Mental Health & Capacity Legislation Committee

Tue 20 July 2021, 10:00 - 12:00

Agenda

1. Welcome & Introductions

Ceri Phillips

2. Apologies for Absence

Ceri Phillips

3. Declarations of Interest

Ceri Phillips

4. Unconfirmed Minutes of the Meeting held on 20 April 2021

Ceri Phillips

4 - Unconfirmed Minutes MHCLC 20.04.21.pdf (10 pages)

5. Action Log from the meeting held on 20 April 2021

Ceri Phillips

5 July MHCLC Action Log.pdf (2 pages)

6. Chair's Action taken since last meeting

Ceri Phillips

7. Any Other Urgent Business Agreed with the Chair

Ceri Phillips

8. Patient / Staff Story

8.1. Staff Story – Shielding & My Mental Well-being

Ian Wile / Ruth Walker

Video

9. Mental Capacity Act

9.1. Mental Capacity Act Monitoring Report & DoLs Report – Update

Ruth Walker / Jason Roberts

- 9.1 MHCLC assurance report - July 2021 (1).pdf (4 pages)
- 9.1aa Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1ab Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1ac Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1ad Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1ae Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1af Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)
- 9.1ag Appendix 1 - MCA and DoLs Indicators - July 2021 completed.pdf (1 pages)

10. Mental Health Act

10.1. Mental Health Act Monitoring Exception Report

Ian Wile

- 10.1 Mental Health Act Monitoring Exception Report.pdf (8 pages)
- 10.1a Mental Health Act Monitoring Report April - June 2021.pdf (48 pages)

10.2. Update on the Reform of the Mental Health Act

Sunni Webb / David Seward

Verbal

11. Mental Health Measure

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

Ian Wile

- 11.1 Mental Health Measure June 2021 AMS and CAMHS.pdf (12 pages)

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

12.1. HIW MHA Inspection Reports:

Sunni Webb / David Seward

a) Hazel Ward
b) East 12 Ward

- 12.1a Hazel Ward - Hafan Y Coed - Findings Record - FINAL - 2021-05-04....pdf (12 pages)
- 12.1b East 12 HIW Findings 2021.pdf (8 pages)

12.2. Hospital Managers Power of Discharge Sub Committee Annual Report

Jeff Champney - Smith

- 12.2 PoD Group Annual Report 2021.pdf (3 pages)

12.3. Sub-Committee Meeting Minutes:

Jeff Champney - Smith / Robert Kidd

a) Hospital Managers Power of Discharge Minutes

b) Mental Health Legislation and Governance Group Minutes

- 12.3a PoD Minutes 06 July 2021 - Final.pdf (6 pages)
- 12.3b MHLGG minutes 08 July 2021 Final.doc.pdf (7 pages)

12.4. Self-assessment of effectiveness

Nicola Foreman

- 12.4 Cover Report Annual Board Effectiveness Survey 2020-2021 - MHLC Committee je.pdf (3 pages)
- 12.4a Appendix 1 - Board Effectiveness Survey - MHCLC Committee Results 2020-2021.pdf (9 pages)
- 12.4b Appendix 2 - Board Effectiveness Action Plan 2020-2021 NF.pdf (3 pages)

12.5. Corporate Risk Register

Nicola Foreman

- 12.5 MHCLC - Corporate Risk Register Covering Report - April 2021.NF.pdf (3 pages)
- 12.5a MH Risk Reg.pdf (1 pages)

13. Items for Approval Ratification

14. Review of the Meeting

Ceri Phillips

15. Date, time and venue of the next meeting:

Tuesday 19 October 2021 at 10am
via MS teams

Unconfirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 20 April 2021 – 10am
Via MS Teams

Chair:

Sara Moseley	SM / CC	Interim Chair and Independent Member – Third Sector
Present:		
Ceri Phillips	CP	Vice Chair
Charles Janczewski	CJ	Chair of Cardiff and Vale University Health Board
Michael Imperato	MI	Independent Member - Legal
In Attendance:		
Amanda Morgan	AM	Service User – Voice of a Carer
Carol Evans	CE	Assistant Director of Patient Safety and Quality
Ian Wile	IW	Head of Operations, Mental Health
Jacqueline Evans	JW	Interim Head of Corporate Governance
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Nicola Foreman	NF	Director of Corporate Governance
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
Ruth Walker	RW	Executive Nurse Director
Scott Mclean	SMc	Director of Operations – Children & Women's
Sunni Webb	SW	Mental Health Act Manager
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Steve Curry	SC	Chief Operating Officer

MHCL 21/04/001	**1. Welcome & Introductions** The CC welcomed everybody to the meeting and introduced Ceri Phillips, Vice Chair of Cardiff and Vale University Health Board (CVUHB) who would take over as the Mental Health and Capacity Legislation Committee Chair at the July meeting.	**ACTION**
MHCL 21/04/002	**2. Apologies for Absence** Apologies for Absence were noted from Steve Curry, the Chief Operating Officer.	
MHCL 21/04/003	**3. Declarations of Interest** No declarations of interest were noted.	
MHCL 21/04/004	**4. Minutes of the Committee Meeting held on 19 January 2021** The minutes of the meeting held on the 19 January were received and confirmed as a true and accurate record of the meeting. **The Committee resolved that:**	

	a) The minutes of the meeting held on 19 January be approved as a true and accurate record of the meeting.	
MHCL 21/04/005	**5. Action Log 19 January 2021** The action log was received The Chair of Cardiff and Vale University Health Board noted that Action ***MHCL 19/10/012*** had no date set against it. The Director of Corporate Governance (DCG) responded that it would be picked up with the executives and suggested that it come to the July meeting. The DCG advised the Committee that her team would ensure that when draft agendas are created, any actions to go to other Committee's or the Board would be carried forward. **The Committee resolved that:** a) The action log of the meeting held on 19 January 2021 be approved as a true and accurate record of the meeting.	**NS**
MHCL 21/04/006	**6. Chair's Action taken since last meeting** The CC advised the Committee that no Chair's Action had been taken.	
MHCL 21/04/007	**7. Any Other Urgent Business Agreed with the Chair** There was no other urgent business shared.	
MHCL 21/04/008	**8. Patient Story** The Patient Story – 'Sectioned under the Mental Health Act' was received. The END advised the Committee that in line with the Institute for Healthcare Improvement (IHI) the story had been shared to inform and take learning into clinical practice. The story highlighted the experiences of a patient who had been sectioned under the Mental Health Act within CVUHB inpatient facilities. The END asked Committee members to share feedback directly offline and to confirm whether it was the type of item they would want to see at future meetings. The CC noted that that the story provided a strong sense of how scared the patient had been. The Head of Operations for Mental Health (HOMH) advised the Committee that there was a growing ambition around the presence and use of peer support workers within the recovery college.	

	The Committee noted that there was a huge amount of support from Service Users and that that the reassuring presence of people who had been through the service themselves would be important moving forward. The CC suggested that the Patient Story be sent to the Service Users who had not been in attendance to allow their feedback. **The Committee resolved that:** a) The Patient Story was noted.	**NS**
MHCL 21/04/009	**9.1 Mental Capacity Act Monitoring Report** **9.2 DoLs Report – Verbal Update:** The Mental Capacity Act Monitoring Report and DoLs Report were received. The END advised the Committee that agenda item 9.1 and 9.2 had been combined and would be discussed together. It was noted that CVUHB had received a letter from the Welsh Government (WG) to inform the implementation of the Liberty Protection Safeguards (LPS) which were planned to come into force in April 2022. The Assistant Director of Patient Safety and Quality advised the Committee that the dashboard shared required feedback and discussion. The CC responded that the dashboard should be circulated to Committee members offline and feedback could be provided at the July meeting. The END advised the Committee that the indicators would give the Committee a trajectory over a period of time including data on items such as the number of DoLs applications. It was noted that since the last Committee a number of issues of concern had arisen: • A Lack of understanding and acknowledgement from professionals across the health board in relation to Court of Protection processes and requirements. This had been identified as a training issue and CVUHB would liaise with Legal and Risk services to provide relevant training for staff in the following months and the provision of guidance to support staff with difficult clinical decision making. • There were inconsistencies across wards and hospitals in regards to speaking to patients by telephone/video calling. Some were able to facilitate this whilst others were not. Partnership discussions were taking place about re-instating normal face to face assessments so that the process would become more robust.	**CE**

	The Independent Member – Legal (IML) asked how he and other Independent Members could get a guide on the developments being discussed. The END responded that everybody would need retraining as part of the new process and a project plan would need to be put together. The Committee noted that the project plan would be brought to a future committee meeting. The CC asked for more clarity around the extension of powers to 16 and 17 year olds. The END responded that work would need to be undertaken with Schools of Nursing, Midwifery and others providing training for staff coming into the Health Service as well as additional training for those already in service. It was noted that each of the Clinical Boards had Quality and Safety Governance arrangements in place so they could monitor the level of training in their areas. **The Committee resolved that:** a) The contents of the report were noted and it was agreed that the proposed set of MCA and DoLS indicators would be discussed at a future meeting.	**END**
MHCL 21/04/010	**10.1 Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The Mental Health Act Manager (MHAM) advised the Committee that the issue of when the clock started ticking for custody of mental health patients in A&E remained unresolved albeit further legal opinion had been sought and the Mental Health Clinical Board were awaiting a response. The IML noted that this was the case 6 months ago and if a response was not received the clinical board should seek alternative legal arrangements. The DCG responded that she would support that and consult with the CVUHB legal and risk team. The Vice Chair (VC) suggested that when the response from WG was received it could be taken to the Vice Chair's meeting. The MHAM advised the Committee that the numbers of CAMHS section 136 patients had increased and there were no repeat presentations so each assessment was in relation to a different child. The outcome of those assessments was 86% admission to hospital.	

	The Director of Operations – Children & Women's (DOCW) noted that a very startling increase in demand was being seen. The HOMH advised that the Mental Health service dealt with adolescent patients and had seen a marked increase in demand and that Covid-19 had contributed to unsettling the age group. He advised the Committee that he and the DOCW had looked at a joint funded project to explore good practice in the area to try and make improvements. The DOCW added that it was better to keep these patients at home and that the children should not be in the children's hospital and certainly should not be in an adult mental health hospital. The CC advised the Committee that compliance needed to be looked at and an action around how the DOCW and HOMH's teams were supported to do something to improve the areas discussed. The END advised the Committee that information should be fed back to the board, recognising that there were some children below the line of requiring admission. The MHAM advised the Committee that the team had been in discussion with the Mental Health Tribunal and had met with the Vice President because concerns had been raised in relation to how the tribunals were being conducted by telephone only and questions were raised as to how that affected a person's right to a fair trial. The CC noted that the Patient Story had alerted the committee to how scared the patient felt once sectioned and she strongly advised that not letting patients communicate in other ways (other than telephone) was not acceptable. It was suggested that this be kept on the agenda to provide updates at future committee meetings. The IML asked why this had not progressed because other areas such as courts and hospitals had moved to Skype at the beginning of the pandemic. The MHAM responded that the response they had received was that they wanted to give all patients across the board the same opportunities and that not all hospitals had the right equipment to provide video calling. The CC responded that it was fundamentally discriminatory and the Vice Chair (VC) advised the Committee that a discussion would need to take place with the MHAM outside of the meeting to formulate a strong response on the issue. **The Committee resolved that:**	**NS** **CP**

	a) The report was noted and the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA was supported.	
MHCL 21/04/011	**10.2 Reforming the Mental Health Act – Update** The Reforming the Mental Health Act update was received. The MHAM advised the Committee that all of the recommendations had been sent to clinical colleagues and feedback had been received. It was noted that the biggest response was in relation to the increase in work demand and how that would be managed. The HOMH advised the Committee that the consultation with staff lasted over a month and was also shared with Local Authority (LA) staff via the integrated teams but the responses were from CVUHB and not the LA. All the responses from Wales would be sent to the WG and a decision would then be made. The MHAM advised the Committee that the consultation closed the following day with a further month for those who wanted to respond in Welsh. The CC asked that the committee receive updates on the progress of the reform process for decisions to be made how to manage change proactively. The HOMH advised that it would be a little while before a proper assessment could be undertaken on the impact of the local administration team but added that it was a step in the right direction for the modernisation of services but support in those areas was needed. **The Committee resolved that:** a) The report was noted and the approach taken by the Mental Health Clinical Board to ensure compliance with the MHA was supported. b) The approach taken by the Mental Health Clinical Board in collating a response to the White Paper on behalf of Cardiff and Vale UHB was supported.	
MHCL 21/04/012	**11.1 Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report** The Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report was received. The HOMH advised the Committee that the service had been through an exceptional period and it was still challenging to deliver the Mental Health Measure.	

	It was noted that Part 1a of the measure – 28 day referral to assessment compliance target of 80% was particularly challenging. In the context of Covid-19 it was noted that the service had started to see a surge in demand for Mental Health service with 150 referrals in March. The main 3rd sector providers had seen the highest number of referrals in February and they were seeing almost 500 referrals a month between them. The Primary Care liaison team were seeing twice as many people referred by GPs compared to 14 months ago. Trying to get information from Primary Care, specifically about activity rates was difficult but they were trying to understand the demand in that area. The DOCW presented to the Committee the Part 1a of the Mental Health Measure compliance report in under 18s. It was noted that a significant uptake in referrals had been seen and teams were fearful that once schools reopened fully, another increase would be seen. Similar to the adult service, the children's service suffered from a 25% vacancy rate. There was increasing demand and decreased capacity due to the effects of Covid-19 and some tier 0 work with education would be needed. This had received around £600k of funding which would be looked at moving forward. The CC suggested that the compliance figures should be part of the report at future meetings. The Chair of Cardiff and Vale University Health Board emphasised the CC's point around the compliance figures and added that they were not the strategic or action plans but the actual compliance figures. It was noted that the Strategy and Delivery committee would take on the mantle of seeking assurance for the board of how that performance would be corrected or calibrated. The CC noted that the Committee could not provide assurance around compliance and a decision as to how the board would be alerted needed to be taken. The DCG advised the CC that issues needed to be escalated through the Chairs Report and actions needed to be reviewed and reported to Board when back on track. The Chair of Cardiff and Vale University Health Board asked the HOMH to link with the Chief Operating Officer (COO) to add a comprehensive presentation in regards to Mental Health services across CVUUHB to the Board's July agenda.	IW

	The Committee resolved that: a) The report was noted.	
MHCL 21/04/013	**12.1 Induction Support for New Committee Members** The Induction Support for New Committee Members was received. The DCG advised the Committee that the item had been added to all Committee agendas due to 3 new Independent Members joining CVUHB. It was noted that the induction would allow for new members to learn about the committee. **The Committee resolved:** a) The Induction Support for New Committee Members was noted.	
MHCL 21/01/014	**12.2 The Hospital Managers Power of Discharge Minutes** The Hospital Managers Power of Discharge Minutes were received **a) Hospital Managers Power of Discharge Minutes** The Chair of the Powers of Discharge sub-Committee (CPDSC) advised the Committee that there was nothing to raise and that the minutes were shared for information. The Mental Health Legislation and Governance Group Minutes were received. **a) Mental Health Legislation and Governance Group Minutes** The Consultant Clinical and Forensic Psychologist (CCFP) noted the procedures around s.136 sections and advised the Committee that there were still issues as to when the clock starts in A&E. The CC responded that it had been discussed earlier in the meeting and that the action would be taken to other Vice Chairs by the Vice Chair. The CCFP highlighted information around voluntary assessments and advised the Committee that a piece of work was being undertaken to look at how much of the assessment was going on. It was noted that good work had been developed between medical consultant colleagues and consultants in CAMHS about responsibility for younger people. The Committee resolved that: **b)** The Hospital Managers Power of Discharge Minutes and Mental Health Legislation and Governance Group Minutes were noted.	

MHCL 21/01/015	**12.3 Corporate Risk Register – Mental Health Clinical Board Risks** The Corporate Risk Register – Mental Health Clinical Board Risks was received. The DCG advised the Committee that the full Corporate Risk Register is sent to the Board and then committee relevant risks are shared at committee meetings to provide oversight and assurance. It was noted that there were 2 risks with scores over 15 relevant to the Mental Health Clinical Board. The risks remained stagnant since March's Board meeting however it was anticipated that both entries would be de-escalated at May's Board meeting following the successful implementation of appropriate controls for each risk. The DCG advised the Committee that there was ongoing risk training across the whole of CVUHB and that the next session would be on 11th May for the Mental Health Clinical Board. The CC noted that the risks needed to be reviewed in light of conversations had today. The DCG responded that it would be reviewed and updated. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Mental Health Capacity and Legislation Committee was noted and the progressing work was noted.	
MHCL 20/10/016	**13.1 Committee Work Plan** The Committee Work Plan was received. The DCG advised the Committee that the work plan reflected what was detailed in the Terms of Reference which was approved at the last Committee meeting. It was noted that the Patient Story needed to be added as a standing item. The Mental Health Updates would also regularly be brought to the committee which would be discussed at future agenda setting meetings. **The Committee resolved that:** a) The Work Plan 2021/22 was reviewed. b) The Work Plan 2021/22 was approved with changes. c) The Work Plan 2021/22 was recommended for approval to the Board of Directors.	**NS**

MHCL 21/04/017	**13.2 Committee Annual Report 2020/21** The Committee Annual Report 2020/21 was received. The DCG advised the Committee that the Committee Annual Report 2020/21 was brought for ratification as a Chairs Action was taken previously to allow the Committee Annual Report 2020/21 to go to the Board meeting in March 2021. **The Committee resolved that:** a) The Annual Report 2020/21 of the Mental Health and Capacity Legislation Committee was reviewed and retrospectively approved	
MHCL 20/10/018	**14. Review of the Meeting** The CC opened the Committee to review the meeting. The SU advised the Committee that she had to chase for the papers and so it was resolved that she would receive them at the same time as all other members in future.	
MHCL 20/10/019	**15. Date & Time of next Committee Meeting** The CC thanked everyone for their attendance and contribution to the meeting and confirmed that the next meeting would be held on Tuesday 20 July at 10am via MS Teams.	

ACTION LOG
MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE
UPDATE FOR JULY 2021 MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCL 21/01/009	Mental Capacity Act Monitoring Report	Update on use of IMCA's to be provided.	**20/04/21**	Ruth Walker	**COMPLETE** Verbal update to be shared as part of the Mental Capacity Act Monitoring Report, item **10.1**.
Actions in Progress					
MHCL 21/04/009	MCA and DoLs indicators	Discussion and feedback on the MCA and DoLs indicators	**20/07/21**	Ruth Walker	The indicators were available on April's paper bundle but formatting issues caused them to be missed. The CC asked for them to be brought back. **To be brought to the July Committee Meeting – Agenda Item 9.1**
MHCL 21/04/011	Reforming the Mental Health Act – Update	The committee to receive updates on progress made and decisions needed.	**20/07/21**	Ian Wile/ Sunni Webb	**To be brought to the July Committee Meeting – Agenda Item 10.2.**
MHCL 21/04/009	Project Plan - Training	Project Plan to include training for MHCLC.	**TBC**	Ruth Walker	No date provided at meeting – To discuss at July agenda setting.
MHCL 21/01/009	Mental Capacity Act Training	A proposal as to what that training would look like, what opportunities were available and how medical staff would access the training.	**20/07/21**	Ruth Walker	Added to Action log at request of the Chair (SM)
MHCL 20/10/009	DOLS	Internal Audit Report on DoLS - further work needed to be undertaken to progress the audit outcomes by the next meeting.	**20/07/21**	Ruth Walker	Verbal update to be shared as part of standing DoLS Report **To be brought to the July Committee Meeting – Agenda Item 9.1**

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 20/10/14	Mental Health and Equality	DCG to liaise with the EDWOD to discuss the possibility of equality training and updates being shared with the committee.	**20/07/21**	Nicola Foreman	Ongoing discussions to be had following departure of the EDWOD **Update to be shared at the July Committee Meeting.**
Actions referred to committees of the Board					
MHCL 21/04/012	CVUHB Mental Health services - Update	add a comprehensive presentation in regards to Mental Health services across CVUUHB to the Board's July agenda	**29/07/2021**	Ian Wile / Steve Curry	To be shared with the Board in June at the Board Development meeting - **Complete**
MHCL 19/10/012	HIW Mental Health Act Report	Bring all Estates concerns together to be reported at a Management Executive Meeting.	**20/07/21**	Nicola Foreman	**To be Shared with the Board at the July Board meeting.**
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 will be reviewed by the S&D Committee and reported back to a future meeting.

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring report**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	20.07.2021	
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Deputy Executive Nurse Director** **Assistant Director of Patient Safety and Quality**								

Background and current situation:

The purpose of this report is to provide a general update on current issues and to introduce a set of key MCA and DoLs indicators, which have been identified in order to provide the Committee with a greater level of assurance and monitoring, than has previously been in place. Once agreed, it is proposed that the fully populated dashboard is presented at each Committee meeting. The Committee should be advised, that not all data is currently available due to a current vacancy in the Mental Capacity Act Manger role.

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

A range of proposed MCA and DoLS indicators have been identified in order to strengthen current monitoring and assurance processes. These are attached in Appendix 1.

The Liberty Protection Safeguards (LPS) Code of Practice and Welsh Regulations, which will provide the detail required to support implementation of LPS, will not be published until Winter 2021. Despite this, there is an expectation that health boards will commence planning well in advance of that date, due to the scale of the project.

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

ASSESSMENT

Liberty Protection Safeguards (LPS)

In 2019 the Law Commission's review of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (2009) (DoLS) resulted in new legislation; the Mental Capacity [Amendment] Act 2019 (MC(A)A). This legislation is expected to come into force from 1st April 2022 where it will replace the Deprivation of Liberty Safeguards with the new Liberty Protection Safeguards scheme (LPS).

The LPS Code of Practice and Welsh Regulations, which will provide the detail required to support implementation of LPS, will not be published until Winter 2021. However, there is an expectation that health boards will commence planning well in advance of that date, due to the scale of the project.

The Vice Chairs across Wales, are planned to continue more detailed discussions with with the Deputy Minister in relation to Liberty Protection Standards. This is in response to the draft legislation having been approved and the consultation planned to start in July 2021, before summer recess. There has been a request therefore, that Health Boards provide assurance that preparations are under way for the transition to the new LPS system in April 2022.

It is important to note that LPS will apply to all patients who are deprived of their liberty as a consequence of the arrangements for their care and treatment, and do not have mental capacity to consent to those care arrangements. The scope of this new legislation will be far reaching and have an impact on health professionals and managers across our acute and community hospitals, mental health and learning disabilities services, nursing/care homes caring for patients in receipt of CHC funding, and in any independent hospitals within the Cardiff & Vale geographical area.

A detailed SBAR is currently being developed for sharing with the Executive team which will outline the key areas of implementation, to include:

1. Development and delivery of a detailed implementation plan which reflects legislative and Welsh Government requirements.
2. Identification of Project Manager for LPS implementation.
3. Establishment of monitoring and reporting mechanisms to provide assurance to the Board in relation to LPS implementation.
4. Work to assess, understand and communicate the scale of work likely to arise from the legislative changes.
5. Agreement of a coordinated approach to LPS with our Local Authority colleagues.
6. Mapping of LPS role requirements (statutory and non-statutory).
7. Establishment and delivery of awareness raising, training and support programme for all relevant staff.
8. Agreement of required documentation, record keeping and reporting requirements.
9. Management of the 12 month transition period where both DoLS and LPS schemes will exist.
10. Revision of all relevant health board procedures, policies and strategies in line with LPS.
11. Development of information for patients and carers.

The SBAR and developing implementation plan will be shared with the MHCLC at it's next meeting.

More information is available within the UK Government fact sheets;
https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets

Mental Capacity Act Manager

The UHB is currently recruiting in to this post following the resignation of the previous post-holder. Currently, the Patient Safety Team is providing basic advice to staff and liaising with Legal and Risk for advice in more complicated cases.

Independent Mental Capacity Act (IMCA) referrals

Total number of referrals received from January 2021 – March 2021 – 62 Referrals

- Serious Medical Treatment – 13
- Long Term Move of Accommodation – 8
- Adult Safeguarding – 2
- Care Review – 0
- Relevant Person's Representative (RPR) – 34
- IMCA 39d – 5
- IMCA 39C – 0
- IMCA 39a – 0

Total number of referrals received from April 2021 – June 2021 – 79 Referrals

- Serious Medical Treatment – 6
- Long Term Move of Accommodation – 11
- Adult Safeguarding – 2
- Care Review – 1
- Relevant Person's Representative (RPR) – 44
- IMCA 39d – 10
- IMCA 39C – 0
- IMCA 39a – 5

Recommendation:

The Mental Health and Capacity Legislation Committee is asked to **NOTE** the contents of the report and the current compliance with MCA and DoLS indicators (noting that these are incomplete due to a current vacancy in the MCA Manager role).

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.*								

MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE INDICATORS

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
DoLS												
1. Number of DoLS applications made	80	90	101	96	89	121						
2. No of DoLS applications completed	*74 (5)	*76 (28)	77 (43)	23 (11)	13 (10)	107(49)						
a. No of DoLS applications assessed	*12 (5)	*20 (8)	22 (15)	91 (47)	61 (21)	27(16)						
b. No of DoLS applications withdrawn	*62 (33)	*56 (20)	55 (28)	114 (58)	74 (31)	80(33)						
4. Breach of timescales including length of breach												
a. Urgent authorisation	January Tab	February Tab	March Tab	April Tab	May Tab							
b. Standard authorisation	January Tab	February Tab	March Tab	April Tab	May Tab							
c. Further authorisation	January Tab	February Tab	March Tab	April Tab	May Tab							
5. Requests for reviews of the DoLS authorisation	1	0	1	0	1							
6. Appeals made to Court of Protection												
a. No of 21a Application	0	0	0	0	0							
b. No of Joined as Party / Welfare order	1	2	0	0	1							
8. Appointment of IMCA as RPR	10	16										
MCA												
9. Number of queries to MCA Manager	10	10	13									
10. Number of IMCA referrals				Figures April to June 79								
11. Number of monitoring reports from the IMCA service												
12. Appointment of IMCA under:												
a. s39a						5						
b. s39c						0						
c. s39d						10						
13. Number of HIW reports received regarding compliance of clinicians	0	0	0	0	0	0						
14. Number of complaints received from patients/carers regarding compliance of clinicians	0	0	0	0	0	0						
15. Number of Public Service Ombudsman for Wales Reports citing issues around MCA	0	0	0	0	0	0						
16. Number of staff who have undertaken MCA training												
a. Children & Women Clinical Board	Not available as yet											
b. CD&T Clinical Board												
c. Medicine Clinical Board												
d. Mental Health Clinical Board												
e. PCIC Clinical Board												
f. Specialist Clinical Board												
g. Surgery Clinical Board												

**Any figures in brackets correlates to applications rec'd in that month*

Urgent Jan 21					
Date Signe	Date Rec'd	Assessment	Authorised	Breach	
31/12/2020	08/01/2021	11/01/2021	14/01/2021	7 Days	Fax Error application received on 08/01/2021
29/12/2020	08/01/2021	25/01/2021	27/01/2021	22 Days	Fax Error application received 08/01/2021
11/12/2020	11/12/2020	07/01/2021	12/01/2021	25 Days	
13/01/2021	13/01/2021	25/01/2021	27/01/2021	7 Days	

Standard/Further Jan 21				
Date Signe	Date Rec'd	Assessment	Authorised	Breach
02/12/2020	02/12/2020	06/01/2021	13/01/2021	21 Days
02/12/2020	02/12/2020	08/01/2021	11/01/2021	19 Days
27/12/2020	27/12/2020	22/01/2021	27/01/2021	10 Days
05/10/2020	05/10/2020	25/01/2021	28/01/2021	94 Days

Urgent Withdrawn Jan 21						Information rec'd for w/d by		
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleansed	MA	New App
18/10/2020	11/01/2021				78 Days	Yes	No	No
28/12/2020	11/01/2021				7 Days	Yes	No	No
08/12/2020	12/01/2021				28 Days	No	No	Yes
07/12/2020	20/01/2021		20/01/2021		23 Days	No	No	Yes
05/01/2021	19/01/2021				7 Days	Yes	No	No
16/10/2020	20/01/2021		20/01/2021		89 Days	No	No	Yes
27/11/2020	20/01/2021				48 Days	Yes	No	No
29/12/2021	21/01/2021			08/01/2021	3 Days	Yes	No	No
08/01/2021	21/01/2021	18/01/2021			3 Days	Yes	No	No
24/12/2020	30/01/2021	30/01/2021			30 Days	Yes	No	No
20/12/2020	22/01/2021				26 Days	Yes	No	No
21/12/2020	22/01/2021				25 Days	Yes	No	No
29/12/2020	22/01/2021				17 Days	Yes	No	No
29/12/2020	22/01/2021				17 Days	Yes	No	No
30/12/2020	28/01/2021	28/01/2021			22 Days	Yes	No	No
14/12/2020	22/01/2021				32 Days	Yes	No	No
30/12/2020	22/01/2021				18 days	Yes	No	No
08/01/2021	29/01/2021		29/01/2021		14 Days	No	No	Yes
14/12/2020	22/01/2021			26/12/2021	5 Days	Yes	No	No
11/01/2021	30/01/2021	30/01/2021			12 Days	Yes	No	No
05/01/2021	22/01/2021			13/01/2021	1 Day	Yes	No	No
21/12/2020	22/01/2021		08/01/2021		11 Days	Yes	No	No
30/12/2020	22/01/2021				16 Days	Yes	No	No
21/10/2020	22/01/2021				84 Days	Yes	No	No
21/09/2020	22/01/2021				116 Days	Yes	No	No
01/10/2020	22/01/2021				104 Days	Yes	No	No
24/11/2020	22/01/2021				52 Days	Yes	No	No
08/12/2020	22/01/2021				38 Days	Yes	No	No
08/12/2020	22/01/2021				38 Days	Yes	No	No
14/12/2020	22/01/2021				32 Days	Yes	No	No
19/12/2020	22/01/2021				27 Days	Yes	No	No
19/12/2020	22/01/2021				27 Days	Yes	No	No
19/12/2020	22/01/2021				24 Days	Yes	No	No
24/12/2020	22/01/2021				22 Days	Yes	No	No
24/12/2020	22/01/2021				22 Days	Yes	No	No
26/12/2020	22/01/2021				20 Days	Yes	No	No
28/12/2020	22/01/2021				18 Days	Yes	No	No
05/01/2021	22/01/2021	15/01/2021			3 Days	Yes	No	No
15/12/2020	27/01/2021	27/01/2021			36 Days	Yes	No	No
08/01/2021	22/01/2021	20/01/2021			5 Days	Yes	No	No

Standard/Further Withdrawn Jan 21						Information rec'd for w/d by		
Date Rec'd	Date W/D	Discharged	Transfer	RIP	Breach	Cleansed	MA	New App
18/12/2020	11/01/2021				3 Days	Yes	No	No
30/11/2020	11/01/2021				20 Days	Yes	No	No
11/12/2020	22/01/2021				21 Days	Yes	No	No
26/07/2020	25/01/2021				162 Days	Yes	No	No
07/12/2020	25/01/2021				28 Days	Yes	No	No
30/11/2020	27/01/2021				38 Days	Yes	No	No
03/12/2020	29/01/2021				36 Days	Yes	No	No

Urgent Feb 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
27/10/2020	27/10/2020	10/02/2021	11/02/2021	89 days
05/01/2021	05/01/2021	08/02/2021	11/02/2021	27 Days
08/02/2021	08/02/2021	16/02/2021	17/02/2021	1 Day
09/02/2021	09/02/2021	22/02/2021	01/03/2021	6 Days

Standard/Further Feb 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
25/11/2020	25/11/2020	22/02/2021	28/02/2021	69 Days
25/11/2020	25/11/2020	10/02/2021	11/02/2021	57 Days
27/11/2020	27/11/2020	16/02/2021	22/02/2021	67 Days
11/01/2021	11/01/2021	11/02/2021	16/02/2021	14 Days

Urgent Withdrawn Feb 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
08/01/2021	05/02/2021		05/02/2021		21 Days	No	No	Yes
05/01/2020	07/02/2021				26 Days	Yes	No	No
06/12/2020	07/02/2021				56 Days	Yes	No	No
13/12/2020	07/02/2021				48 Days	Yes	No	No
12/09/2020	07/02/2021				141 Days	Yes	No	No
02/12/2020	07/02/2021				60 Days	Yes	No	No
14/01/2021	07/02/2021	27/01/2021			6 Days	Yes	No	No
24/09/2020	07/02/2021				129 Days	Yes	No	No
08/10/2020	07/02/2021				115 Days	Yes	No	No
04/12/2020	07/02/2021				58 Days	Yes	No	No
25/12/2020	07/02/2021	29/01/2021			28 Days	Yes	No	No
14/01/2021	07/02/2021	27/01/2021			6 Days	Yes	No	No
26/01/2021	07/02/2021		04/02/2021		5 Days	No	No	Yes
26/01/2021	07/02/2021		04/02/2021		5 Days	No	No	Yes
17/11/2020	09/02/2021				47 Days	Yes	No	No
30/01/2021	10/02/2021	10/02/2021			4 Days	No	Yes	No
04/01/2021	15/02/2021	15/02/2021			35 Days	Yes	No	No
03/02/2021	22/02/2021	15/02/2021			12 Days	Yes	No	No
30/01/2021	22/02/2021	09/02/2021			3 Days	Yes	No	No
28/01/2021	23/02/2021	23/02/2021			17 Days	Yes	No	No
07/02/2021	23/02/2021		18/02/2021		4 Days	No	No	Yes
01/02/2021	23/02/2021		20/02/2021		12 Days	No	No	Yes
18/01/2021	23/02/2021	17/02/2021			23 Days	Yes	No	No
31/01/2021	23/02/2021			########	13 Days	Yes	No	No
15/02/2021	24/02/2021			########	1 Day	Yes	No	No
14/02/2021	26/02/2021		25/02/2021		4 Days	No	No	Yes
11/02/2021	26/02/2021	26/02/2021			8 Days	Yes	No	No

Standard/Further Withdrawn Feb 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
01/10/2020	09/02/2021				110 Days	Yes	No	No
07/12/2020	09/02/2021				43 Days	Yes	No	No
07/12/2020	11/02/2021				45 Days	Yes	No	No

Urgent March 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
05/01/2021	05/01/2021	05/03/2021	08/03/2021	52 Days
17/02/2021	17/02/2021	05/03/2021	08/03/2021	9 Days
18/02/2021	18/02/2021	25/03/2021	25/03/2021	56 Days
26/02/2021	26/02/2021	25/03/2021	30/03/2021	20 Days

Standard/Further March 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**

Urgent Withdrawn March 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
06/11/2020	01/03/2021		01/03/2021		108 Days	No	No	Yes
04/02/2021	03/03/2021			11/02/2021	20 Days	Yes	No	No
30/01/2021	04/03/2021	02/03/2021			26 Days	Yes	No	No
30/01/2021	04/03/2021			21/02/2021	15 Days	Yes	No	No
26/01/2021	04/03/2021			23/02/2021	21 Days	Yes	No	No
29/01/2021	04/03/2021	08/02/2021			3 Days	Yes	No	No
30/01/2021	04/03/2021	08/02/2021			2 Days	Yes	No	No
02/02/2021	04/03/2021	10/02/2021			1 Day	No	No	No
19/02/2021	05/03/2021	11/03/2021			13 Days	Yes	No	No
17/02/2021	05/03/2021	25/01/2021			1 Day	Yes	No	No
25/02/2021	12/03/2021	12/03/2021			8 Days	Yes	No	No
22/02/2021	19/03/2021		18/03/2021		17 Days	No	No	Yes
28/02/2021	19/03/2021	11/03/2021			4 Days	Yes	No	No
08/03/2021	22/03/2021	19/03/2021			4 Days	No	No	Yes
23/02/2021	29/03/2021		24/03/2021		27 Days	No	No	Yes
28/02/2021	29/03/2021	11/03/2021			4 Days	Yes	No	No
26/01/2021	30/03/2021	14/03/2021			40 Days	Yes	No	No
17/02/2021	30/03/2021		24/03/2021		28 Days	No	No	Yes
26/02/2021	30/03/2021	26/03/2021			21 Days	Yes	No	No

Standard/Further Withdrawn March 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
10/01/2021	09/03/2021	15/02/2021			15 Days	Yes	No	No
05/02/2021	17/03/2021	12/03/2021			14 Days	Yes	No	No
12/01/2021	22/03/2021		09/03/2021		35 Days	Yes	No	Yes
27/01/2021	23/03/2021	15/03/2021			26 Days	Yes	No	No
16/02/2021	25/03/2021	25/03/2021			16 Days	Yes	No	No
27/01/2021	29/03/2021	01/03/2021			11 Days	Yes	No	No
27/11/2020	31/03/2021	25/03/2021			97 Days	Yes	No	No
07/12/2020	31/03/2021	08/02/2021			42 Days	Yes	No	No
10/01/2021	31/03/2021	24/03/2021			52 Days	Yes	No	No

Urgent April 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
11/02/2021	11/02/2021	09/04/2021	09/04/2021	40 Days
16/02/2021	16/02/2021	12/04/2021	12/04/2021	48 Days
23/02/2021	23/02/2021	27/04/2021	02/05/2021	58 Days
08/03/2021	08/03/2021	29/04/2021	02/05/2021	45 Days
13/03/2021	13/03/2021	22/04/2021	22/04/2021	33 Days
16/03/2021	16/03/2021	12/04/2021	13/04/2021	20 Days
17/03/2021	17/03/2021	22/04/2021	23/04/2021	30 Days
22/03/2021	22/03/2021	14/04/2021	16/04/2021	17 Days
09/04/2021	09/04/2021	27/04/2021	27/04/2021	9 Days
19/04/2021	19/04/2021	29/04/2021	29/04/2021	3 Days

Standard/Further April 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
07/12/2020	07/12/2020	06/04/2021	06/04/2021	99 Days
26/12/2020	26/12/2020	20/04/2021	20/04/2021	94 Days
19/02/2021	19/02/2021	12/04/2021	12/04/2021	21 Days
22/02/2021	22/02/2021	06/04/2021	08/04/2021	16 Days
23/02/2021	23/02/2021	06/04/2021	06/04/2021	13 Days
11/02/2021	11/02/2021	20/04/2021	20/04/2021	47 Days

Urgent Withdrawn April 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
18/03/2021	01/04/2021	30/03/2021			5 Days	Yes	No	No
07/03/2021	01/04/2021	16/03/2021			2 Days	Yes	No	No
19/03/2021	01/04/2021	27/03/2021			1 Day	Yes	No	No
12/03/2021	01/04/2021	24/03/2021			5 Days	Yes	No	No
17/03/2021	01/04/2021	26/03/2021			2 Days	Yes	No	No
09/03/2021	01/04/2021	17/03/2021			1 Day	Yes	No	No
08/02/2021	01/04/2021		25/03/2021		24 Days	No	No	Yes
11/03/2021	01/04/2021	30/03/2021			12 Days	Yes	No	No
02/03/2021	01/04/2021	29/03/2021			20 Days	Yes	No	No
19/02/2021	01/04/2021	02/03/2021			4 Days	Yes	No	No
23/02/2021	01/04/2021	18/03/2021			16 Days	Yes	No	No
02/03/2021	01/04/2021	30/03/2021			21 Days	Yes	No	No
08/03/2021	01/04/2021	31/03/2021			16 Days	Yes	No	No
19/03/2021	01/04/2021	30/03/2021			4 Days	Yes	No	No
15/03/2021	05/04/2021	01/04/2021			9 Days	Yes	No	No
23/02/2021	05/04/2021	15/03/2021			13 Days	Yes	No	No
03/03/2021	06/04/2021		01/04/2021		22 Days	Yes	No	No
03/11/2020	07/04/2021	23/03/2021			133 Days	Yes	No	No
02/03/2021	12/04/2021	07/04/2021			29 Days	Yes	No	No
16/03/2021	15/04/2021	15/04/2021			23 Days	No	Yes	No
02/04/2021	16/04/2021		14/04/2021		5 Days	No	No	Yes
02/03/2021	16/04/2021	14/04/2021			36 Days	Yes	No	No
19/03/2021	19/04/2021	14/04/2021			19 Days	Yes	No	No
19/03/2021	19/04/2021	07/04/2021			11 Days	Yes	No	No
03/04/2021	19/04/2021	15/04/2021			5 Days	Yes	No	No
02/04/2021	19/04/2021	15/04/2021			6 Days	Yes	No	No
05/04/2021	19/04/2021	13/04/2021			1 Day	Yes	No	No
28/02/2021	20/04/2021	31/03/2021			24 Days	Yes	No	No
15/03/2021	20/04/2021			20/04/2021	29 Days	Yes	No	No
19/03/2021	20/04/2021		16/04/2021		21 Days	No	No	Yes
02/04/2021	20/04/2021	20/04/2021			11 Days	Yes	No	No
16/03/2021	20/04/2021	14/04/2021			22 Days	Yes	No	No
08/04/2021	20/04/2021			16/04/2021	1 Day	Yes	No	No
04/04/2021	20/04/2021			17/04/2021	6 Days	Yes	No	No
23/02/2021	22/04/2021	06/03/2021			35 Days	Yes	No	No
22/02/2021	22/04/2021			06/03/2021	5 Days	Yes	No	No
24/03/2021	22/04/2021	01/04/2021			1 Day	Yes	No	No
22/03/2021	26/04/2021		16/04/2021		17 Days	No	No	Yes
12/04/2021	26/04/2021	23/04/2021			4 Days	Yes	No	No
01/04/2021	26/04/2021			20/04/2021	12 Days	Yes	No	No
01/03/2021	26/04/2021	16/04/2021			49 Days	Yes	No	No
17/03/2021	26/04/2021		22/04/2021		29 Days	No	No	Yes
10/03/2021	26/04/2021	09/04/2021			23 Days	Yes	No	No
09/03/2021	28/04/2021	14/04/2021			29 Days	Yes	No	No
04/03/2021	28/04/2021	24/04/2021			44 Days	Yes	No	No
07/02/2021	28/04/2021	17/03/2021			31 Days	Yes	No	No
22/03/2021	28/04/2021	20/04/2021			22 Days	Yes	No	No
12/04/2021	28/04/2021	26/04/2021			7 Days	Yes	No	No
14/04/2021	28/04/2021	22/04/2021			1 Day	Yes	No	No

Standard/Further Withdrawn April 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
19/02/2021	08/04/2021	01/04/2021			20 Days	Yes	No	No
09/02/2021	22/04/2021	29/03/2021			30 Day	Yes	No	No
02/03/2021	26/04/2021	06/04/2021			45 Days	Yes	No	No
06/03/2021	26/04/2021	13/04/2021			17 Days	Yes	No	No
15/03/2021	26/04/2021	08/04/2021			2 Days	Yes	No	No
15/03/2021	26/04/2021	20/04/2021			14 Days	Yes	No	No
18/03/2021	26/04/2021	21/04/2021			12 Days	Yes	No	No

Urgent June 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
02/04/2021	02/04/2021	14/05/2021	14/05/2021	25 Days
22/04/2021	22/04/2021	14/05/2021	14/05/2021	15 Days
30/04/2021	30/04/2021	18/05/2021	18/05/2021	11 Days
03/05/2021	03/05/2021	14/05/2021	14/05/2021	4 Days

Standard/Further June 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
19/01/2021	19/01/2021	27/05/2021	27/05/2021	100 Days
26/02/2021	26/02/2021	05/05/2021	05/05/2021	40 Days

Urgent Withdrawn June 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
31/01/2021	02/05/2021	30/03/2021			51 Days	Yes	No	No
25/03/2021	02/05/2021		30/04/2021		29 Days	No	No	Yes
22/04/2021	02/05/2021		30/04/2021		1 Day	No	No	Yes
05/04/2021	03/05/2021		02/05/2021		25 Days	No	No	Yes
07/04/2021	03/05/2021		28/04/2021		14 Days	No	No	Yes
19/04/2021	03/05/2021	28/04/2021			2 Days	Yes	No	No
20/04/2021	03/05/2021			30/04/2021	3 Days	Yes	No	No
27/02/2021	03/05/2021	18/03/2021			11 Days	Yes	No	No
07/04/2021	03/05/2021	01/05/2021			17 Days	Yes	No	No
21/04/2021	03/05/2021	02/05/2021			4 Days	Yes	No	No
31/03/2021	04/05/2021	16/04/2021			9 Days	Yes	No	No
18/04/2021	12/05/2021	05/05/2021			10 Days	Yes	No	No
22/04/2021	12/05/2021		06/05/2021		7 Days	No	No	Yes
30/04/2021	13/05/2021	13/05/2021			6 Days	Yes	No	No
06/04/2021	17/05/2021	14/05/2021			31 Days	Yes	No	No
14/01/2021	17/05/2021	05/05/2021			89 Days	Yes	No	No
01/04/2021	17/05/2021	04/05/2021			26 Days	Yes	No	No
16/04/2021	17/05/2021			14/05/2021	21 Days	Yes	No	No
19/04/2021	17/05/2021	10/05/2021			14 Days	Yes	No	No
22/04/2021	19/05/2021	18/05/2021			19 Days	Yes	No	No
24/03/2021	19/05/2021	18/05/2021			48 Days	Yes	No	No
10/02/2021	24/05/2021	29/04/2021			71 Days	Yes	No	No
05/05/2021	27/05/2021		27/05/2021		15 Days	No	No	Yes
19/05/2021	27/05/2021	27/05/2021			1 Day	Yes	No	No
01/05/2021	28/05/2021		26/05/2021		17 Days	No	No	Yes
15/05/2021	28/05/2021	24/05/2021			2 Days	Yes	No	No
02/03/2021	28/05/2021	04/05/2021			46 Days	Yes	No	No
12/03/2021	28/05/2021		25/05/2021		67 Days	No	No	Yes
08/05/2021	28/05/2021	18/05/2021			3 Days	Yes	No	No
17/03/2021	28/05/2021	09/04/2021			16 Days	Yes	No	No
17/03/2021	28/05/2021	30/04/2021			37 Days	Yes	No	No
19/02/2021	28/05/2021	28/05/2021			90 Days	Yes	No	No

Standard/Further Withdrawn June 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
16/02/2021	02/05/2021	06/04/2021			28 Days	Yes	No	No
19/02/2021	02/05/2021	08/04/2021			27 Days	Yes	No	No
13/03/2021	04/05/2021		05/05/2021		31 Days	No	No	Yes
08/04/2021	07/05/2021	05/05/2021			6 Days	Yes	No	No
03/03/2021	17/05/2021			08/05/2021	35 Days	Yes	No	No
28/03/2021	25/05/2021	24/05/2021			36 Days	Yes	No	No
11/02/2021	27/05/2021	11/05/2021			68 Days	Yes	No	No
01/04/2021	27/05/2021		07/05/2021		35 Days	No	No	Yes

