Mental Health and Capacity Legislation Committee

Tue 19 October 2021, 10:00 - 12:00

MS Teams

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 July 2021

Ceri Phillips

04 DRAFT MHCLC Minutes 20.07.21 MD CP.pdf (10 pages)

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

Ceri Phillips

05 DRAFT Action LogMD.NF.pdf (2 pages)

6.
Chair's Action taken since last meeting

Ceri Phillips

7.
Any Other Urgent Business Agreed with the Chair

Ceri Phillips

a) Compliance with MH Measure relating to Children and Young People

8.
Patient / Staff Story

8.1.
Patient Story

My Battle with Food - Video

9.
Mental Health Act

9.1.
Mental Health Act Monitoring Exception Report

Daniel Crossland / Scott Mclean

9.1 Mental Health Act Monitoring Exception Report October 2021.pdf (8 pages)
9.1a Mental Health Act Monitoring Report July - September 2021.pdf (46 pages)

9.2.
Update on the Reform of the Mental Health Act (Verbal)

David Seward

9.2 Review of the MHA Exception report.pdf (18 pages)

10.
Mental Health Measure

10.1.
Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report

Daniel Crossland / Scott Mclean

10.1 MHLC - Mental Health Measure Nov 2021 AMS and CAMHS.pdf (12 pages)

11.
Items to bring to the attention of the Committee for Noting / Information

11.1.
HIW MHA Inspection Reports (Verbal Update)

Daniel Crossland

No reports for this period.

11.2.
Sub-Committee Meeting Minutes:

11.2.1.
Hospital Managers Power of Discharge Minutes

11.2.1 Power of Discharge Groups Minutes 5 October 2021 FINAL..pdf (3 pages)

11.2.2.
Mental Health Legislation and Governance Group Minutes

11.2.2 MHLGG Minutes October 2021 Final.pdf (7 pages)

12.
Items for Approval Ratification

13.
Review of the Meeting

Ceri Phillips

14.
To note the date, time and venue of the next meeting:

Date to be confirmed pending reschedule. February 2022 10am

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

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present:		
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Deputy Director of Operations – Mental Health
Nicola Foreman	NF	Director of Corporate Governance
Michael Imperato	MI	Independent Member - Legal
Robert Kidd	RK	Consultant Clinical and Forensic Psychologist
David Seward	DS	Mental Health Act Team Lead
Ruth Walker	RW	Executive Nurse Director
Rose Whittle	RW	Directorate Manager – Child Health
Ian Wile	IW	Head of Operations, Mental Health
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Steve Curry	SC	Chief Operating Officer
Akmal Hanuk	AH	Independent Member - Community
Scott Mclean	SMc	Director of Operations – Children & Women's
Sara Moseley	SM	Independent Member – Third Sector
Sunni Webb	SW	Mental Health Act Manager

MHCL 21/07/001	**1. Welcome & Introductions** The Committee Chair (CC) welcomed everybody to the meeting.	**ACTION**
MHCL 21/07/002	**2. Apologies for Absence** Apologies for Absence were noted	
MHCL 21/07/003	**3. Declarations of Interest** No declarations of interest were noted.	
MHCL 21/07/004	**4. Minutes of the Committee Meeting held on 20 April 2021** The minutes of the meeting held on the 20 April were received. **The Committee resolved that:** a) The minutes of the meeting held on 20 April be approved as a true and accurate record of the meeting.	
MHCL 21/07/005	**a) Action Log 20 April 2021** The action log was received **The Committee resolved that:**	

	a) The Action Log taken from 20 April was noted.	
MHCL 21/07/006	**5. Chair's Action taken since last meeting** The CC advised the Committee that no Chair's Action had been taken.	
MHCL 21/07/007	**6. Any Other Urgent Business Agreed with the Chair** There was no other urgent business shared.	
MHCL 21/07/008	**7. Patient / Staff Story** The Staff Story – 'Shielding & My Mental Well-being was received. Following the staff story, the Executive Nurse Director advised the Committee that Managers would need to listen to staff and also listen to their own mental health and noted that it was important to take the time to talk. The CC asked the END to convey his thanks to the staff member for sharing their story and experience and asked how the staff member was doing at this time. The END responded that the staff member was doing well and was well supported by her line management and team. **The Committee resolved that:** a) The Staff Story was noted.	
MHCL 21/07/009	**9.1 Mental Capacity Act Monitoring Report & DoLs Report – Update** The Mental Capacity Act Monitoring Report and DoLs Report were received. The END advised the Committee that at the last Mental Health and Capacity Legislation Committee (MHCLC) it was asked that a set of indicators could be brought to the meeting. It was noted that the most important thing to highlight was that the whole agenda is changing significantly and that Liberty Protection Safeguards (LPS) was something that would be featured prominently over the coming months. Formal documentation was expected to be issued in the Autumn and it was noted that implementation plans needed to be put together in relation to the requirements. The END advised the Committee that she and the Deputy Executive Nurse Director (DEND) had been looking to have training so they would know what would be required and to get a clearer understanding of what was required of Cardiff and Vale University Health Board (CVUHB).	

