if he/she wishes and/or a nominated representative or advocate
- The patient's Responsible Clinician
- Social Worker/Care Manager
- Support Worker(s)
- GP and other representatives of the Primary Care Team
- Community Psychiatric/Mental Health Nurse
- Independent Mental Health Advocate or Independent Mental Capacity Advocate
- In the case of a restricted patient, the Probation Service / MAPPA Coordinator

- Subject to the patient's consent, any informal carer who will be involved in looking after him/her outside hospital
- Subject to the patient's consent, his/her nearest relative
- Employment/Housing/Education as appropriate
- Primary Mental Health Support Service

13.3 The Health Board and Local Authorities will ensure that all patients subject to s117 will be subject to full CTP procedures. This includes joint assessments, care planning and reviews where agreed under the CTP policies and procedures. Users or carers (where appropriate) will be informed of these policies and will have copies of all their care plans, incorporating the s117 arrangements.

13.3 The review must specifically consider if it is appropriate for the care plan to continue to be provided under s117. It must be made clear which parts of the care plan are s117 services and which are not.

13.4 While the patient is eligible for s117 aftercare, any additional services to address mental health needs are also s117 services.

13.5. Each review must include an explicit decision on whether the person continues to be eligible for s117 aftercare and what services are required to support them.

13.6 Part 2 of the Measure mandates the use of a care and treatment plan for relevant patients who cease to be detained and leave hospital. It sets out the means to record after-care arrangements linked to services provided or actions taken in order to achieve the desired outcome.

13.7 The aftercare plan should be regularly reviewed. The Care Co-ordinator is responsible for arranging reviews of the care plan until it is jointly agreed that the patient no longer needs after-care services.

13.8 All reviews must be formally documented.

14 TRANSFER OF PATIENTS FROM OTHER AREAS

14.1 Section 4(a) of the Social Care and Wellbeing Act states clearly that "A person who is being provided with accommodation under s117 of the Mental Health Act 1983 (after-care) is to be treated for the purposes of this Act as ordinarily resident in the area of the local authority, or the local authority in England, on which the duty to provide that person with services under that section is imposed"

14.2 Responsibility for providing s 117 aftercare services may be formally transferred if the authorities agree. Formal transfer should be recorded through exchange of

correspondence stating that agreement has been reached between the respective authorities to formally transfer responsibility, the date and time the transfer is effected and a statement that the patient would be informed by the accepting team. The Mental Health Act office **must** be informed of any such transfer.

14.2 The only other circumstance when responsibility may change is if an eligible person moves to a new area, becomes "ordinarily" resident in that area and is subsequently detained under a relevant section; this would lead to a re-evaluation of the responsible authorities.

15 RECORD KEEPING

15.1 It is very important to distinguish on care plans and s117 documentation those items of care and support that relate to mental health needs and are provided free of charge, and those items that relate to community care needs unrelated to the relevant mental disorder, which may be subject to a financial assessment the local social services authority. It is therefore important that the care co-ordinator in the aftercare planning arrangements is fully aware of the legal position and any funding commitments that may result.

15.2 Within effective care co-ordination, written documentation giving full assessment details should be available to inform an individual's care plan. All the services relevant to the s117 aftercare plan must be carefully recorded and agreed with the person and or their representative. There should be a record of which services are to be provided by each agency.

15.3 Unwillingness by the service user to receive aftercare services is not a reason to terminate s117, as the need for services may be present. Any such refusal should be considered and reviewed regularly.

15.4 All staff to provide evidence that they have reasonably undertaken investigations to determine the persons last known "ordinary" residence. The address is not a care home of any type or a placement funded under s117 from another area/authority. Evidence to be documented in patients electronic notes as soon as practicable.

16 CHARGING FOR AFTERCARE SERVICES

16.1 Aftercare services provided under s117 aftercare must be provided free of charge.

16.2 The provision of aftercare services under s117 should not be confused with providing essentials for life such as food, clothes, accommodation, heating etc. These remain the responsibility of the individual except in the very special cases where accommodation,

heating etc are provided as part of a residential placement and are an inseparable part of the aftercare plan.

16.3 If the aftercare to be provided includes housing-related support that would normally be funded by Supporting People grants, this will be paid by the local social services authority, unless the housing related support is identified as not being part of s117 aftercare services.

16.4 The Local Authority Circular LAC (2000, paragraph 2) states "occasionally there may be other non-residential community care services provided by the Authority which are not part of the s117 aftercare plan. These may relate to physical disabilities or illnesses, which have no direct bearing on the person's mental health. Such services will generally fall outside s117aftercare." These may therefore incur a charge to the person receiving them.