Urgent June 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**

Standard/Further June 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**

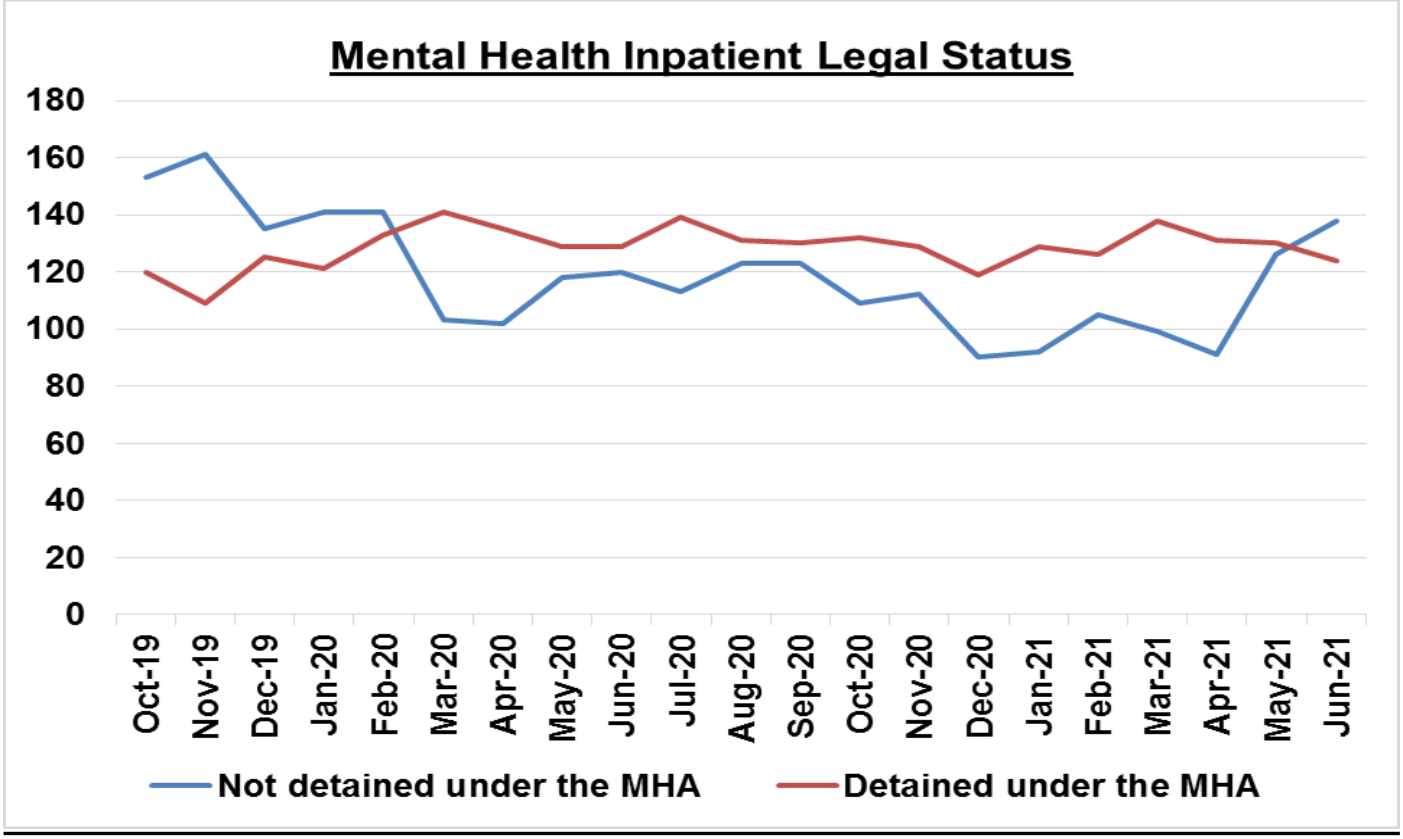
Urgent Withdrawn June 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
29/04/2021	14/06/2021		01/06/2021		26 Days	No	No	Yes
06/05/2021	14/06/2021		09/06/2021		27 Days	No	No	Yes
21/05/2021	18/06/2021	02/06/2021			21 Days	Yes	No	No
20/05/2021	18/06/2021		16/06/2021		20 Days	No	No	Yes
14/06/2021	23/06/2021	24/06/2021			3 Days	Yes	No	No

Standard/Further Withdrawn June 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
09/05/2021	09/06/2021	03/06/2021			4 Days	Yes	No	No

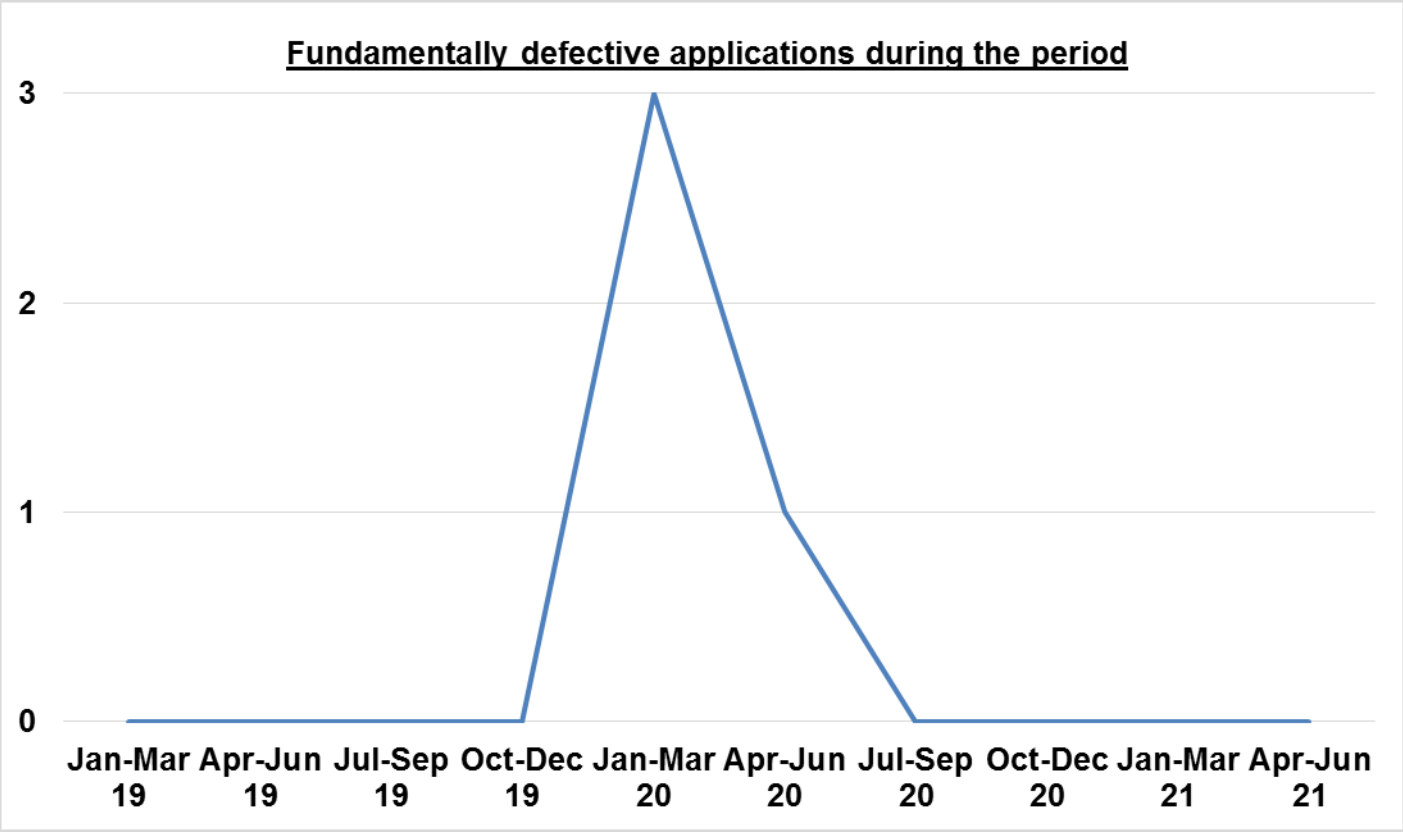
Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**20 July 2021**		
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**	**x**			
Lead Executive:	**Chief Operating 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 decreased by 11%. 58% of in patients were detained under the Act at the end of Qtr. 4 compared to 47% of in patients detained under the Act at the end of Qtr. 1.



Fundamentally defective applications



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

Incidents reported during the period resulting in detention without authority

A prison transfer was received into hospital under section 48/49 during the period (transfer of a prisoner awaiting sentence). Upon processing the order it transpired that the case had actually been heard and acquitted by the Court. Under these circumstances the section 48/49 ceases to have effect immediately. Unfortunately this information was not conveyed to the detaining authority by the Court or the Prison until three days after the disposal. This resulted in the patient being detained without authority by the UHB during this period. The patient was informed released from detention immediately.

Section 136 A&E

Further legal opinion has been sought in relation to the clock ticking in A&E issue. The response is as follows:

"*It is my view that section 7 is providing further guidance with regards to '…or any other suitable place' found at the end of s135(6) MHA. I don't believe that there is any ambiguity in relation to whether a hospital is a place of safety for the purposes of the legislation. A hospital is a place of safety. Further, I don't consider that it is for a person responsible for management of a hospital to determine if a hospital is to be a place of safety.*

I can see how the legislation could be interpreted as ambiguous (to a certain degree) which the Health Board may wish to put forward, when dealing with the police, but when reading the relevant

sections in their entirety, a hospital (as defined by s.145 MHA) is a place of safety for the purposes of s.135 and s.136 MHA.

The purpose of s.136 MHA is to provide a pathway for the police when dealing with a person they consider to be suffering from a mental disorder AND who requires immediate care and control for the interests of that person or for the protection of others. Whilst a hospital is given as an option, it is not exclusive. The section refers to residential accommodation provided by Local Authority, a police station, an independent hospital of care home for mentally disordered persons, or any other suitable place as a potential place of safety. In reality, this is a wide range of places.

s.136(2) does then go on to say that the 24 hour detention can enable a registered medical practitioner to carry out an assessment or the person can be interviewed by an approved mental health professional and any necessary arrangements for his treatment or care can be made. I am unsure what situations have arisen when you say that it can take over 24hrs for medical attention to be given before a mental health assessment. If further details can be provided in relation to this, I can consider further. ***It is noted that a police constable, under s.136(1C) of MHA is directed to consult with a registered medical practitioner, a registered nurse, an approved mental health professional, or a person of a description specified in regulations made by the Secretary of State, prior to removing a person to a place of safety****. I am unsure if this step is being taken by police constables in Cardiff and Vale and if so, whether that assists when relying on s.136 MHA and the timeframes permitted for detention."*

Examples have been provided in response to the above for the issue to be considered further. In the meantime the UHB are adhering to the clock ticking in A&E.

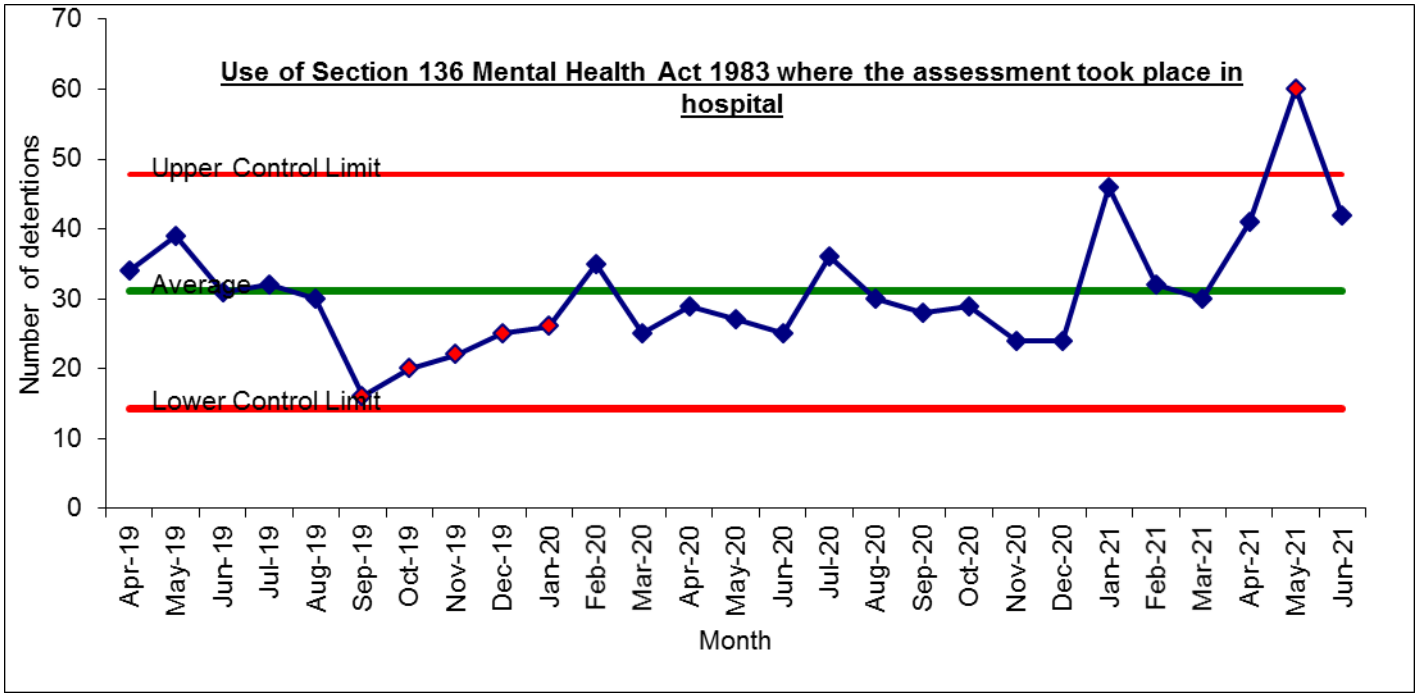
Section 136

The use of section 136 hit a record high in May 2021, this followed a substantial increase in the number of section 136 assessments conducted in January 2021. Further investigation indicates that 73.5% of individuals assessed were not admitted to hospital during the period.

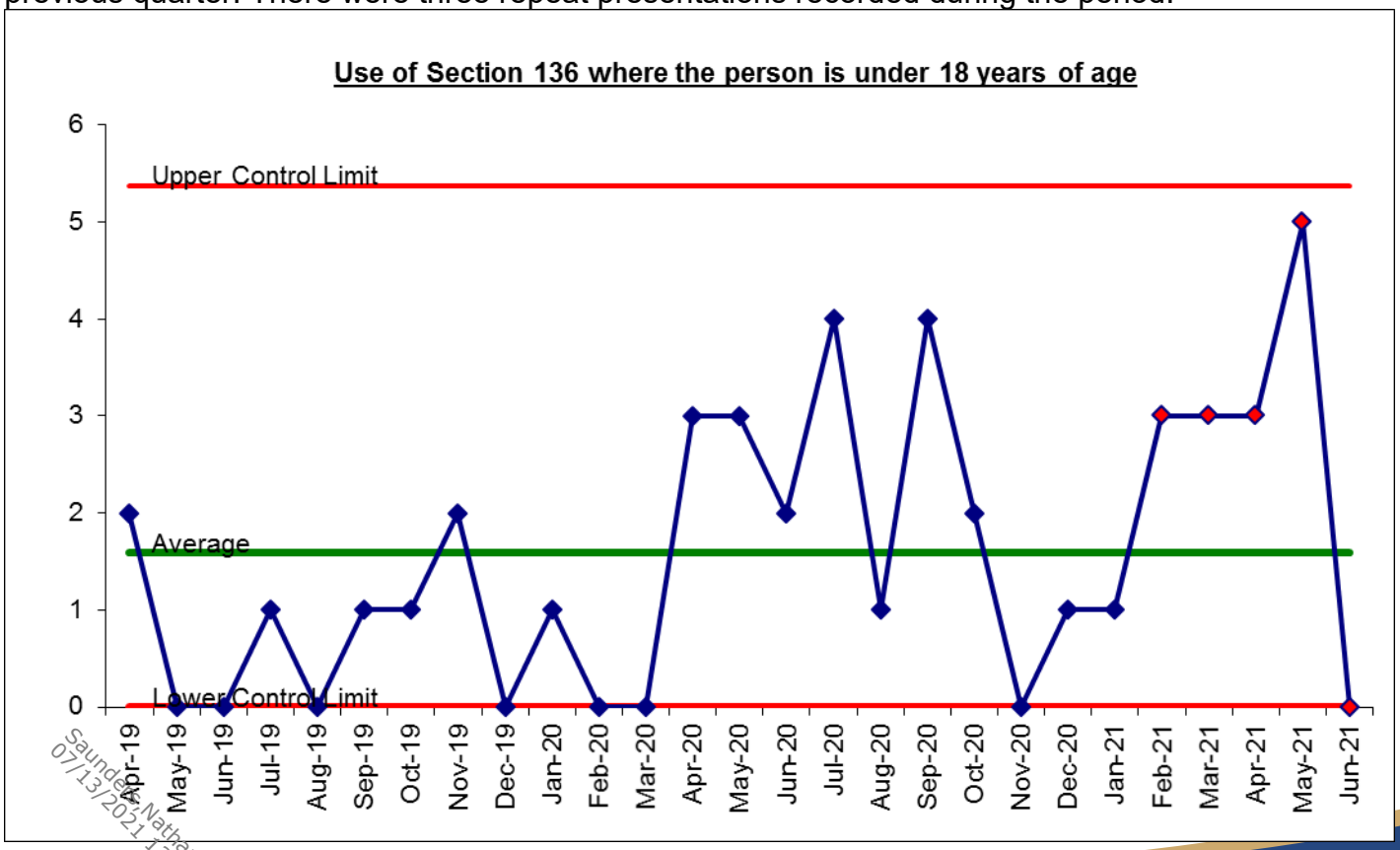
In May 2021 the admission rate subsequent to a section 136 assessment was 37%, with only 9% of assessments resulting in discharge with no follow up and 54% discharged with community support. Police colleagues have noted the increase and will be issuing further training to officers to ensure that the use of section 136 powers are only used when absolutely necessary and as a last resort. However there is nothing to indicate an inappropriate use of the power in May 2021 and overall during the period the number of those admitted to hospital has increased by 12%.

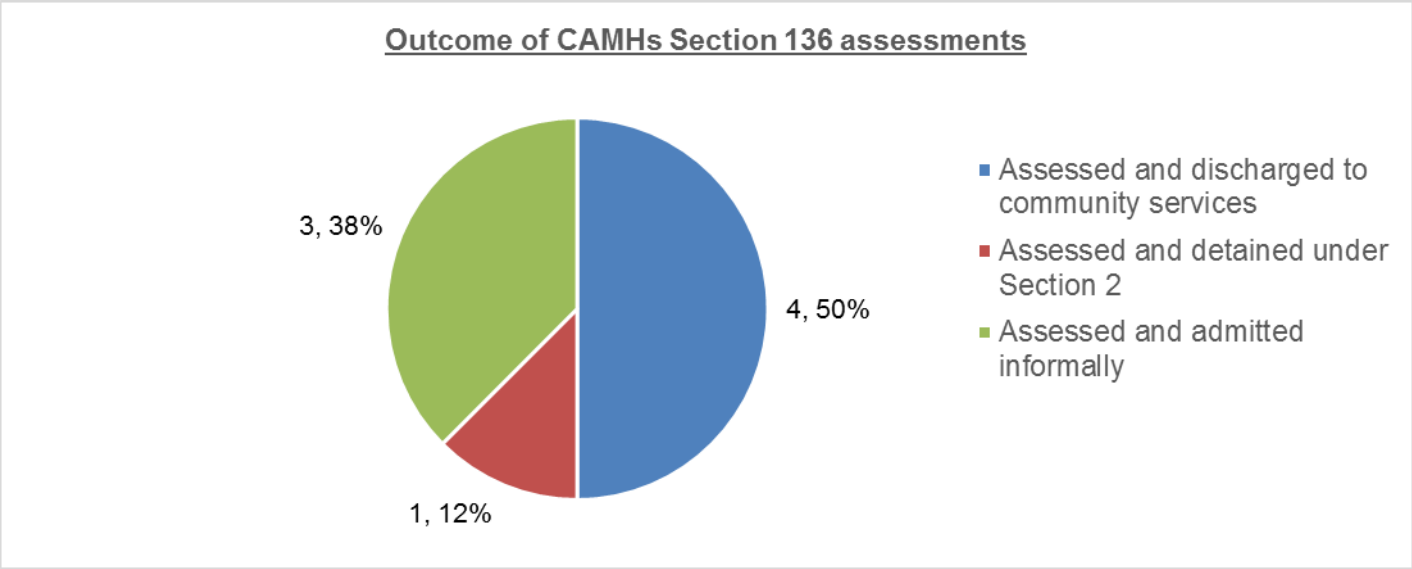
Period	% not admitted to hospital
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%
April – June 2020	70.4%
January – March 2020	62.8%

Section 136 - CAMHS



The number of those under 18 assessed under section 136 has increased in comparison to the previous quarter. There were three repeat presentations recorded during the period.





Mental Health Review Tribunal for Wales (MHRT)

Further to a meeting with the Vice President of the MHRT to discuss concerns in relation to the safety of staff and a patient's right to a fair hearing. It has been agreed that the MHRT will conduct a pilot of VC hearings to assess how they can manage these within the very limited resources that they have. The first VC hearing in Cardiff and Vale UHB is due to take place mid July.

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

Fundamentally defective applications

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

Incidents reported during the period resulting in detention without authority

As a result of the incident describe above the Delivery Manager, Cardiff Crown Court has amended procedures to ensure that the Mental Health Act Department are included in any Mental Health Act related communications.

Section 136 in A&E

If it is accepted that the clock starts ticking in A&E there is a danger that the UHB could exceed the detention period under certain circumstances, resulting in no authority to conduct a mental health assessment if the patient does not agree to it. For example when the time taken for medical treatment exceeds the 24/36 hour period.

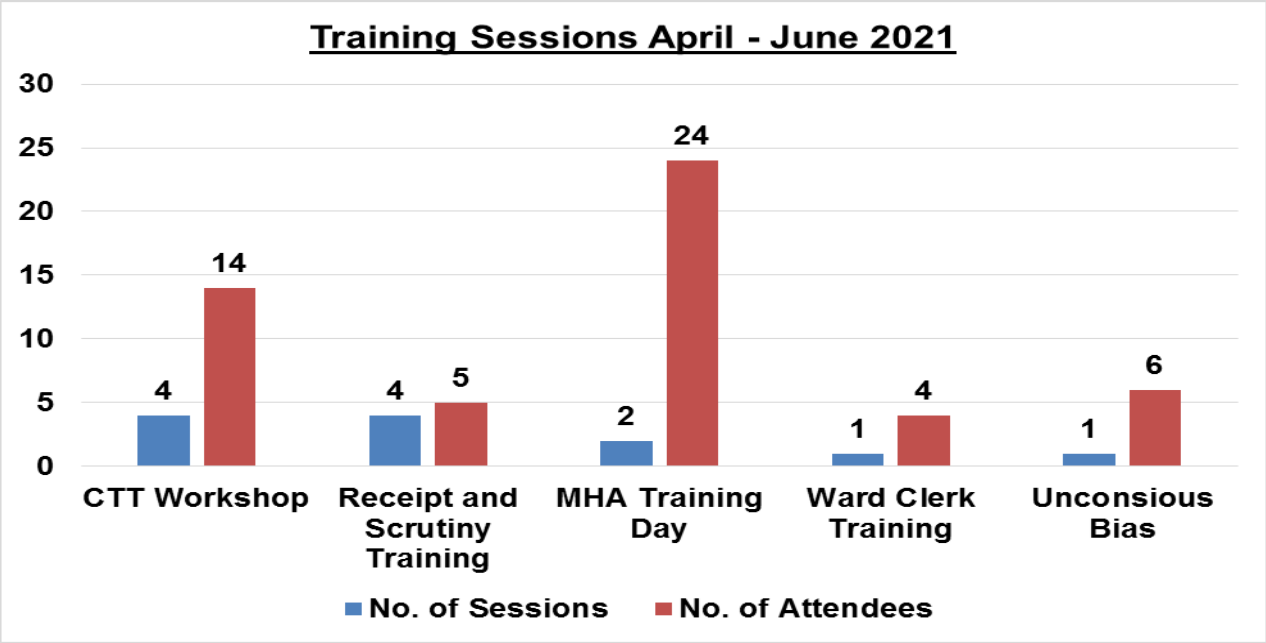
Mental Health Review Tribunal for Wales (MHRT)

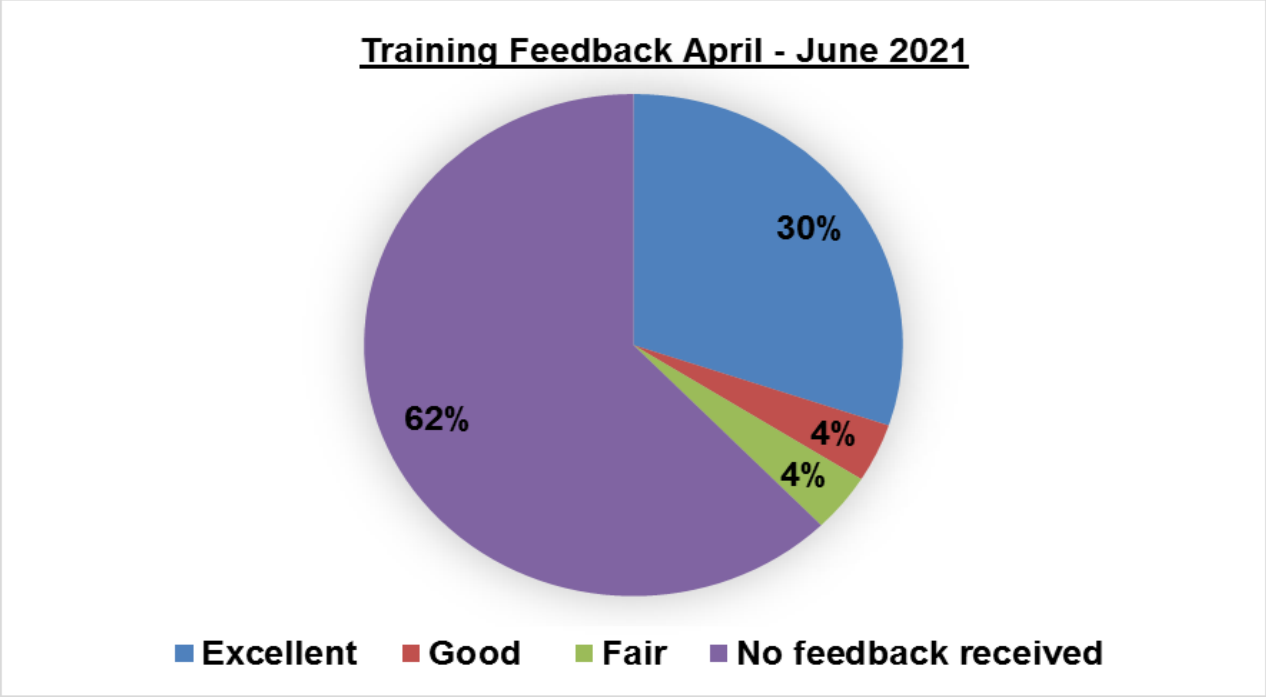
Clinicians continue to become increasingly concerned about the safety of staff during MHRT hearings being conducted by telephone, this means that the nurse attending the hearing is often sat on their own with the patient while giving evidence that the patient may not like hearing.

Development sessions

Mental Health Act awareness session continue to take place on a monthly basis. In addition to the Receipt and Scrutiny workshops the Mental Health Act Department has implmented the consent to treatment workshop.

During the period the Mental Health Act Department has continued to deliver the following development sessions:





Recommendation:

Fundamentally defective applications

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

Section 136

Continue to monitor in the Mental Health Act Office and work with South Wales Police and ensure any incidents related to the clock ticking in A&E are reported accordingly.

Section 136 – CAMHS

Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal

Continue to work with the Mental Health Review Tribunal for Wales to find a suitable resolution, to ensure that action is taken to mitigate the risks highlighted above and protect the patients' right to a fair hearing and ensure any incidents are reported accordingly.

Development sessions

Continue to develop a robust rota to ensure that development sessions in relation to all areas of the Mental Health Act are available and easily accessible and explore the possibility of devising a Mental Health Act e-learning module.

ASSURANCE is provided by:

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

The Committee 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.*								

NHS WALES GIG CYMRU

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Report to the

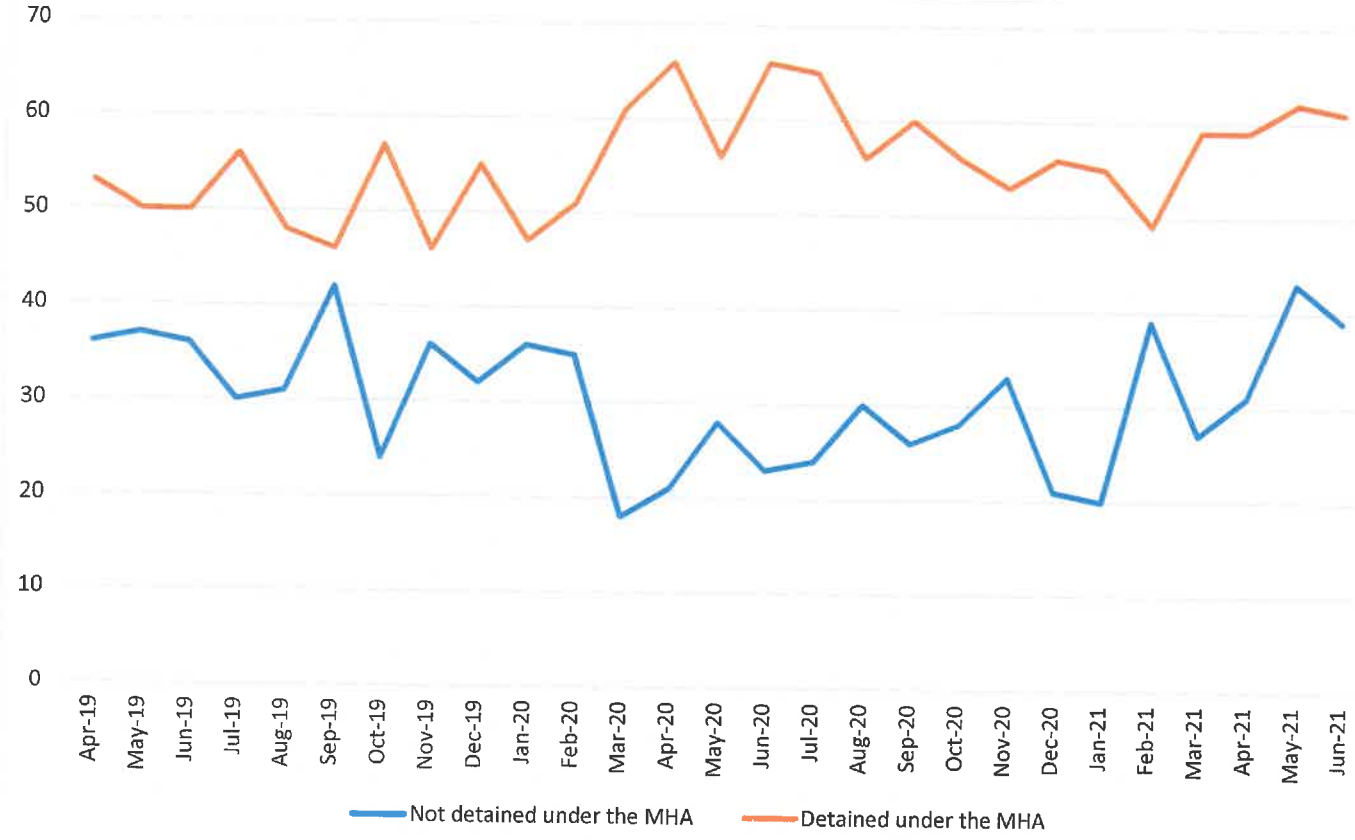
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

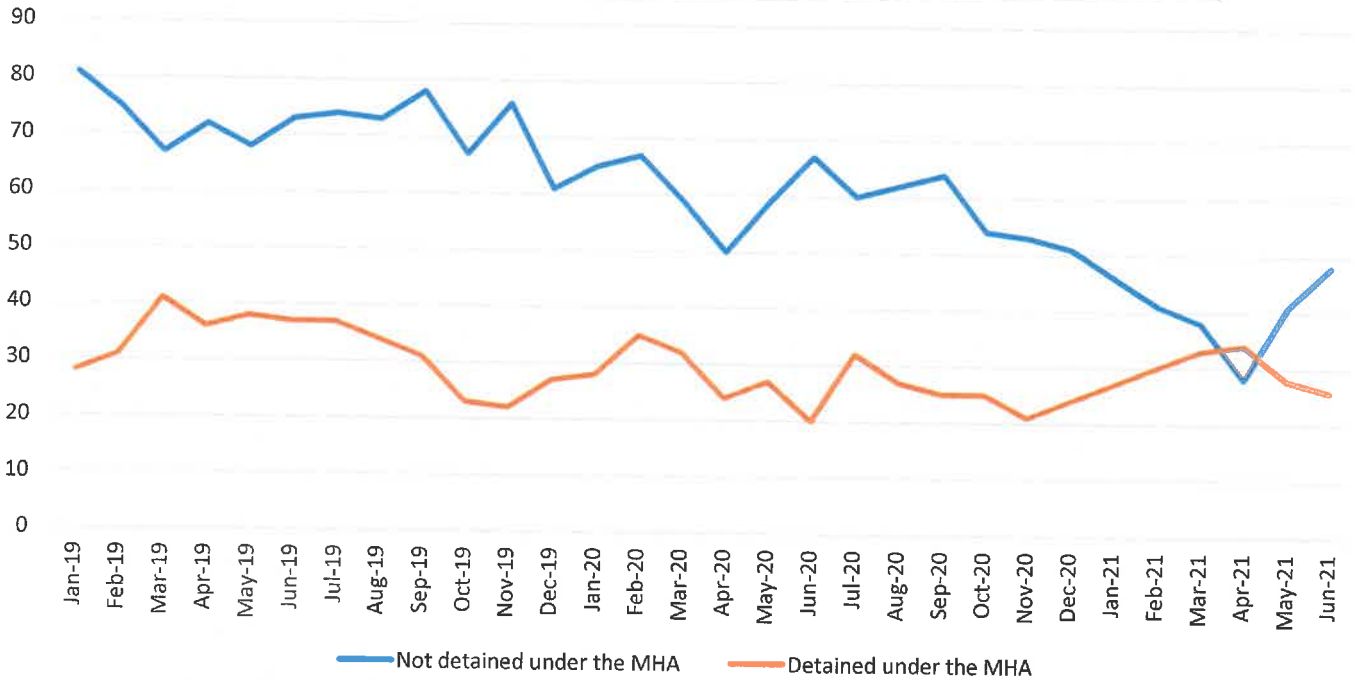
April- June 2021

Contents	Page

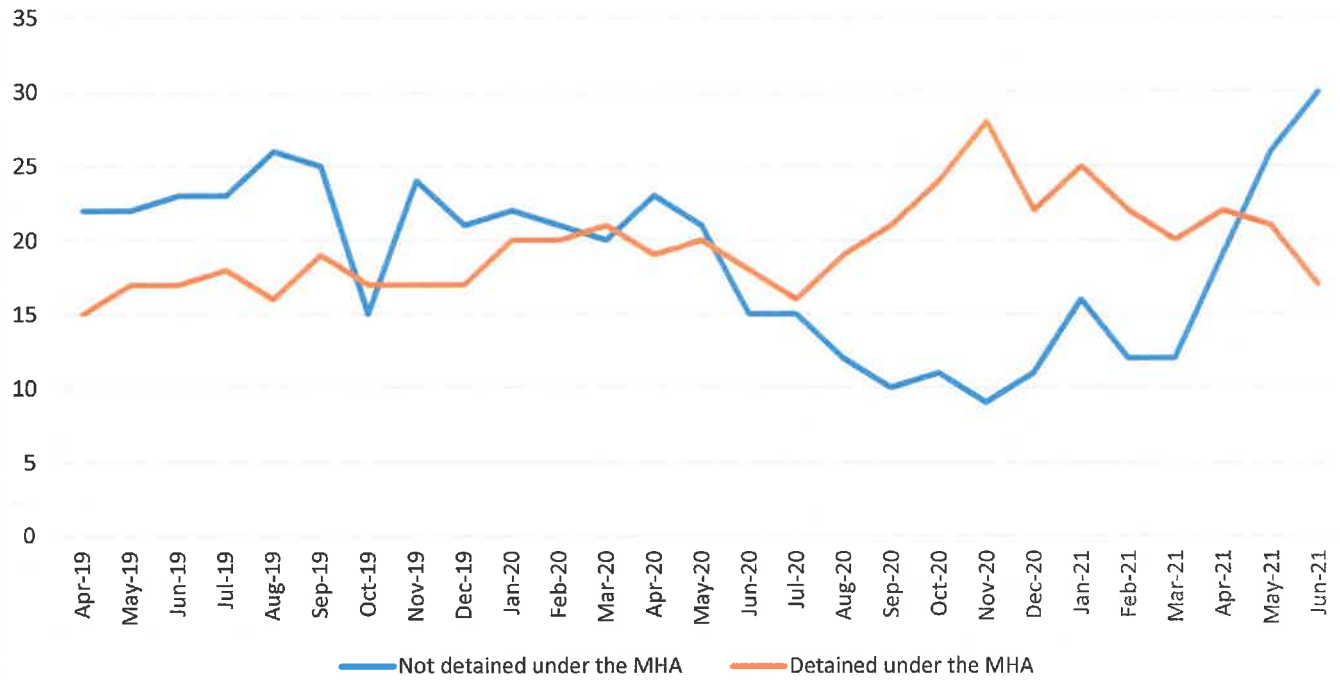
Adult Acute- Detained MHA/ Not Detained MHA



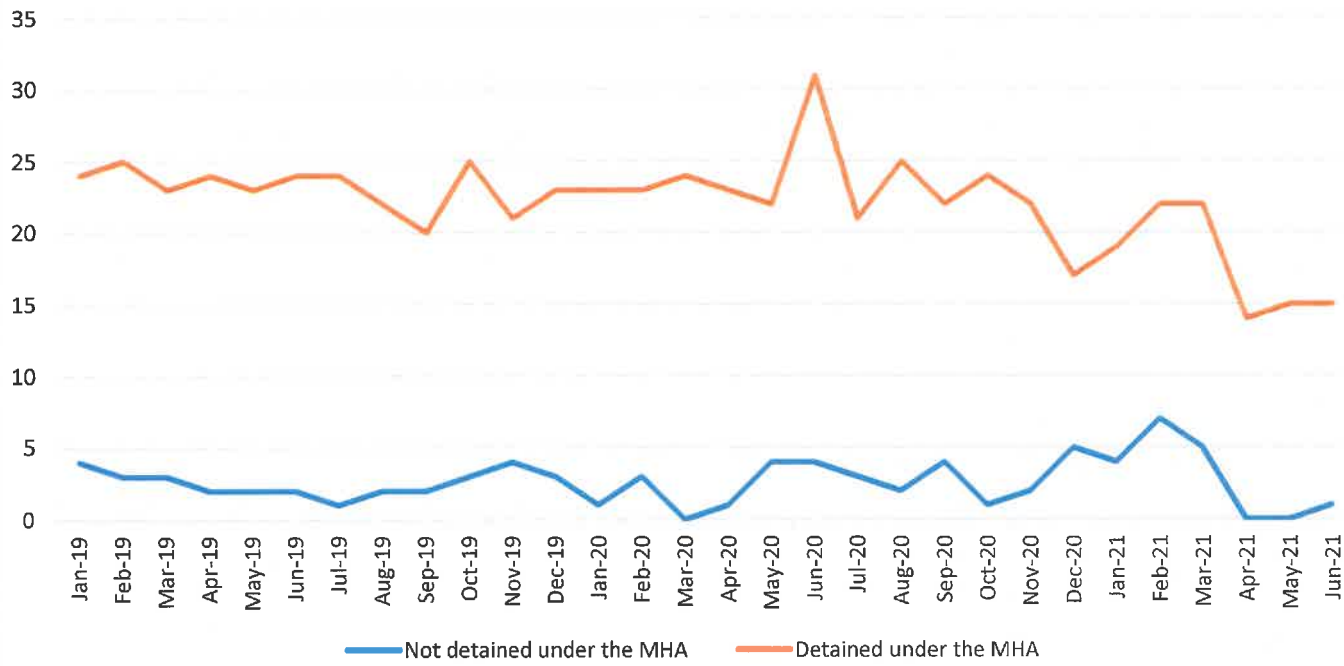
Mental Health Services for Older People- Detained/ Not Detained MHA



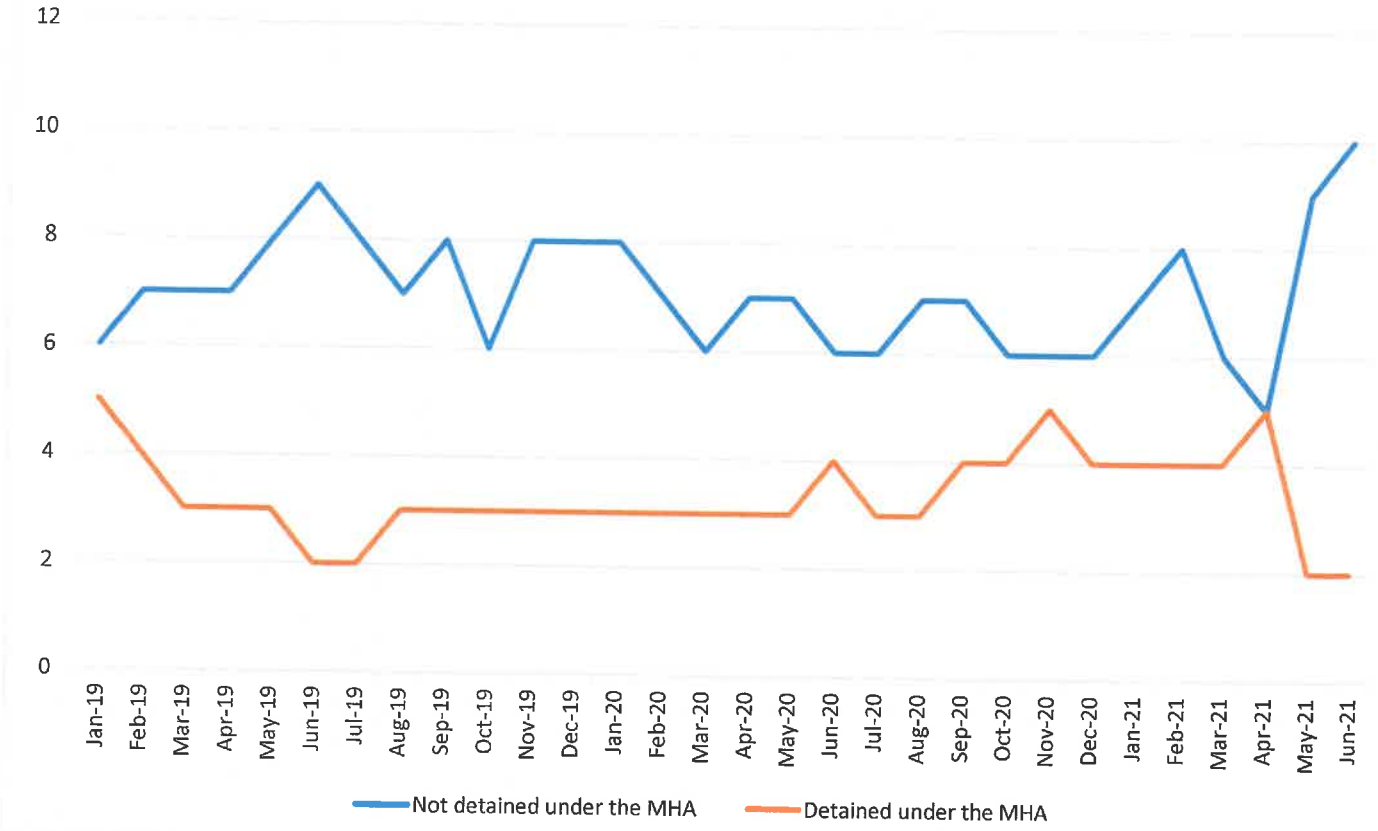
Rehabilitation- Detained MHA/ Not Detained MHA



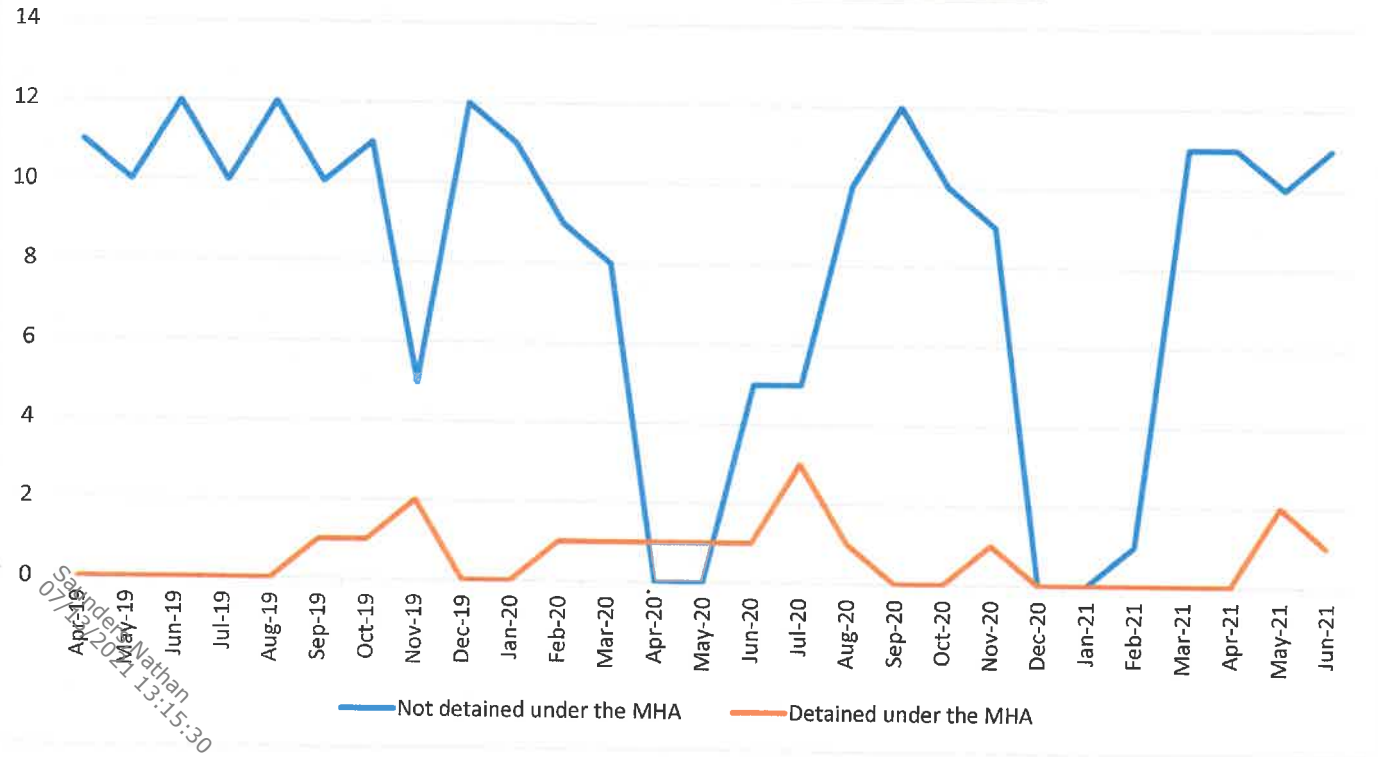
Low Secure- Detained/ Not Detained MHA



Neuropsychiatry- Detained MHA/ Not Detained MHA

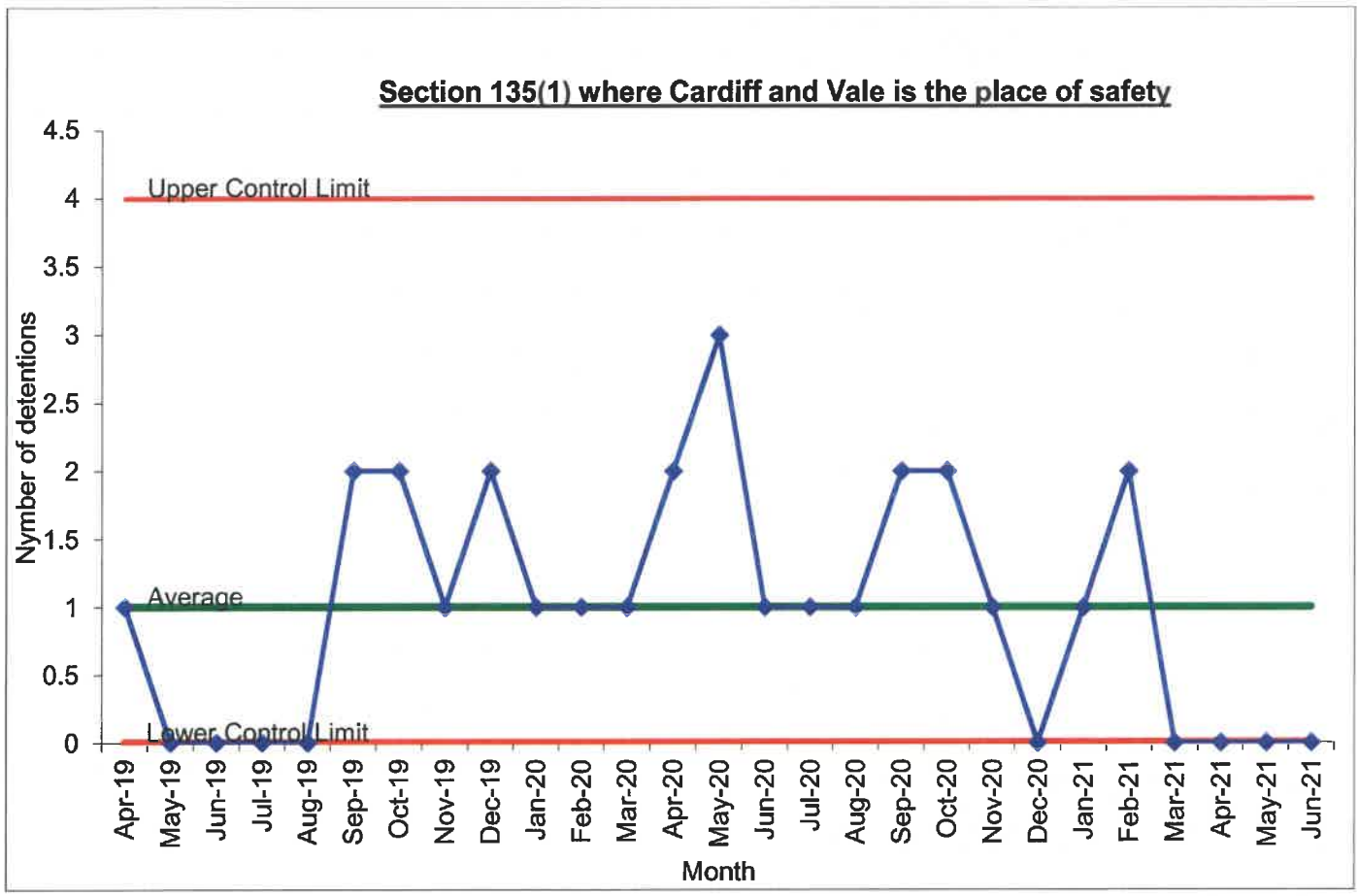


Addictions- Detained MHA/ Not Detained MHA



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

During the period Section 135 (1) powers were not used.