	The Independent Member – Legal asked if there would be training for other members of the Committee. The END responded that there would be and that who required training needed to be identified and noted that there would be a new Mental Capacity Act Manager recruited. It was noted that Hywel Dda University Health Board had moved further forward in the implementation for a number of reasons and so CVUHB have been in correspondence with them to see what work has been done. The Consultant Clinical and Forensic Psychologist (CCFP) advised the Committee that there were a number of CVUHB staff who had been trained as best interest assessors and asked if it could be useful to get an up to date list of those staff so that they could be used within the new system of LPS. The END responded that it was a very helpful point and noted that a lot of people would be required. The CC asked the Director of Corporate Governance (DCG) about the revision of all relevant health board procedures, policies and strategies in line with LPS and noted that it was a mammoth task in itself. The DCG responded that policies and procedures were reviewed on a rolling programme and noted that it was constant and recommended that the LPS elements be included as and when required. The END advised the Committee that an SBAR update would be required at the next Committee meeting. The CC responded that the SBAR item be added as a standing item on the agenda. **The Committee resolved that:** a) 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) was noted.	NS
MHCL 21/07/010	**10.1 Mental Health Act Monitoring Exception Report** The Mental Health Act Monitoring Exception Report was received. The CCFP advised the Committee that when the reports were scrutinised it was noted that there was potentially a period in June 2021 where there were more informal patients rather than detained patients and it was unknown why that was and what led to that. The CC asked for clarity on the work being continued with the Mental Health Review Tribunal for Wales to find a suitable resolution, to ensure that action was taken to mitigate the risks highlighted and protect the	

	patient's right to a fair hearing and ensure any incidents are reported accordingly. The Mental Health Act Team Lead (MHATL) responded that the Tribunal had organised a pilot for video conference hearings and CVUHB were due to have one on Older Peoples' wards but noted that it was cancelled and so the Mental Health Act Manager (MHAM) had gone back to the Tribunal receive an update. The CC advised the Committee that he had been impressed by the work around the recovery college and asked the Deputy Director of Operations – Mental Health (DDOMH) if there was anything to be added around the Mental Health Act e-learning module. The DDOMH responded that the Mental Health Act Training was separate to the recovery college but noted that patients had asked for the development of a course around their rights around the Mental Health Act and Mental Health Measure. The MHATL added that in relation to the Mental Health Training, workshops for patient rights had been provided to staff and these could be extended to patients in future. The Independent Member – Legal (IML) asked what was being done to move the Tribunal's technology forward in order to provide a much better virtual service. The MHATL responded that the MHAM would go back to the Mental Health Tribunal to note those queries raised by the Committee. The CCFP responded that CVUHB hospital managers had adapted very well to virtual hearings and recommended that the Committee write to the Ttribunal to ask what steps were being taken to improve the Tribunal's virtual meeting service. The CC noted that he would contact the MHAM to develop this further as it was not acceptable that virtual hearings had not been happening. The IML asked for further clarity around the Section 136 legal opinion that had been obtained. The MHATL responded that following the legal advice, it was noted that the clock started ticking for section 136 in Accident & Emergency (A&E) but advised the Committee that he and the MHAM had been collecting data as to what would happen if the patient was too unwell in A&E to receive the assessment. The IML asked why further legal advice had not been obtained if the advice given was not favoured. The CCFP responded that the legal advice had been obtained by Richard Jones and that the advice received had been very clear that what was being done was the correct reading of the law.	CP / NS