16.5 Where s117 aftercare is meeting a social care need and the local social services authority commits itself to providing a level of funding that will adequately meet the assessed need of the patient, there is nothing to prevent top up payments being made by the patient to fund additional or higher level of services.

16.6 s117 imposes a joint duty on the local authorities and the Local Health Board to provide a seamless aftercare service. If all the required aftercare services are to be provided under s117 it is not necessary to assess for eligibility for NHS continuing healthcare (CHC) funding. In other words, a primary healthcare need does not need to be established to require the Health Board to fund, and in most cases the complexity of a patient's need will require both the Health Board and the local authority to work together to achieve the outcomes set out in s117.

16.7 In the absence of an agreement between the Local Authority and the Local Health Board, an assessment is required to determine whether the service is to be paid for out of an NHS or local authority budget or as a joint arrangement. This funding decision is then referred to a funding panel consisting of all partner agencies and should be made on the basis of a comprehensive assessment.

16.8 A person in receipt of s117 aftercare services may also have needs for continuing health care (CHC) not related to their mental health. In such a case a CHC assessment may be necessary to establish how these needs will be addressed.

16.9 Disputes regarding ongoing funding responsibility **must** not be a reason for delaying care planning or discharge planning.

17 RESIDENCE

17.1 The responsible aftercare bodies in Wales and England are the LSSA in which the person concerned was ordinarily resident before being detained under a qualifying section of the MHA, or in any other case, the area in which the person is resident, or sent on discharge by the hospital in which they were detained.*"*[10]

17.2 Guidance on s117 of the MHA was given in the case of *R v Mental Health Review Tribunal Ex p. Hall (1999) 4 All ER 883*. This case made clear that responsibility for the provision of aftercare services falls to the local authority and Local Health Board (Wales), (Primary Care Trust in England) for the area in which the person was resident when they were detained in hospital, even if the person does not return to that area on discharge. Only if no such residence can be established does the duty fall on the authority where the person is to go on discharge from hospital.

17.3 Decisions about residence may in some cases be difficult to determine and as such legal advice should be sought from the appropriate authority legal advisors.

17.4 Disputes about ordinary residence are determined by Welsh Ministers. [11]

18 DIRECT PAYMENTS

18.1 Where a local authority is under a duty to provide aftercare services for a person under s117 of the Mental Health Act 1983 and the person is eligible to receive such payments under sections 50, 51 and 52 of the Social Services and Wellbeing Act, then it must make direct payments to discharge its duty.

18.2 The local authority duty to offer direct payments to anyone receiving services under s117 is subject to the exception of persons detailed in the schedule to Regulation 14(1) The Care and Support (Direct Payments) (Wales) Regulations 2015, where the local authority *may* provide direct payments subject to certain conditions.

19 THIRD PARTY PAYMENTS

19.1 The right to third party payments and top up payments are not affected by being subject to section 117.

[10] Section 117(3) Mental Health Act 1983
[11] Mental Health Act 1983, Code of Practice for Wales, Revised 2016, 33.9

20 DURATION

20.1 The duty on the relevant bodies will continue until they are satisfied that the patient no longer needs aftercare services for their mental health needs.

20.2 Section 194(1), Social Services and Wellbeing Act 2014 (SSWA 2014) deals with where an adult is to be treated as ordinarily resident, if the local authority which is responsible for meeting their needs for care and support makes arrangements for the adult to live in accommodation of a particular type. As a consequence of these arrangements, the adult may move to another area. In this situation, the effect of this provision is that the adult will be treated, for the purposes of the SSWA 2014, as being ordinarily resident in the area of the local authority which made the arrangements (and not in the area to which they move).[12]

21 ENDING SECTION 117 AFTERCARE

21.1 Aftercare provision under s117 does not have to continue indefinitely. It is for the responsible health and social services authorities to decide in each case when aftercare provided under s117 should end, taking account of the patient's needs at the time. It is for the authority responsible for providing particular services to take the lead in determining when those services are no longer required. The patient, his/her carers, and other agencies should always be consulted.

21.2 Once triggered, the right to after-care is ongoing and remains in place irrespective of a person's circumstances. Aftercare services must be provided until both the Health Board and social services authorities are satisfied that the patient is no longer in need of such aftercare services.

21.3 Patients are not legally obliged to accept aftercare services offered but any decisions they make to decline services should be fully informed. A patient's unwillingness to accept services does not mean they have no need for them; neither does it relieve the statutory agencies of their responsibility to offer aftercare.

21.4 When considering discharging a patient from s117 aftercare both authorities are required to jointly review the aftercare plan, even if the aftercare services are provided by a single authority. In practice, this is likely to be a decision made by the patient's integrated multi-disciplinary team. There must be a joint formal statement of the agreement to discontinue after-care services, made by representatives of the local authority and the local health board.