Section 135(2) powers were used twice during the period. Both patients were then detained under Section 3.

Voluntary Assessment

On the 14th of July 2020, the electronic All Wales Monitoring Form (AWMF) was put into use. This is an electronic form that should be completed by Police Officers for every occasion that they bring a patient to Hospital for a Mental Health Assessment. The reasons for this can be;-

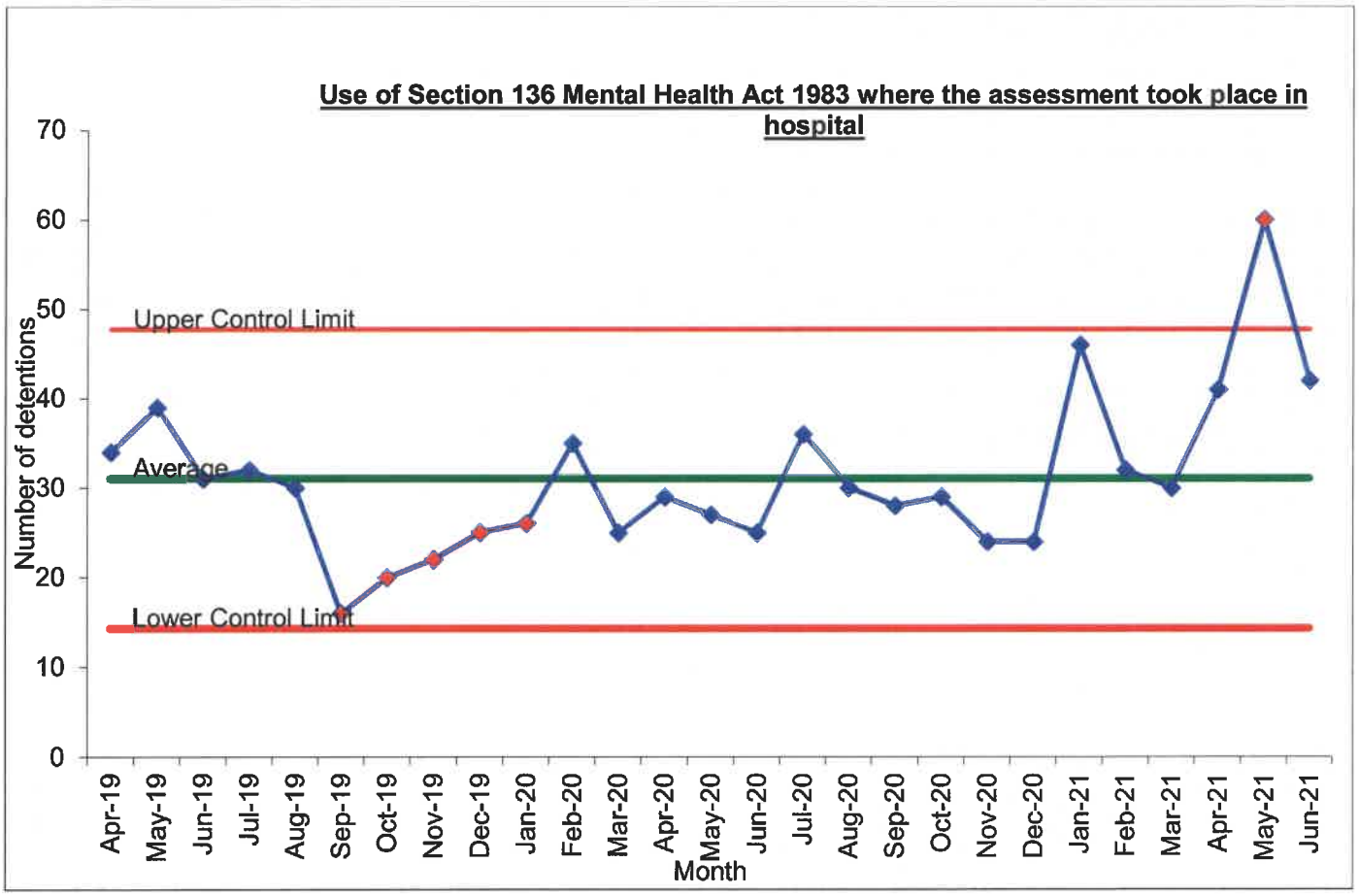
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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

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

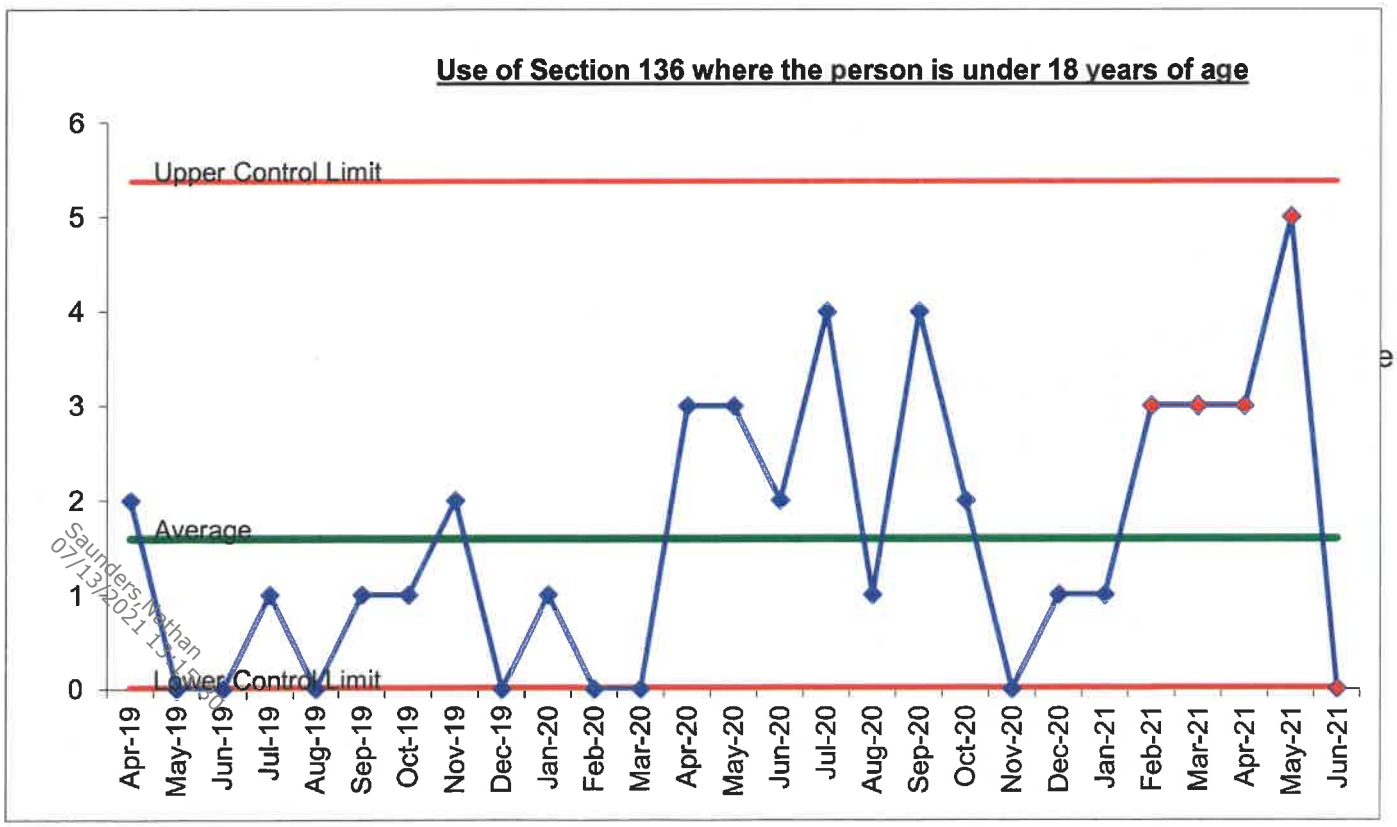
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

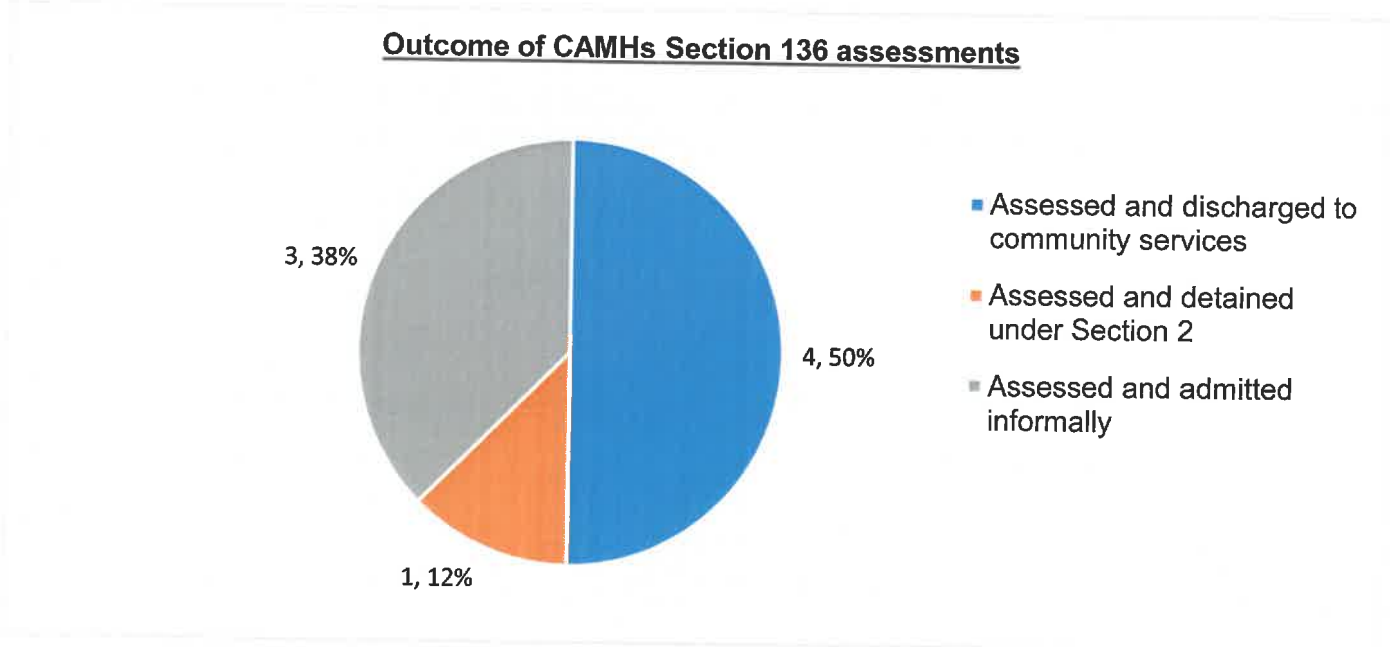
During the period a total of 143 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



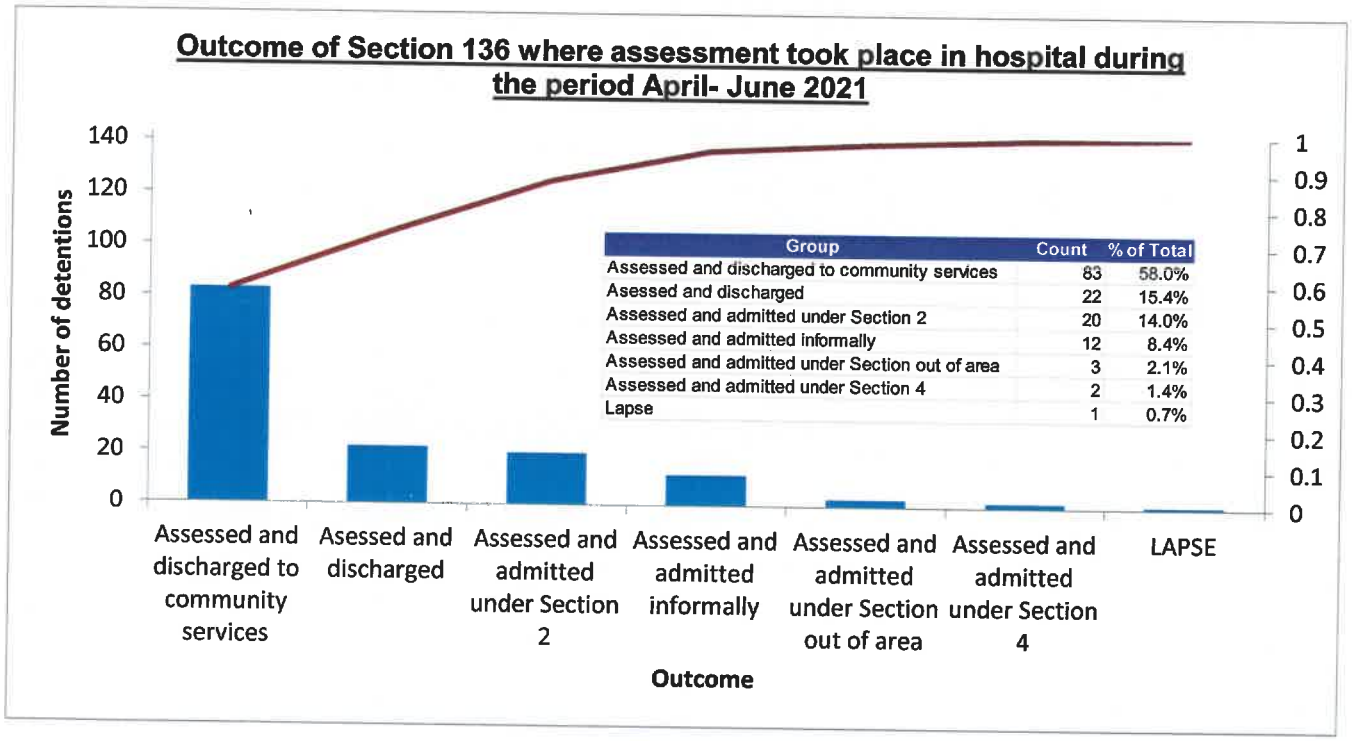
Eight of those assessments were carried out on patients under the age of 18.

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



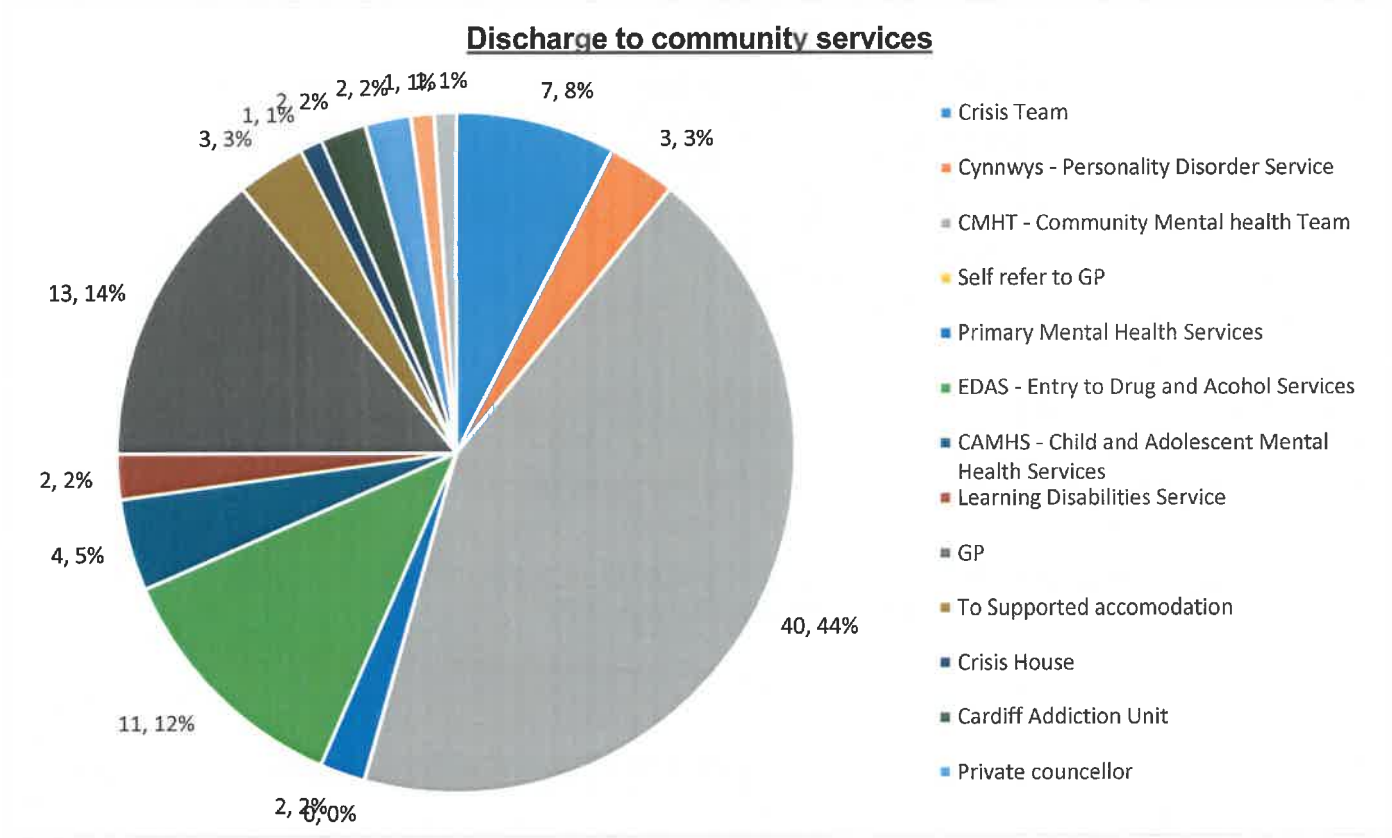


Three of these presentions were in relation to the same patient.



The detention under Section 136 which lapsed was because the patient was too physically unwell to be assessed.

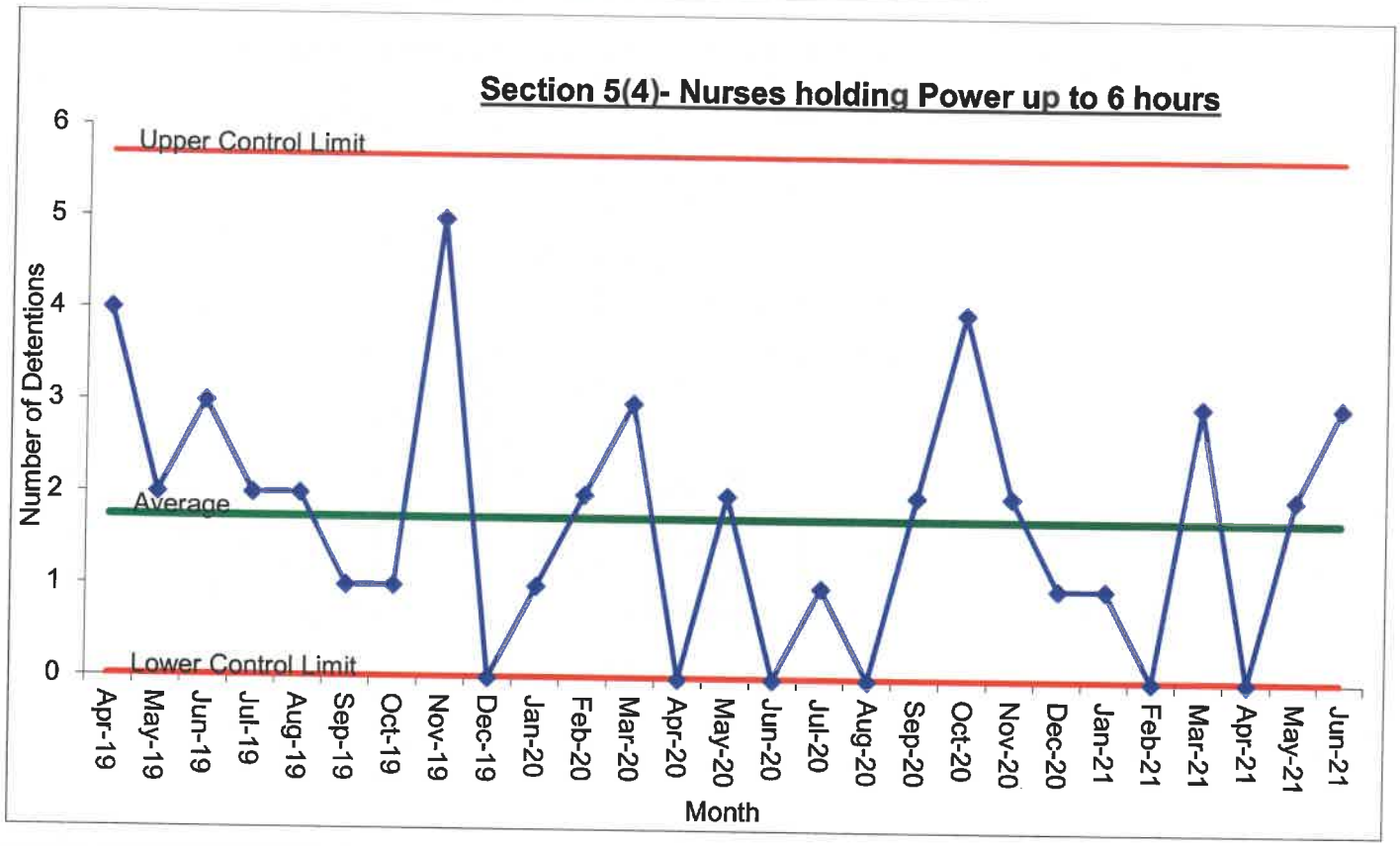
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.



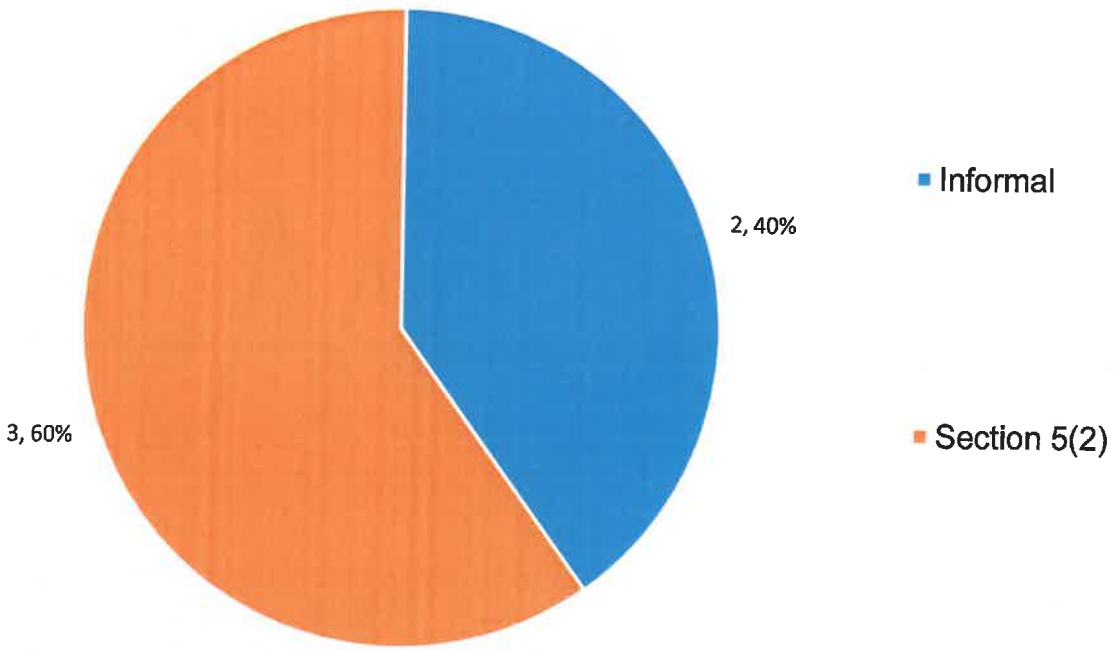
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

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

Section 5(4) - Nurses Holding Power

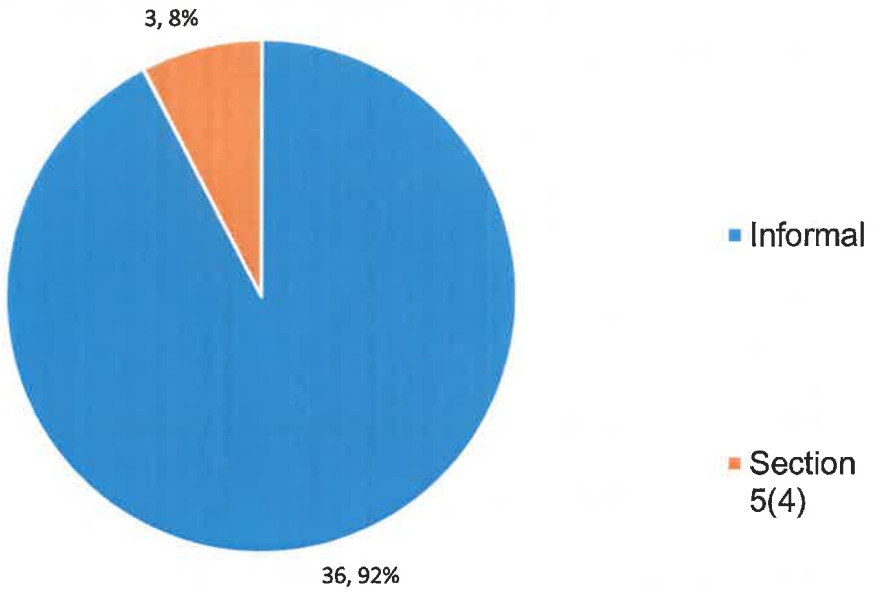


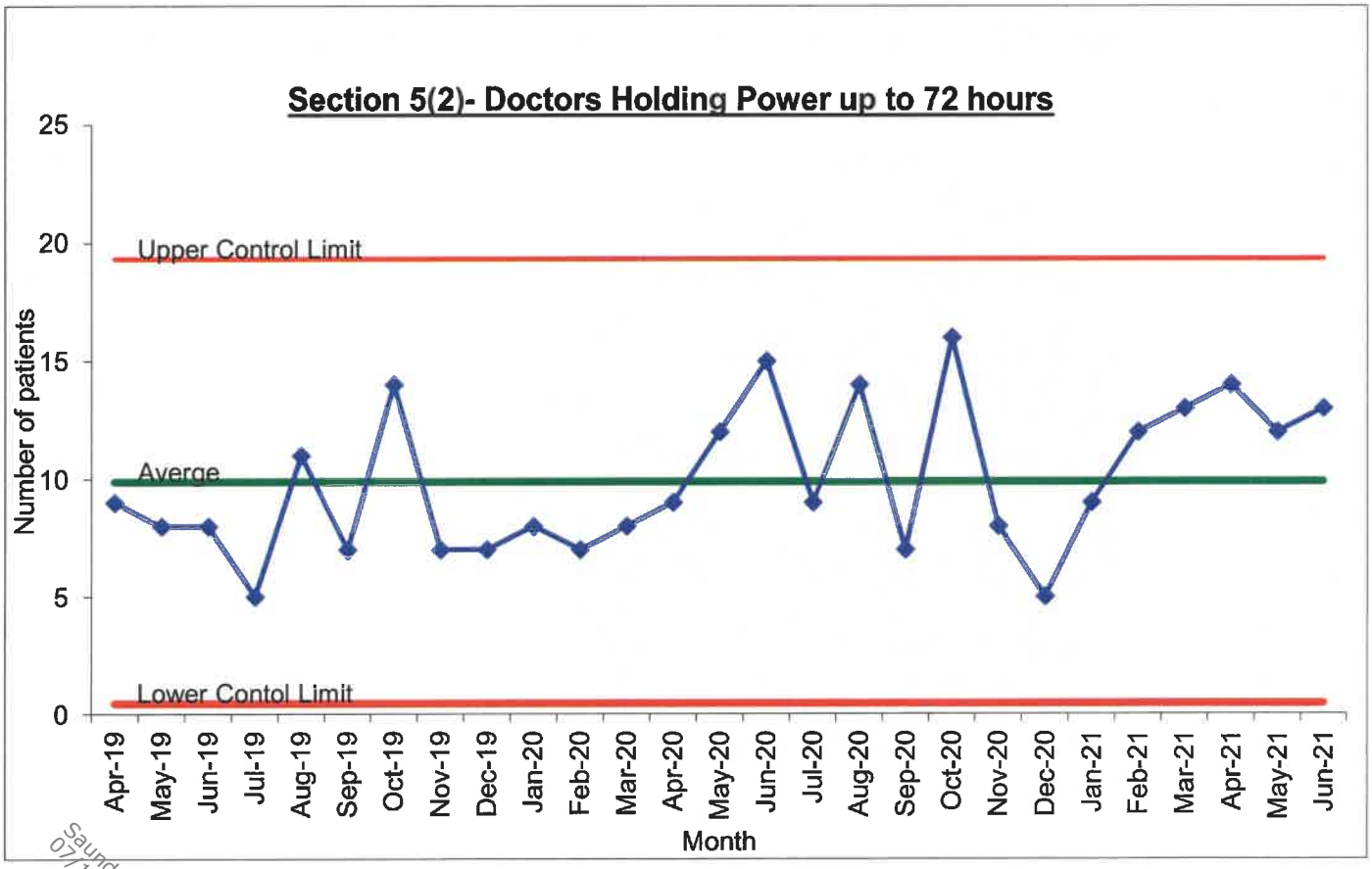
Outcome of Section 5(4) during the period April- June 2021

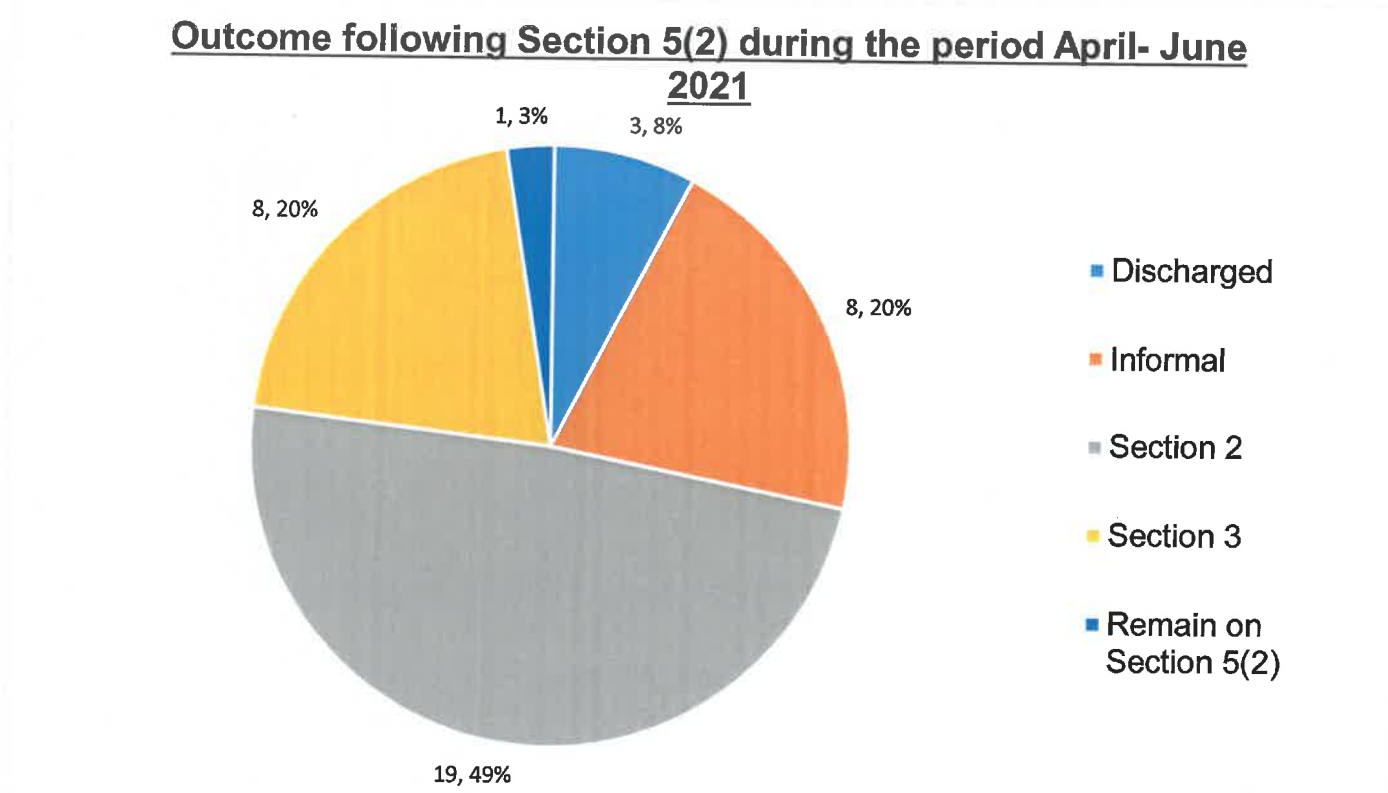


Section 5(2) - Doctors holding power

Legal Status Prior to Section 5(2) during the period April- June 2021



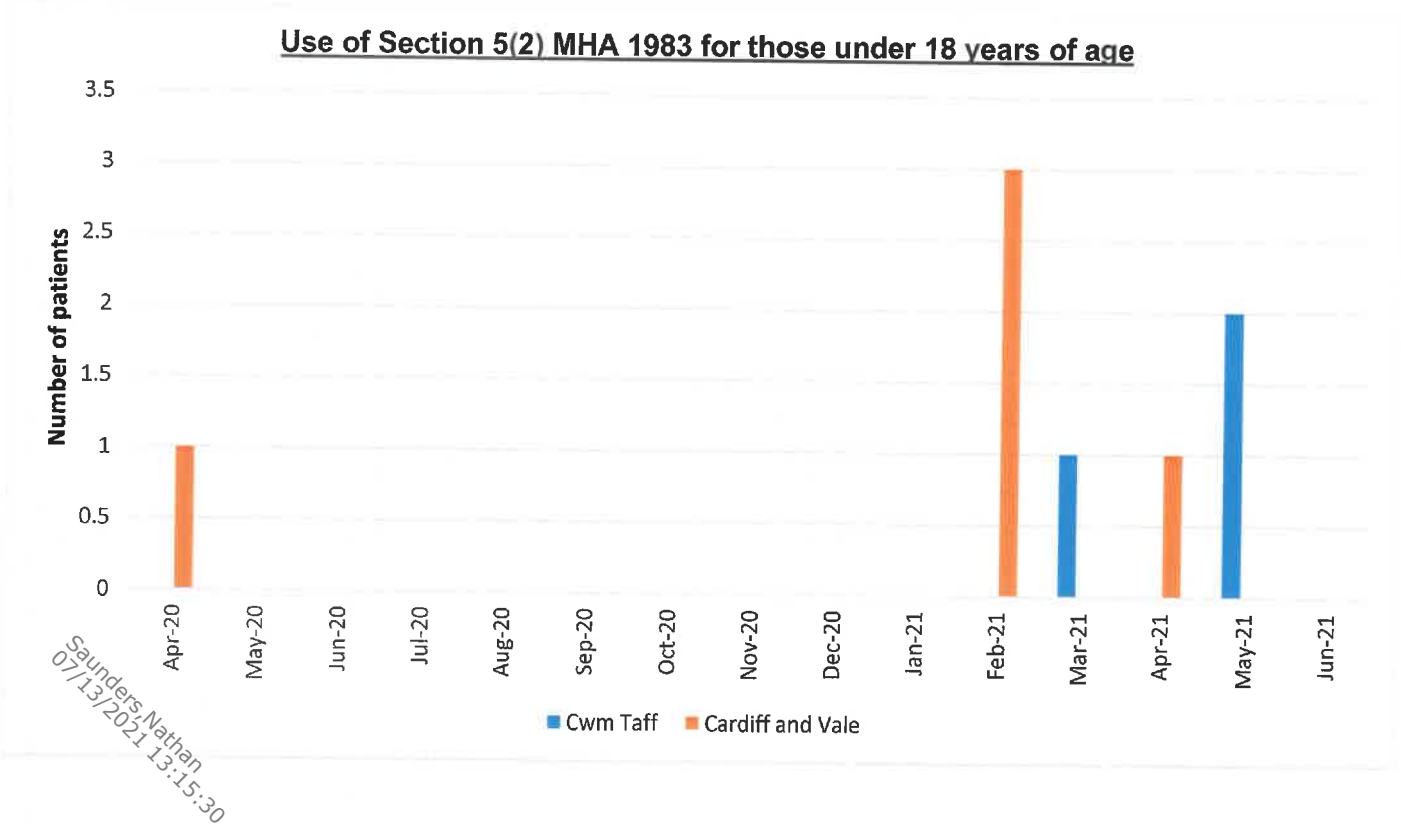


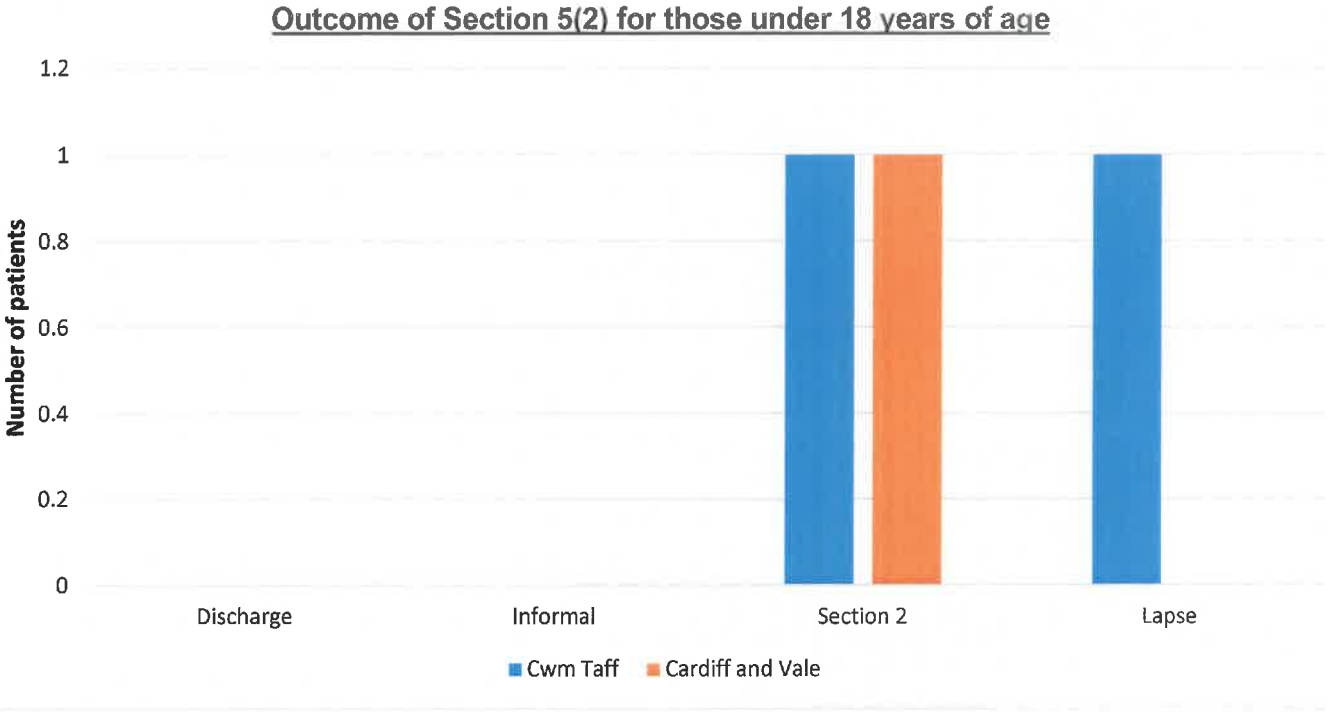


CAMHS Commissioned Inpatient Data

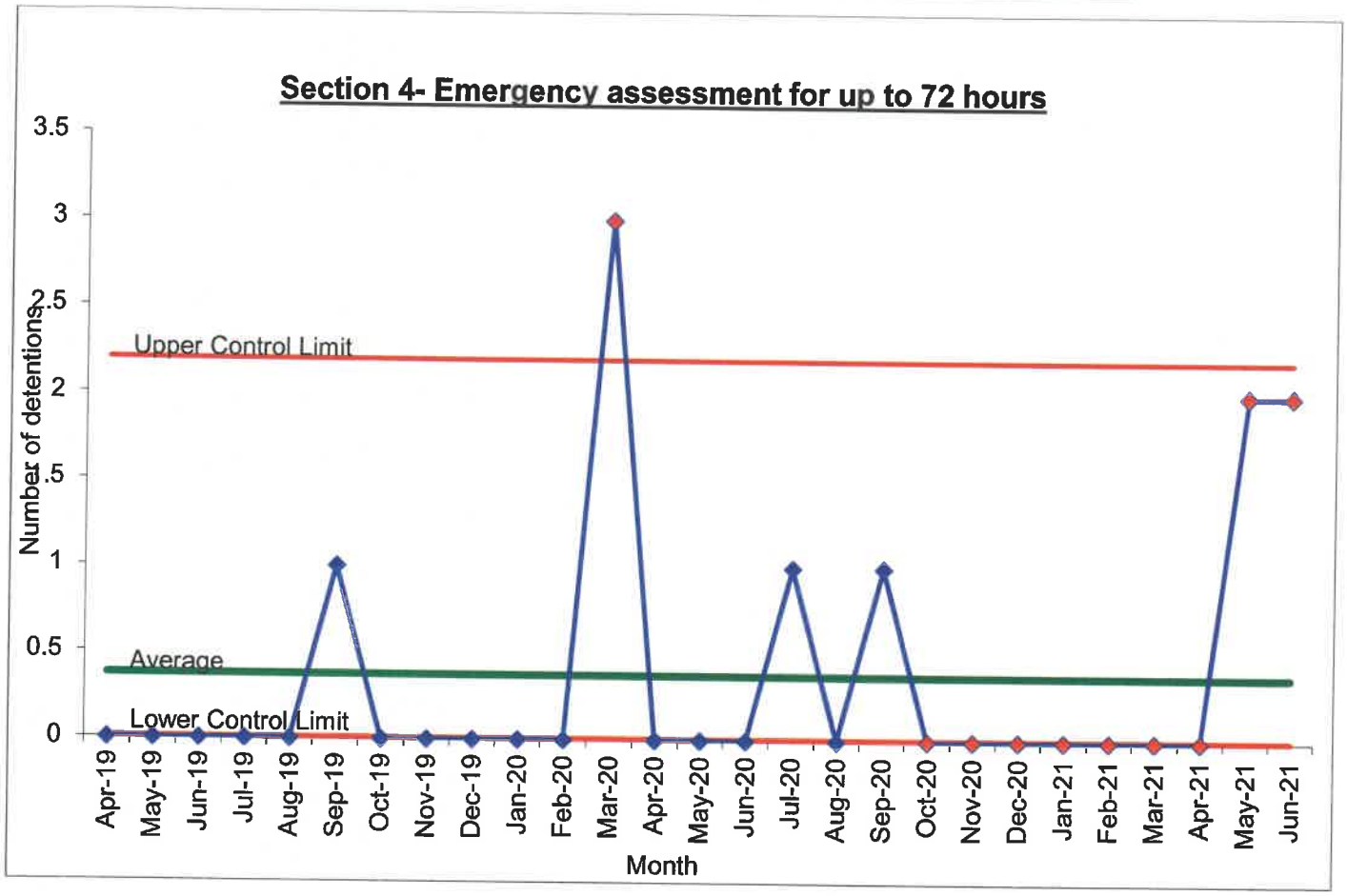
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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





Section 4 - Admission for Assessment in Cases of Emergency



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

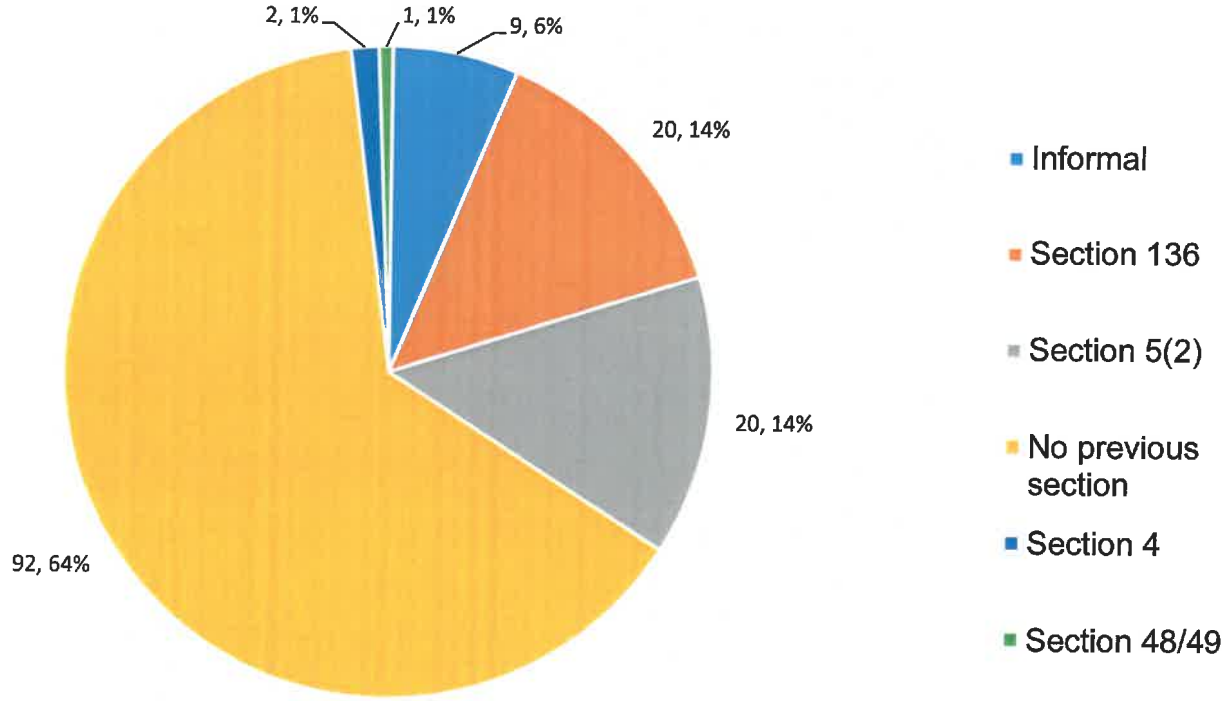
Two patients were detained under Section 2, one was made informal and one was discharged.