	It was noted that there had been pressure from outside of the Health Board which is why secondary legal advice was obtained which went against what was originally advised. However the first legal advice was deemed appropriate as it did not alter the code of practice for Wales. **The Committee resolved that:** a) The approach taken by the Mental Health Clinical Board to ensure compliance with the MHA was supported.	
MHCL 21/07/011	**10.2 Update on the Reform of the Mental Health Act** The Reform of the Mental Health Act update was received. **The Committee resolved that:** a) The Reform of the Mental Health Act update was noted.	
MHCL 21/07/012	**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 DDOMH provided assurance to the Committee on Part 1 of the Measure. • <u>Part 1a : Adult and Children PMHSS</u> It was noted that referral activity for Q4 2020 & Q1 2021 had seen a gradual decrease in referral rates following the initial steep rise in referrals in the first two quarters after the first lockdown but with a notable spike in referrals in March 2021. The DDOMH advised the Committee that a recovery plan was in place to return to compliance and noted that an update would be provided to the July Board meeting. It was noted that the Did Not Attend (DNA) rate had shot up during the period of good weather which could help with a return to target. Regarding the over-18 Part 1a performance, the initial impact of COVID-19 had affected performance in the early stages of lockdown but compliance was reinstated quickly before a shortfall in four qualified staff in August subsequently had affected performance going forward. It was noted that the staffing issue had been partly rectified in early September but further vacancies had seen the service remain understaffed. However after a recent successful recruitment drive, an additional 2 staff had started in June 2021.	

The Directorate Manager – Child Health (DMCH) advised the Committee that an unprecedented amount of referrals had been received and, as a result, Child Health were not compliant.

Compliance against the part 1 target had not been achieved since October 2020 and 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.

It was noted that this had sharply increased from March 2021 and remained significantly higher than pre-Covid levels.

- Part 1b – 28 day assessment to intervention compliance target of 80% - Adult and Children

The DDOMH advised the Committee that by having clarified reporting processes, PMHSS (adults) had been compliant with the Part 1b performance target since August 2020 and this has continued during the Covid 19 period.

It was noted that compliance against Part 1b of the target for children had been achieved in 6 of the last 10 months and within 10% of 3 months. January was a challenging month for the service with significantly reduced capacity due to sickness, maternity leave and annual leave.

It was noted that the team continued to work to ensure that young people were seen within 28 days for the commencement of their treatment, following assessment.

- Part 2 Care and Treatment Planning – Adult and Children.

The DDOMH advised the Committee that since the previous MHCLC meeting, Care Aims and Open Dialogue training had continued in spite of the Covid restrictions.

It was noted that compliance had reduced in April and May 2021. This was due to an 18.8% increase in patients in receipt of secondary care services between April 2020 and May 2021 and a 74.5% decrease in discharges comparing to April 2020 to May 2021.

The DMCH advised the Committee the Child Health had worked hard around compliance with part 2 of the Measure.

It was noted that the service continued to underperform against the target and that challenges to achievement included:

- Poor engagement from patients in the CTP process.

- A high number of new patients requiring the CTP process.
- Complex cases that required a CTP where those have been unable to be facilitated as a result of wider system issues e.g. social care placements not being agreed which led to delays in completion.

The Chair, Powers of Discharge sub-Committee (CPDSD) advised the Committee that the quality of Care and Treatment Planning remained the hospital managers biggest concern and in particular, the lack of outcome and focus and noted that a number of the care and treatment plans did not reflect the current care of the patient.

The CC invited the DDOMH to provide information around the work that Dr Neil Jones had been doing.

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

The IML asked if there was one area that caused the greatest concern.

The DDOMH responded that in terms of where the service was breaching, the areas with a large demand had been the mild stress demands of Covid-19 which created a large amount of referrals.

It was noted that the areas that caused the most concern clinically was protecting part 2 services and upwards from individuals who carried much higher risks. Red flags such as eating disorders and individuals who were physically compromised due to having long term mental health conditions.

The DMCH added that Children and Young People in Crisis was also a clinical concern along with the eating disorders and noted that there was unprecedented demand on those areas.

The END advised the Committee that she would add that a clinical concern were the number of children who were inpatients in inappropriate settings and noted that it was not the right environment to be caring for them and asked the Committee to focus on that area in future.