[12] Welsh Government, Law Wales Helping you understand Welsh Law, *Ordinary Residence* <https://law.gov.wales/publicservices/social-care/9692237/Care-and-support-for-adults-and-children/ordinary-residence/?lang=en#/publicservices/social-care/9692237/Care-and-support-for-adults-and-children/ordinary-residence/?tab=overview&lang=en> accessed 20 May 2019

21.5 The decision to end s117 aftercare services must only be taken at a multi-disciplinary team meeting. The patient should be fully involved in the decision making process and their involvement recorded on the relevant form.

21.6 In the event that a patient disengages with Mental Health Services but remains subject to s117 aftercare, attempts should be made to invite the patient to a review meeting. If the patient does not attend this, a review meeting between Health and Local Authority representatives must be held to facilitate a clinical decision whether the entitlement to aftercare should continue. This review should evidence where able that efforts have been taken to ascertain the person's current mental state along with any identified needs, also whether the opinions of their family and GP have been sought where appropriate. In the absence of any information being available, the decision to close to s117 aftercare should then be based on clinical decision making and risk analysis.

21.7 The rationale behind the decision to discharge from s117 must be clearly recorded in the patient's record giving reasons as well as details of who was involved in the decision making.

21.8 Discharge from s117 must be recorded in case notes on PARIS, in the Mental Health Act module, and the register on PARIS will be updated.

21.9 The "Discharge from Section 117 After-care" form bearing the Health Board and Local Authority logos must be signed by the relevant representatives; a copy must be sent to the Mental Health Act Office for retention in the patient's Mental Health Act file.

21.10 If s117 after-care ends, it cannot be reinstated if the patient becomes in need of further mental health services. The patient can only receive further s117 services if they are readmitted to hospital under a qualifying section.

21.11 However, nothing in this policy should restrict a patient who is not subject to s117 to be assessed for and receive the appropriate mental health services.

22 TRAINING

22.1 All staff who work within Partner Agencies are responsible for ensuring that they maintain an up to date knowledge of the Mental Health Act 1983 and associated legislation as it applies within their practice.

23 IMPLEMENTATION

This document will be widely disseminated to staff across Cardiff and Vale University Health Board and Cardiff and Vale of Glamorgan Councils. It will be published on the organisations intranet site and referred to during training relevant to the Act.

24 RESPONSIBILITIES

24.1 Chief Executive - The Chief Executive Officer has overarching responsibility for ensuring that Cardiff and Vale University Health Board is compliant with the law in relation to the Mental Health Act.

24.2 Chief Operating Officer - The Chief Operating Officer is the Executive Lead for Mental Health. He has overarching responsibility for ensuring compliance with the contents of this procedure.

24.3 Integrated Team Managers/Service Managers - It is the responsibility of all clinical managers to:

- Ensure that this procedure is brought to the attention of all their staff, and that they understand and adhere to the guidance/procedure contained within.
- Ensure that all staff involved in the care and treatment of individuals subject to s117 aftercare have received adequate training and are competent to carry out these functions.

25 REFERENCES

25.1 All staff will work within in accordance with:

- Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
- Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
- Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
- Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
- Domestic Violence, Crime and Victims Act 2004
- Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008
- Mental Health Wales Measure (2010)

26 APPENDICIES

Appendix A – Discharge from Section 117 After-Care form (overleaf)

Discharge from Section 117 After-Care

Patient's full name:

Patient's home address:

Patient's date of birth: Identifier:

The following people have been consulted regarding the ongoing need for the above named to receive after-care under Section 117 of the Mental Health Act 1983.

Following consultation, it has been determined that with effect from _____ (date), this patient shall cease to be subject to section 117 after-care because:

Representative of Cardiff and Vale UHB Designation:

Print name: _____ Signed: _____ Date: _____

Representative of: Cardiff Council ☐ Vale of Glamorgan Council ☐

Designation: _____ Date: _____

Print name: _____ Signed: _____

This decision has been reviewed and agreed by the following Team Managers:

Representative of Cardiff and Vale UHB Designation:

Print name: _____ Signed: _____ Date: _____

Representative of: Cardiff Council ☐ Vale of Glamorgan Council ☐

Designation: _____ Date: _____

Print name: _____ Signed: _____

On completion, please forward a copy to: Mental Health Act Manager, Mental Health Act Department, Hafan Y Coed, University Hospital Llandough.