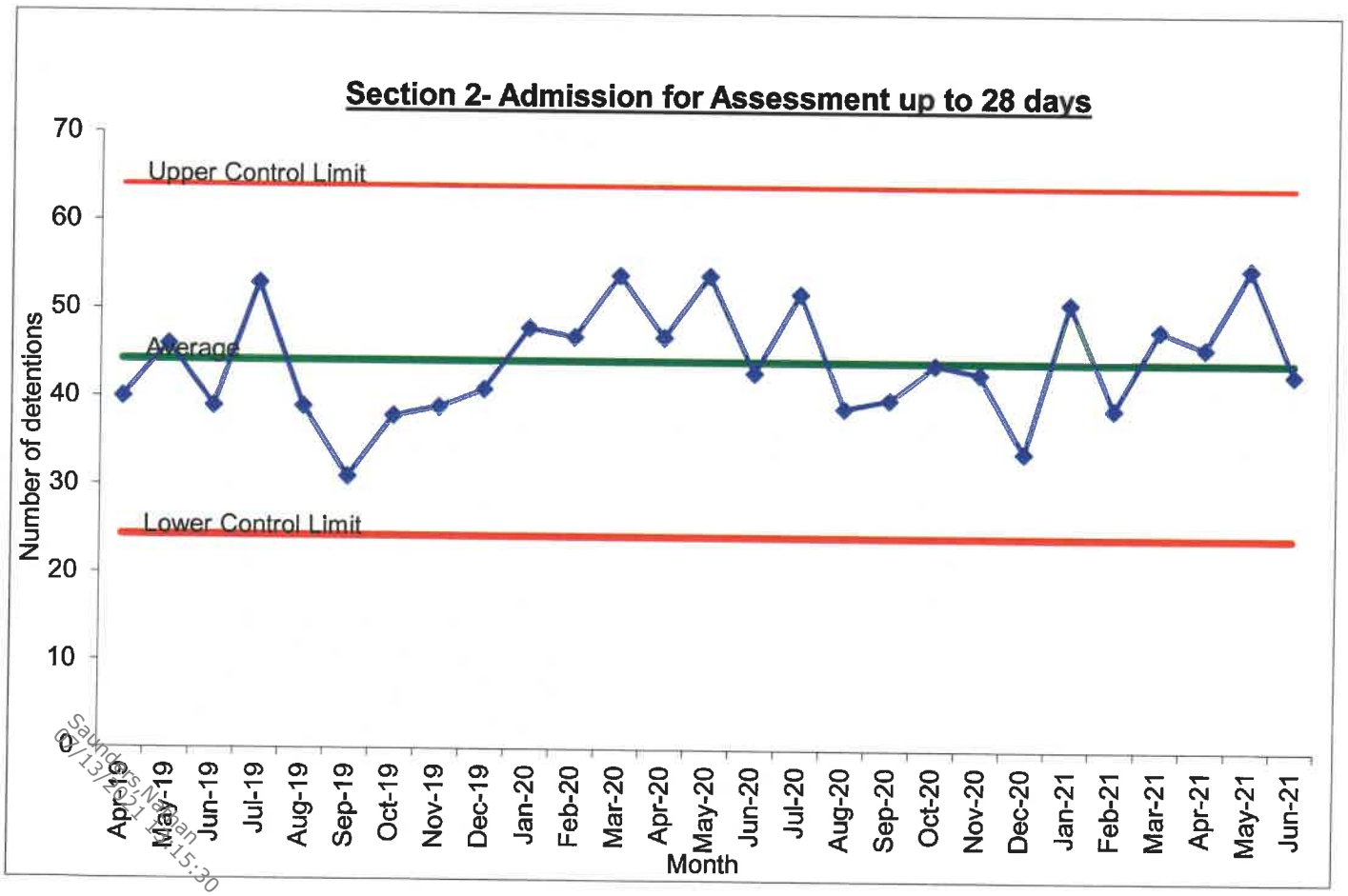
On all four occasions the AMHP was unable to obtain a section 12 doctor in less than a few hours which would result in a significant delay. Three out of the four assessments were conducted out of hours.

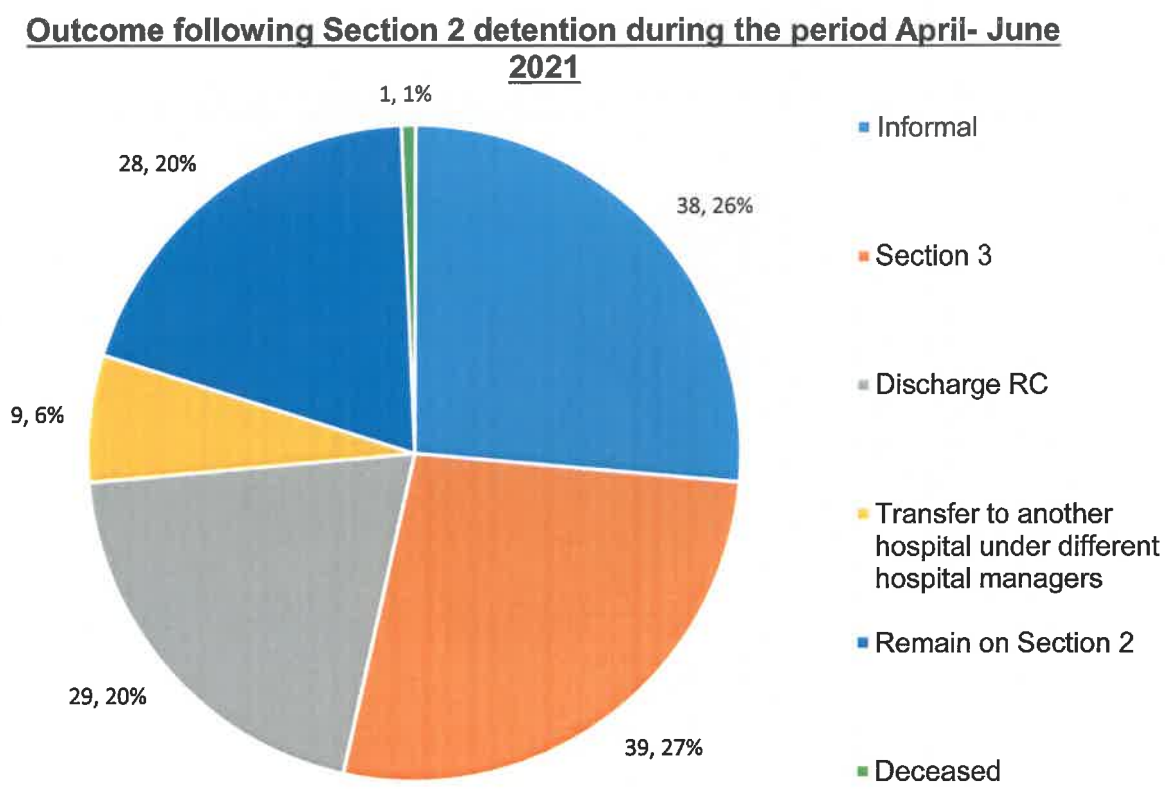
A shortage of section 12 doctors has been identified as an issue out of hours and is being investigated further by the Mental Health Clinical Board.

Section 2 – Admission for Assessment

Legal Status Prior to Section 2 during the period April- June 2021



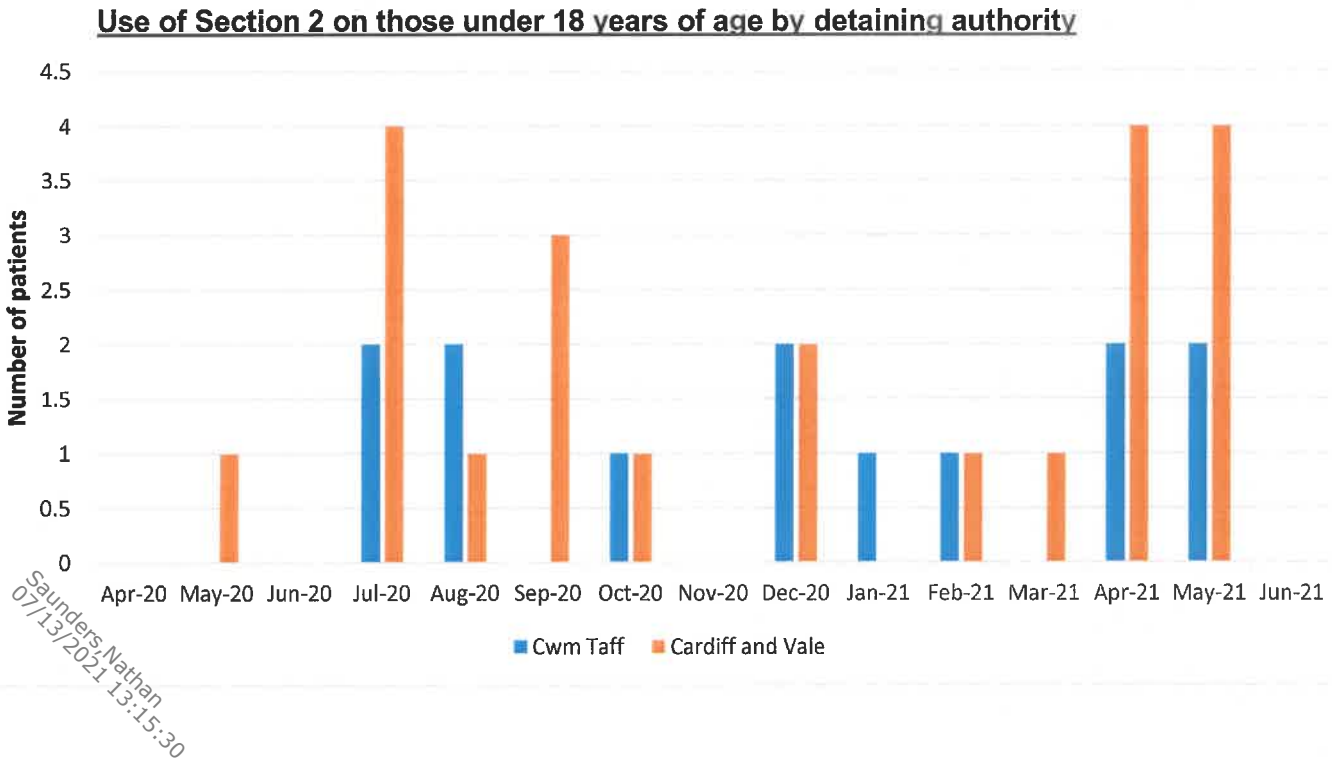


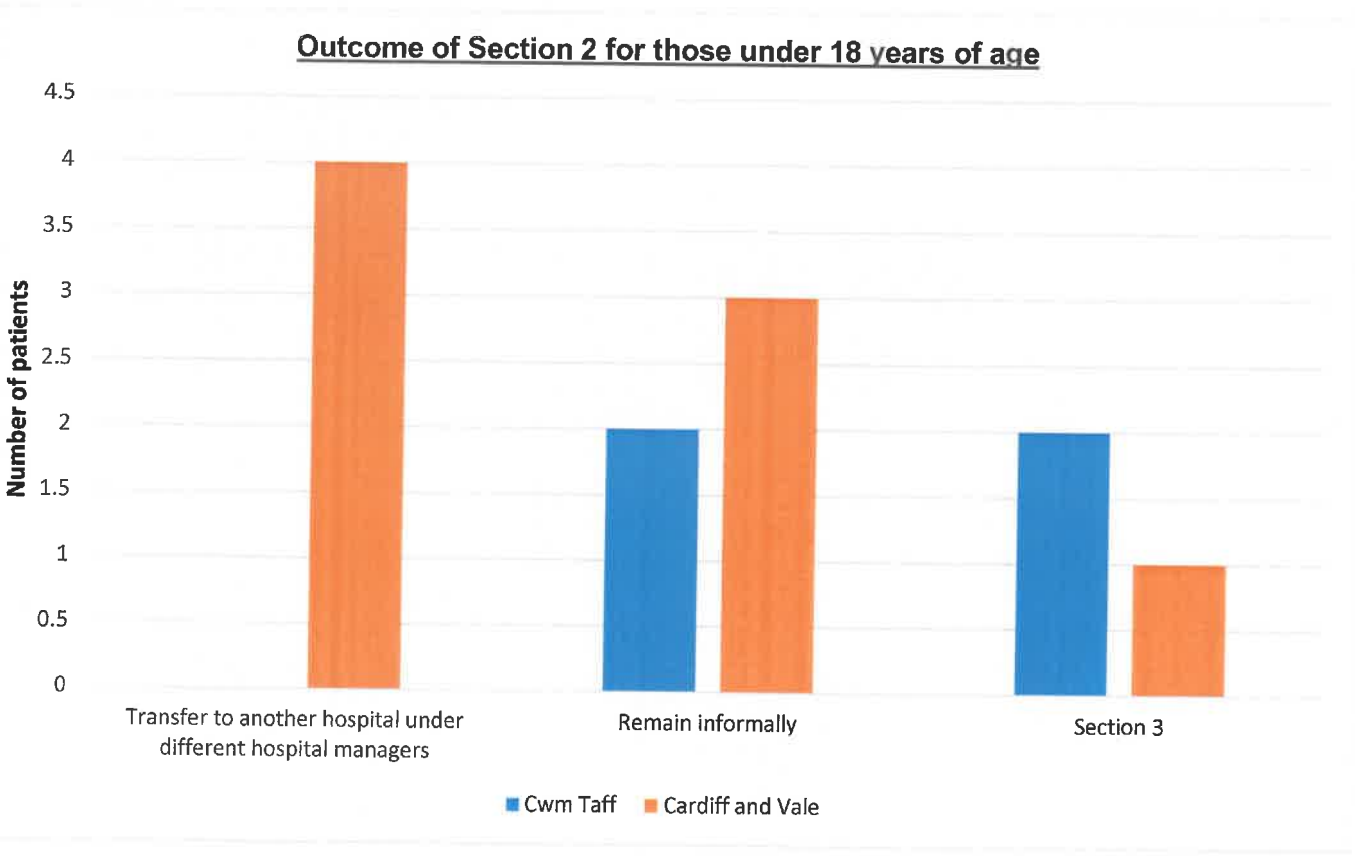


CAMHS Commissioned Inpatient Data

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

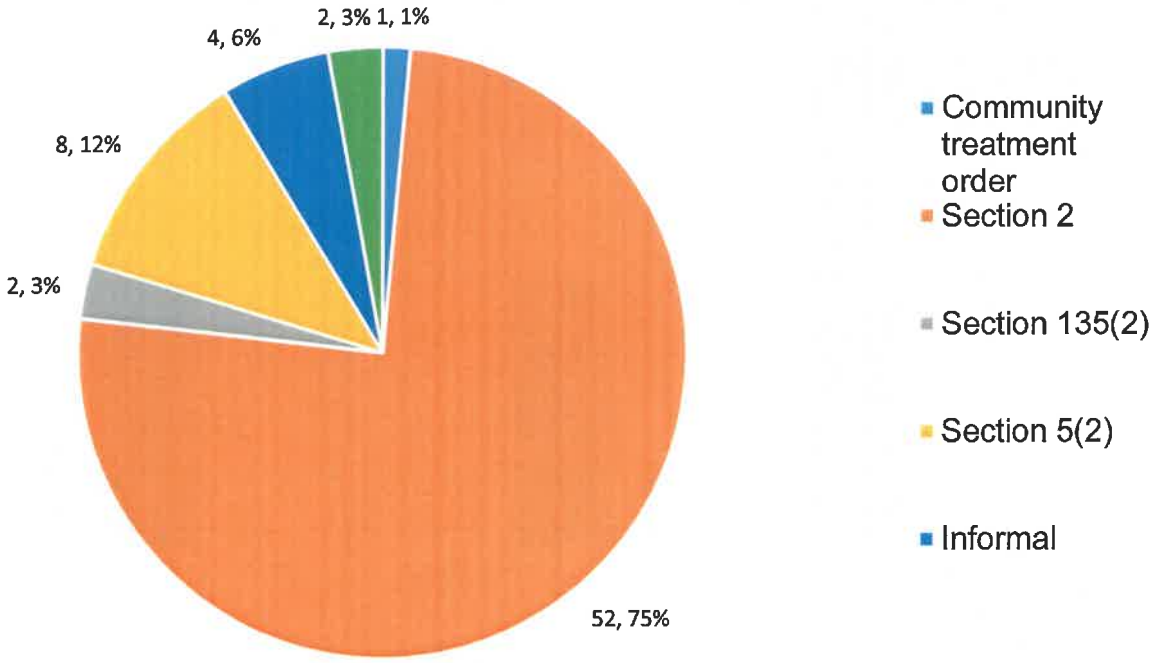
Included in the above data are those under 18 years of age. This is extracted below;-

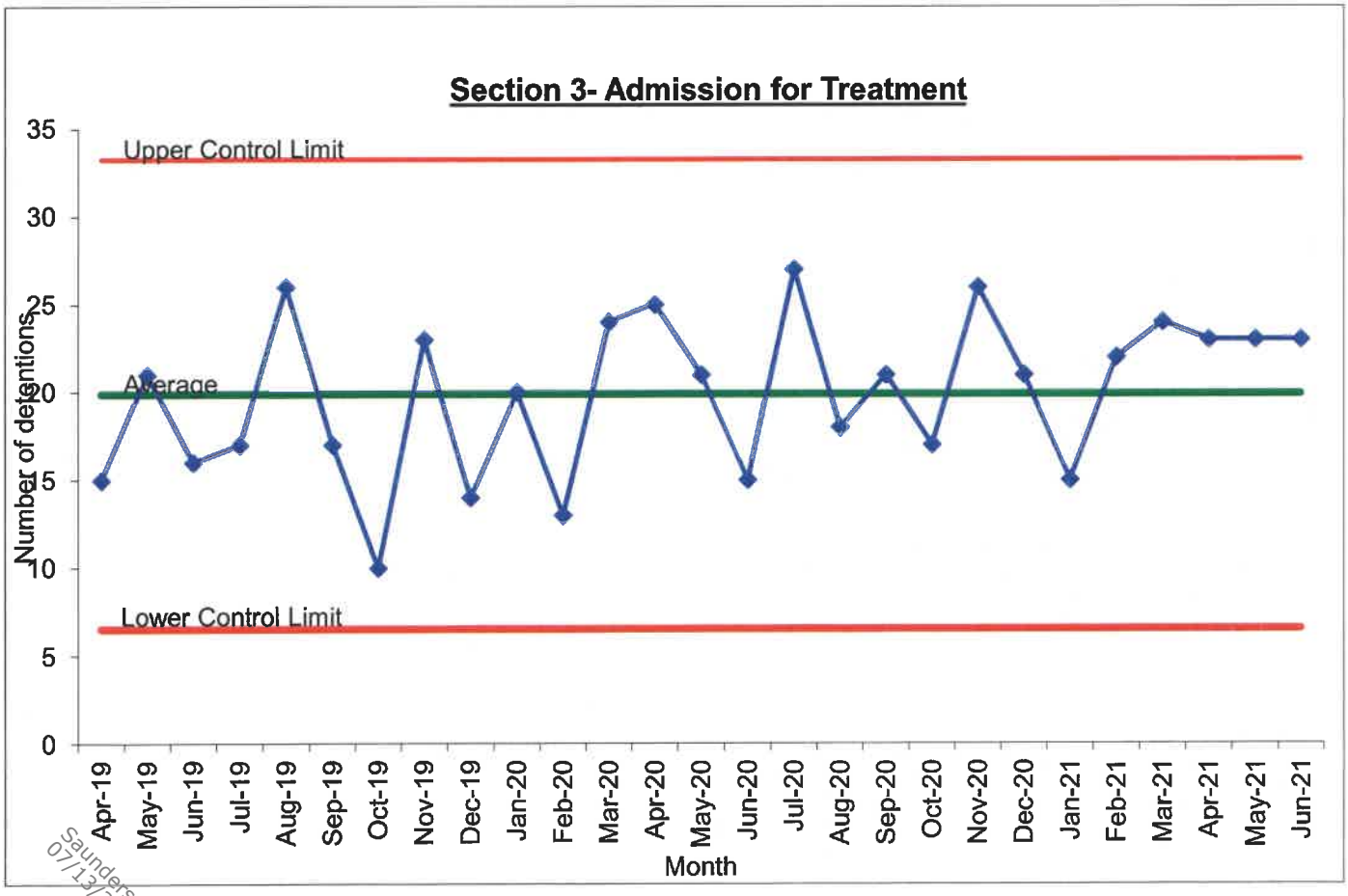


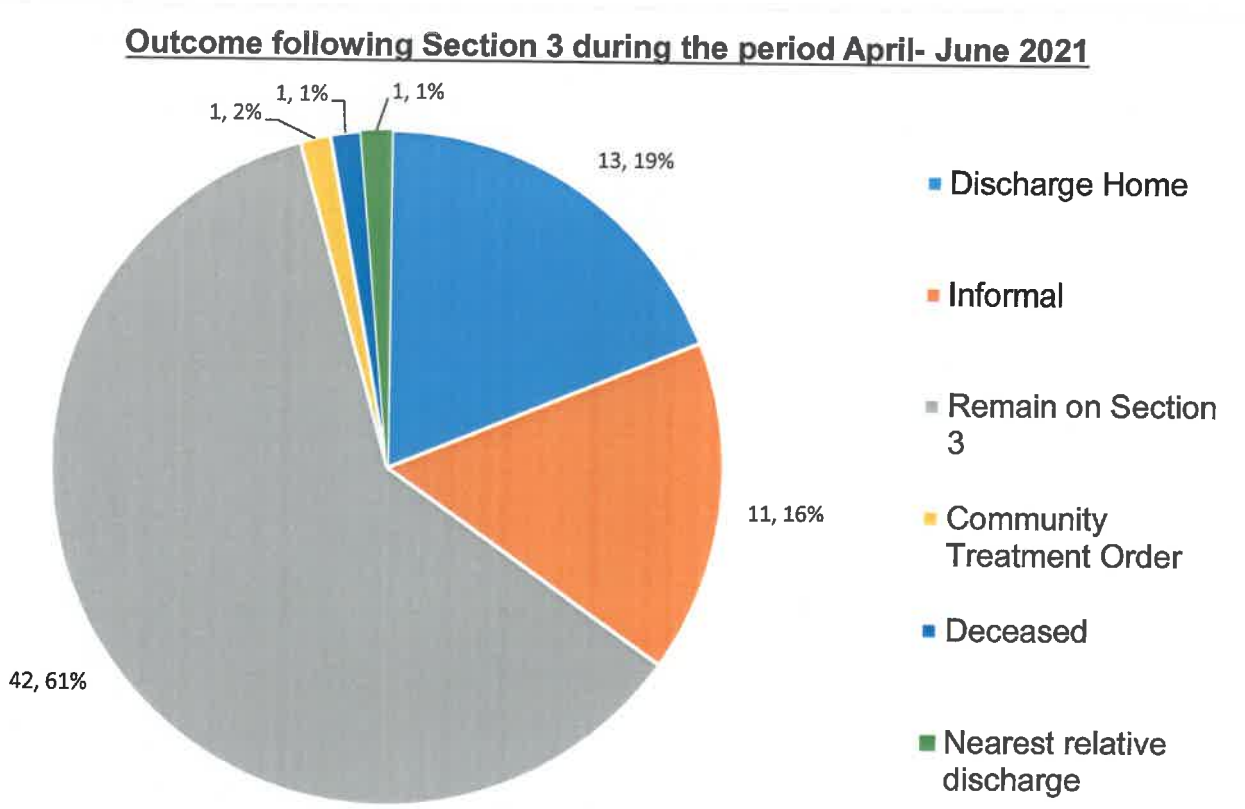


Section 3 – Admission for Treatment

Legal Status prior to Section 3 during the period April- June 2021

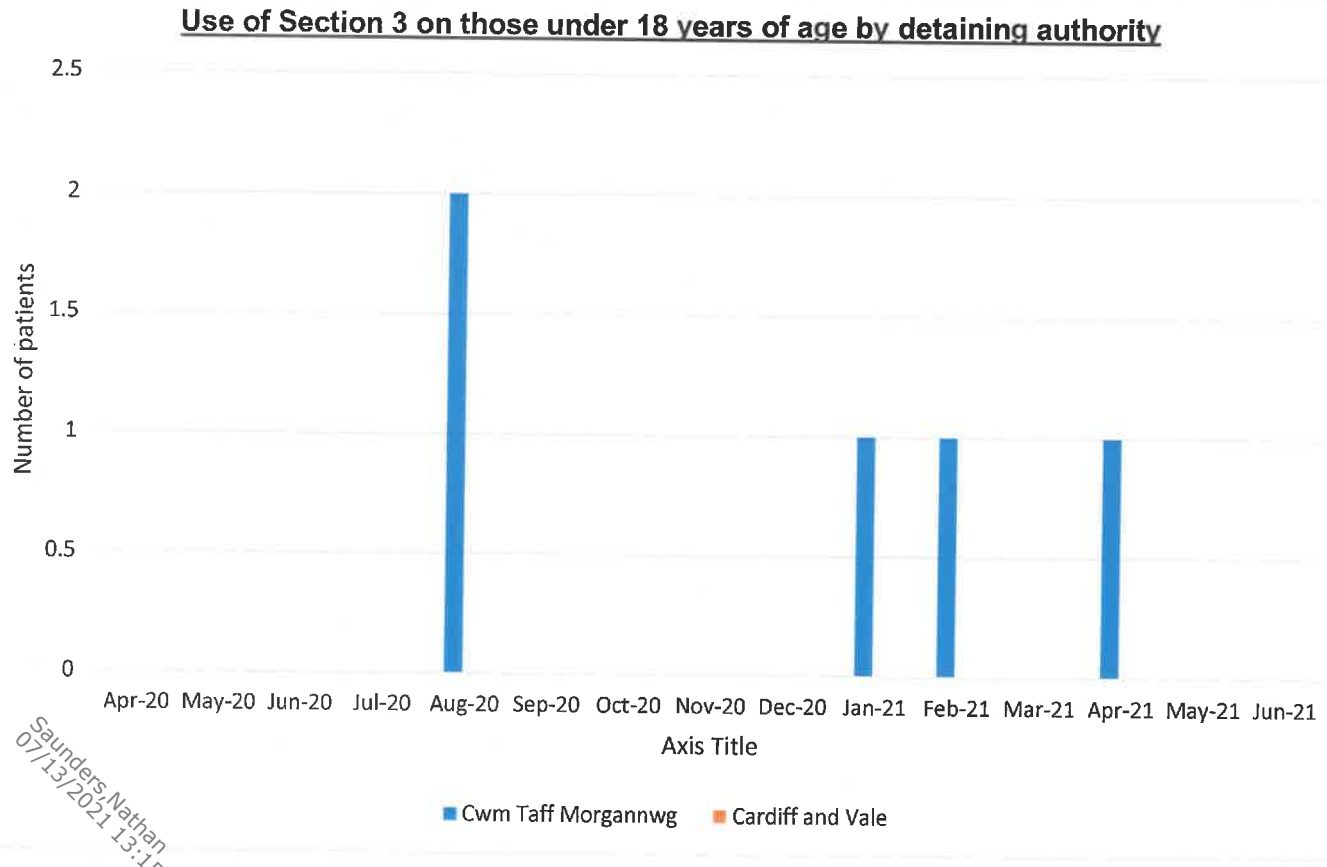




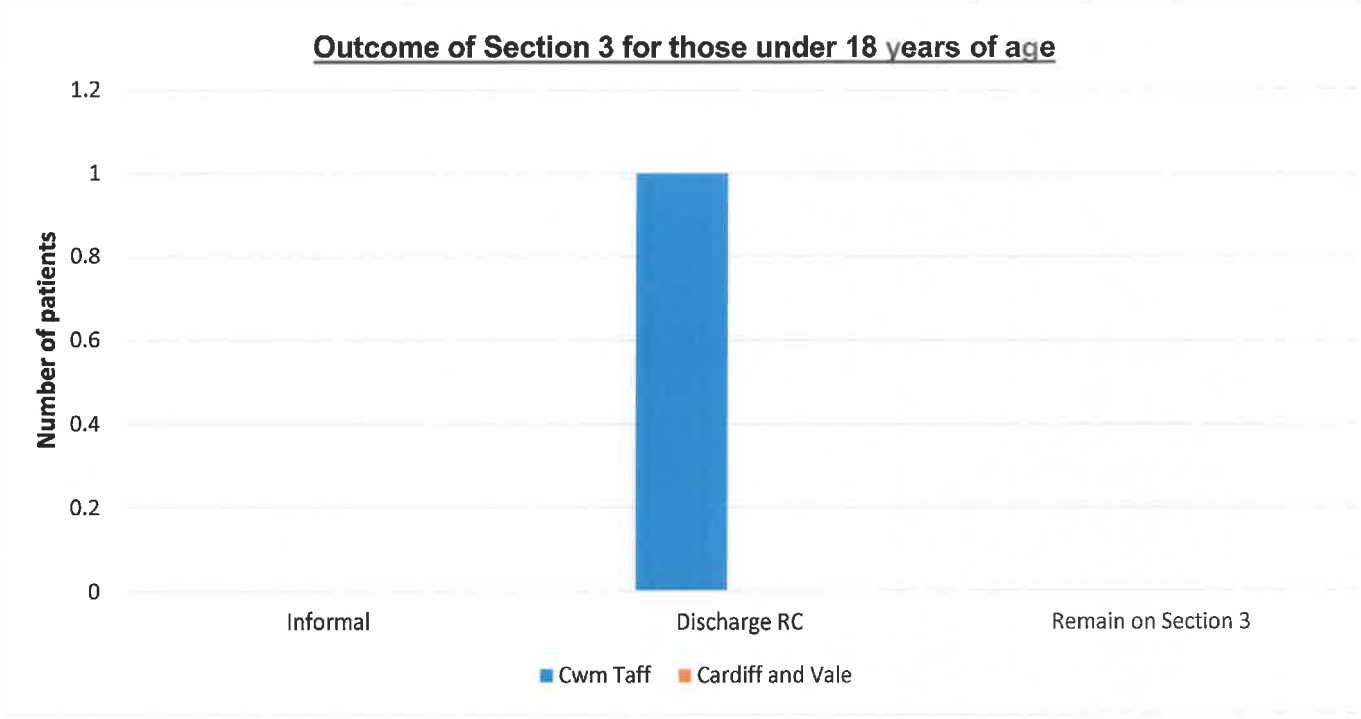


CAMHS Commissioned Inpatient Data

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



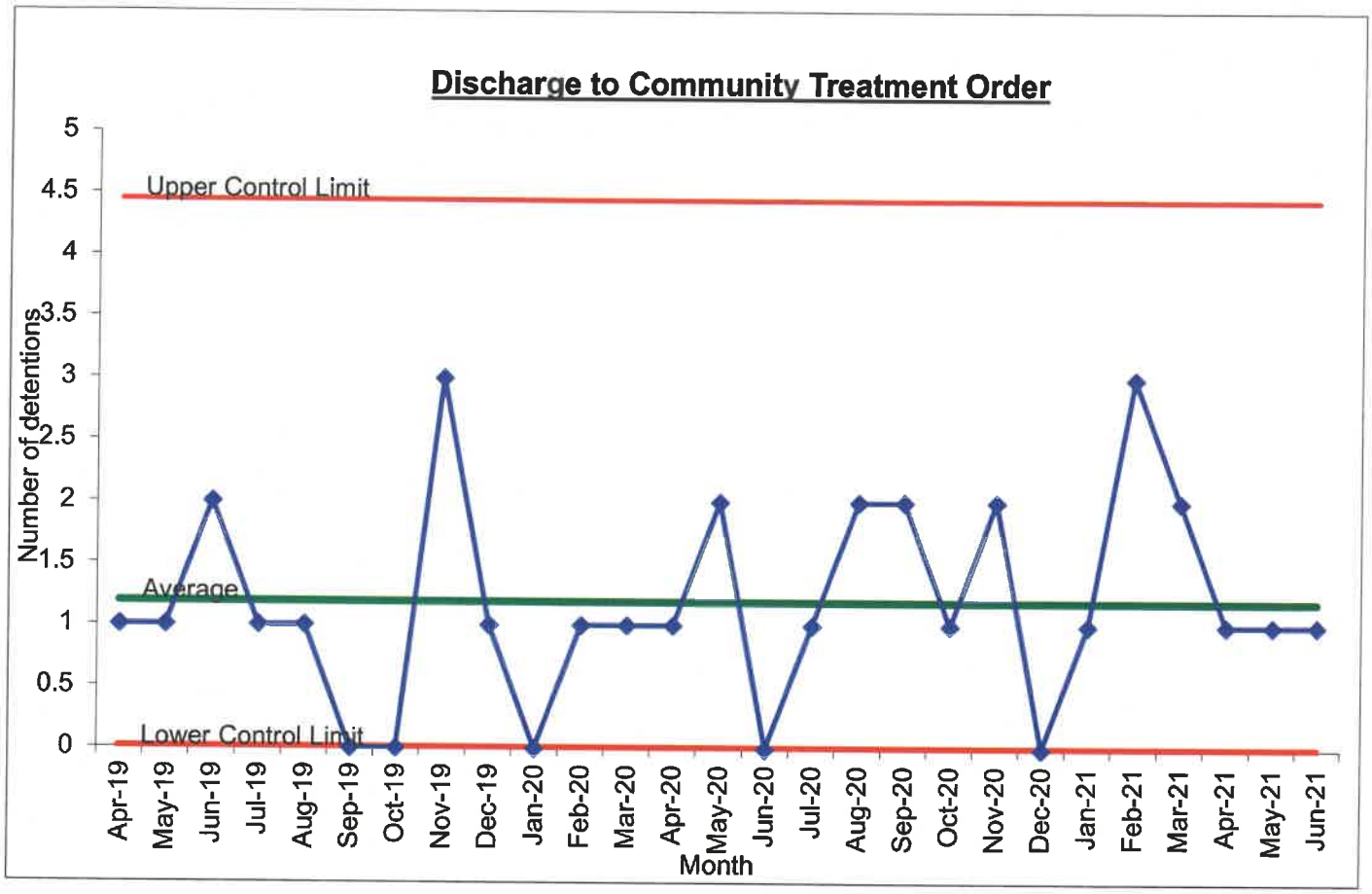
The above data would include those under 18 years of age.

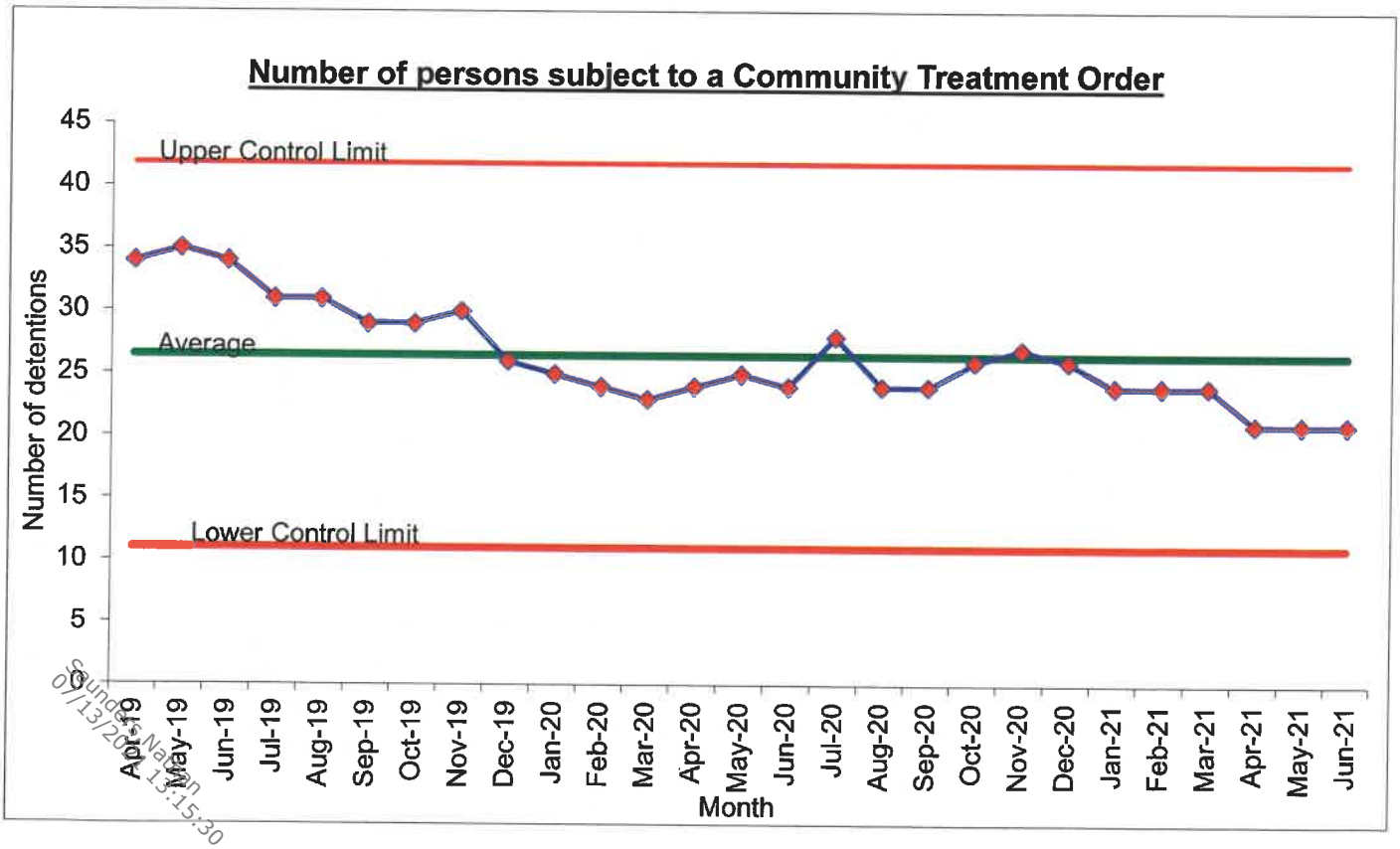


Community Treatment Order

During the period April- June 2021 three patients were discharged to Community Treatment Order.

As at 30 June 2021, 21 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 occasions. The patient's CTO was subsequently revoked.