The Committee resolved that:

	a) The content of the Mental Health Measure (Wales) 2010 incl. Part 2 update was noted.	
MHCL 21/07/013	**12.1 HIW MHA Inspection Reports:** The HIW MHA inspection reports were received. a) Hazel Ward b) East 12 Ward The END provided assurance to the Committee that all HIW reports were discussed at the Quality, Safety and Experience (QSE) Committee and noted that the reports had been brought for information. It was noted that progress had been made in the areas and that it should be discussed in future to highlight good practice and to provide assurance. **The Committee resolved:** a) The HIW MHA Inspection Reports were noted.	
MHCL 21/07/014	**12.2 Hospital Managers Power of Discharge Sub Committee Annual Report** The Hospital Managers Power of Discharge Sub Committee Annual Report was received. The Chair, Powers of Discharge sub-Committee (CPDSC) advised the Committee that the Hospital Managers had learnt a new skill set during the pandemic with the help of the Mental Health Act Office and noted that Patient and Relative feedback had been mostly positive around the virtual hearings. It was noted that a hybrid model would be looked at moving forward when face to face hearings could be reinstated. **The Committee resolved:** a) The Hospital Managers Power of Discharge Sub Committee Annual Report was noted.	
MHCL 21/07/015	**12.3 The Hospital Managers Power of Discharge Minutes** The Hospital Managers Power of Discharge Minutes were received **a) Hospital Managers Power of Discharge Minutes** **b) Mental Health Legislation and Governance Group Minutes** The CCFP advised the Committee that the Mental Health Legislation and Governance group (MHLGG) had met just one week prior to the MHCLC	

	meeting and noted that a Local Authority representative had raised the UK Government's proposed changes to the Mental Health Act in England and Wales. The CCFP noted that the proposed changes mean that the inability to detain persons with a learning disability under section 3 could pose difficulties as there was not the resource to provide adequate care to those patients in the community at present. It was noted that the MHLGG still wanted to pursue the issue of repeat 136 assessments and that there was still an issue around a change that South Wales Police had made about the creation of the voluntary assessment whereby the person would agree to go to hospital but the relevant 136 paperwork was not completed. It was noted that over the Summer, there had been 2 meetings between Mental Health Services and Liaison staff to talk about the issue regarding assessments for people who had been engaging in suicidal behaviours. The CCFP advised the Committee that the Mental Health Clinical Board had trained 2 trainers into a system called "Connecting with People" and it was hoped that it would lower some of the variability in Mental Health assessments. It was concluded that the LPS had been looked at by the MHLGG and what that meant for the Mental Health Services. **The Committee resolved:** a) The Hospital Managers Power of Discharge Minutes were noted. b) The Mental Health Legislation and Governance Group Minutes were noted.	
MHCL 21/07/016	**12.4 Self-assessment of effectiveness** The DCG advised the Committee that the self-assessment of effectiveness results had been reported to the Board. **The Committee resolved:** a) The results of the Annual Board Effectiveness Survey 2020-2021, relating to the Mental Health Legislation Capacity Committee were noted. b) The action plan developed for 2020-2021, which would be progressed via Board Development sessions, was noted.	
MHCL 21/07/017	**12.5 Corporate Risk Register** The Corporate Risk Register was received.	

	The DCG advised the Committee that there were 2 risks from the Corporate Risk Register that sat with the MHCLC and noted that in the future all risks with a score of 20 or above would be reported to the Board. The Committee was advised that the 2 risks were around (i) poor patient conveyancing and (ii) young people being placed in adult mental health areas. The CCFP advised the Committee that the conveyancing situation was much improved when discussed the previous week at the MHLGG meeting. The DCG responded that there would always be a little lag due to when the Risk Registers were updated and when reports were written. The DDOMH advised the Committee that after the latest review, it was deemed that it could be removed from the Corporate Risk Register. The DCG noted the update. The CC asked if the LPS should be considered on the Corporate Risk Register. The END responded that it should be but was unsure as to what the risk was at this time. **The Committee resolved that:** a) The Corporate Risk Register risk entries linked to the Mental Health Capacity and Legislation Committee and the work which was now progressing was noted	
MHCL 21/07/018	**14. Review of the Meeting** The CC opened the Committee to review the meeting.	
MHCL 21/07/019	**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 19 October 10am via MS Teams.	