GLOSSARY

Glossary of terms Term	Definition
Care Coordinator	Care Co-ordinators are the principle source of information for the relevant patient and are responsible for seeking their active involvement and engagement in the care planning process.
Care Management	Framework of assessment, care planning, provision of care packages and review for people who receive services via Local Social Services Authorities
Care and Treatment planning (CTP) assessment	CTP is a way of co-ordinating mental health services for people with mental health problems. It means that once you have an assessment detailing your needs, one person will be able to co-ordinate all aspects of your care. For example, this could be your medical and social care and community services available to you. This assessment will be carried out by a care co-ordinator.
Community Mental Health Services	Community mental health services support individuals with mental health problems who are living in the community. Teams include a range of professionals drawn from the local NHS and social services.
Community Mental Health Team (CMHT)	A team of mental health professionals who support people with mental health problems living in the community.
Continuing NHS Health Care (CHC)	There are no powers to charge for services provided under S117 of the 1983 Act, regardless of whether those services are provided by the NHS or Local Authorities. It is not appropriate to assess eligibility for CHC if all the services in question are to be provided as after-care under S117. However, a person in receipt of after-care services under S117 may also have needs for continuing care which are not related to their mental disorder and which may therefore fall outside the scope of S117.
Direct Payments	Payments from the local council for people who have been assessed as needing help, and who would like to arrange and pay for their own care and support services. These payments are made directly to the person (or to someone acting on their behalf), to arrange their own care package.
Independent Mental Health Advocates	Under the MCA, NHS bodies or Local Authorities (as appropriate) are required to instruct independent

	mental capacity advocates (IMCA's) to represent people who have no family or friends who it would be appropriate to consult.
Local Authority (LA)	At a local level, the country is divided into a series of local authorities or councils. These authorities are responsible for providing local services to the community such as education, adult and children social care, regeneration, support for carers, leisure, housing and environmental services
LAC	Local Authority Circular alerts convey important information for local authorities
Mental Health Act 1983 (MHA)	An Act of Parliament that governs the treatment and care of some individuals incapacitated through mental illness.
Mental Health (Wales) Measure 2010	Framework of assessment, care planning and review for people who receive mental health services.
Multidisciplinary team	A multidisciplinary team (MDT) is a group of professionals from a range of different professions.
NHS Continuing Healthcare	Package of care arranged and funded solely by the NHS.
NHS Funded Nursing Care	The money paid by the NHS for the nursing care component of a person's care package is known as the NHS Funded Nursing Care.
Primary Care	Primary Care is the care provided by people you normally see when you first have a health problem. For example a doctor or dentist, an optician for an eye test, a pharmacist. NHS Walk-in Centres, and the phone line service NHS Direct, are also part of primary care.
Responsible clinician (RC)	A patient's responsible clinician is defined as the approved clinician with overall responsibility for the patient's case. All patients subject to detention or Community Treatment Order have a Responsible Clinician; Nurse, Occupational therapist, Psychiatrist, Psychologist, Social Worker.
S117 Aftercare Responsibilities	Services that normally include treatment for mental health disorder, social work support to help the patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential services.
Section 117 Register	Register of service users subject to S117 to be maintained.
Responsible clinician (RC)	A patient's responsible clinician is defined as the approved clinician with overall responsibility for the patient's case. All patients subject to detention or

	Community Treatment Order have a Responsible Clinician, Nurse, Occupational therapist, Psychiatrist, Psychologist, Social Worker.
Service user / Client / Patient	A person receiving any health or social care services, from going to the family doctor, the pharmacist, to accessing social services such as home care or direct payments.

RELEVANT SECTIONS OF THE MENTAL HEALTH ACT 1983

Section 3	Order detaining an individual in hospital for treatment.
Section 17 leave of Absence	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time.
Section 17A (Community Treatment Order(CTO))	Order providing a legal framework around the care plan of an individual who has been detained under section 3 (or section 37 hospital order), when they are discharged from hospital, although they remain liable for recall or revocation from the Community Treatment Order.
Section 37	Hospital Order detaining an individual who has been transferred by the Courts to hospital for treatment. Note: Guardianship under section 37 does not confer s117 status.
Section 37/41	Order detaining an individual who has been transferred by the Courts to hospital for treatment, with restrictions.
Section 37/41 – conditionally discharged	Section 42 allows the Secretary of State to direct that someone under a restriction order should be discharged from hospital but subject to conditions e.g. place of residence, supervision by psychiatrist and social supervisor.
Section 45A	When imposing a prison sentence for an offence other than when the sentence is fixed by law, the Crown Court can give a direction for immediate admission to and detention in a specified hospital, with a limitation direction under Section 41. The directions form part of the sentence and have the same effect as a hospital order. The Home Secretary can approve transfer back to prison at any time.
Section 47 or 48	Orders detaining an individual transferred from prison to hospital for treatment.
Section 47/49 or 48/49	Orders detaining an individual transferred from prison to hospital for treatment, with restrictions.