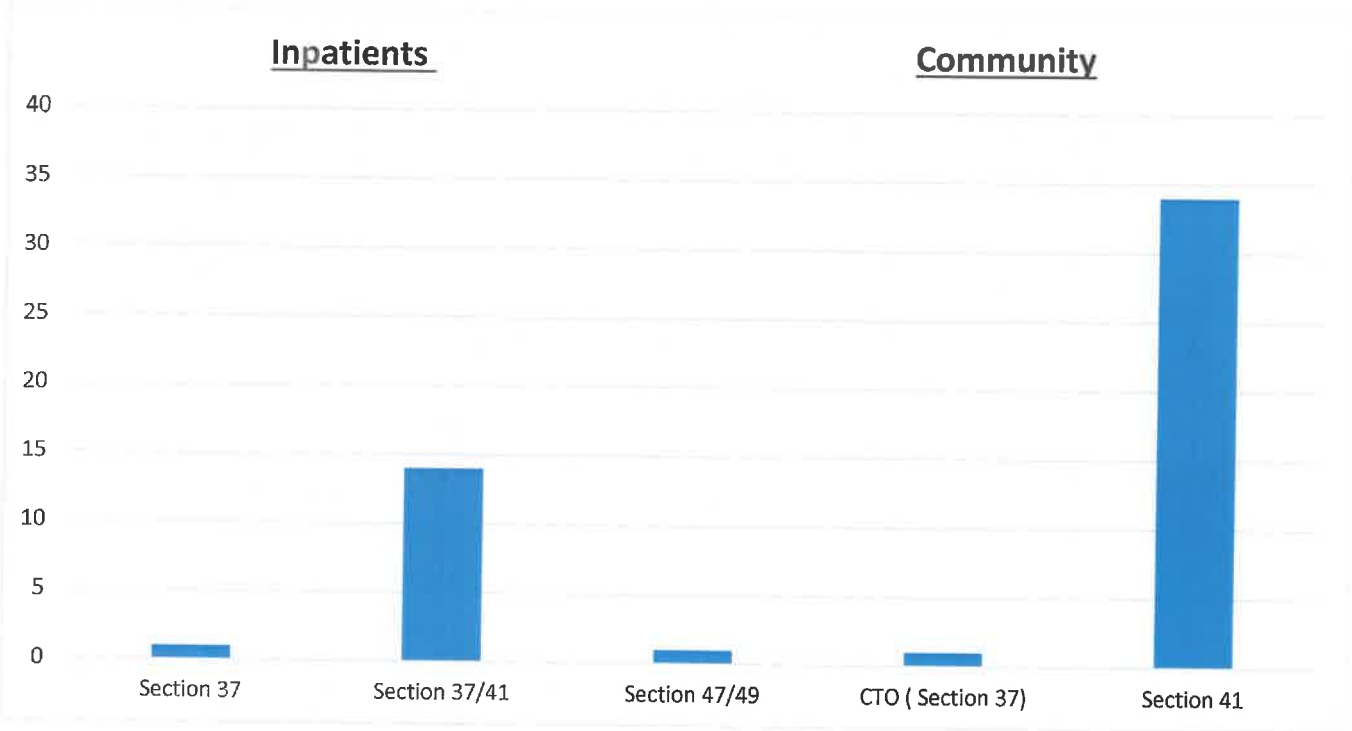
CAMHS Commissioned Inpatient Data

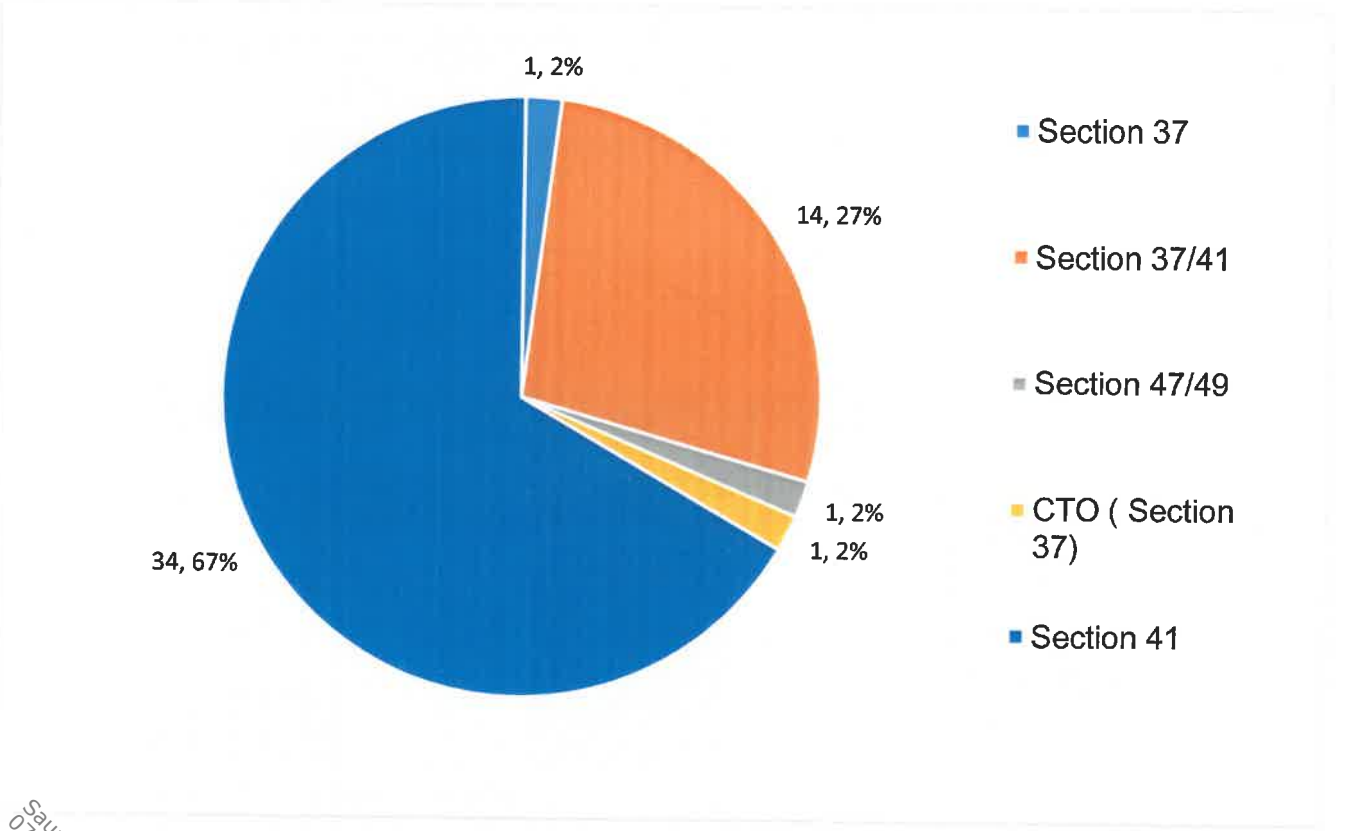
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

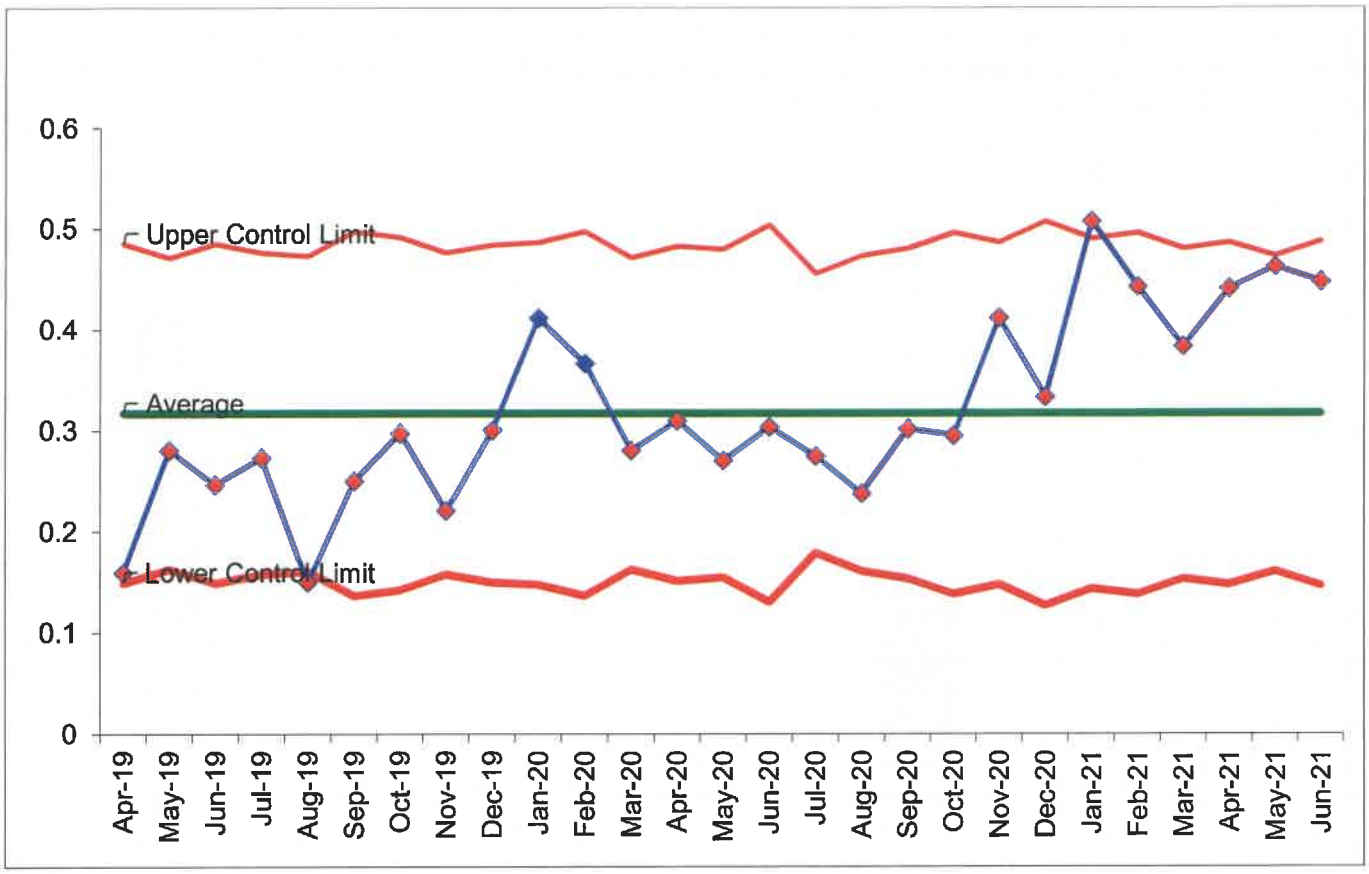
Part 3 of the Mental Health Act 1983

The number of Part 3 patient detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/Conditional Discharge in the community as at 30 June 2021.



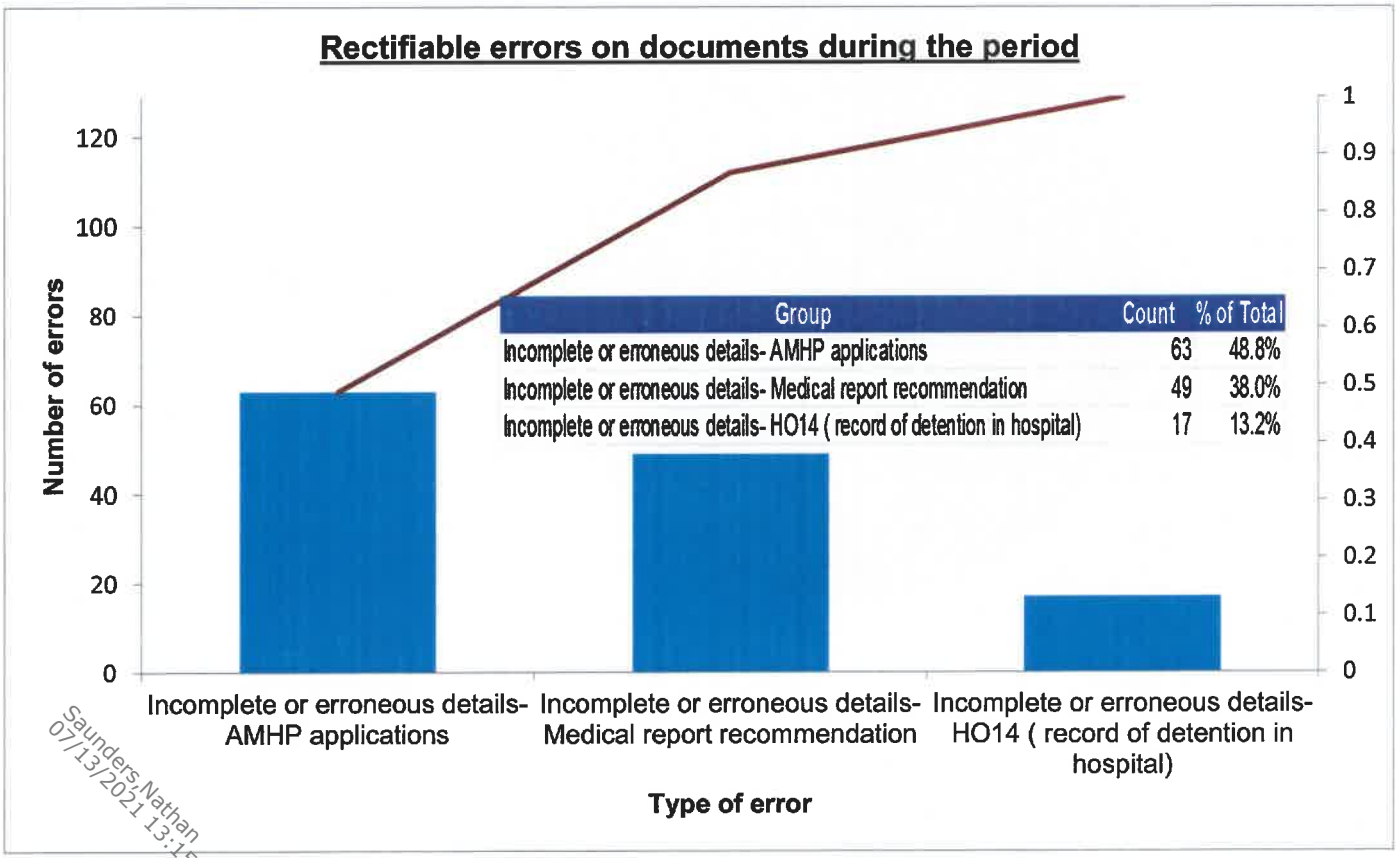


Scrutiny of documents during the period

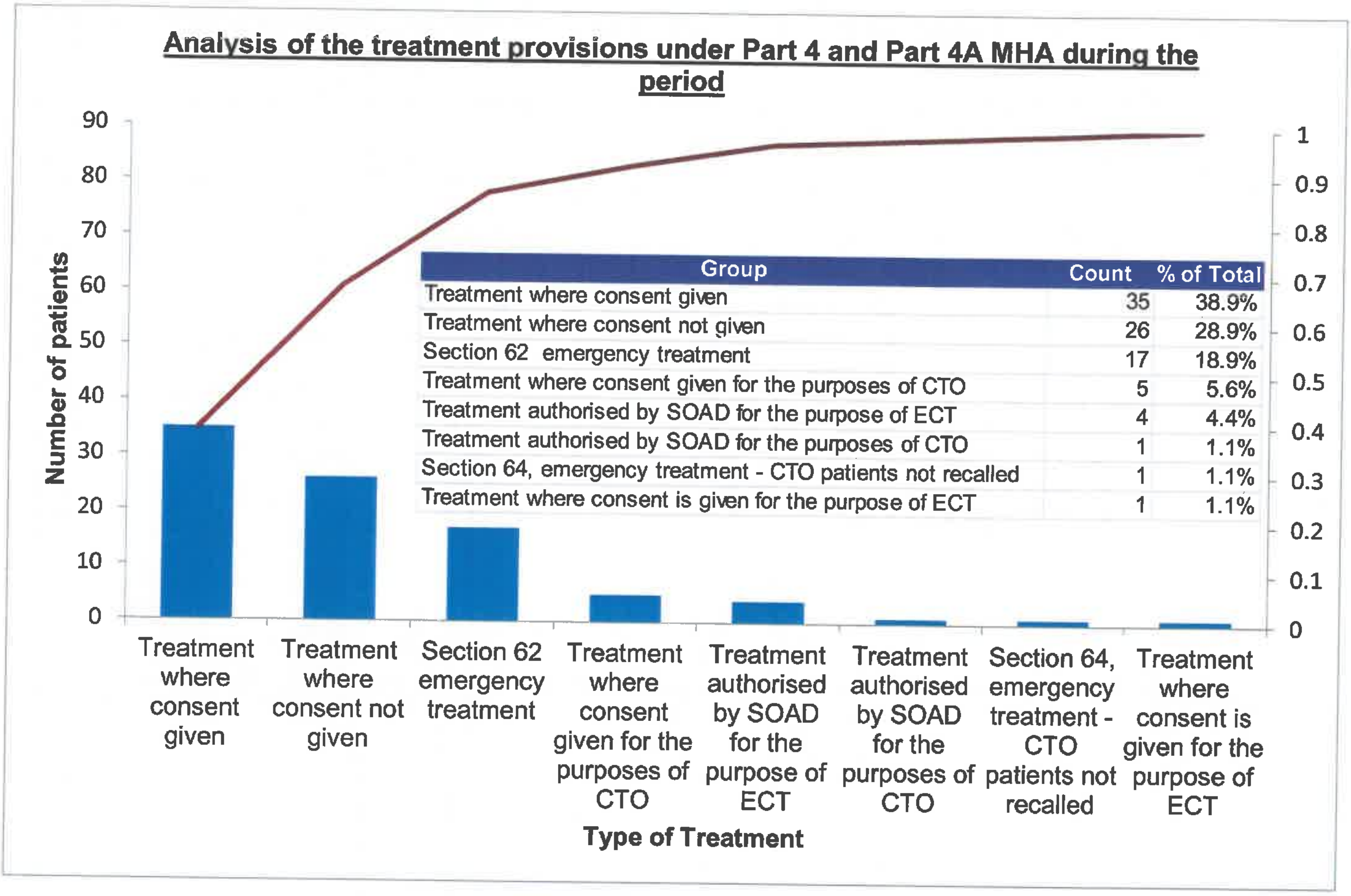


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.

Rectifiable errors on documents during the period



Saunders,Nathan 07/13/2021 13:15:30



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:

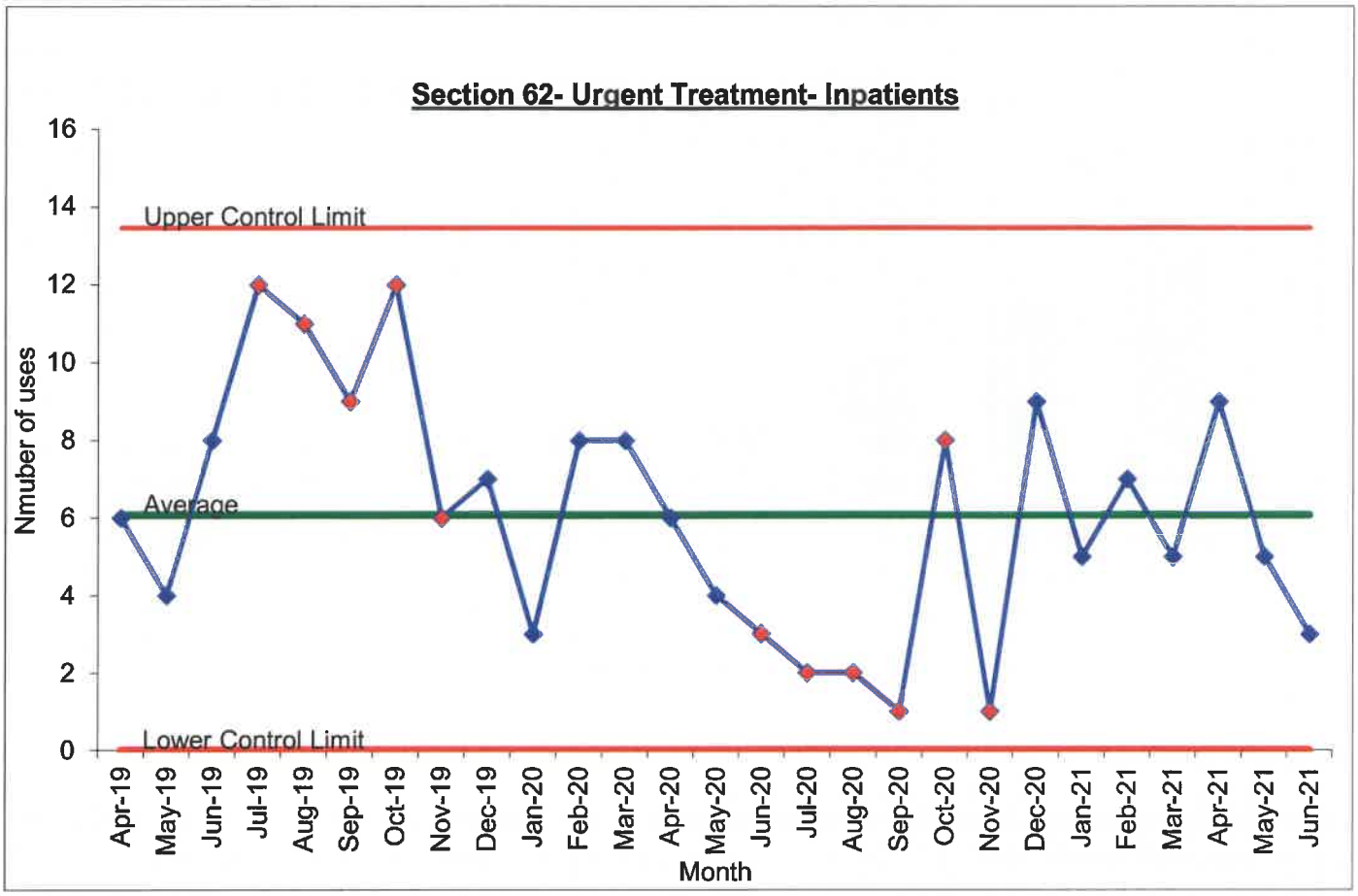
- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That 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:

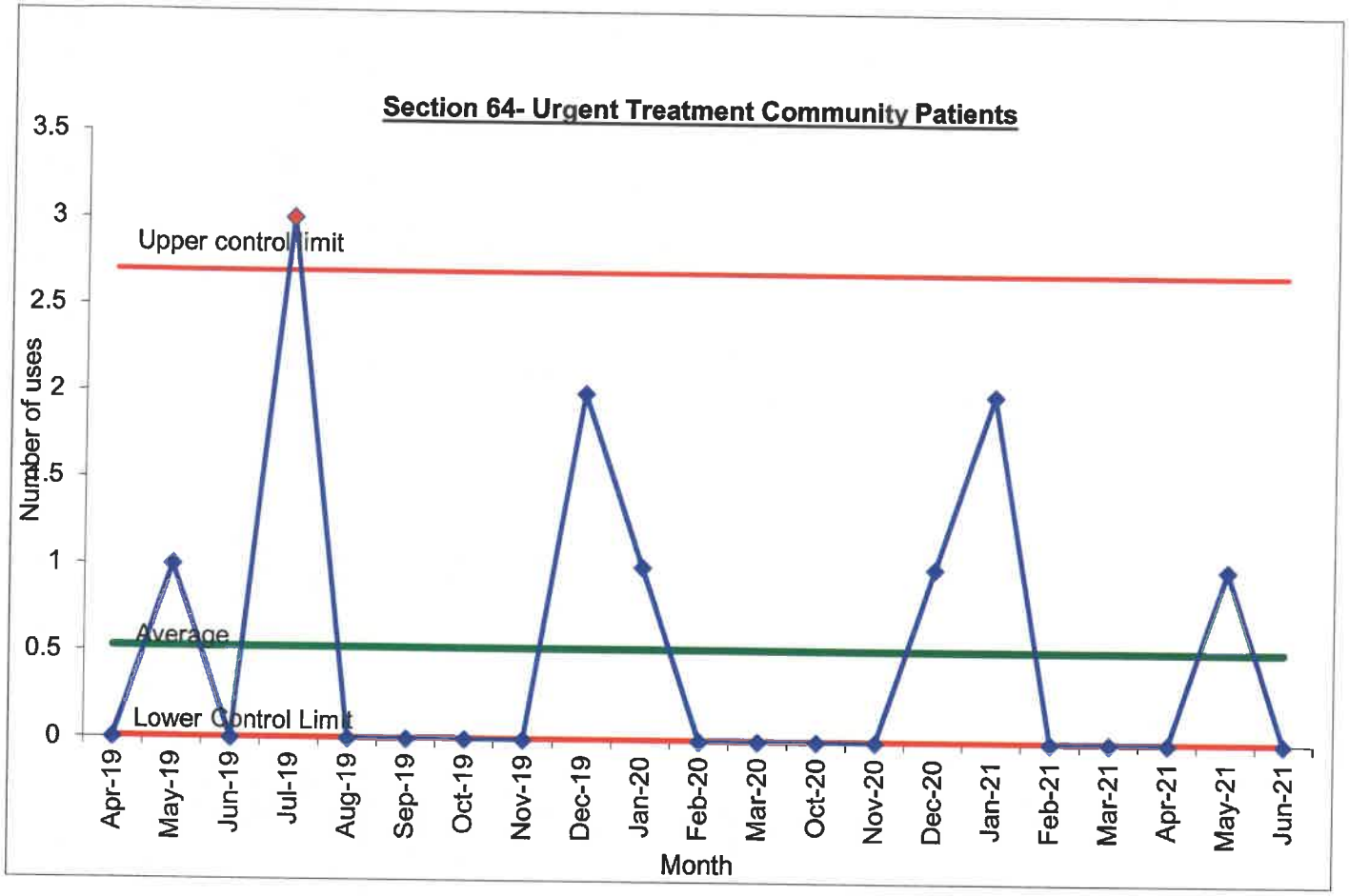
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.

- 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 seventeen occasions for the following reasons:

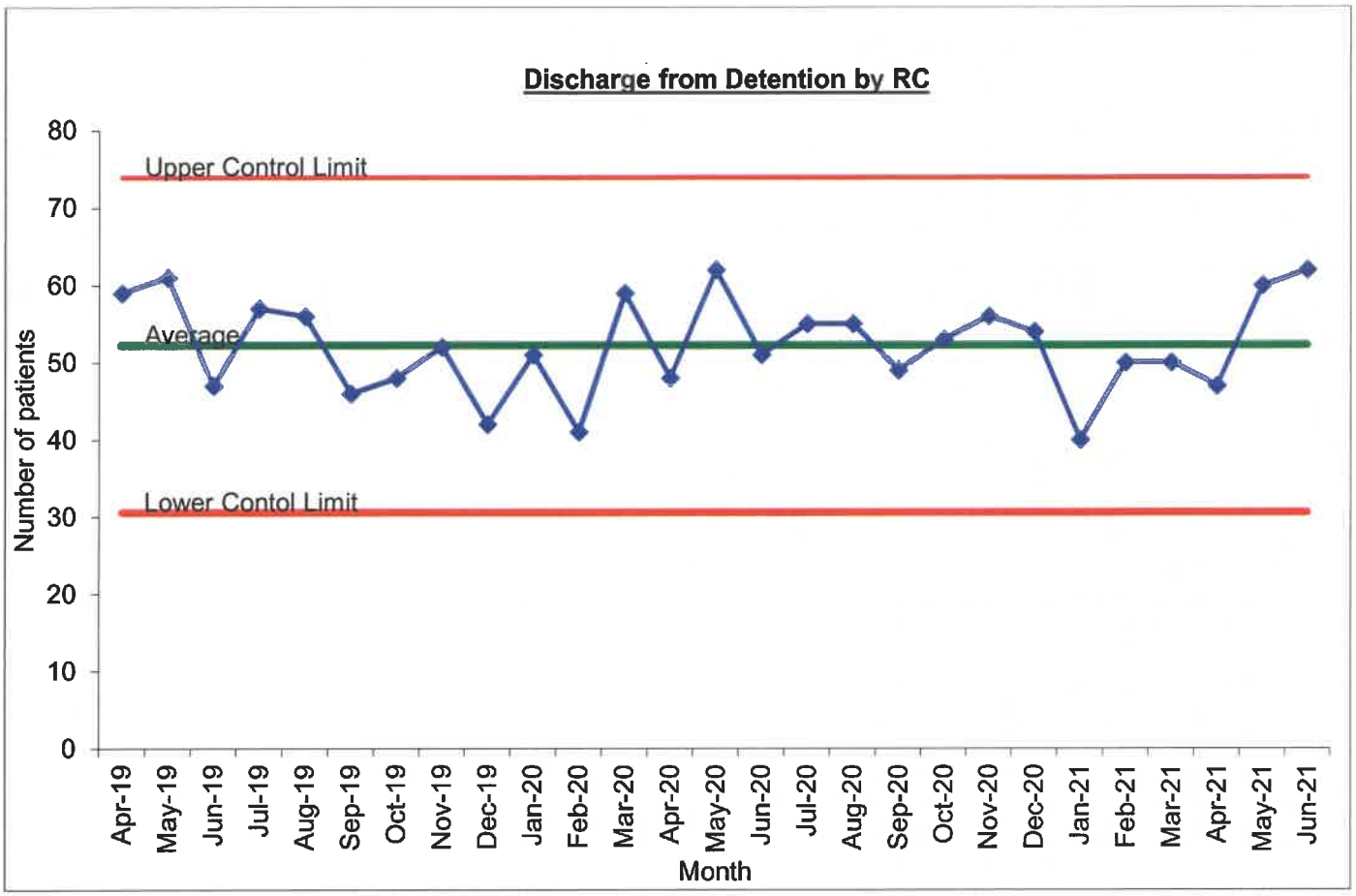
- Pending SOAD – 3 month rule x 9
- Change of capacity to consent x 4
- CTO Revoke x 1
- Awaiting new certificate due to time limited certificate x 1
- Change of medication x 2

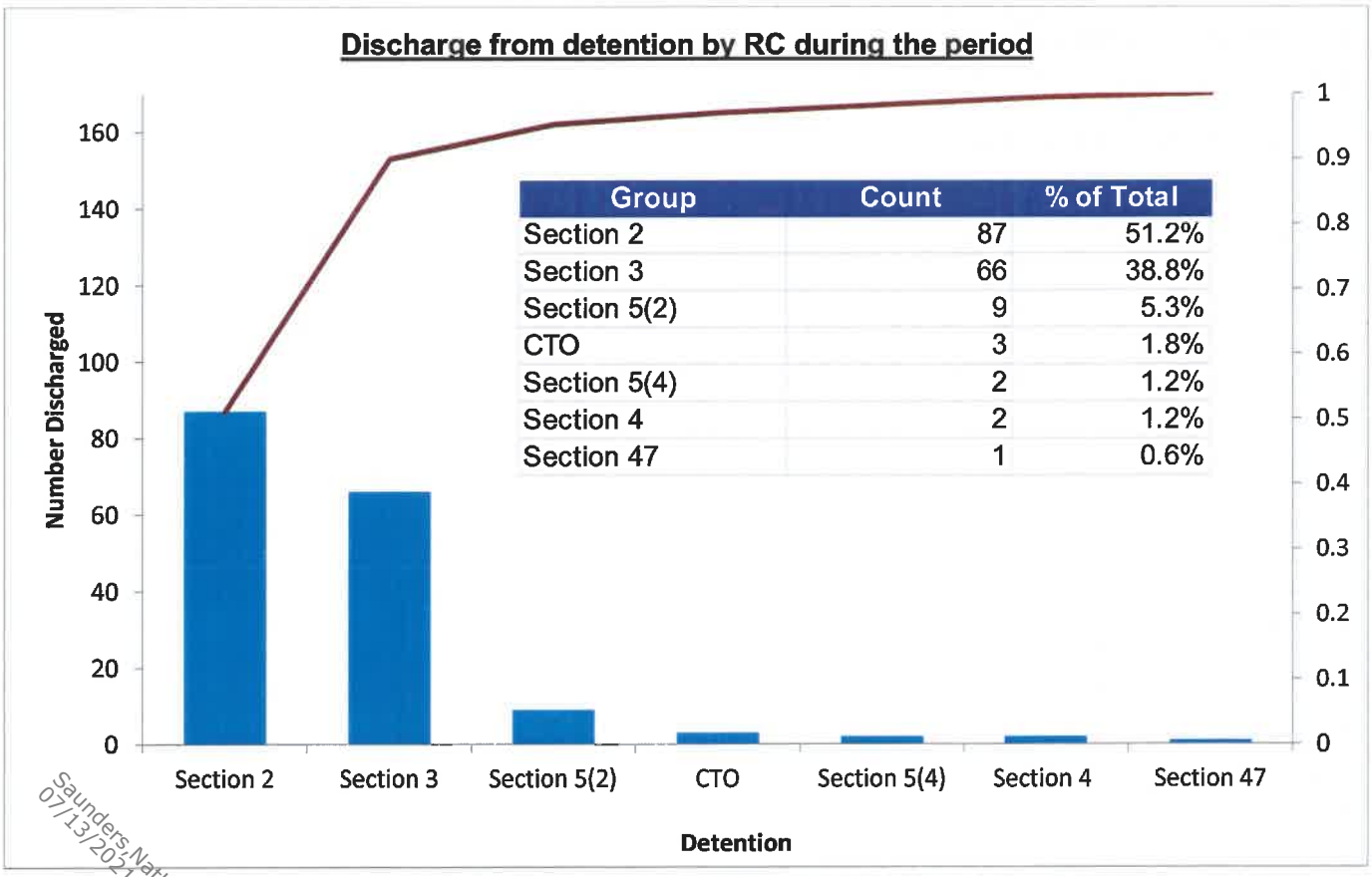


The above chart highlights that Section 64 was used on one occasion during the period for following reasons:

- Change of capacity x 1

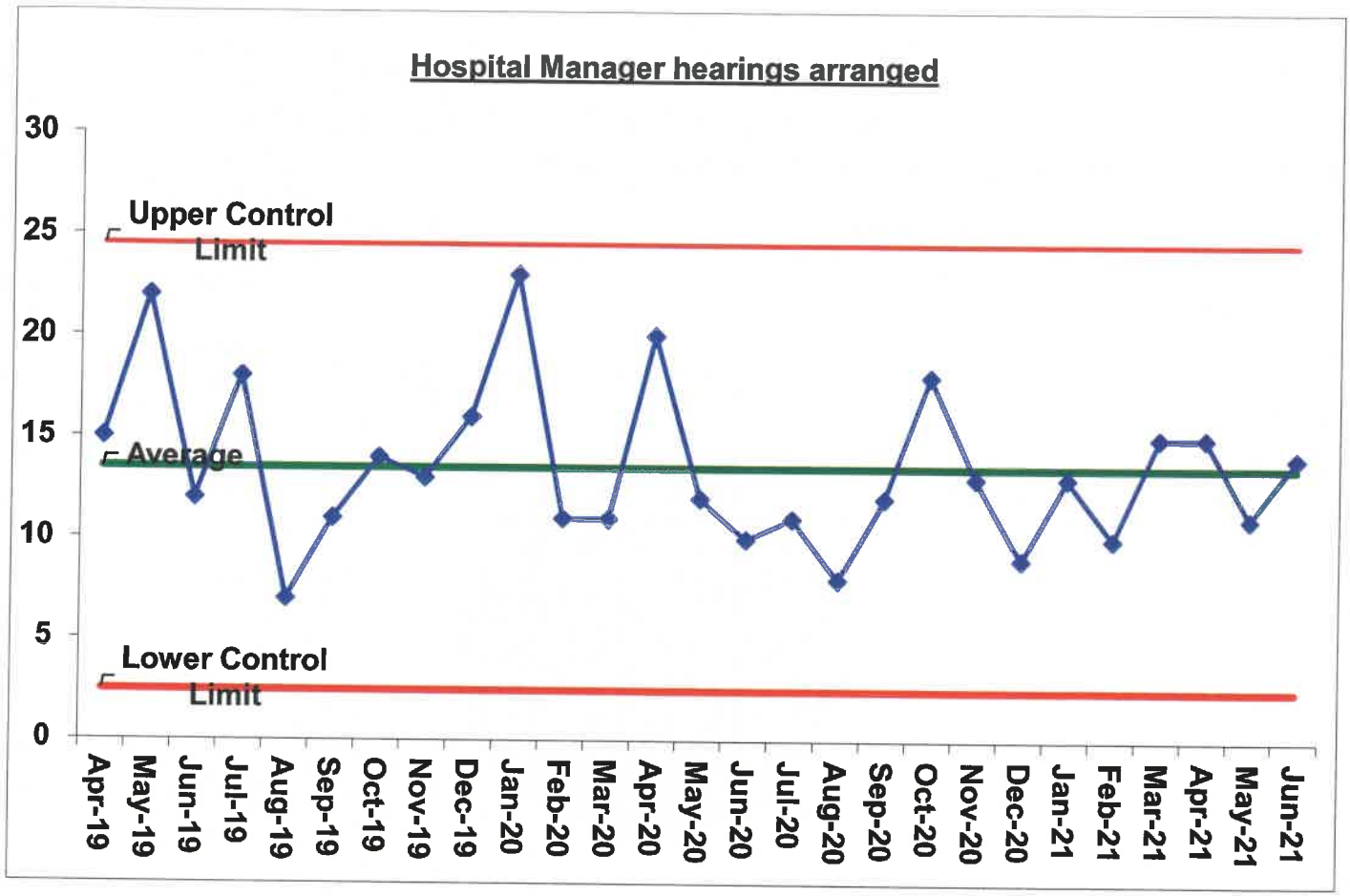
Discharge

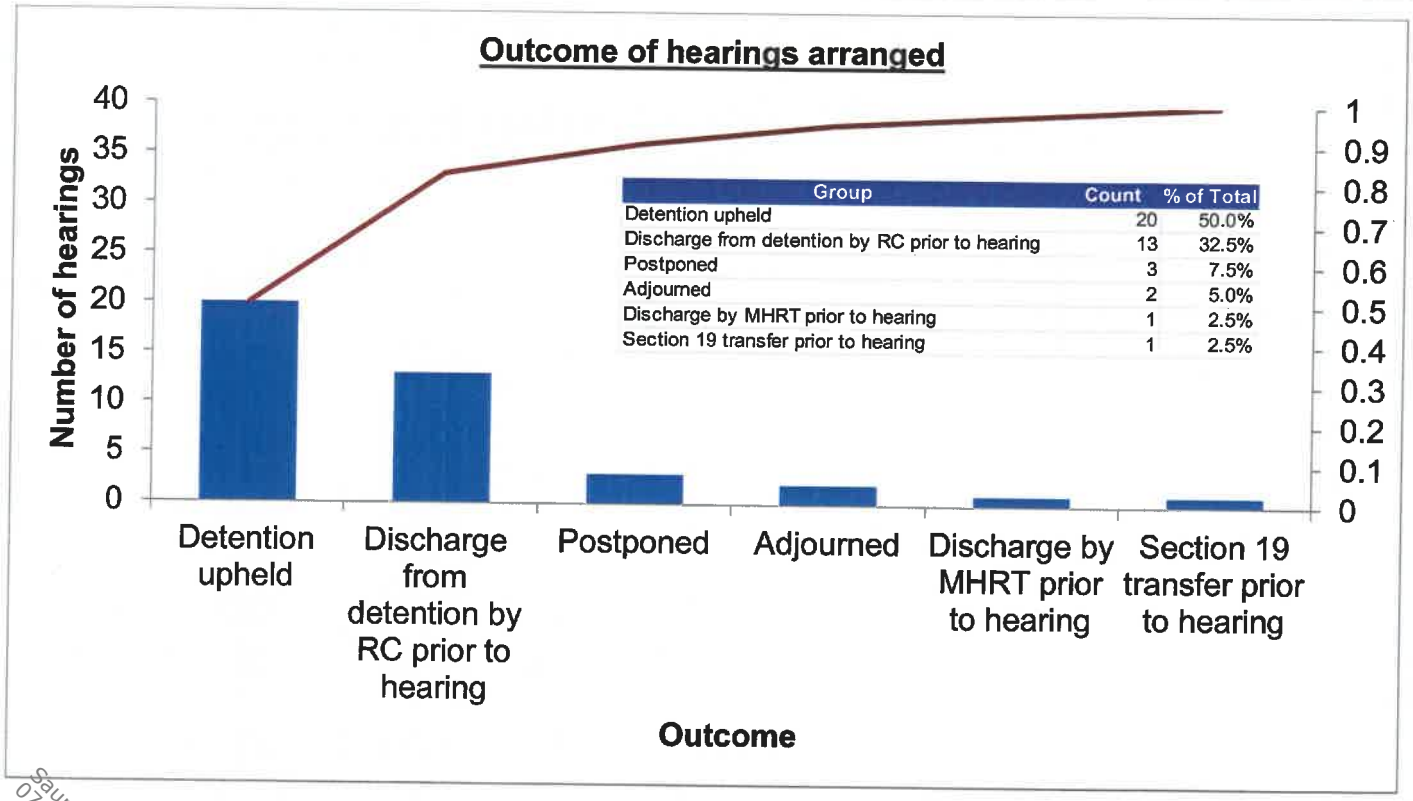




Group	Count	% of Total
Section 2	87	51.2%
Section 3	66	38.8%
Section 5(2)	9	5.3%
CTO	3	1.8%
Section 5(4)	2	1.2%
Section 4	2	1.2%
Section 47	1	0.6%

Hospital Managers – Power of Discharge





Group	Count	% of Total
Detention upheld	20	50.0%
Discharge from detention by RC prior to hearing	13	32.5%
Postponed	3	7.5%
Adjourned	2	5.0%
Discharge by MHRT prior to hearing	1	2.5%
Section 19 transfer prior to hearing	1	2.5%

Two hearings were adjourned for the following reasons:

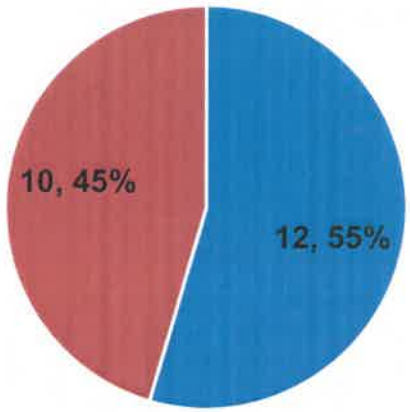
- Nearest relative unable to connect
- Further information required and Responsible Clinician required to attend

Three hearings were postponed for the following reasons:

- Discharge discussion required
- Medical report not available in time for the hearing

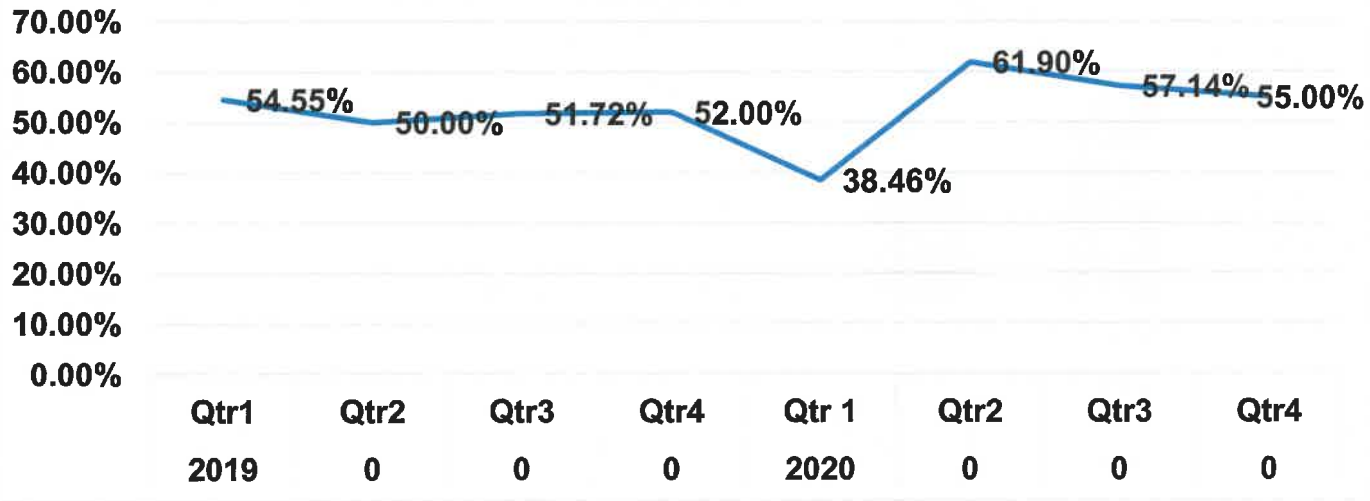
Social Worker unavailable

Number of patients represented by Advocacy Support Cymru



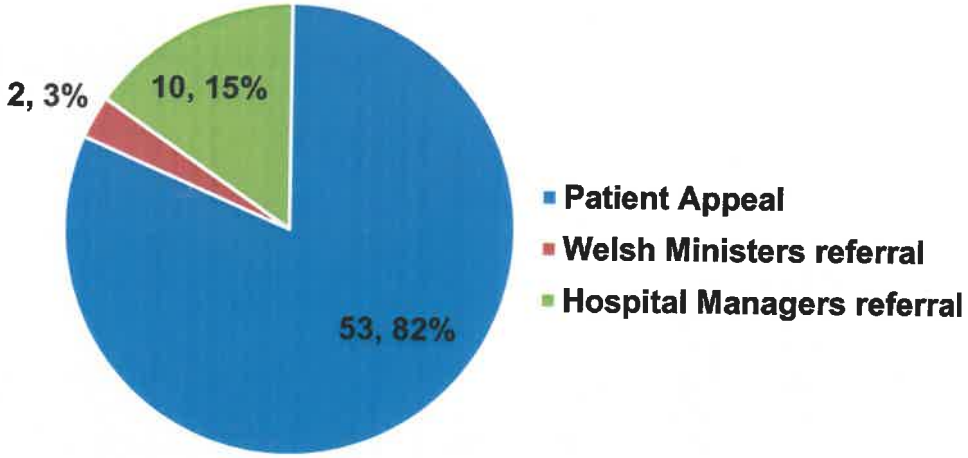
Advocate present Advocate not present

Percentage with Independant Mental Health Advocate present

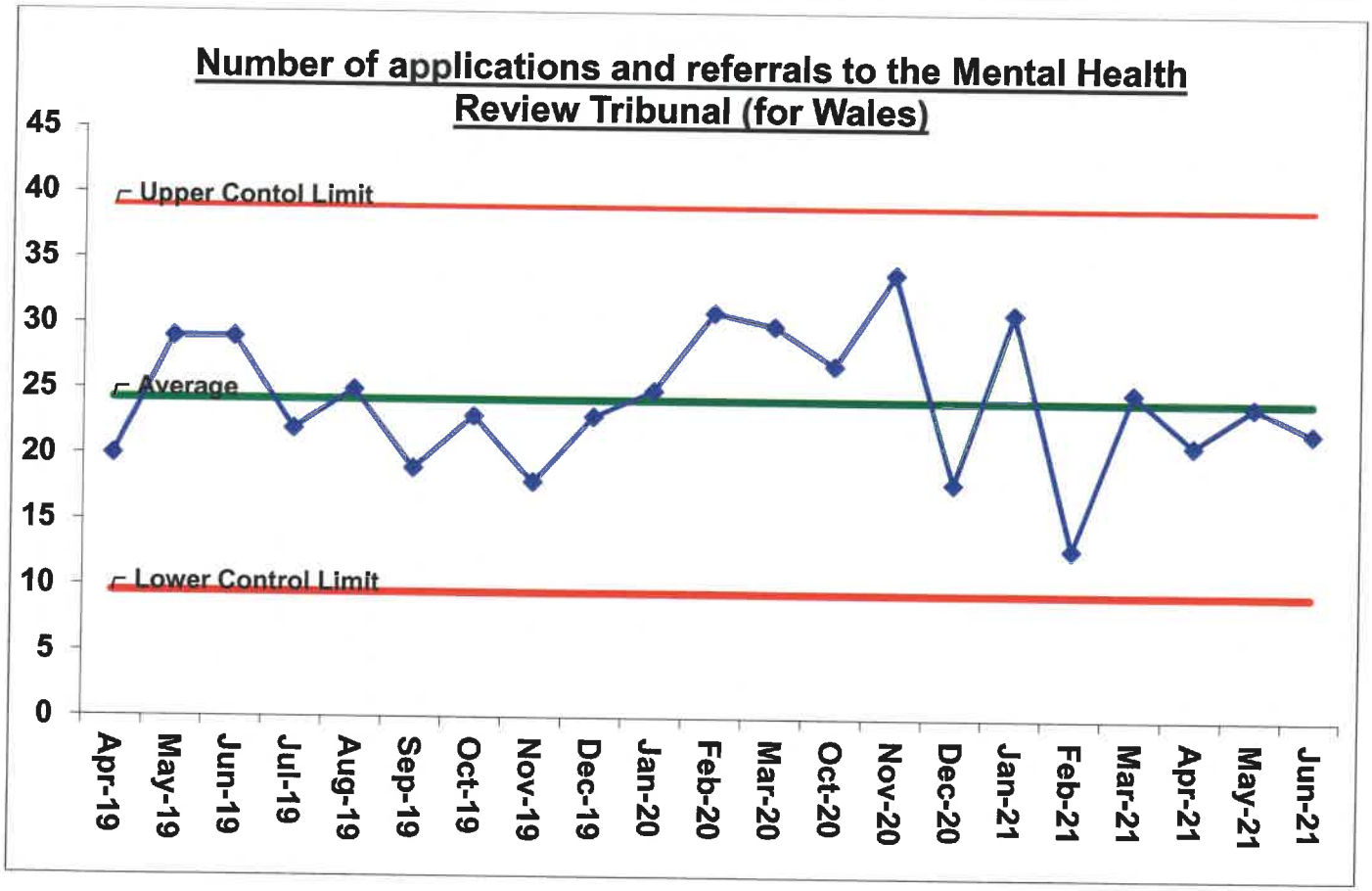


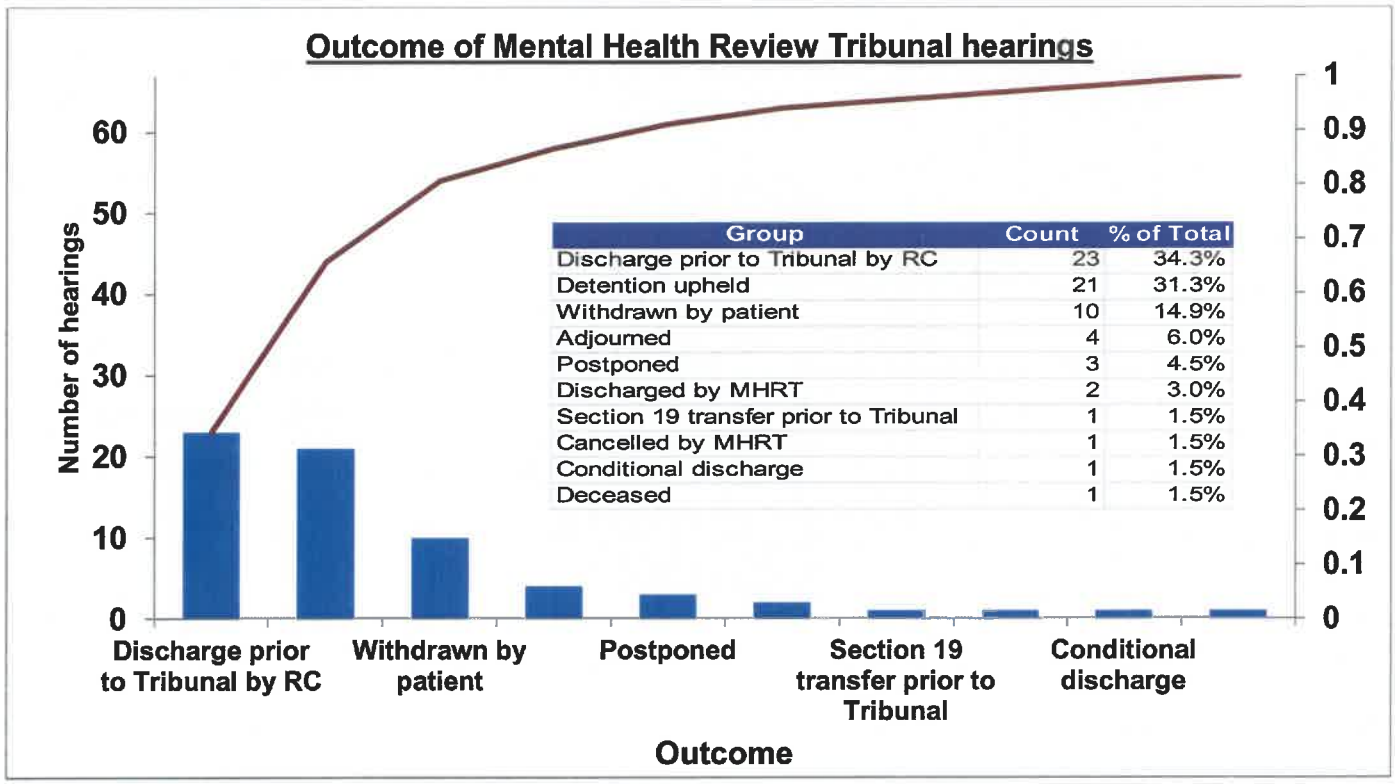
During the period the Mental Health Act Office made twelve referrals to Advocacy Support Cymru where the patient was deemed not to have capacity make this decision. Six hearings were either postponed/ cancelled and therefore weren't attended by an advocate On six occasions an advocate was instructed by the patient.