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

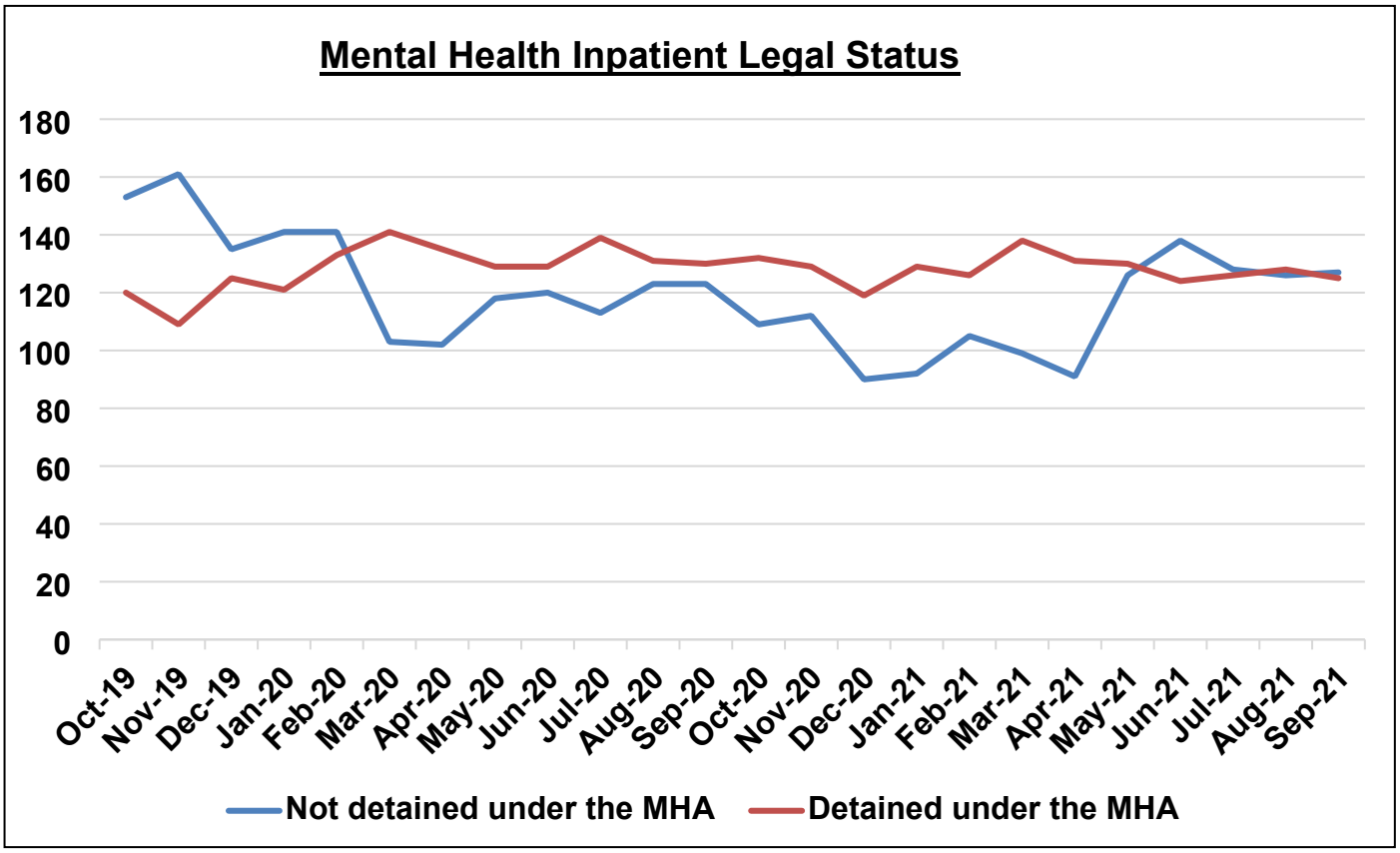
MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
MHCL 20/10/009	DOLS	Internal Audit Report on DoLS - further work needed to be undertaken to progress the audit outcomes by the next meeting.	**20/07/21**	Ruth Walker	**COMPLETE** Taken to the July Committee Meeting – Agenda Item 9.1
MHCL 21/04/009	MCA and DoLs indicators	Discussion and feedback on the MCA and DoLs indicators	**20/07/21**	Ruth Walker	**COMPLETE**
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	**COMPLETE** Taken to the July Committee Meeting – Agenda Item 10.2.
MHCL 21/04/009	Project Plan – Training Mental Capacity Act Training	Project Plan to include training for MHCLC. 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	**COMPLETE** No date provided at meeting – To discuss at July agenda setting.
MHCL 21/07/010	Mental Health Tribunal - Letter	It was noted that the committee should write to the Mental Health Tribunal to ask what steps are being taken to improve the virtual hearings system to address the lack of virtual hearings.	**19/10/2021**	Sunni Webb / Ceri Phillips	**COMPLETE** Update to be provided to members via email.
Actions in Progress					

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 21/07/009	SBAR update	The SBAR item be added as a standing item on the agenda.	**19/10/2021**	Ruth Walker	Added to October Agenda Future Standing Item
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.	**19/10/2021**	Nicola Foreman	Ongoing discussions to be had following departure of the EDWOD
Actions referred to committees of the Board					
MHCL 19/10/012	HIW Mental Health Act Report	Bring all Estates concerns together to be reported at a Management Executive Meeting.	**20/07/21**	Nicola Foreman	**COMPLETE** **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.

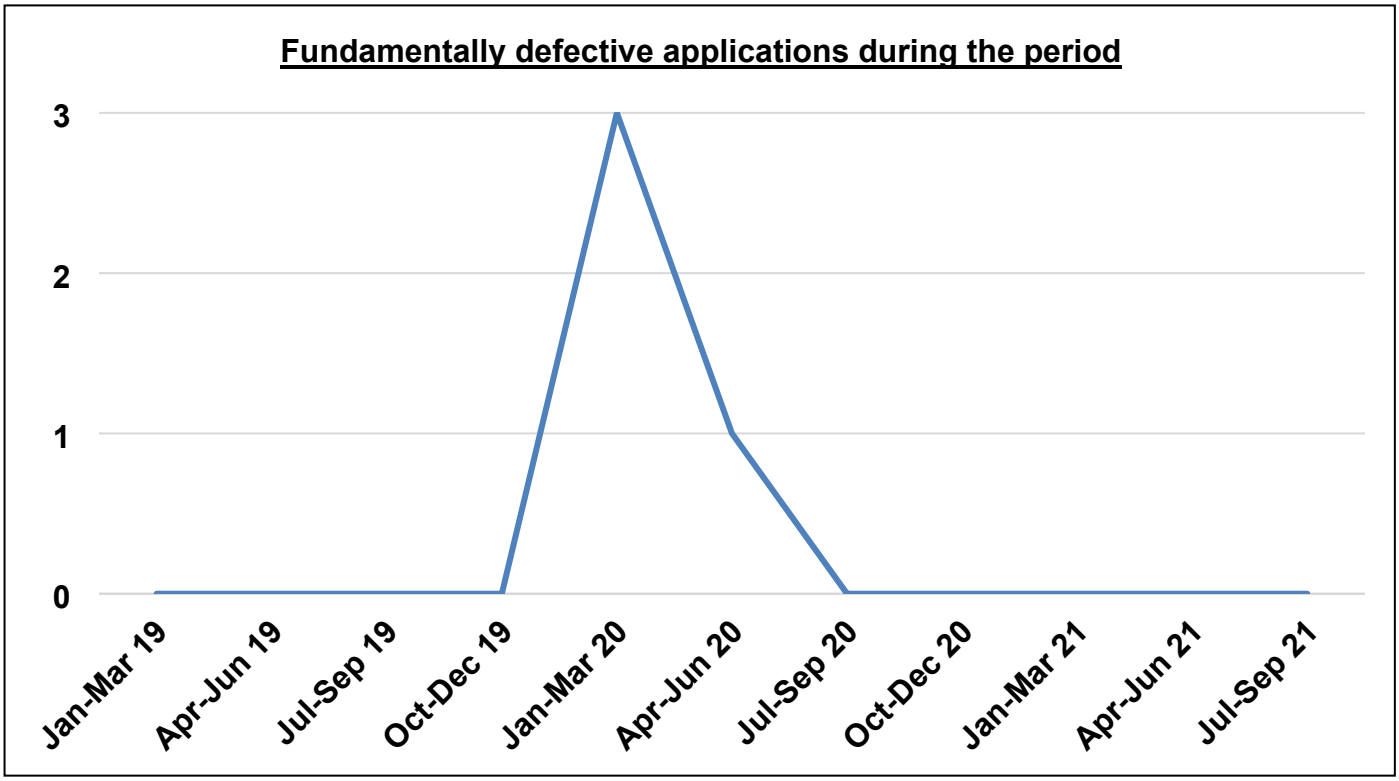
Report Title:	**MENTAL HEALTH ACT MONITORING**										
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**07 October 2021**		
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**	**x**			
Lead Executive:	**Chief Operating 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 remained fairly consistent throughout this period. 49% of inpatients were detained under the Act at the end of Qtr.2 compared to 47% at the end of Qtr.1.



Fundamentally defective applications



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

Section 136 A&E

The MHCB has confirmed that the clock will start ticking in A&E in the majority of cases following the recent legal advice;

> *"For the avoidance of doubt, in my opinion the terms of section 136(2) justify treating the patient for the physical consequences of his mental disorder, for example suturing a wound caused by a suicide attempt. The time taken to undertake this procedure should therefore be counted in calculating the 24-hour period allowed for in section 136."*

In circumstances where the physical treatment is unrelated to the mental disorder the clock will not start ticking until the patient is fit for a mental health act assessment. It has been agreed that the shift coordinator will be responsible for making this determination as they are responsible for coordinating the mental health act assessment.