Source of applications to the Mental Health Review Tribunal (for wales)



Number of applications and referrals to the Mental Health Review Tribunal (for Wales)





Group	Count	% of Total
Discharge prior to Tribunal by RC	23	34.3%
Detention upheld	21	31.3%
Withdrawn by patient	10	14.9%
Adjourned	4	6.0%
Postponed	3	4.5%
Discharged by MHRT	2	3.0%
Section 19 transfer prior to Tribunal	1	1.5%
Cancelled by MHRT	1	1.5%
Conditional discharge	1	1.5%
Deceased	1	1.5%

Four hearings were adjourned for the following reasons:

- Patient AWOL
- Updated reports required
- Patient and nurse did not attend
- Patient changed legal representation

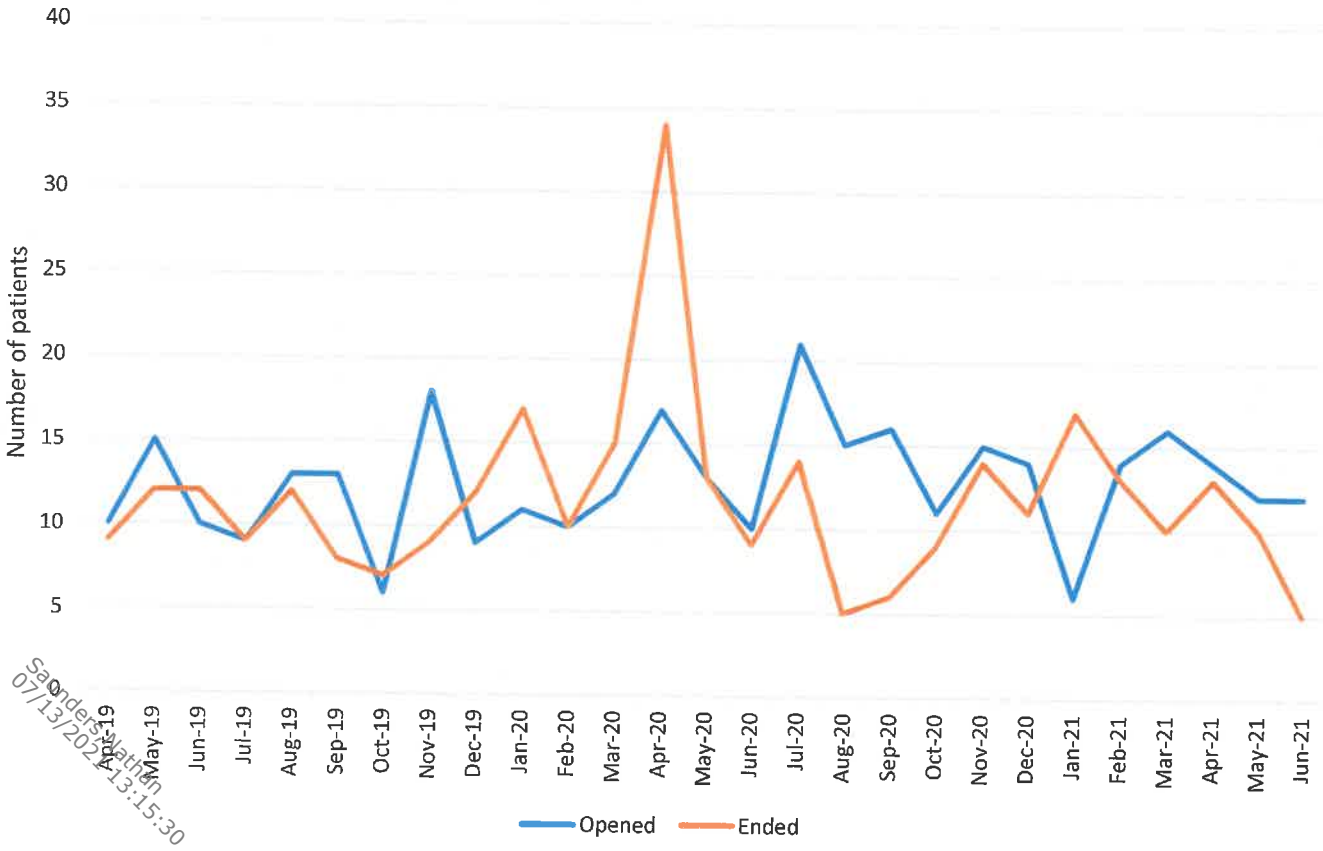
Three hearings were postponed for the following reasons:

- Responsible Clinician unavailable to attend
- Social worker unavailable to attend
- Professional team unavailable to attend

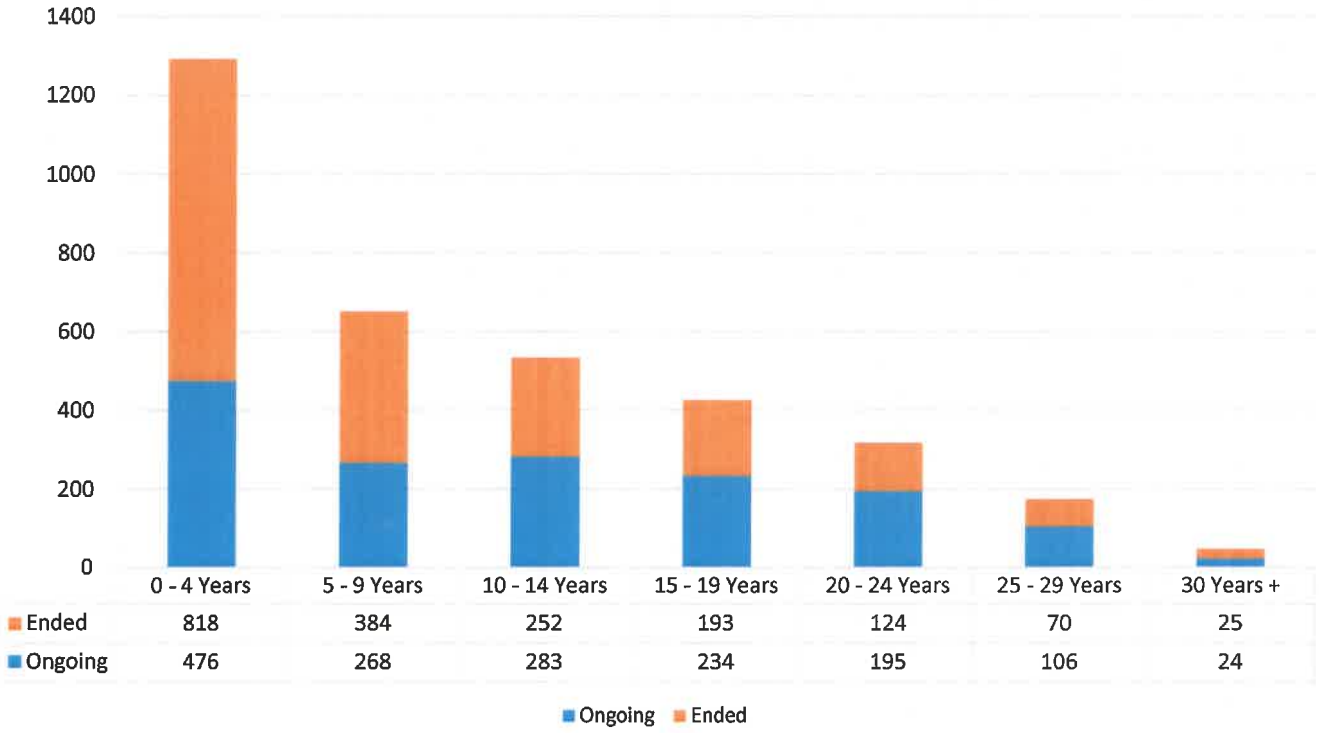
Section 117 Aftercare

Patients eligable for 117

Section 117 Activity



Periods of time that patients remain eligable 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	818	384	252	193	124	70	25
Ongoing	476	268	283	234	195	106	24

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

April- June 2021

Exclusion of visitors

We restarted visiting on Hafan Y Coed wards from the 19th April. This is managed through a booking in system, which has gone very well over the last 2 months.

Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- 14 patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
    - Two to return to their home area
    - One to a specialist placement
    - Four to CAMHS
    - Six to a private PICU bed
    - One to a medium secure bed

Ten 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:

- Six from PICU beds
- three to return to their home area
- one from a CAMHS bed

One patient detained under Part 3 of the Mental Health Act was transferred into Cardiff and Vale UHB from a hospital under a different set of managers in order to return to their home area.

Death of detained patients

During the period there were two deaths of detained patients.

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having committed a criminal offence. The person can be detained in a place of safety initially for up to 24 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her

	treatment or care. The detention can be extended by a further 12 hours by a Registered Medical Professional. The detained person can be transferred to another place of safety as long as the maximum time period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act. A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.
Section 5(4)	Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required. During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2). Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.
Section 5(2)	Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under section 2 or 3 ought to be made. The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or

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

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

	Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Community Treatment Order (CTO)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. CTO provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer

	people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person

	can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.
Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position

	is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for CTO
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion. If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally concerned with the medical treatment of the patient for mental disorder. If the patient lacks capacity to consent SOAD authorisation is required.
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)

Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or CTO is due to expire.

Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to CTO patients and conditionally discharged patients as well as those who have been absolutely discharged.

REPORT TITLE:	Mental Health Measure (Wales) 2010 incl. Part 2								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	**January 2021**	
STATUS:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**		**For Information**		
LEAD EXECUTIVE:	Chief Operating Officer								
REPORT AUTHOR (TITLE):	Director of Operations, Mental Health								

Backgrond and Current Situation:

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

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

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. For the information of the committee the Delivery Unit has restarted its 90 day cycle of mental health services reviews across Wales to discuss performance against the various mental health specific targets. Cardiff and Vale has been visited with no exceptional issues to report.

BACKGROUND

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

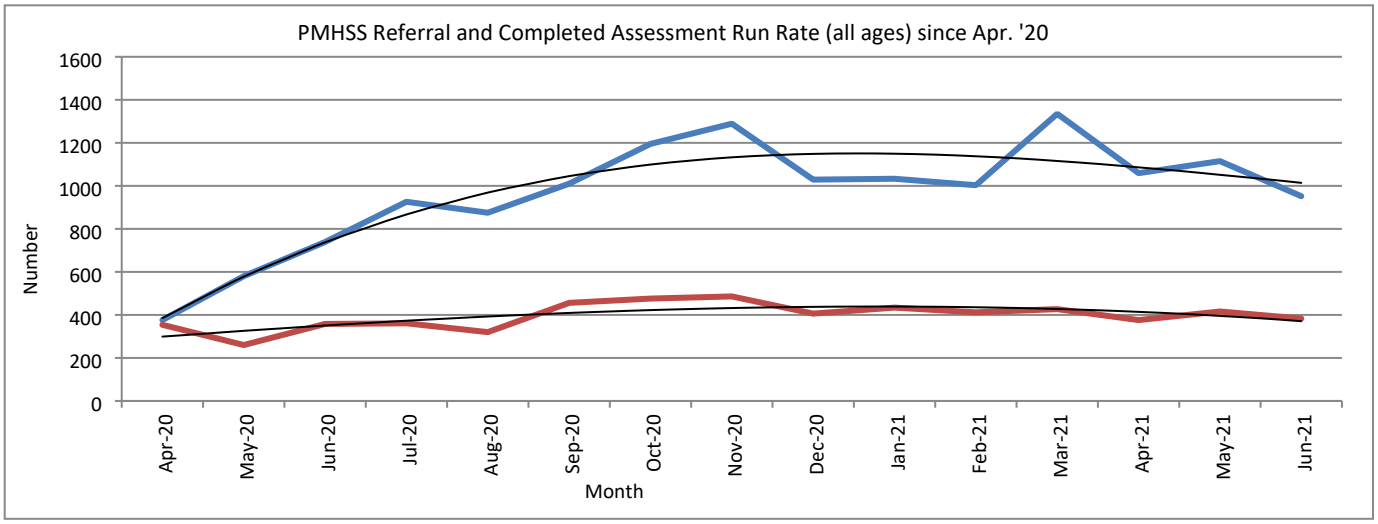
ASSESSMENT AND ASSURANCE

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

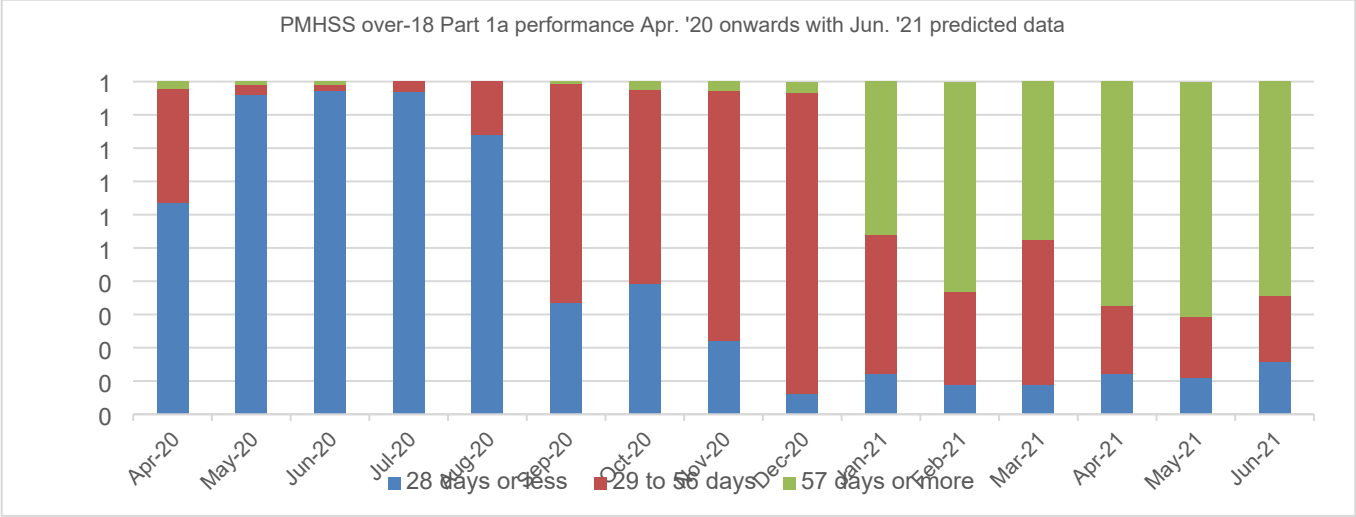
Part 1 : PMHSS

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

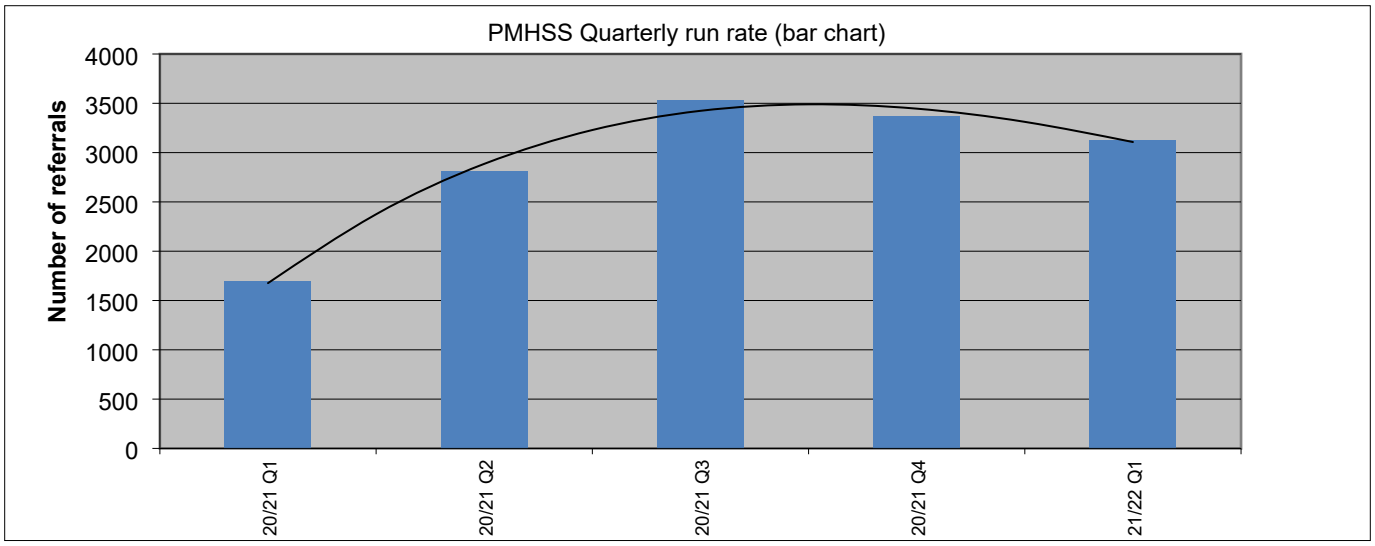
Referral activity for Q4 2020 & Q1 2021 has seen a gradual decrease in referral rates following the initial quite steep rise in referrals the first two quarters after the first lockdown but with a notable spike in referrals in March '21. Completed assessment rates have remained fairly uniform looking at the financial year as a whole (See Graph 1).



Regarding the over-18 Part 1a performance (see Graph 2), the initial impact of COVID-19 affected performance in the early stages of lockdown but compliance was reinstated quickly before a shortfall in four qualified (3.6wte) staff in August subsequently affected performance going forward. This staffing issue was partly rectified in early September but further vacancies and the continuing 1.0wte maternity leave has seen the service remain understaffed. A recent successful recruitment drive, however, will see an additional 2.0wte staff commencing in late June '21, with a remaining additional 1.0wte vacancy to be filled.



Despite a quite dramatic increase in referral numbers in Q2 and Q3 2020/21 following the first lockdown, subsequent quarters imply a steady reduction in referrals (See Graph 3).



From March 2020 onwards the MHCB took a decision to amalgamate the PMHSS and Primary Care Counselling referrals. This decision was based on the strategic direction of the service to make access to MH services simplified for GPs and Service Users, avoiding referrals to the PCCS going to the back of their waiting lists of up to 6 months. These service users are now screened and triaged by the merged Single Point of Entry (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 to reduce demand on Part 1.

The continuing trend based on early indications is:

- Reduced demand for counselling. Since inception (Apr. '20) referral numbers to PCCS have averaged 165 per month compared with a monthly average of over 550 in 2019/20
- Reduced waiting times for counselling, down from 6 months to 4-6 weeks.
- Better uptake of a first appointment for counselling. Approximately 75% of the referrals to PCCS in April '20 had at least one session of counselling. s

Actions to restore Part 1 compliance:

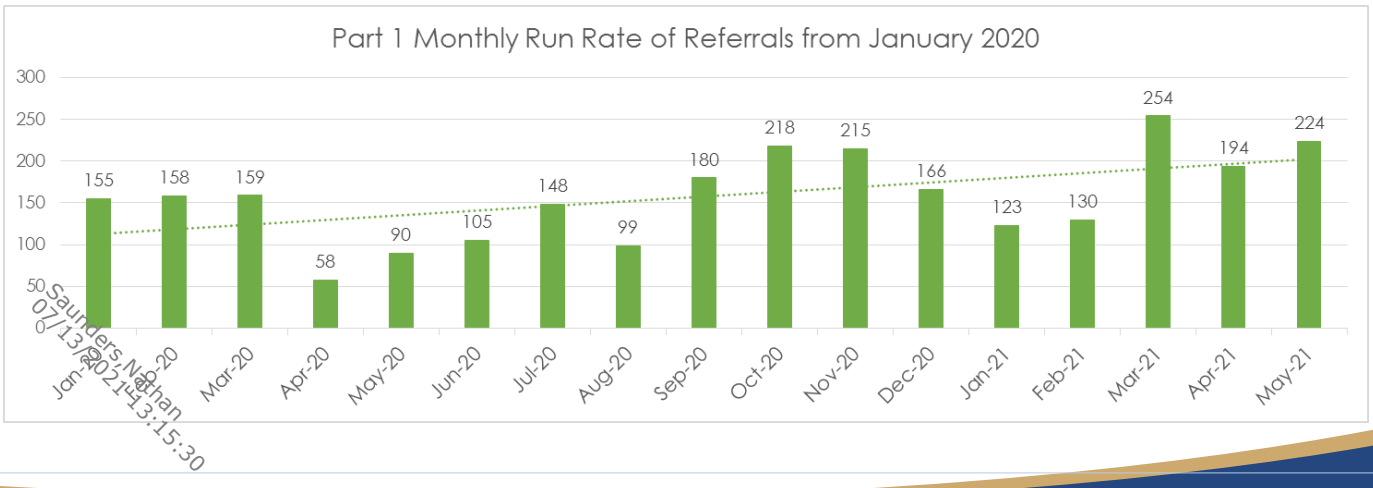
- Ensure all referrals that can be accommodated at Tier 0/1 through intervention of the third sector or the GP PCLT are dealt with there - completed
- Encourage direct referrals by the public into Tier 0 third sector support through advertising and awareness raising on the UHB website and public health advertising - completed
- Encourage GPs to refer directly to the third sector through awareness raising in the PCIC CD forum and via the cluster development managers - completed
- Develop additional capacity within the Primary Care Liaison Team to offer some extra capacity to accommodate staff losses through covid-19 - completed
- Develop additional capacity within the third sector to offer some extra capacity to accommodate staff losses through covid-19 – completed
- Develop temporary capacity within the PMHSS team assessors, through fast track recruitment, agency block booking and exploration of private companies – completed. Interviews commenced 6th January 2021 with an initially poor response. Subsequent recruitment days and recruitment of bank workers have been more successful, with 1.0wte to be recruited.

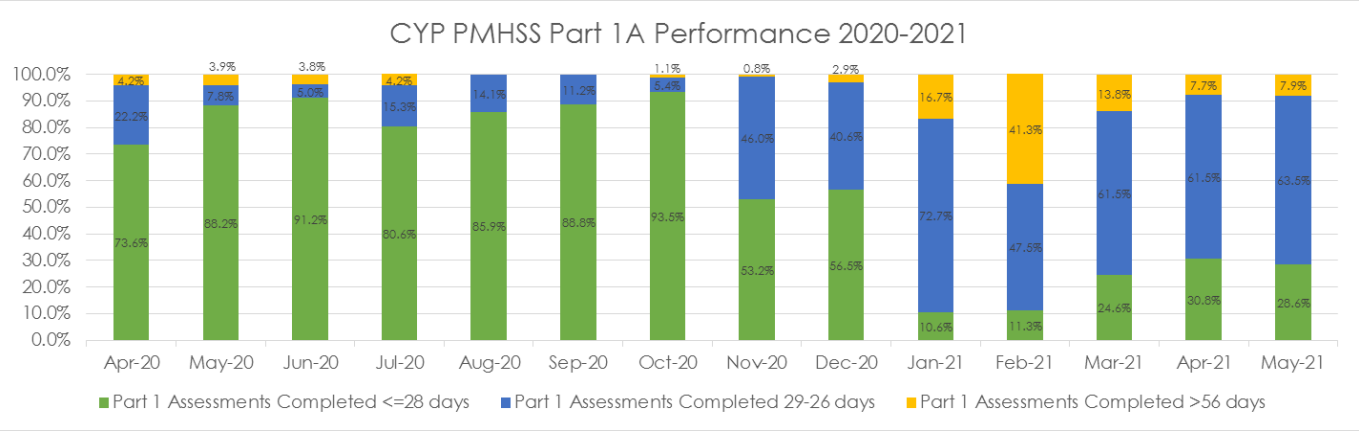
Revised trajectories currently being developed in light of the impact of the above measures. Currently referrals are being booked in at 37 days

Part 1a – target: 28 day referral to assessment compliance target of 80% (Children & Young People)

Compliance against the part 1 target not been achieved since October 2020. Following a decline in referrals during the height of Covid, referral levels significantly increased during October 2020 and November 2020 following the re-opening of schools, and whilst saw a decrease between December and February, have sharply increased from March and remain significantly higher than pre-Covid levels.

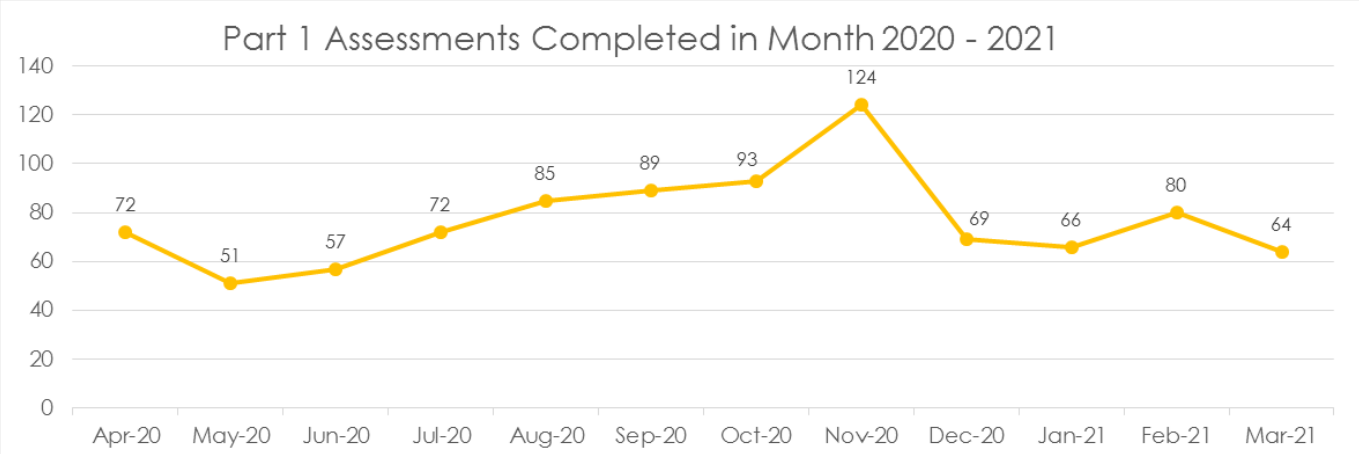
The average wait for assessment is currently *37 days.*





Capacity has been a challenge for the team, with a mixture of short and long term sickness, the team has been operating on approximately 66% capacity since the beginning of December.

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



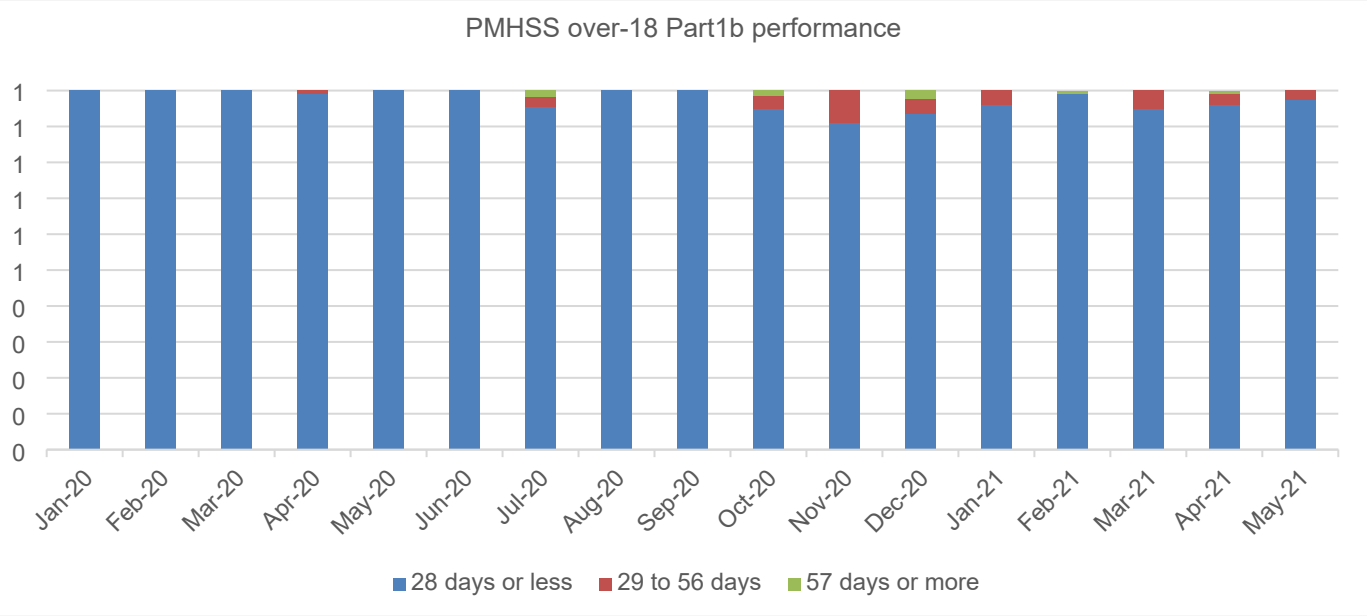
Actions to improve compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of agency staff to deliver assessment and where required ongoing intervention
- Continued use of Healios for additional capacity to deliver Part 1 assessments and interventions

- Improved referral management processes including the development of the Single Point of Access, which following successul recruitment to the staffing strucure is expected to be fully live from October 2021
- The Leadership Team are seeking to develop a new assessment team model, with dedicated capacity for assessment, initial consultation with staff across CYP emotional wellbeing and mental health services has commenced.

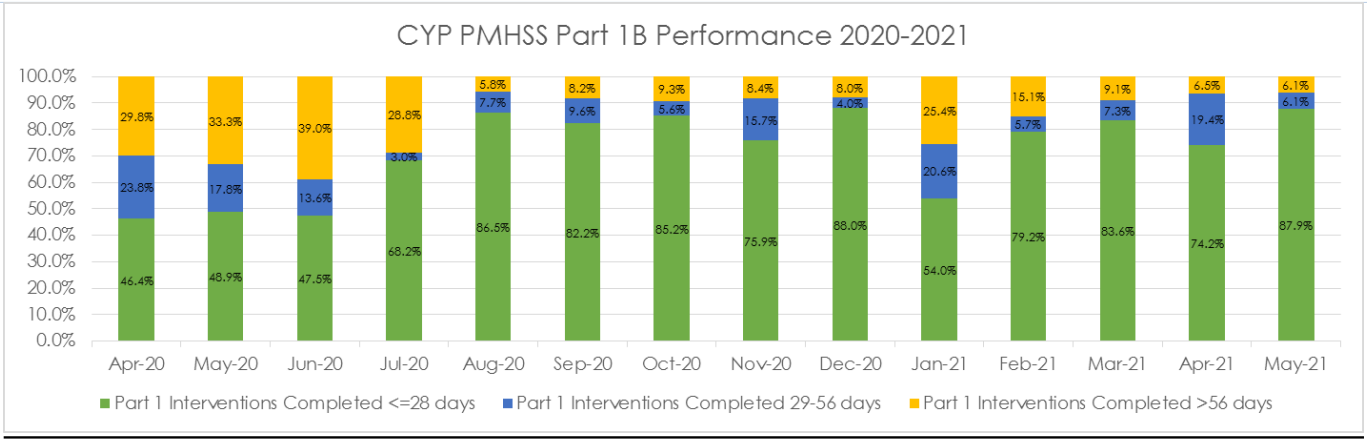
Part 1b – 28 day assessment to intervention compliance target of 80% (Adult)

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



Part 1b – 28 day assessment to intervention compliance target of 80% (Children & Young People)

Compliance against Part 1b of the target has been achieved in 6 of the last 10 months and within 10% on 3 months. January was a challenging month for the service with significantly reduced capacity due to sickness, maternity leave and annual leave. The team continue to work to ensure that young people are seen within 28 days for the commencement of their treatment, following assessment.



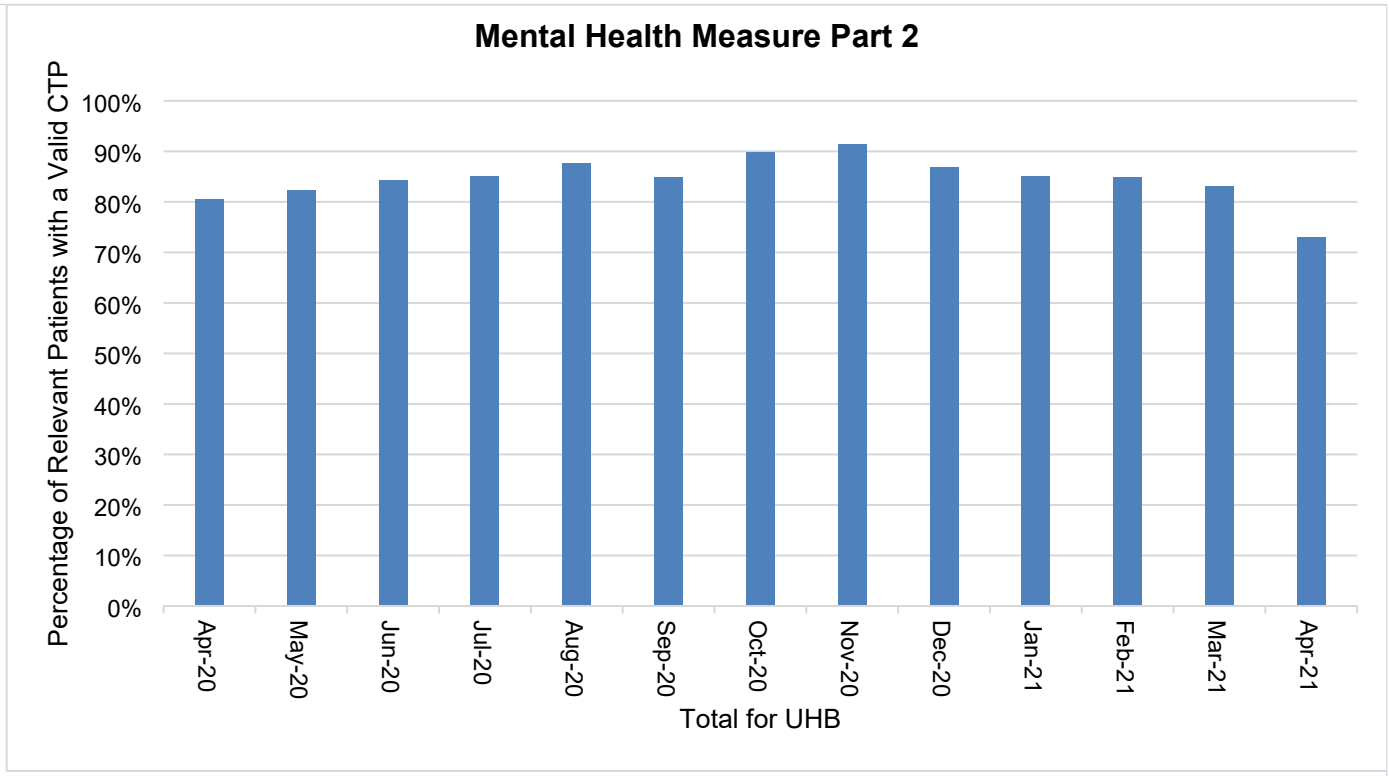
Part 2 – Care and Treatment Planning (Adult)

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

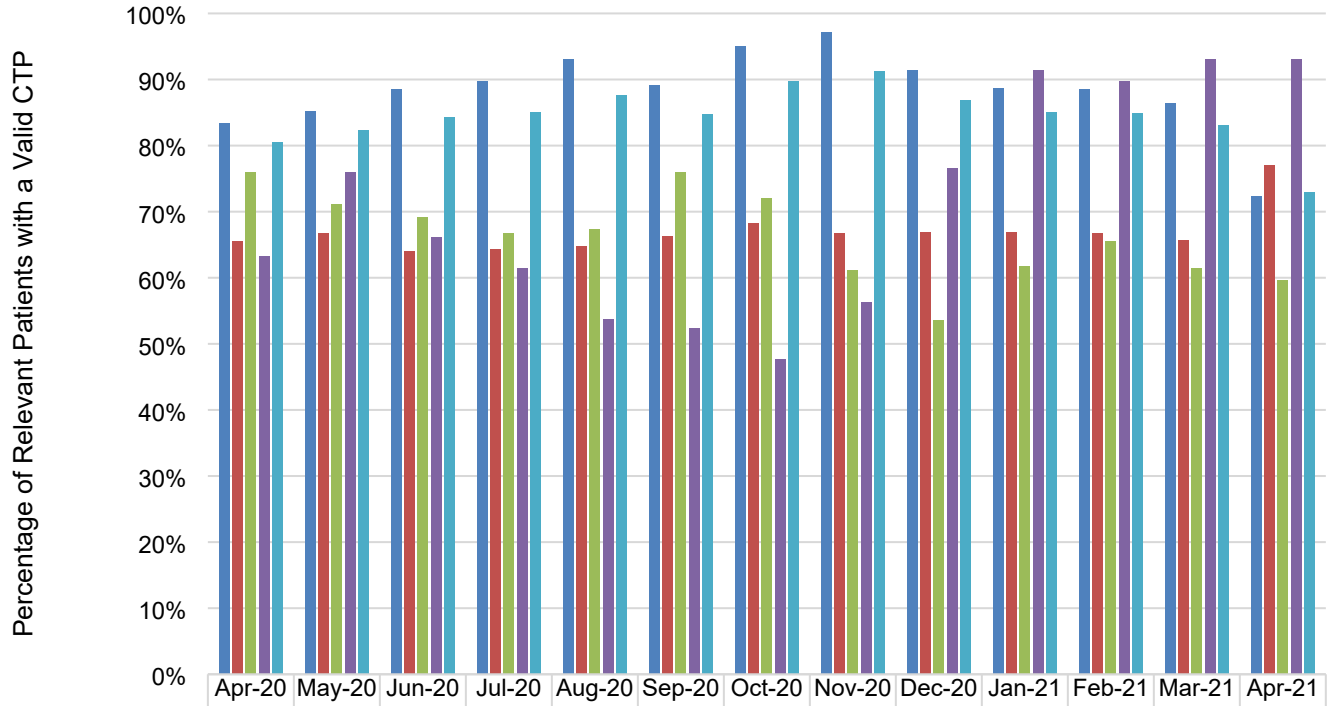
Care and Treatment planning is a complex and challenging area to get right, particularly co-producing outcomes based care planning which requires cultural change from services. Prior to the Covid period the service was following an action plan co-written with the Delivery Unit which included a multi-dimensional 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. This plan remains relevant.

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

Since the previous Mental Health Legislation Committee meeting Care Aims and Open Dialogue training has continued in spite of the Covid restrictions. Compliance has reduced in April and May 21, however this may be due to a 18.8% increase in patients in receipt of secondary care services between April 20 and May 21 and a 74.5% decrease in discharges comparing April 20 to May 21. This is likely to be creating additional demands to maintain compliance as well as commencing new planning. Locally there is a 4 week period of planning or alternatively, 3 sessions of 'ongoing assessment' before Care and Treatment Planning commences, increased allocations are likely to be represented in these numbers. MHSOP Care and Treatment plans have risen by 11.5% in the last year, while Adult compliance has dropped by 11% in the last year.

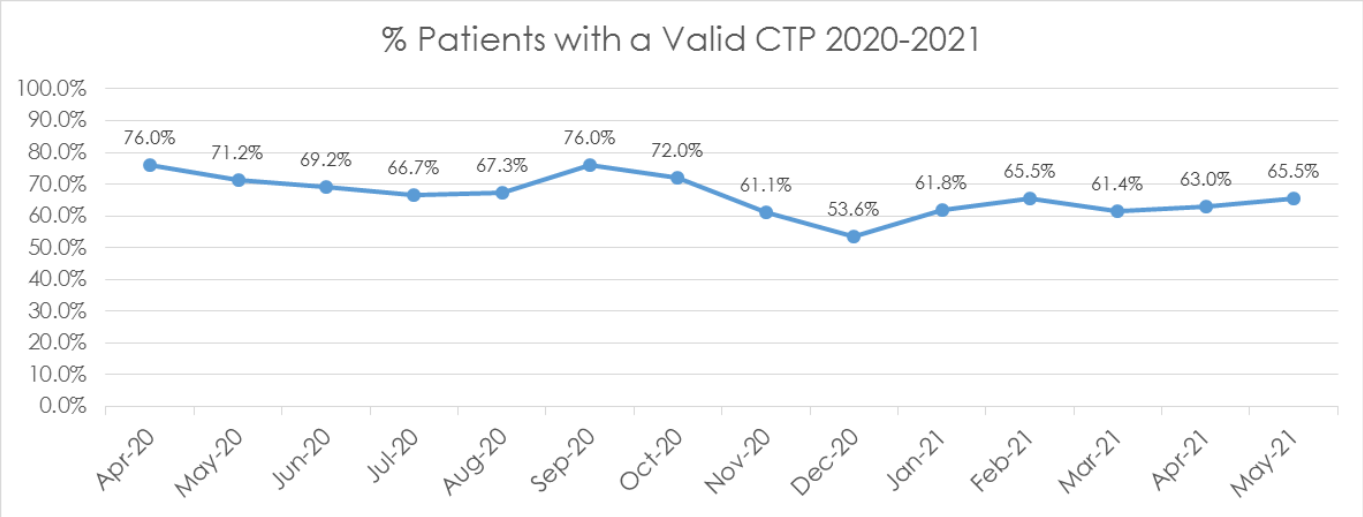


Mental Health Measure Part 2 by Service



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Adult	83.4%	85.2%	88.5%	89.8%	93.0%	89.2%	95.0%	97.2%	91.4%	88.7%	88.5%	86.4%	72.4%
MHSOP	65.5%	66.7%	64.0%	64.3%	64.8%	66.3%	68.2%	66.7%	66.9%	66.9%	66.7%	65.7%	77.0%
CAMHS	76.0%	71.2%	69.2%	66.7%	67.3%	76.0%	72.0%	61.1%	53.6%	61.8%	65.5%	61.4%	59.6%
LD	63.2%	75.9%	66.2%	61.5%	53.8%	52.3%	47.7%	56.3%	76.6%	91.4%	89.7%	93.0%	93.1%
Total for UHB	80.5%	82.3%	84.3%	85.1%	87.6%	84.8%	89.7%	91.3%	86.9%	85.1%	84.9%	83.1%	73.0%

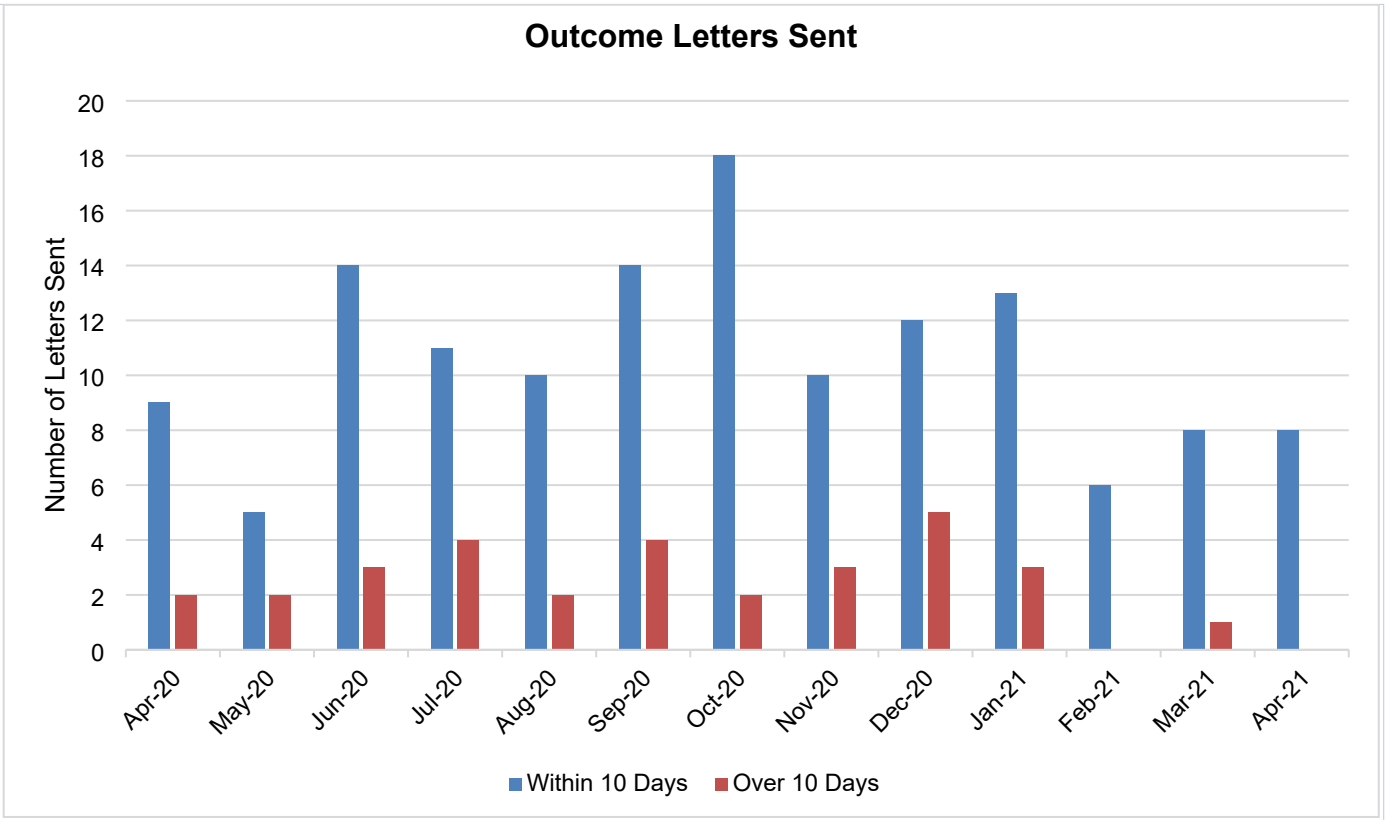
Part 2 – Care and Treatment Planning (Children & Young People)



The service continues to underperform against the target, challenges to achievement have included poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable to be facilitated as a result of wider system issues e.g. social care placements not being in agreed leading to delays in completion. The team are working hard to ensure that the process can be completed in a meaningful manner through a range of options including face to face, telephone and VC where appropriate and in a supportive multi-agency approach. Improvement in compliance remains a priority for the service.