Further legal advice will need to be sought in relation to any 136's where the treatment is related to the mental disorder but the patient is not fit for a mental health act assessment within the 24/36-hour period causing the 136 to lapse, for example,

> *Patient has taken an overdose which is related to their mental disorder. Needs to go to A&E for physical treatment, therefore the clock starts ticking when they arrive in A&E. Patient receiving physical treatment beyond the 24/36-hour period. 136 has lapsed with no mental health act assessment.*

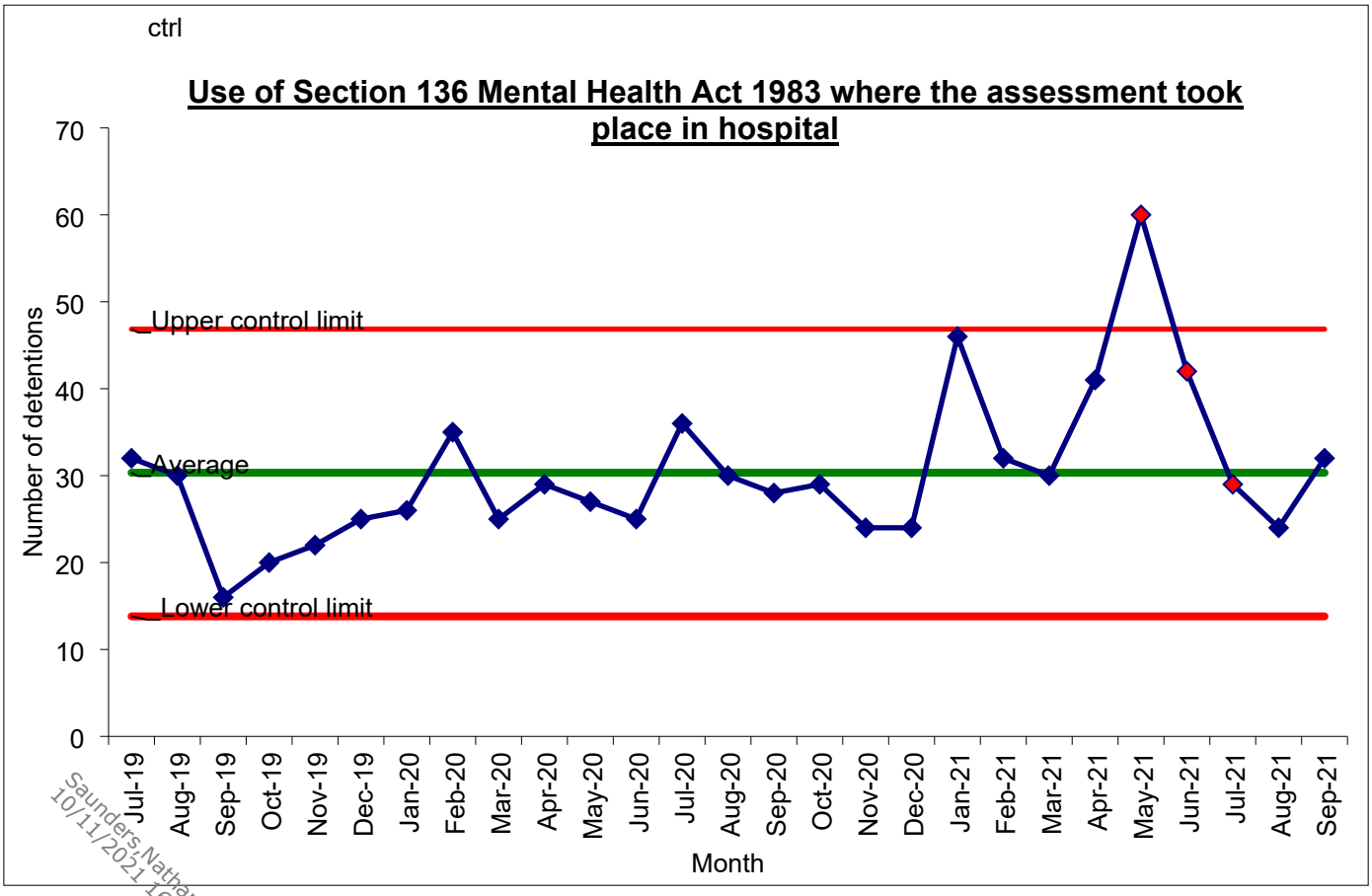
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

During the quarter the use of section 136 has decreased significantly since the record high reported in May 2021. This suggests that the section 136 powers are only used when absolutely necessary by the police. The police have received further training on 136's which could contribute to the decrease in their use.