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

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



The performance of the service fluctuates with steady improvement seen between September 19 and December 19 with 100% compliance in January. Since then the teams have seen circa 80% compliance amid the administration pressures of covid 19. 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.

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

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

The IMHA agreement expired on the 31st December 2020 and renewal process was halted due to a delay in the recommendations following the review of the Mental Health Act being communicated. As such the existing agreements were extended for 12 months in line with Regulation 72 (1)(c) of the Public Contract Regulations 2015.
The Health Boards are currently meeting with Procurement to agree collaboratively the options beyond December 2021.

Recommendation:

The Committee are requested to:

NOTE the content of the Mental Health Measure (Wales) 2010 incl. Part 2 update.

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.

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name:
Hazel Ward,
Hafan Y Coed

Activity date**:18**
March 2021

Publication date:

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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Digital ISBN XX

WG41024

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of Hazel Ward, Hafan Y Coed as part of its programme of assurance work. Hazel ward is currently a 13 bed, mixed gender, rehabilitation and recovery ward for people experiencing a range of mental health illnesses.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the ward manager on 18 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

During the COVID-19 pandemic, Hazel Ward increased its bedding capacity from a 10 bed ward into a 13 bed ward, by converting the rooms which were previously used as activity rooms and meeting rooms into bedrooms. This change took place due to Meadow Ward temporarily been designated as a COVID–19 ward. We were told that the newly converted rooms do not offer the patients en-suite facilities and some patients did not like being admitted into these rooms as they don't have private bathroom facilities.

We saw evidence to confirm that Hazel Ward conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. We were told that social distancing measures have been put in place, both staff and patients wear masks on the ward and posters displayed in the ward to remind patients of social distancing measures.

The ward manager explained how office spaces had been adapted to ensure social distancing guidance were maintained as best practicable. This included the removal of chairs from the staff office which only allowed a maximum of two people to be present together in the office.

We were told that the ward did not have any positive COVID-19 patients, or any other healthcare acquired infections at the time of our call.

We were told that visiting arrangements have been changed in line with government and health board guidelines. No visitors were allowed on the wards and patient access to leave is currently limited to 2 separate 30 minute sessions of ground leave within the hospital.

The ward manager explained how the current restrictions has significantly impacted rehabilitation activities on the ward, patients are unable to join staff for shopping trips etc. Walking groups and other community activities are currently on hold. We were told that this has impacted on patients' behaviours and staff have noted increased frustrations in the patient group.

It was positive to hear that staff had adapted to the changes and created soothing boxes for some patients which included resources to help calm and control behaviours. In addition staff had created an exercise board competition amongst staff and patients, themed 'Around the World' cooking classes, and the garden area was being re-developed by patients. The ward manager told us that all these activities were helping to alleviate boredom and frustration within the patient group.

The ward manager told us that patient participation was good and it had helped foster good relationships between the staff and patient group. We were also told that no restraints had taken place on the ward from the period of December to February.

We were told patients' routines within the ward continued as normal. Weekly patient meetings take place with the multi-disciplinary team (MDT) where patients are provided with COVID-19 advice and guidance updates.

Due to the restrictions in place, alternative means of communication are being utilised for patients to maintain contact with their family and friends. The ward had iPads available for patients use and patients' are able to use their own devices. We were told patients can be assisted and supported to face-time and send e-mails.

The following areas for improvement were identified:

We spoke to the ward manager about ligature audits and were told that these take place annually by an external provider. The ligature audit for Hazel Ward should have been undertaken in January 2021, however due to the COVID -19 pandemic it had not taken place. The health board must ensure that a ligature audit is undertaken immediately.

We were told that risk assessments had taken place on the 3 rooms which have been converted and some work was identified for estates to complete. This work has not yet been completed and the health board must ensure that ligature audits and any outstanding work identified from the risk assessments are completed to ensure patient safety.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were provided with the policies and procedures in place for the prevention and control of infection. These included both the standard Infection prevention and control precautions and the further guidance issued relating to COVID-19. These were reviewed and updated regularly and we were told that staff were informed of any updates.

We were told that COVID-19 risk assessments were in place for all staff and patients. We

were also told that staff have increased cleaning throughout the hospital for all patient and staff areas. Hand washing facilities are available for patients and staff throughout the ward and posters regarding hand washing and COVID-19 information is available as a visual reminder for staff and patients.

The ward manager stated that good working relationships had developed with the Infection Prevention Control department (IPC) and also the designated COVID -19 ward within Hafan Y Coed which helped contribute to the effective running of the ward and supported the ward team in providing safe and effective care to the patients.

We were told of the systems in place to ensure all staff were aware of and discharged their responsibilities for preventing and controlling infection. This was evidenced by the COVID 19-policies and procedures in place. In addition, FFP31 mask training had been delivered for staff.

In addition to staff training, instruction posters are displayed in clinical areas informing the staff of PPE requirements, importance of cleaning touch points regularly, using appropriate wipes, and ensuring that hands are being washed by staff and patients as often as possible.

The ward manager advised us that staff were encouraged to challenge any staff members who were not compliant with the PPE and 'bare below the elbow' requirements which are subject to regular management spot checks to ensure compliance.

We were told that all patients have physical checks taken on a daily basis, patients are assessed for COVID symptoms each day and temperatures are recorded twice daily any patients who display symptoms are asked to isolate in their bedrooms pending the outcome of a swab test. Any patients who are unable to isolate due to complex needs or challenging behaviours are relocated to the dedicated COVID Ward.

The ward manager explained that if patients leave the hospital and breach the current guidelines, upon their return they are requested to self-isolate pending the outcome of a swab result. Patients who are being transferred to an external placement also require a negative swab result before leaving the hospital. Staff and other professionals who visit take their temperature before entering the ward and on leaving the ward.

We were also told that if patients are being transferred to an external placement a negative result is required. The ward manager stated that swab results come back quickly and rapid swab results are also available in exceptional circumstances.

The following areas for improvement were identified:

We were told that regular cleaning takes place on the ward and were provided with

[1] A FFP3 mask is worn when carrying out potentially infectious aerosol generating procedures

environmental daily check lists, regular fridge temperature checks, and fire safety checks. However the cleaning audit sent to us was dated August 2018. The health board must complete and provide a formal infection, prevention and control cleaning audit.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

A review of the staff vacancies and absence data did not indicate any staffing issues. We were told that some staff from Meadow Ward had been moved into Hazel Ward. The ward manager assured us that ongoing discussions with senior management were taking place regarding any vacancies on Hazel Ward when staff return to Meadow Ward.

Staffing resources are planned in advance and reviewed daily, and bed flow meetings take place weekly. The ward manager spoke positively about the ward social media group which helps ensure sufficient staff numbers were on shift to meet the care needs of the patients on Hazel Ward. The social media communication highlights any deficiencies and staff are able to work extra shifts or extending their shift.

We were provided with copies of incident data for November 2020, December 2020 and January 2021, which show that incidents are recorded and reported on appropriately.

Mental Health Act reviews, and other contact with external professionals, such as advocacy, had continued through phone calls and video conferencing. Access to advocacy services were now back up and running on the ward.

We were told that tribunals are held by phone, no face to face tribunals have taken place during the pandemic. The ward manager reported that patients have not engaged well in this process and patients have complained and cannot understand why Mental Health Tribunals can't be undertaken virtually.

We were told that the Mental Health Act administration team carry out double scrutiny alongside a consultant psychiatrist for all section papers on admission. All consent to treatment certificates are also scrutinised by a consultant psychiatrist.

Consent to treatment and medication charts are checked on a weekly basis by the ward pharmacist during patient reviews.

We were provided with compliance data for staff mandatory training. Whilst there were a number of areas showing a high rate of compliance, this was not reflected in all training topics. During review of the training statistics, there were issues identified which need to be reviewed. These are listed below in the Improvements Identified section.

We were told that staff had access to computers to complete online training and that the ward manager encourages staff to complete their training when they experience quiet periods on the ward.

The ward manager told us that in addition to the daily handovers, staff meetings had been conducted to ensure staff had up to date information. We were told that there was adequate support in place for staff. In addition to the employee assistance scheme, the psychology team were offering support to any member of staff who may be experiencing anxiety or similar as a result of COVID-19.

We did not receive a copy of the escalation policy, however the ward manager did tell us that immediate risk would be escalated to the appropriate person directly. Regular meetings which involve senior staff members take place regularly and provide platforms for discussing issues. The ward manager told us that she felt supported by the senior leadership team in the health board.

The ward manager spoke positively about her team, describing the team as a cohesive, hardworking and dedicated team. The ward manager described how involved the consultant is with all the patients and is a great support to the wider team and throughout the interview the ward manager complimented her team and stated that she was proud of how her team had worked and adapted throughout the pandemic.

The following areas for improvement were identified:

We noted compliance rates with face to face mandatory training are low, for example Fire Safety Level 2 (52%), Manual Handling (20%), Information Governance (60%), Strategies and Interventions for Managing Aggression (68%), and Violence and Aggression Against Women (64%). We recognise that mandatory training figures have been effected due to changes in ways of working as a consequence of COVID-19 and difficulties in securing the services of training providers under current circumstances. The health board should consider all options to address the risks of not keeping up to date with mandatory training. This could include continuing to look for available internal or external providers to deliver face to face training when this mode of delivery has been assessed as safe and appropriate. When this is not achievable, to consider whether the training can be delivered via digitally enabled means such as through webinars, video conferencing or e-learning programmes.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Improvement plan

Setting: Hafan Y Coed

Ward: Hazel Ward

Date of activity: 18 March 2021

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must ensure ligature risk assessment is carried out on Hazel Ward and any remedial work identified must be completed by estates to prevent any risk of harm to patients	Health & Care Standards – 2.1 managing risk & promoting health and safety	Health and Safety have been contacted to undertake a ligature audit as soon as possible, first available date 4/5/21	Ward Manger	04/05/2021
2	The health board must complete and supply a recent cleaning audit and ensure any outstanding actions are completed.	Health & Care Standards – 2.1 managing risk & promoting health and safety	To Liaise with Housekeeping services to ensure to obtain audits/ cleaning scores for Hazel Ward	Senior Nurse	Complete
3	The health board must review the training data and provide	Health & Care Standards – 3.4 information governance & communication	Face to face training has been discontinued during the	Ward manager/ Senior nurse	

	assurance that staffs have up to date skills and knowledge to provide safe and effective care as well as reviewing the training data to ensure the reports provide an accurate and current compliance figure.	s technology and 7.1 workforce	COVID pandemic to reduce the risk of transmission. Where possible mandatory training has been delivered online, however this has not been possible with all mandatory training. Face to Face training is in the process of being reinstated. Fire training has now restarted, and dates for manual handling are expected shortly. These training days will still be subject to social distancing rules and limited numbers in the training venues which will affect the number of places available A review of compliance with online mandatory training		October 2021 June 2021

			revealed difficulties in accessing ESR during work hours and from home. All staff will now be booked on a study day to complete the online mandatory training. Compliance with mandatory training will be an agenda item for discussion in monthly team meetings to ensure that the data and compliance is accurate.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: TRACEY LEWIS

Date: 23/04/2021

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Setting Name:
East 12, University Hospital Llandough

Activity date: **10 March 2021**

Publication date:

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

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Digital ISBN XX

WG41024

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of ward East 12, in the University Hospital Llandough as part of its programme of assurance work. East 12 is a 14 bedded ward providing acute dementia assessment for male patients.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the ward manager and senior nurse manager on 10 March 2021 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The following positive evidence was received:

We were told that a number of changes had been made to the ward environment as a result of the pandemic. East 10 ward became a designated COVID-19 ward for patients in the Mental Health Services for Older Persons directorate. As a result of this East 12 ward changed to an acute dementia assessment ward for male patients.

East 12 ward have reduced their bed numbers from 17 to 14 to ensure that single occupancy rooms are available for new admission patients whom require a period of isolation from the main patient group. Social distancing measures have been put in place, which included rearranging the dining area so more space is available between tables and patients. Also, the staff room displays a maximum number of people allowed in at a time.

We were told that visiting arrangements have been changed in line with government and health board guidelines. Whilst visitors were not permitted to the ward, visits are currently limited to palliative care or specific needs as identified in the guidance.

A designated visitors pod is available and allows families to visit (when permitted by government guidance) whilst maintaining social distance measures. Changes to visiting times and patient leave is being monitored in multi-disciplinary team meetings to ensure risk and patient capacity/understanding is being checked.

Due to the restrictions in place, alternative means of communication are being utilised for patients to maintain contact with their family and friends. We were told that throughout the duration of the pandemic, video calls have been facilitated by a newly established designated team called the Family Liaison Team. These staff work shift patterns and ensure patients receive calls with family throughout the day.

We were told that patient routines were being maintained as normally as possible. To help staff deal with peaks in challenging behaviours, additional initiatives were put in place to reduce these. Occupational therapy staff offered additional activities and therapies and physiotherapy sessions were delivered to patients requiring this. Staff communicated to patients individually to ensure messages were being received and understood. The ward manager expressed their gratitude of the staff and their achievements during the pandemic to keep patients active and engaged.

We were reassured from discussions with the ward manager that any staff or patient diagnosed with COVID-19 would be managed appropriately.

The following areas for improvement were identified:

We were told that a formal environmental risk assessment has not been completed for East 12 since 2019. Despite measures undertaken at ward level to ensure the ward remains safe and fit for purpose, a formal risk assessment must be completed.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We were provided with the policies and procedures in place for the prevention and control of infection, which included their COVID-19 Infection Prevention and Control Guidance.

We were told that advice and guidance is received from the infection control team to ensure best practice and that they undertake regular visits to the ward. We were told staff have increased cleaning throughout the hospital for all patient and staff areas alongside the implementation of PPE stations and temperature checking upon entering the ward. Hand washing facilities are available for patients and staff throughout the ward.

We were told of the systems and procedures in place to identify any staff or patient who may be at risk of developing COVID-19. We were told risk assessments have been completed for all staff. Depending on the outcome of the assessment, the organisation will determine if the staff member needs to be removed from patient areas or self isolate. In addition, any member of staff that is symptomatic had access to COVID-19 testing and results shared with necessary parties to ensure appropriate measures were taken.

We were told of the systems in place to ensure all staff were aware of and discharged their responsibilities for preventing and controlling infection. This was evidenced by the compliance data submitted for infection, prevention and control training. In addition, PPE donning and doffing training and FFP3[1] mask training had been delivered for staff. As a result of these measures the current infection rates for Clostridium Difficile[2] and Norovirus[3] were

[1] A FFP3 mask is worn when carrying out potentially infectious aerosol generating procedures
[2] Clostridium difficile, also known C. diff, is bacteria that can infect the bowel and cause diarrhea. The infection most commonly affects people who have recently been treated with antibiotics.
[3] Norovirus, also called the "winter vomiting bug", is a stomach bug that causes vomiting and diarrhea. It can be very unpleasant, but usually goes away in about 2 days.

nil.

The following areas for improvement were identified:

We were told that due to COVID-19 restrictions, a formal infection, prevention and control risk assessment has not been completed for East 12 since 2019. Despite measures undertaken at ward level to ensure the ward remains safe and fit for purpose, a formal infection, prevention and control risk assessment must be completed.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

The following positive evidence was received:

We were provided with staffing numbers that we were told are considered sufficient to maintain patient care and safety on the ward. We were told that patient acuity can fluctuate with no predictable pattern. As a result of this the staffing levels and requirements are reviewed on a daily basis in order to support the team in providing safe and efficient care. We were told of the ways staffing has been adjusted to ensure sufficient numbers on the wards. This included community nursing staff being deployed from their community posts to work on the ward. The hospital has issued a number of fixed term contracts that increased staffing numbers. In addition, there is a pool of nursing staff that can be used to support wards when staffing levels need to be adjusted at short notice.

The data provided showed the ward had two staff on short term sick leave and one staff member on long term sick leave. There are currently vacancies for staff nurses and these are being recruited into.

We were provided with compliance data for staff mandatory training. Whilst the majority of completed training showed a high rate of compliance, there were some areas that were under 50% compliance (fire safety and information governance). We were told that COVID-19 had impacted training, especially classroom style. Training statistics are reviewed regularly and assurance was given to improving those areas that have been affected by the pandemic.

We were told of the physical health care training provided for staff on East 12 during the

beginning of the pandemic. This ensured that the physical health of patients was being maintained by East 12 ward staff and helped to reduce the need of additional staff entering the ward. We were told of the benefits this training had during the second and third lockdowns for the ward.

We were told that there was adequate support in place for staff. The ward manager told us that in addition to the daily handovers, staff meetings had been conducted to ensure staff had up to date information. In addition to the employee well-being programme, the psychology team were offering support to any member of staff who may be experiencing anxiety or similar as a result of COVID-19. The ward manager conducts monthly supervisions with all staff and has an open door policy in place. In addition, we were told of the support provided by the senior nursing team and of the communications being discussed and received to ensure up to date information and guidance. The ward manager was very complimentary about the staff and the work that they had accomplished during the pandemic.

We were told that there was no formal escalation policy, however, we were provided with an escalation process. We were told that staff are aware of the escalation process. Therefore it was recommended that the process is made into a policy so all staff have an official document to refer to.

We were told that the clinical treatment and intervention for patients has mainly stayed the same during the pandemic. Multi-disciplinary team meetings, involving external professionals, have continued with all reviews scheduled under the Mental Health Act 1983, conducted within prescribed timeframes. Face to face meetings were suspended at the outset of the pandemic, with telephone and video calls used to ensure patients continue to have access to external professional services, including advocacy. Some face to face visits have recently resumed with adherence to social distancing guidelines.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed

- Ensure required evidence against stated actions is provided to HIW within three months of the Quality Check.

As a result of the findings from this quality check, the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Power of Discharge Group – Hospital Managers' Annual Report 1st April 2020 - 31st March 2021

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

Attachment 2

1. **Membership**:
   There are Nineteen Hospital Managers at present:

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

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

2. **Videoconferencing**

   The year started with the introduction of homeworking as a result of the pandemic. The Power of Discharge Group started conducting hearings by videoconference first using Skype for Business and subsequently Microsoft Teams. The team had to take on a new set of skills with the support of the Mental Health Act office. New protocols were written to support the changes in process. There were a number of minor issue but overall it proved a successful transition that was welcomed by patients and their nearest relatives.

3. **Activity – Outcome of Hospital Managers' Power of Discharge Group hearings during the period 1st April 2020 - 31st March 2021.**

Section upheld	95
Discharged from Section prior to hearing	33
Discharged by PoD	3
Hearing adjourned by PoD Panel	8
Hearing postponed in period	8
Cancelled by patient prior to hearing	0
Cancelled by PoD prior to hearing	1
CTO applied before hearing	2
CTO Revoked before hearing	1

Advocates have represented patients at 58 Panel Hearings (61%) a decrease of 3% compared to 2019/2020.

4. Training Activity

Due to Covid-19 the group have only recently been able to attend a face to face training session on unconscious bias. There has been informal training on using Skype/Teams to conduct hearings virtually during the pandemic along with how to record outcomes electronically.

Upcoming training topics:

- Unconscious Bias (session 2)
- ECT (pending confirmation)
- Annual All Wales Associate Hospital Manager Event (when restrictions allow, likely to be spring 2022)
- Less common mental disorders
- Working with interpreters and people with communication difficulties

5. Quarterly Power of Discharge Group and Peer Support Meeting

A formal business meeting takes place on a quarterly basis. Members have the opportunity to share learning and reflect on specific hearings at the start of this meeting. The agenda includes such items as training needs, activity reports, items of interest gleaned from hearings and legal advice. Minutes are made available to the Mental Health Capacity and Legislation Committee for noting and approval.

6. Recruitment

We have been very fortunate in recruiting two new members to the group who come with excellent credentials. They have undergone their initial induction, delivered by the Mental Health Act Manager and observed a number of hearings with experienced group members. Both members currently participate as panel members and it is anticipated that they will progress to undertake the role of Chair. One Independent Member of the Board has also participated as a panel member on a number of occasions throughout the year but unfortunately is no longer available due to work commitments.

7. Annual Reviews

A small working groups has been set up to review the self-assessment process in line with the UHB appraisal process. As a result annual reviews were held during March 2021 using a pilot self-assessment questionnaire and one-to-one interviews with Jeff Champney-Smith, Chair POD Group. The group has looked at feedback from this exercise and will refine the questionnaire and intends to improve the peer feedback at the end of each hearing.

8. Observations

The Mental Health Act Team continue to observe hearings in order to assure the Board that managers hearings are being conducted appropriately and to a standard. Any performance issues are addressed and lessons learned shared with the Power of Discharge Group to ensure continuous improvement in the service Delivered. The Vice Chair of the UHB has also expressed an interest in taking part in the observation of hearings. This will be coordinated by the Mental Health Act Team. Feedback will be provided to the panel after the hearing and collated to form part of the discussion at the annual review. The intention is to improve peer feedback at the end of each hearing

9. Reports from participants

Feedback is encouraged from all those who are present at managers Hearings. A leaflet is sent following the hearing to provide information on how to raise a matter of concern or praise. This feedback is collated and feedback through the Power of Discharge Group and Mental Health Legislation and Governance Group.

10. Comments

Hospital Managers have the opportunity to make comments, raise concerns, and compliment staff. These are captured on the minutes that are completed at the end of each hearing. These are shared with the professional team who respond to the issues raised. There is an annual review and analysis of the issues raised to look for any trends that may need consideration. A report is compiled and discussed at a POD business meeting.

The main highlights were as follows:

- The number of comments had almost doubled compared to the previous year.
- The quality of care and treatment plans still is a cause for concern~~s~~ despite acknowledged recent improvements
- Increased concern from family and patients about the hospital environment including lack of facilities locally and ward activity have been reflected in the managers' comments.

Jeff Champney-Smith
Chair, Power of Discharge Group

June 2021

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON 6th JULY 2021 VIA Teams

Present:
Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer Vice Chair, Pod Group
Alan Parker PoD member
Alex Nute PoD member
Carol Thomas PoD member
Dr John Copley PoD member
John Owen PoD member
Mike Lewis PoD member
Sarah Vetter PoD member
Sharon Dixon PoD member
Teresa Goss PoD member
Mary Williams PoD member
Mair Rawle PoD member
Amanda Morgan PoD Member

In attendance:
Sunni Webb - Mental Health Act Manager
David Seward - Deputy Mental Health Act Manager
Morgan Bellamy - Mental Health Act Team Lead
Daniel Marsh – Management trainee

Apologies:
Huw Roberts PoD member
Wendy Hewitt-Sayer PoD member
Rashpal Singh PoD member
Peter Kelly PoD member
Professor Ceri Phillips – Vice -chair Cardiff and Vale health Board
Dan Crossland – Deputy Operations Manager

1 Welcome and Introductions

The meeting was held via Teams and the Chair welcomed all to the meeting. He introduced Daniel Marsh a management trainee in the Health Board who was doing his final placement on the Mental Health Clinical Board. The Chair invited Daniel to remain on the call after the meeting had finished to discuss any questions he might have.

2 New Members and Independent Members

There were no new members. The Chair informed the meeting that Pat Hallet had resigned from the PoD. She had sent her best wishes to panel members. A formal letter from the Clinical Board will be sent to Pat to thank her for her contribution. Michael

Imperato had stepped down for the time being due to work commitments. As a non-executive member of the Health Board he was entitled to sit at any time.

The Chair advised that he had met with Professor Ceri Phillips the Vice-Chair of the Health Board. Professor Phillips had indicated that he would be attending the PoD business meetings when his commitments permitted him to do so and would be observing Hearings. He was also keen to be involved with the annual review process.
Dan Crossland, Deputy Director of Operations, Mental Health Clinical Board had signalled his intentions to attend the PoD business meetings in the future.

3 Apologies
Apologies were received and noted.

4 Members points for open discussion

Professionals to read all reports
Mary Williams provided the background to the issue. After a discussion it was agreed that the matter should be taken to MHLGG as it highlighted a training/induction issue for new staff. The Mental Health Act Manager advised that all reports were uploaded to the PARIS system and therefore, professionals should be able to access each other's reports ahead of the managers hearing. She further advised that the Tribunal does not send out reports to the other professionals. It wasn't clear whether this was a more general problem but members are asked to note any problems in the comment section of the minutes.
There was some surprise that at a Hearing there was a difference of opinion between the professionals that hadn't been known to the parties beforehand.

Action - Chair to take the issue to the MHLGG

5 Minutes of Meeting held on 23rd March 2021
These were agreed as an accurate record of the meeting with no amendments.

6 Matters Arising

White Paper – the Mental Health Act Manager confirmed that she had submitted a response on behalf of the PoD as well as one from the Health Board. There was no further update.

CTO training – Hywel Dda had run CTO training for their medical staff. After consideration it was decided it wasn't applicable for Hospital Managers although would be incorporated in training at the national event.

Human Rights legislation and MHA update – this will be included in the programme for the national training event.

Social Fund – Chair agreed to manage a social fund and suggested that members contributed £15. He would be sending out an email within the next two weeks with his bank details.

7. Operational Issues
Unanimous/split decisions
Having sought advice from Richard Jones, in the event of a split decision a patient will remain detained and the section upheld. The Hearing should not be adjourned although

consideration can be given to holding a discretionary review. However, a decision on a discretionary review will need to be signed off by the Mental Health Act Manager or Deputy and the Chair or Vice Chair of the PoD. In the event a discretionary Hearing is agreed, a new panel will be assembled. There was a general discussion on the wording in the reasons if there had been a split decision. In the event of difficulties advice can be sought from the MHA office or the Chair.

Annual Report
The Chair invited comments and the report was noted.

Power of Discharge Hospital Managers Hearings Conduct Protocol
The Chair thanked those involved in the revision of the document and invited members to send any comment to the Mental Health Act Manager. It was noted that although not employees of the Health Board the protocol needed to state the status of the Associate Hospital Managers within the Health Board. The group also agreed that the protocol should include technical issues as a reason to adjourn.

Action - MHA office to amend

Observations and feedback
In order to improve the Annual Review process and make it more meaningful and robust it is intended to formalise feedback. There will be some changes to the minutes to allow the panel to reflect on what went well and ways in which “would be even better if”. In addition, observers of the Hearing will provide feedback. Any feedback from patients, relatives, professionals and advocates will be sent to the panel members. The revisions to the minutes will be circulated for comment.

Action Chair, Annual Review Sub Group and MHA office

Using abbreviations and initials in decisions.
Members were asked to desist from using these in the minutes as they can cause confusion and misunderstanding.

Reasons for decisions
These should provide context and add weight to the detention criteria. Any comments or observations should be recorded under the comment section. The only exception would be to give a positive message to the patient.

How to resolve differences in writing reasons
Post hearing the panel should agree the salient points to be included in the reasons. It may be necessary for a number of exchanges of emails in order to get the wording right. It is important that information is accurate and all panel members have a responsibility to check for accuracy and advise the panel Chair. In the event the panel can’t agree the wording advice should be sought from the MHA office.

Feedback on the Annual Review Process
The Chair apologised but it hadn’t been possible to arrange a further meeting. However, as discussed earlier the minutes will be revised to capture feedback that will inform the Annual Review Process.

8 Lessons Learnt

Not for disclosure – a brief context was provided and after discussion it was agreed that the matter would be raised at MHLGG as it highlighted a training issue regarding the process for non-disclosure. The Chair reminded the meeting that the bar for non-disclosure was high and had to, in the opinion of the panel, have a detrimental effect on the persons mental health. Any future issues to be recorded in the comments section of the minutes. It was agreed that the panel on the day had acted appropriately and adjourned the Hearing. The Mental Health Act Manager reminded the meeting that the

Panel can insist on the Responsible Clinician being present especially for the renewal of a section.

Action – Chair to be discussed at MHLGG

Near Miss - the Chair advised there had been a near miss that had been dealt with promptly and in line with the Health Boards policy. The Chair reiterated the importance of accurate information in the minutes and reasons.

Panel remain present to agree decision
There was a discussion and it was agreed that before leaving a hearing the headlines to be included in the minutes and reasons should be agreed. The advice was to read for accuracy and then for semantics.

9 MHA Activity Monitoring Report January - March 2021 April -June 2021

The reports were noted. It was acknowledged that the number of hearings and tribunals were below average for the last quarter. This may be due to a number of patients being placed outside the unit because of bed shortages. Also, there was a 10% reduction in the number of detained patients.

Advocates were present in 55% of Hearings and the MHA office continue to do all they can to promote the service.

There was a discussion around the relatively high number of cancellations recently. Currently, the Hearings are arranged 6 weeks in advance to give professionals time to compile reports. The Mental Health Act Manager agreed to look at whether it was feasible to have a shorter lead in time to arrange panels.

Action - MHA Manager

There was also a discussion regarding a CAMHS case. It was agreed that some training on the Children's Act may be appropriate.

Action - MHA Manager

10 Concerns/compliments from Power of Discharge group Hearings

These were noted. Again the issue of CTP's dominated the comments. This issue to be raised at MHLGG.

Action – Chair

The Vice Chair agreed to provide the annual report for the October Business meeting on compliments and concerns.

Action -Vice Chair

11 Committee and Sub-Committee Feedback

Mental Health Legislation and Governance Group
The Chair informed the meeting that there was nothing to report. The meeting was to be held on the 8th July. It was noted that the minutes from the previous meeting were included in the PoD papers.

Mental Health and Capacity Legislation Committee –There was nothing to report

12 Training

Training is still on hold at present other than unconscious bias training. A further session on unconscious bias is being held in September. All were reminded that this training is mandatory.

The National Conference is scheduled for the spring of 2022 but further information will be provided.

Action MHA office

Other less common disorders
Paul Cantrell has agreed to hold a session on 12th January 2022.

Working with interpreters
The Deputy Mental Health Act Manager advised that he has had difficulty in organising this session and Carol Thomas agreed to assist.

Action Deputy MHA manager and Carol Thomas

ECT
Deputy Mental Health Act Manager is awaiting dates from the ECT department. It isn't clear at this stage whether this will be in person training or via Teams.

Action Deputy MHA manager

The Chair invited members to share ideas for training with him and the Mental Health Act Manager.

13 Any Other Business

Mental Health Act Office Update -The Mental Health Act Manager advised of the changes within the MHA office. Simon MacDonald was seconded to the digital lead post in the Mental Health Clinical Board. David Seward is now the Deputy Mental Health Act Manager with Morgan Bellamy stepping up into the Mental Health Act Team Lead role. Beth is responsible for all the legal documentation with Georgia concentrating on managers and tribunal hearings. Bianca's role is more of a statistical one and Nicola and Laura have been appointed as Assistant Mental Health Act Administrators to support with rights, s17 leave, scrutiny etc. The Mental Health Act Manager will be on maternity leave from October and David Seward will be acting up. The Chair wished her well and asked the PoD for their continued support of the MHA office team.

Face to face hearings
The return to face to face hearings was now being considered. Some research is being undertaken to determine patient preference and attendance at virtual hearings. The Chair will update the PoD as the discussions continue.

Action MHA office and Chair.

14 Date of future meetings to be held at 10:00hrs in the Seminar Room, First Floor, HYC, UHL or via Teams:
6th October 2022
04 January 2022

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 8th July 2021 via Microsoft Teams

Present	
Robert Kidd	(Chair) Consultant Forensic Clinical Psychologist
Sunni Webb	Mental Health Act Manager
David Seward	Acting Deputy Mental Health Act Manager
Bianca Simpson Lepore	Mental Health Act Admin Team Lead
Mary Lawrence	Consultant Representative
Simon McDonald	Digital Lead for Mental Health
Simon Amphlett	Senior Nurse Manager Liaison Services
Ceri Phillips	Vice Chair, Cardiff and Vale UHB
Elizabeth Singer	Vice Chair, Power of Discharge Group
Alex Alegretto	Independent Mental Health Advocacy Manager
Katherine Lewis	Consultant Social Worker DOLS/ AMHP
Daniel Mash	Graduate Management Trainee
Lynda Woodley	Operational Manager, Vale of Glamorgan, Local Authority
Adele Watkins	Paediatric Representative
Apologies	
Daniel Crossland	Deputy Director of Operations
Tara Robinson	Lead nurse for Adult Mental Health
Stephen Clarke	Welsh Ambulance Representative
Kara Hanningan	Clinical Nurse Specialist for Physical Health and ECT
Jane Jones	Clinical Director, CAMHS
Catherine Morris	Emergency Unit Representative
Andrea Sullivan	Clinical Governance Lead, Mental Health

1 Welcome and Introductions

The chair welcomed members and those in attendance.

2 Apologies for Absence

Apologies were accepted and noted.

3 Minutes of meeting held on 11 March 2021

Not discussed during the meeting- advised that any change requests should be emailed to the minute taker.

4 MHA Activity

The Mental Health Act Manager informed the group that they only needed to focus on attachment six as the other attachments have already been considered due to the timings of the various meetings held over the last number of months.

The review of the Mental Health Act exception report was discussed but the group were informed that despite the window for submitting responses being closed now, there is no further update. The Operational Manager, Vale Local Authority confirmed their response has been submitted and that she would forward this on to the MHA manager for information. The consultant social worker for Cardiff confirmed Cardiff Local Authority has done the same.
The chair of the meeting felt the proposed changes to the legislation around patient consenting or not consenting to treatment were unusual and that they potentially will not pass into legislation.

The Operational Manager, Vale of Glamorgan Local Authority commented that the inability to detain learning disability patients under Section 3 could pose difficulties as there is currently nowhere near the resource to provide adequate care for these patients in the community.

The exception report for July will be submitted to the committee next week. The group agreed that it was surprising to see that in June 2021 there were more informal patients than detained. It was proposed that this may be due to a lack of information in regard to whether patients are being held under DoLs or not and due to the bed shortages that we have recently been experiencing.

5 Matters Arising

SOAD Telephone Consultations

The use of solely telephone been raised with Healthcare Inspectorate Wales. The use of the attend anywhere software has been suggested but we haven't moved any further with this item. It was confirmed that HIW work in the same way across Wales.

Silver on Call Training

The Silver on Call training agenda item has been listed for some time and can be removed for future reference. It was confirmed that the Silver on call can authorise private transport. Both local authority representatives agreed that the transport issue has improved since the pilot with St Johns ambulance started. The only issue to

highlight with regard to this is that there is only one St Johns ambulance available and it is in high demand. The local authority representative for the Vale commented that at present the rapid and secure transport is sometimes slow and leaves the potential for patients to become more distressed whilst waiting. It is thought this may be due to demand for private transport across the whole country- meaning waiting times have increased for vehicles to get from one place to another. It was proposed that perhaps utilising another company as well as our current private transport provider to help overcome this. This will be added to the next agenda.

Action- Chair to feedback to Director of Operations and Delivery

The group were informed that the money providing the St Johns ambulance is now permanent but that the way it is currently being used is still a pilot and could change.

Recording of Repeat Section 136 Admissions
The digital lead confirmed that in the foreseeable future the police triage team based in police headquarters will have access to PARIS in order for them to record whether they've been consulted with and subsequently whether their advice has been followed. The digital lead confirmed that inputting the repeat section 136 patients' information in the LDR (local data repository) is being investigated. This will more easily highlight the information across settings- i.e. accident and emergency and Hafan Y Coed. Unfortunately at present there is no easy fix to this is issue via PARIS.

The lack of accurate information regarding mental capacity Act and Voluntary assessments was raised. It was agreed that this should be picked up on with our police colleagues in order to gain more accurate data going forward.

Action- to liaise with Peter Thomas in regard to monitoring this

MHA/MCA/Suicide Meetings
The chair of the meeting was pleased to say that there has been progress with regards to suicide training. It was confirmed that the "Connecting with people" suicide prevention training will be offered to all mental health professionals.

The Senior Nurse Manager, Liaison Services raised a concern to the team that out of hours MHA assessments requested by psychiatric liaison nurses are being denied on the basis that the request should come from a medic rather than a nurse. This is not a problem for day time assessments. It was agreed that requests should be screened by facts and need rather than by the person referring in. The issue will be discussed with the senior members of the EDT team in order to find a resolution.

Quality Indicators and Audit Activities
The quality and audit templates have been shared with the board director to explore whether they need amending before being used further.

Action - to include the Section 12 doctor workforce issues on template

MHRT Concerns
Concerns have previously been raised for the safety of staff conducting telephone hearings on their own with patients. The MHRT are now piloting video conferencing for hearings. The first one for Cardiff and Vale UHB was due to take place mid - July. However the Mental Health Act Office have been informed that this pilot will not be going ahead due to the patient being deemed to lack capacity. The Group agreed to discuss this matter further with the MHRT as the general feeling is that this delivery method should be used for all hearings, including patients without capacity. It was confirmed that video conferencing is being used for DoLs assessments and that this is working very well. The Mental Health Act Manager reminded all those present to not share devices when taking part in hearings. This will be being monitored by the MHA Office and passed back to the Senior Team if it continues to pose a problem.

Action – Mental Health Act Manager to liaise with MHRT

LPS Update
The Liberty Protection Safeguards were discussed at some length. The proposal is that the new legislation will come into force in April 2022. Several working groups have been set up in regard to how best to implement this new framework. The group were informed that there is currently no Mental Capacity Act Manager in place and that queries relating to this are being directed to the Patient Safety Team. The working groups are a combination of health board and local authority staff and aim to provide the Welsh Government with the information they've requested. It was agreed across the board that training needs to start being delivered urgently in order for professionals to be adhering to the new legislation when the time comes. Prior training (for instance best interest decision training) will be of benefit to staff but shouldn't be relied upon in order to implement the new LPS'. It was agreed that thorough training on how to conduct a good mental capacity Act assessment will be beneficial for anyone involved with the LPS'. The Vale local authority representative felt that the LPS' will be more labour intensive for each team individually. Whereas at present there is a DOLs team, no such overarching team will be in place for LPS'. The chair of the meeting felt that health board staff were perhaps not aware of this. There has been no discussion in MAC meetings about the upcoming changes. It was mentioned that LPS' will now cover 16 and 17 year olds and that CAMHs should therefore be included in discussion/training. The paediatric representative believed her lead would already be aware of the changes. The backlog of DOLs assessments is still being worked through but extra funding from the Welsh Government has allowed the backlog to decrease to its lowest level in some time.

It was agreed by the Chair of the meeting and the MHA manager that LPS' should stay on the agenda and that they would approach the Patient Safety Team to ascertain what their plan is.

Action- Chair, MHLGG to contact patient safety team

6 Feedback on operational issues and incidents

There have been no changes in our processes for working during the COVID 19 Pandemic. Video conferencing is being used where possible but face to face assessments are still being carried out when necessary. Hospital managers'

hearings are still being held remotely and is this working well. It is encouraging to note that piloting of video conferencing by the MHRT.

The use of St Johns ambulance is working well and the AMHPs would like this to continue. The incidence of CAMHs patients being detained in Hafan Y Coed has increased over 2020/ 2021. Unfortunately there is still no formal agreement on how to allocate an RC to CAMHs patients detained in HYC. The matter will be discussed further.

There is no update in regard to the implementation of digital signatures.

The mental health Act manager highlighted the high use of Section 62 emergency treatment due to SOAD request not being submitted in good time of the three month rule expiring. The MHA manager requested that the consultant representative bring this back to the MAC meeting to hopefully remind RC's to utilise the daily PARIS report which they receive in order to prompt them.

The current shortage of Section 12 doctors was discussed. The mental health Act manager confirmed that there doesn't seem to be consensus across health Boards as to how to recruit/ train Section 12 doctors. It was felt the issue should be raised to the medical and clinical directors and the Chair of the meeting agreed he would bring the item back to the quality and safety group for them to look into also. It was suggested that the recent increase in the use of Section 4 may be due to this lack of availability, but this will be further investigated by the MHA team.

The section 12 doctors list needs to be fully updated and some doctors' availability seems to have changed since the time it was complied.

Action- MHA Admin team lead to update section 12 list and look into use of section 4.

7 Feedback from other meetings

Feedback from the Cardiff AMHP forum is in regard to lack of availability of section 12 doctors and beds. A potentially risky situation was discussed whereby a bed couldn't be located for a patient who needed to be detained in a PICU setting. The incident will be discussed in Sentinels. It was agreed that professionals will really benefit from having a protocol of what to do if this situation arises again. The chair of the group asked that the MHA manager keep track of this incident in order to work out what the resolution will be.

Action- Chair/Mental Health Act Manager to keep track of incident above

The Vale AHMP forum informed the group of an increase in doctors leaving medical recommendations on wards and then requesting MHA assessments. This is not in line with best practice which dictates that assessments should be held jointly if possible. The consultant representative agreed to feed this back to her counterparts. To back this up the Operational Manager, Vale of Glamorgan Local Authority will provide a small paragraph on why joint assessments are so important for patients.

The Operational Manager, Vale of Glamorgan Local Authority also mentioned a scheme called “breathing spaces” which is a debt respite scheme set up by the Government. At present an AMHP has to authorise the eligibility of this even if they don’t know the client well at all. It was suggested this should perhaps be under the remit of the care coordinator. The Operational Manager, Vale of Glamorgan Local Authority informed the group that representations have been made to social services and WG to see if this policy can be altered.

The paediatric representative requested that AMHPs provide more guidance to her staff when detaining a young person to the children’s hospital. Paediatric nurses are not au-fait with the correct processes when sending MHA documentation to the MHA office. Training for staff is being looked into but may take a while to roll out.

The Independent Mental Health Advocacy Manager confirmed that things were running smoothly from his perspective and that they had seen an increase in referrals from secondary services.

8 Power of discharge group comments, compliments and feedback

The PoD representative informed the group of a near miss in regard to inaccurate information being submitted on a decision which subsequently went to a nearest relative. Lessons have been learnt from this incident.

The annual review of PoD members is likely to become more robust and it is hoped that the Vice Chair of the health board may be interested in taking part.

The PoD representative asked that new staff be reminded of the not for disclosure guidance as a recent incident regarding this resulted in a hearing being adjourned.

PoD members also asked that staff be reminded that they can access the reports of other professionals via PARIS prior to hearings.

Care and Treatment plans are still the most common reason for comments from the PoD group.

9 External Reviews- Healthcare Inspectorate Wales

The Mental Health Act Manager highlighted that HIW had acknowledged that patients had not engaged well with tribunals held by telephone in their report for Hazel Ward.

The Group are not aware of any future HIW visits.

10 Interface MHA/ MCA/ DoLs

Discussed previously.

11 Quality indicators and audit activities

Discussed previously.

12 Any other business

Attachment 13 was shared for information.

The Mental Health Act Manager informed the group that in Hazels HIW report states that consent to treatment certificates are scrutinised by a consultant psychiatrist and clarified that this is not currently to protocol in Cardiff and Vale. The Mental Health Act Manager informed the group that some other health boards ensure medical scrutiny of consent to treatment certificates is undertaken as an extra safeguard even though it is not a requirement of the Act. It was agreed that MHA office staff are not clinical and therefore aren't appropriately trained for this A few options were suggested including Ward Managers, Consultant Psychiatrists' and Pharmacy. However the group were informed that discussions had previously taken place with Pharmacy who were unable to assist due to the COVID situation and lack of resources. The group agreed the matter should be raised with senior nurses to gain their perspective.

13 Date of future meetings- venue to be confirmed:

07 October 2021
06 January 2022

Report Title:	**Annual Board Effectiveness Survey 2020-2021 - Mental Health Legislation Capacity Committee**								
Meeting:	Audit and Assurance Committee						**Meeting Date:**	20/07/2021	
Status:	**For Discussion**	**X**	**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Interim Head of Corporate Governance** **Corporate Governance Officer**								

Background and current situation:

Effective Board and Committee meetings are a key part of an effective governance structure and it is important to ensure that Cardiff and Vale University Health Board's (CVUHB's) organisational governance is compliant with the provisions of its Standing Orders which state that:

10.2.2 The Board shall introduce a process of regular and rigorous self- assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

CVUHB has undertaken a review of the Board and its sub-committees, using survey questions derived from best practice guidance, including the NHS Audit Handbook, and using the following principles:

- the need for sub-committees to strengthen the governance arrangements of the Health Board and support the Board in the achievement of the strategic objectives,
- the requirement for a committee structure that strengthens the role of the Board in strategic decision making and supports the role of Independent Members in challenging executive management actions,
- maximising the value of the input from Independent Members , given their limited time commitment,
- supporting the Board in fulfilling its role, given the nature and magnitude of the Health Board's agenda.

For the 2020-2021 self-assessment, a survey was disseminated via Survey Monkey to all Board members enabling an efficient yet effective reflection on Board effectiveness and mirroring the method used for the Committees.

The purpose of this report is to present the findings of the Annual Board Effectiveness Survey 2020-2021, which relate to the Mental Health Legislation Capacity Committee and to present the action plan 2020-2021 developed to address the areas identified for improvement.

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

- The survey questionnaire for the annual Board/Committee effectiveness survey 2020-2021 was issued in early April 2021 and attained a positive response rate overall,

- The overall findings are positive which provides an assurance that the governance arrangements and Committee structure in place are effective, and that the Committees are effectively supporting the Board in fulfilling its role,
- The individual findings of the Annual Board/Committee Effectiveness Survey 2020-2021 relating to the Mental Health Legislation Capacity Committee are presented at ***Appendix 1*** for information,
- Out of the questions posed, room for improvement was identified in 5 areas and a Board Effectiveness Action Plan 2020-2021 has been developed to address them which is presented at ***Appendix 2*** and outlines proposed actions to strengthen and develop the areas identifed, it is suggested that this action plan be progressed via Board, Development sessions. Assurance is provided by work already in train in many of these areas as referenced in the action plan,
- The individual Board/Committee findings will be presented to each relevant Committee for assurance,
- When considering the findings, they should be considered in the context that the survey was issued to the 22 Members of the Board and only those who were members of the relevant Committees were in a position to respond. Further work will be undertaken in 2021-2022 to encourage Board members to complete the survey.

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

To ensure effective governance the Board Effectiveness Survey is undertaken on an annual basis, in accordance with the provisions of the Standing Orders for NHS Wales.

The next self-assessment will be undertaken in March/April 2022 to coincide with the end of financial year reporting requirements of the Annual Governance Statement 2021-2022.

Recommendation:

The Committee are requested to:

a) **NOTE** the results of the Annual Board Effectiveness Survey 2020-2021, relating to the Mental Health Legislation Capacity Committee,
b) **NOTE** the action plan developed for 2020-2021, which will be progressed via Board Development sessions.

Shaping our Future Wellbeing Strategic Objectives

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

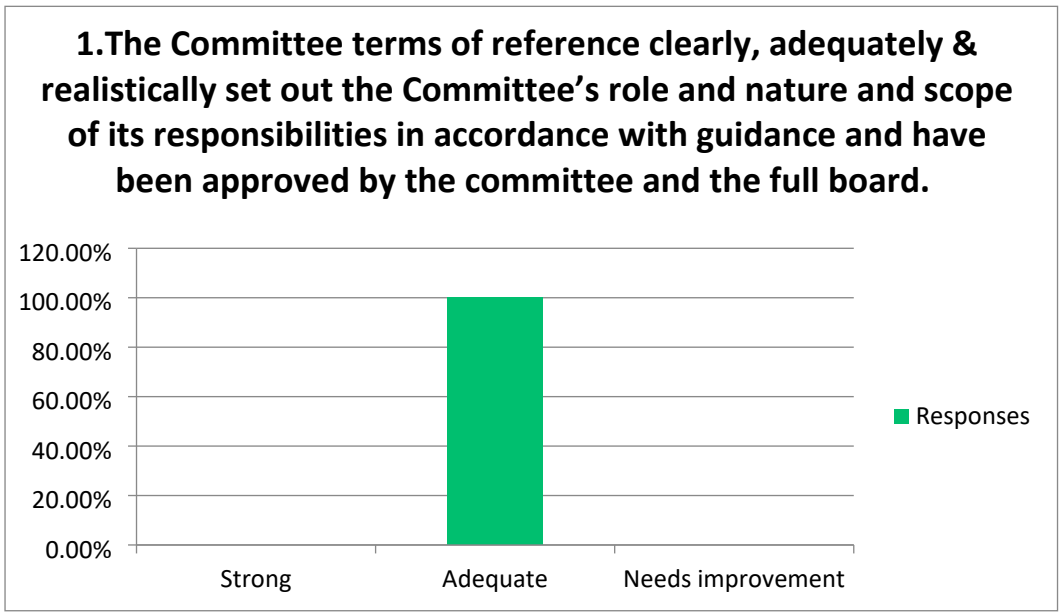
1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	X
3. All take responsibility for improving our health and wellbeing		8. Work better together with partners to deliver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

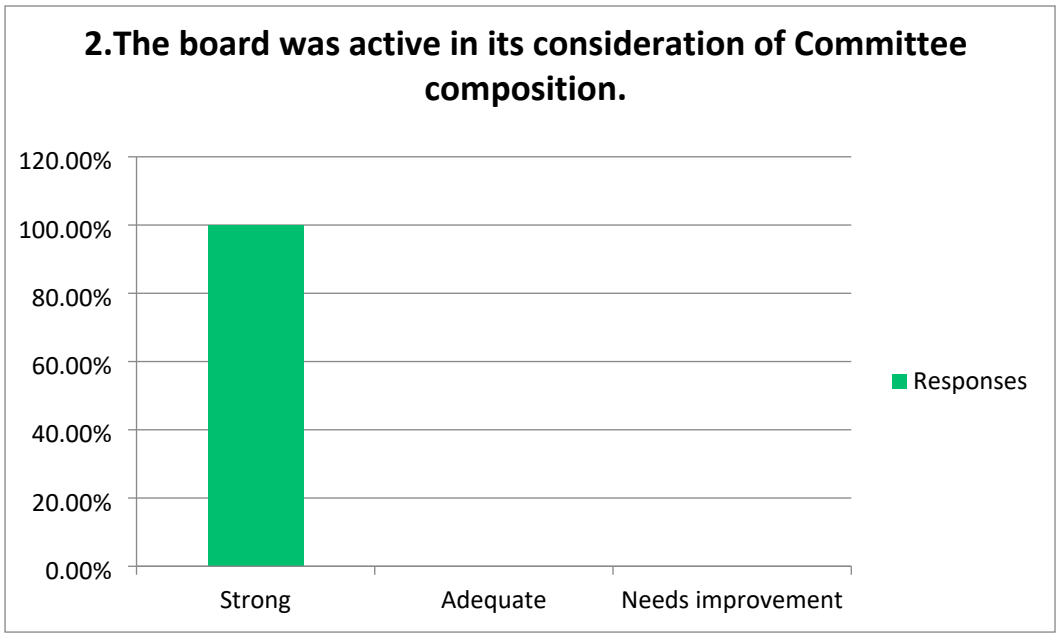
Five Ways of Working (Sustainable Development Principles) considered *Please tick as relevant, click here for more information*									
Prevention		Long term	X	Integration		Collaboration		Involvement	
Equality and Health Impact Assessment Completed:	Not Applicable								

Annual Board Effectiveness Survey 2020-2021

Mental Health and Capacity Legislation Committee Self Evaluation 2020-2021

- 3 responses received

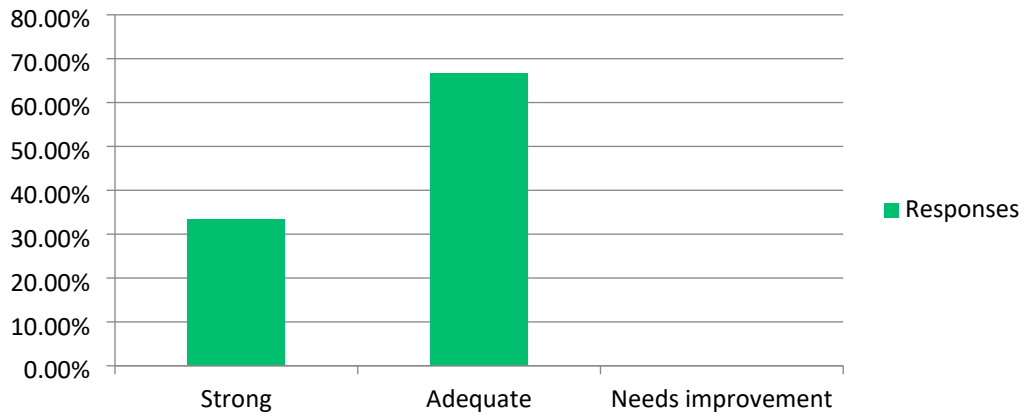




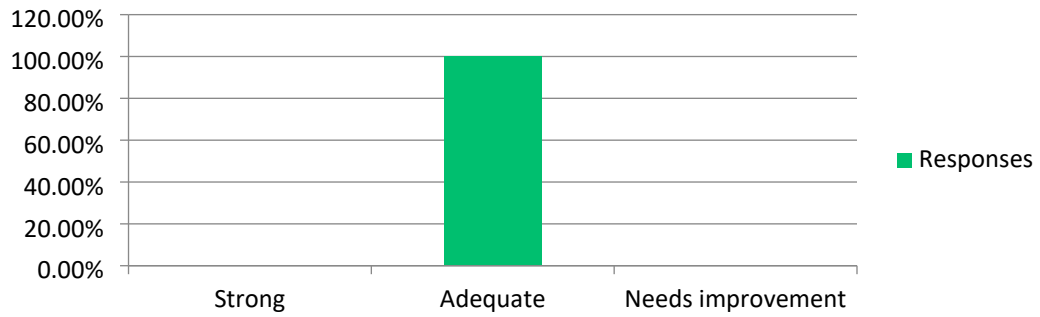
Comments received:

- *All Committees of the Board are approved on an annual basis as are the composition of the Committees.*

3.The Committee actions reflect independence from management, ethical behaviour and the best interests of the Health Board and its stakeholders.

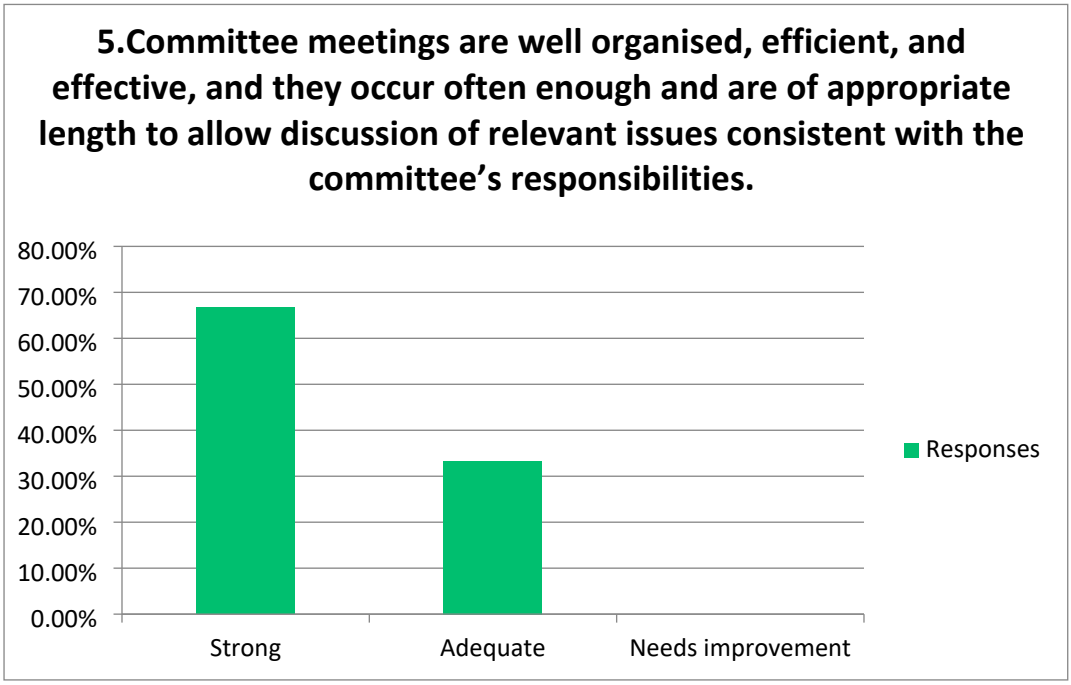


4.The Committee meeting packages are complete, are received with enough lead time for members to give them due consideration and include the right information to allow meaningful discussion. Minutes are received as soon as possible after meetings.



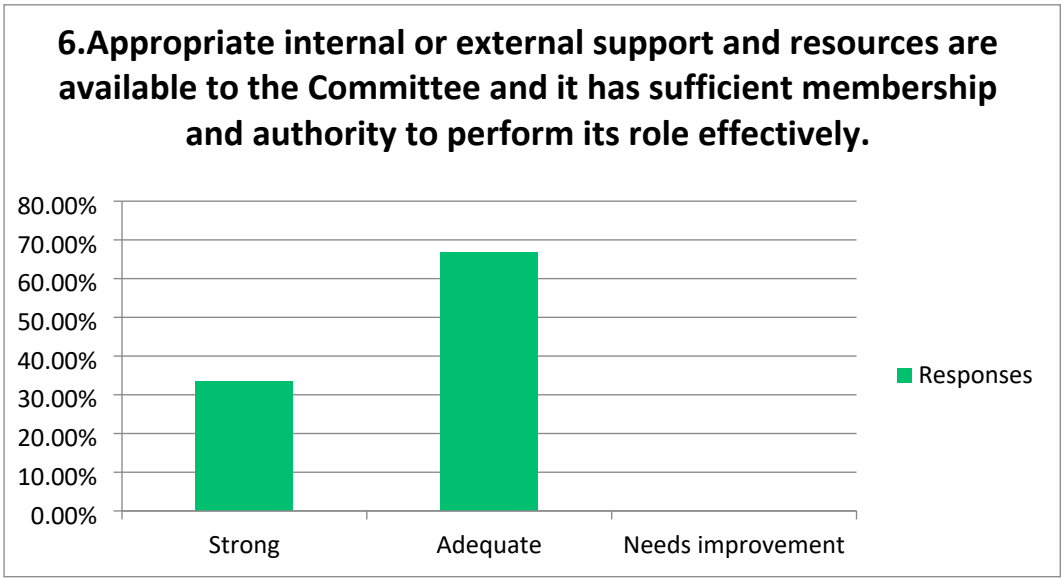
Comments received:

- *Maybe a little too much information*

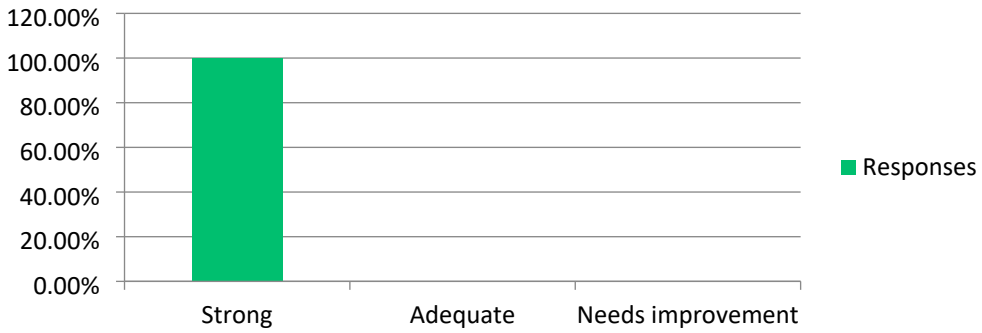


Comments received:

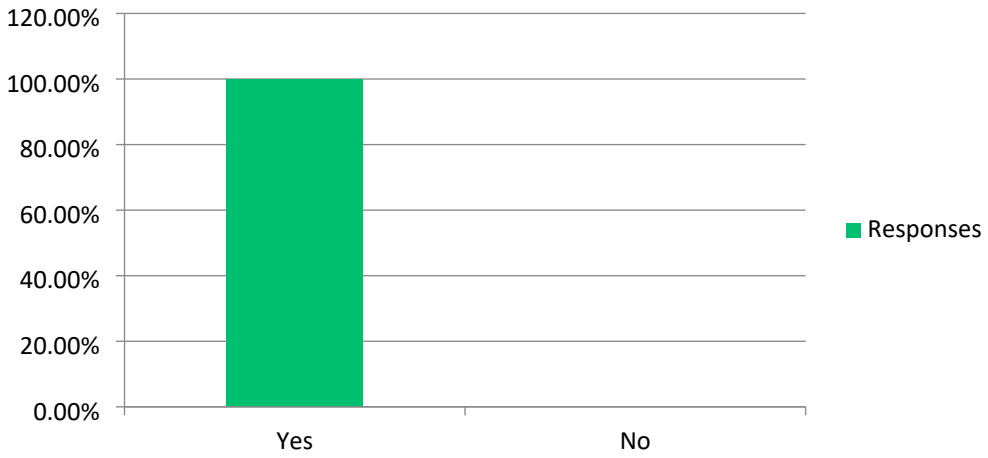
- *Sometimes the Committee has a tendency to drift into discussion about individual service user experience.*

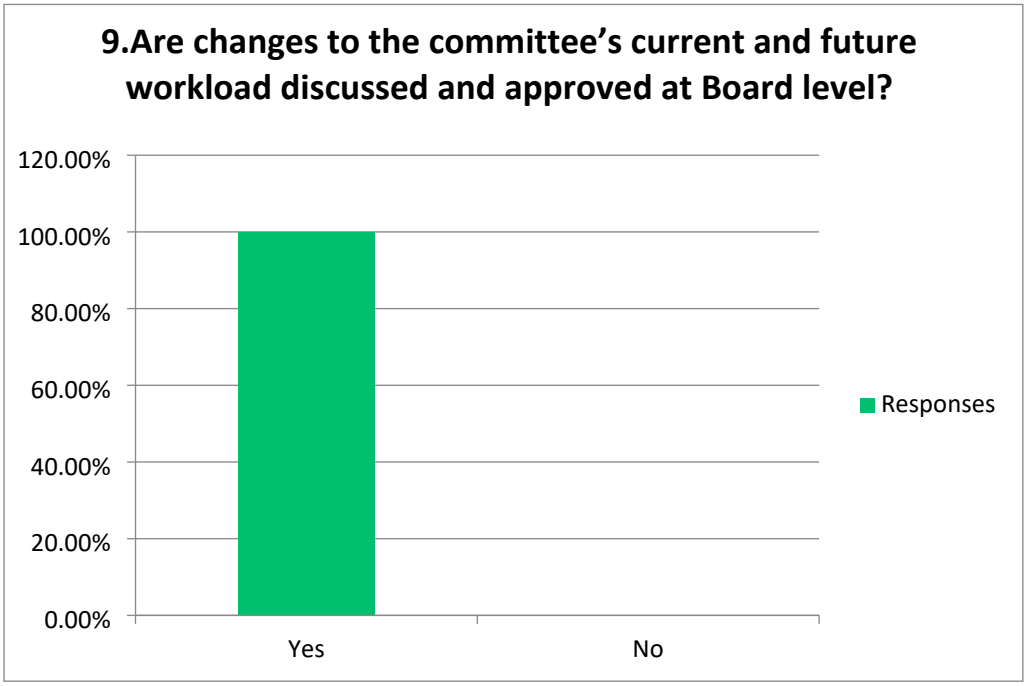


7.The Committee informs the Board on its significant activities, actions, recommendations and on its performance through minutes and regular reports and has appropriate relationships with other committees.



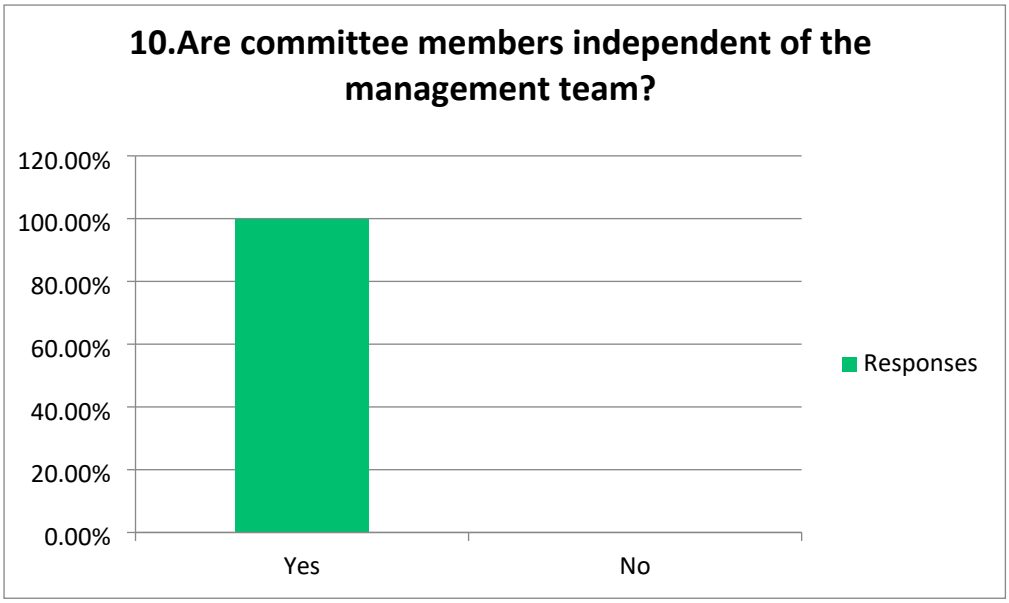
8.Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?

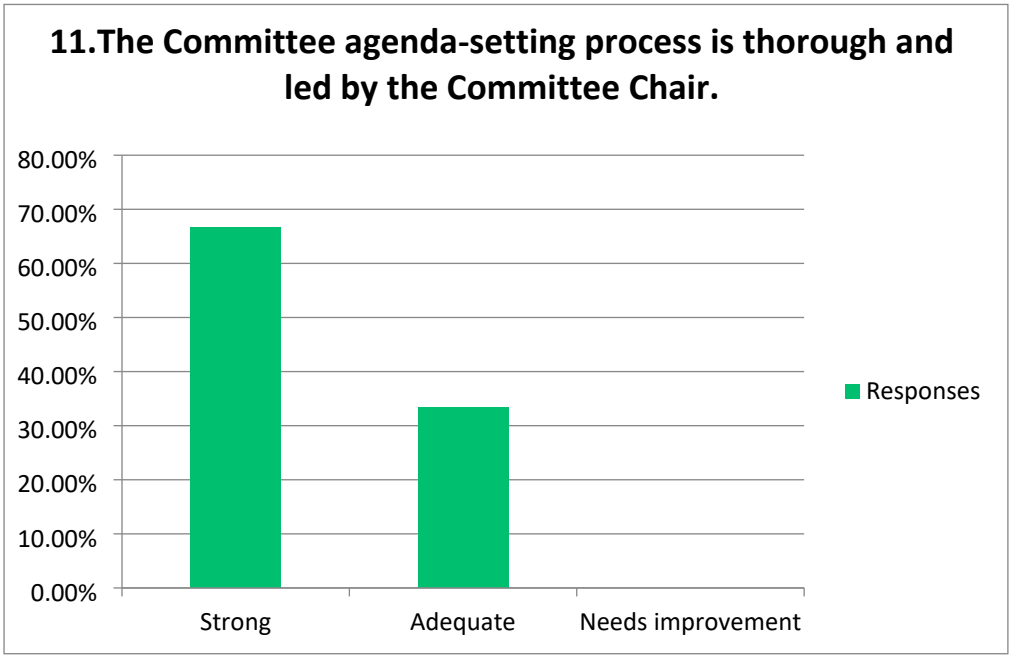


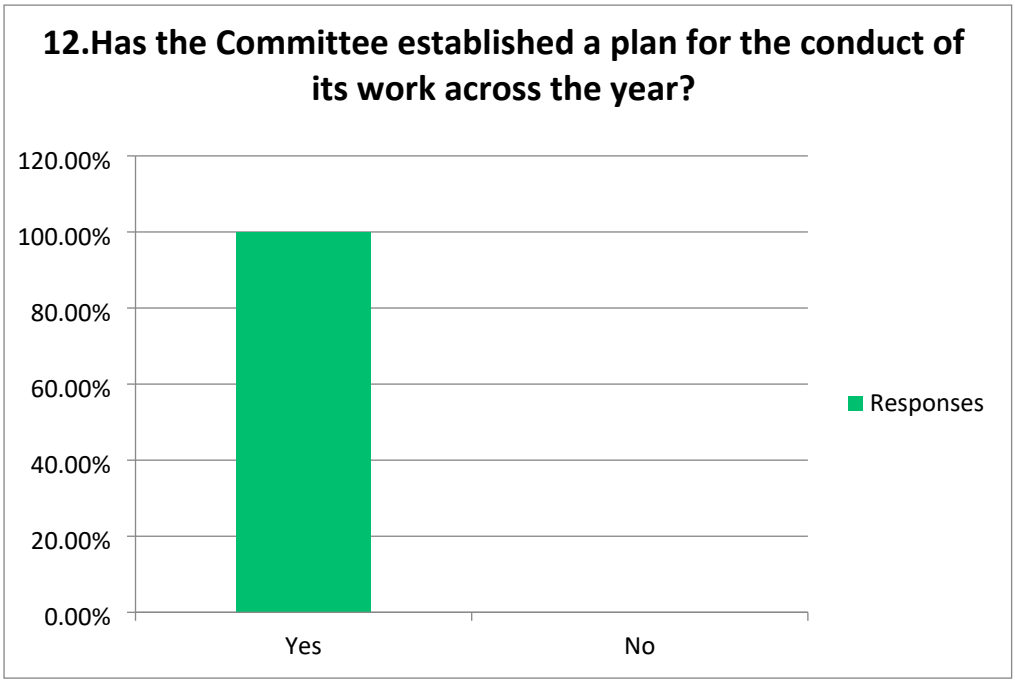


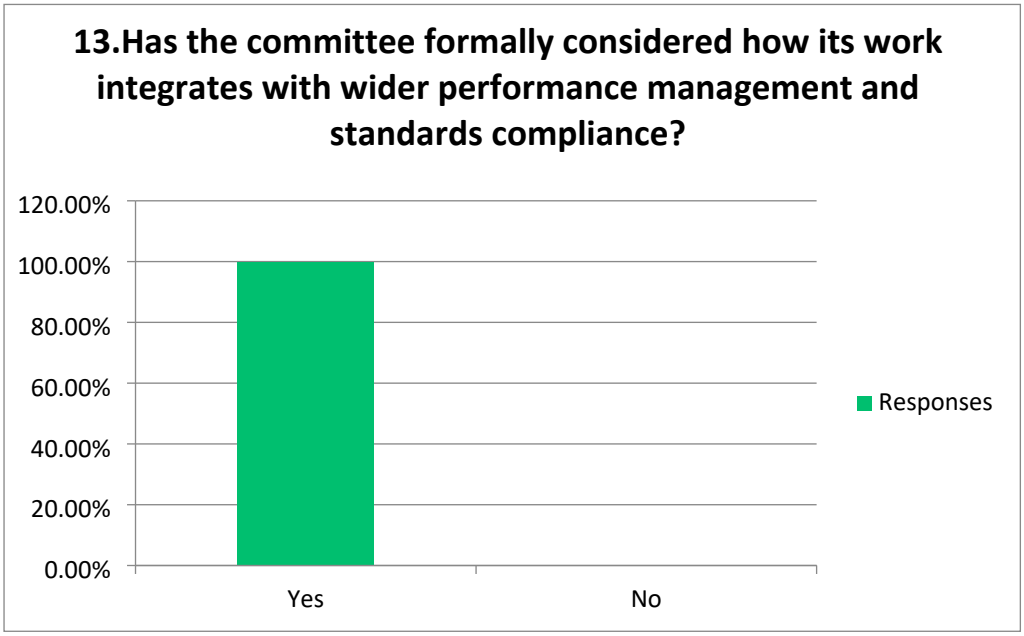
Comments received:

- *An annual plan of business is agreed each year.*



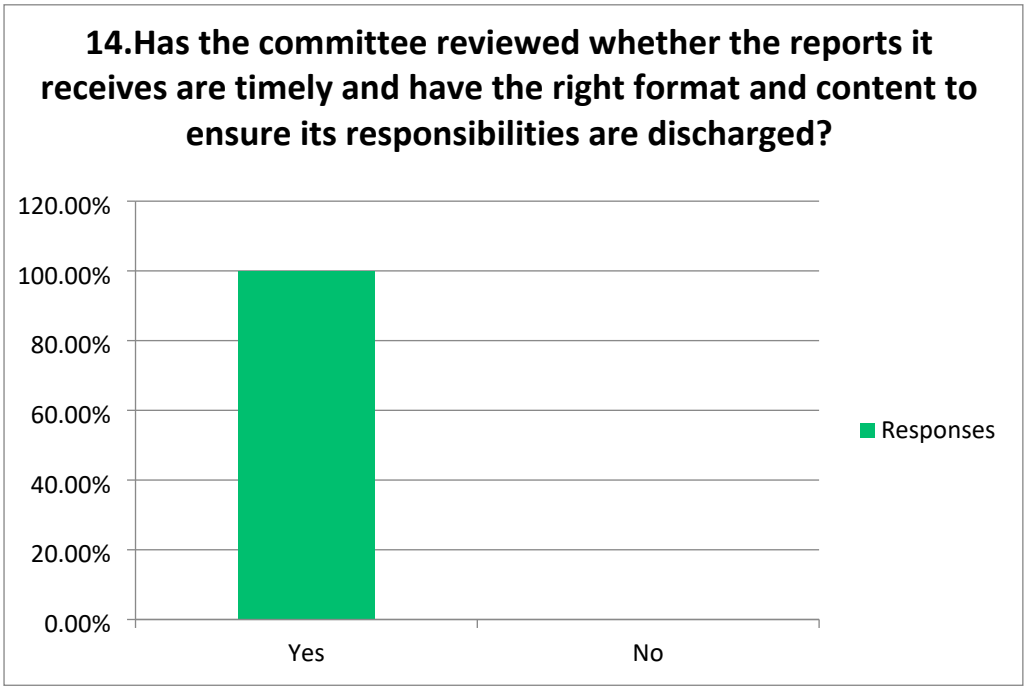


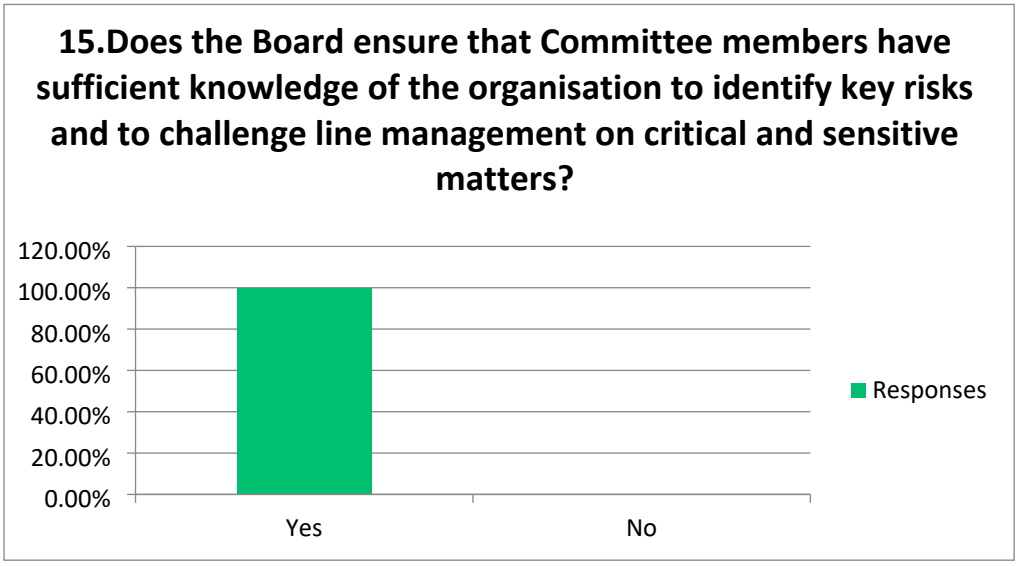




Comments received:

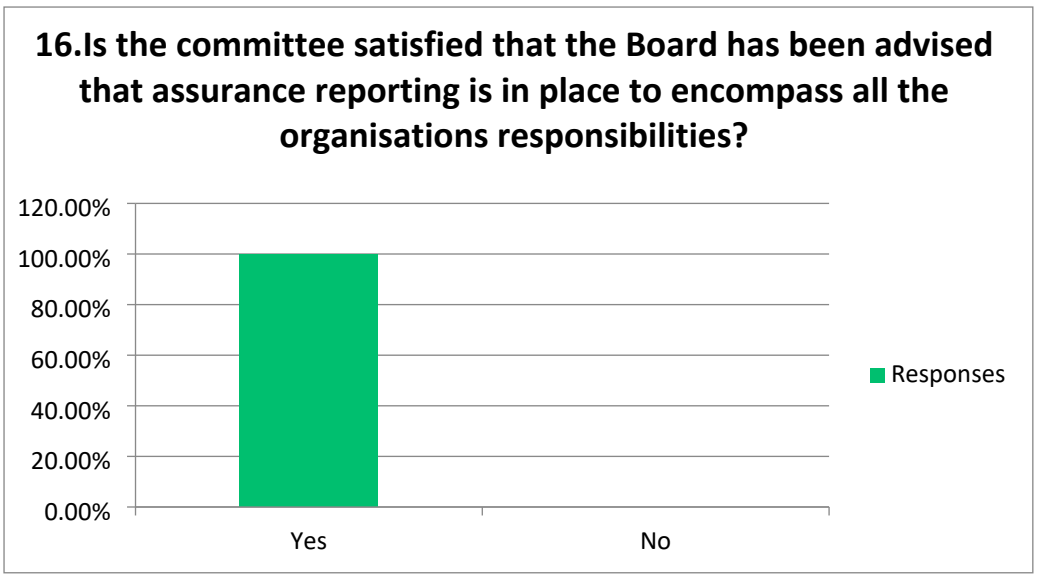
- *An annual report has been done to Audit Committee to look at interrelationships between Committees*

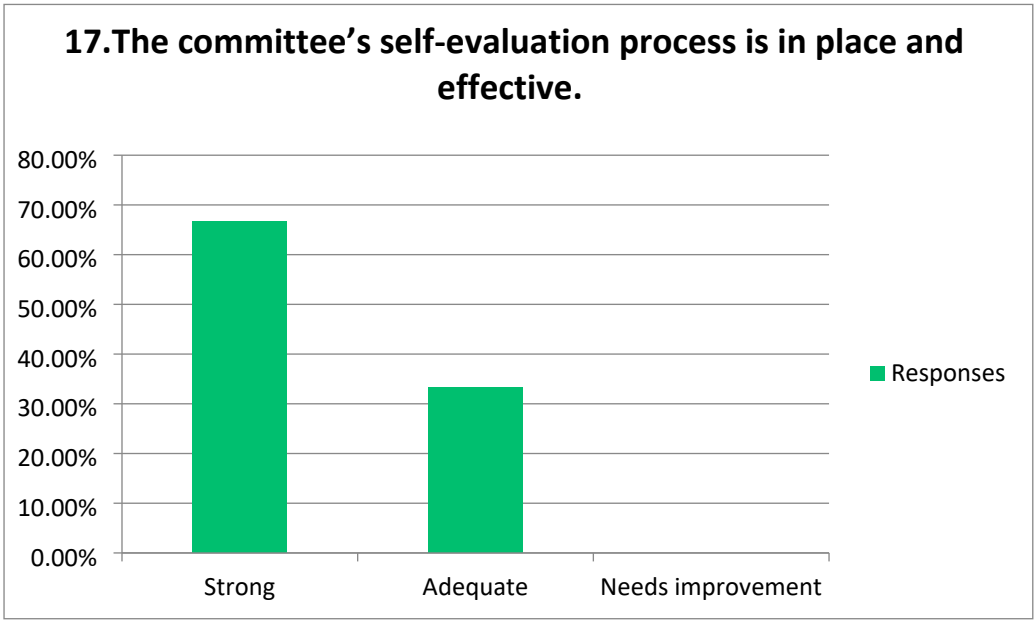


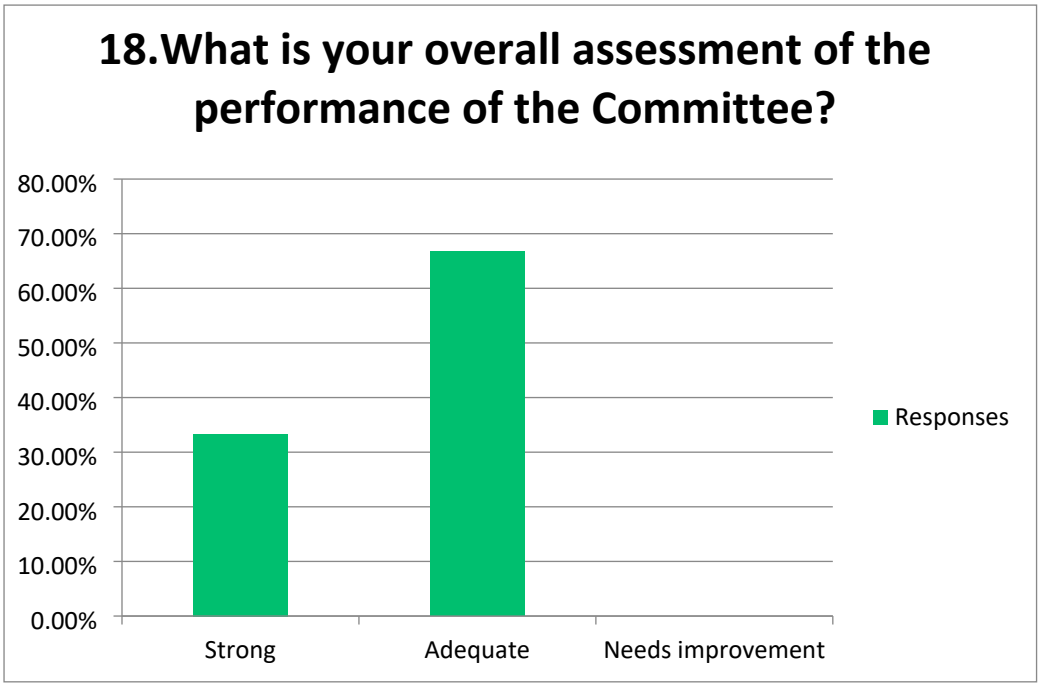


Comments received:

- *Training has been undertaken with this Committee during the last financial year*







Board Effectiveness – Self Assessment 2020-2021 Action Plan

The table below identified areas from the Annual Committee Effectiveness Survey 2020-2021 undertaken in April 2021, that suggested a need for Further Improvement

Question asked 2020-2021	Response and Action Required	Lead	Timescale to complete
Board **8. We Identify and Share Best Practice and benchmark**	The Board are proactive in utilising business intelligence to support effective decision making and benchmarking is undertaken through the various NHS Wales professional peer groups, for example the NHS Wales Directors of Nursing Group, NHS Wales Board Secretaries Network etc. **Action** Consider strengthening and developing sharing best practice and benchmarking at a future Board Development session.	Executive Nurse Director, Executive Director for Strategic Planning Executive Medical Director, Chief Operating Officer, Executive Director of Workforce and OD.	Dec 2021
Charitable Funds Committee **4.Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting.**	All Committee papers are issued in accordance with section 7.4.3 of the Standing Orders, specifically: *"7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least **10 calendar days** before a formal Board meeting."* *Action* - The Corporate Governance team will continue to adhere to internal performance standards for the review, approval and issuing of minutes, and will ensure that all minutes are issued swiftly. A review of the timeliness of papers being issued against the internal targets set will be undertaken to monitor effectiveness.	Director of Corporate Governance	Dec 2021

	Agenda planning meetings will confirm that minutes have been approved by the Chair and circulated to Members as required.		
<u>Health & Safety Committee</u> **2. The Board is active in its consideration of the Committee's composition**	The Composition of the Health & Safety Committee is outlined in its Terms of Reference which are agreed by the Board. The DCG will liaise with the Chair and review the composition of all Committees and the scheme of delegation within the Standing Orders will be updated.	Director of Corporate Governance	Sept 2021
<u>Health & Safety Committee</u> **4.Committee meetings packages are complete, received with enough lead time for members to give them due consideration and include the right information. Minutes are received as soon as possible after the meeting.**	All Committee papers are issued in accordance with section 7.4.3 of the Standing Orders, specifically: *"7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least* ***10 calendar days*** *before a formal Board meeting."* *Action* - The Corporate Governance team will continue to adhere to internal performance standards for the review, approval and issuing of minutes, and will ensure that all minutes are issued swiftly. A review of the timeliness of papers being issued against the internal targets set will be undertaken to monitor effectiveness. Agenda planning meetings will confirm that minutes have been approved by the Chair and circulated to Members as required.	Director of Corporate Governance	Dec 2021
<u>Quality, Safety, Experience Committee</u> **The Committee agenda setting process is thorough and led by the Committee Chair.**	All Board/Committee meetings are supported through an agenda planning meeting which reviews the agenda, minutes, action log and length of the meeting. The Committee Chair attends the meeting and is involved in setting	Director of Corporate Governance	May 2021

	the agenda with the Director of Corporate Governance. A meeting guidance document will be produced and issued to Officers and Independent Members and all agenda planning meetings will consider the length of the agenda, items for the agenda, time allowed for agenda items, approval of minutes and action logs, terms of reference, quoracy, Chairs report for Board etc		

Report Title:	**Corporate Risk Register**								
Meeting:	Mental Health Capacity and Legislation Committee					**Meeting Date:**	20/07/2021		
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information**	✓	
Lead Executive:	**Director of Corporate Governance**								
Report Author (Title):	**Head of Risk and Regulation**								

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates and has, since January 2021, been shared with the Board and it's Csub-committees at Public meetings for additional scruinty and assurance having previously been shared in private.

The Register has historically included those risks which are rated 15 and above to provide the Board and it's Ccommittees with an overview of the Health Board's extreme Operational Risks. The Health Board's Risk Management and Board Assurance Framework Strategy and Procedure has recently been amended so that the Corporate Risk Register only records those risks scored at 20 ~~or~~ and above. This change will be implemented for future iterations of this report following the July Board meeting.

Each risk within the Register is linked to a Committee of the Board and the Board Assurance Framework. The entries within the Corporate Risk Register which are linked to the Mental Health Capacity and Legislation Committee for assurance are attached at Appendix 1.

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

The Risk and Regulation Team ("the Team") continue to work alongside Clinical Boards and Corporate Directorates to ensure that risks are clearly defined and appropriately scored in line with the Health Board's Risk Management Strategy and Procedure. To achieve this the Team now provide a risk register 'check and challenge' feedback report to Clinical Boards/Corporate Directorates detailing recommendations for the improvement of their risk registers and, where relevant, the rationale for not placing candidate risks onto the Corporate Risk Register (e.g. due to significantly aberrant scoring).

Since the last Ccommittee Mmeeting the Team have undertaken this task with the Mental Health Clinical Board which has led to one risk being included within the Corporate Risk Register for July. For the purpose of this report only, the detail of that risk, and a further risk scored at 15 are detailed below and on the attached risk register extract.

Following the introduction of the check and challenge system a further training session for Mental Health Clinical Board leads has been scheduled to take place in August 2021.

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

At July's Board meeting one Extreme Risk will be reported to the Board which is linked to the Mental Health Capacity and Legislation Committee for assurance purposes. That risk can be summarised as follows:

Risk Description Summary	Risk Score (1 to 25)
Risk to the health and wellbeing of a minor inpatient following admission to adult mental health services	20

This risk has remained on the Corporate Risk Register since January and has remained ~~stagnant~~ the same ~~since~~ despite the presence of appropriate controls being in place. As part of the Team's Check and Challenge system the Mental Health Clinical Board have been asked to give greater consideration to the controls they have in place and whether the provision of additional staffing provides sufficient control to reduce the scoring of this risk to 15 and if not whether additional controls should be implemented. It is hoped that the scoring of this risk will have reduced prior to the next Committee ~~meeting~~ Meeting because of either, a reconsideration of the scoring applied to the risk, or the introduction of more appropriate controls to mitigate the likelihood of the risk occurring.

Alongside the above risk, the below Extreme Risk, continues to be recorded on the Mental Health Clinical Board Risk Register which has previously been shared with the Committee.

Risk Description Summary	Risk Score (1 to 25)
Poor WAST response to MH services with conveyancing of 1) detained patients to hospital from community and 2) transferring medically unwell patients on the UHL site from MH to Physical health facilities.	15

This risk has remained the same~~stagnant~~ since March's Board meeting however the Clinical Board have secured the service of St John's Ambulance to provide the conveyancing service moving forward. It is anticipated that the continued use of St John's ambulance will reduce this likelihood of this risk occurring significantly.

The Risk and Regulation team will continue to work with the Mental Health Clinical Board (and other areas) to further integrate the Health Board's Risk Management policies and procedures to ensure that those entries detailed on the Register provide an accurate indication of the risks that the Health Board is dealing with operationally.

ASSURANCE is provided by:

- Ongoing discussions with Clinical Boards and the Corporate Directorates regarding the scoring of risk.
- The programme of education and training that will be rolled out by the Risk and Regulation team to ensure that the Health Board's Risk Management policy is engrained and followed within Clinical Boards and Corporate Directorates.

RECOMMENDATION

The Committee is asked to:

NOTE the Corporate Risk Register risk entries linked to the Mental Health Capacity and Legislation Committee and the work which is now progressing.

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	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	

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

Equality and Health Impact Assessment Completed:	Not Applicable

CORPORATE RISK REGISTER JULY 2021

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
	4	Jan-20	**Patient Conveyancing** There is a poor (delayed) WAST response to MH services with conveyancing of 1) detained patients to hospital from community and 2) transferring medically unwell patients on the UHL site from MH to Physical health facilities. This risks rapid deterioration of patients' mental and/or physical symptoms with a potentially adverse impact on patients safety, quality of service and reputation.	5	4	**20**	Attempts made to performance manage WAST response with no improvement. Escalation of risks through local WAST meets. Use of costly private transport providers for most urgent and high risk cases. The services of St John's ambulance have been secured to provide conveyancing services.	5	3	**15**	Ongoing monitoring and escalation	4	2	**8**	Sep-21	Mental Health and Capacity Legislation Committee	Patient Safety
	5	Aug-20	**Young Person in Adult Mental Health Placement** Young person with complex needs required admission to adult mental health services as no suitable alternative available. There is a risk that the patient will be in a sub-optimal clinical environment which will adversely impact on the patient's safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.	5	5	**25**	Additional staff allocated to the care of the patient.	5	4	**20**	Safeguarding discussions ongoing with private care providers with no realistic placement available for the forseeable future.	5	2	**10**	Sep-21	Mental Health and Capacity Legislation Committee	Patient Safety