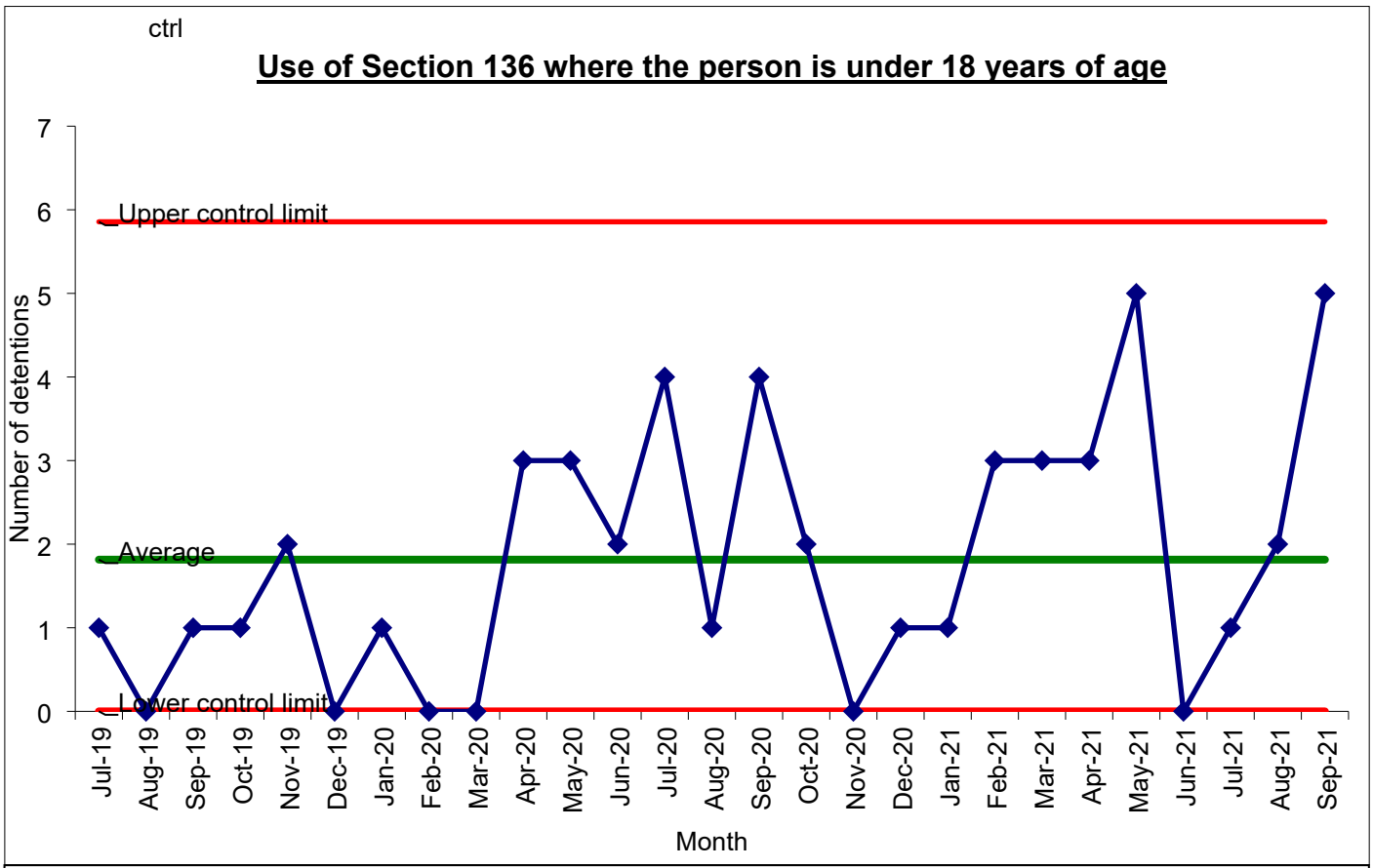
It was noted that 74.1% of individuals assessed were not admitted to hospital with 55.3% being discharged with community support and 18.8% were discharged with no follow up. Overall during the period 25.9% of patients were admitted to hospital following a 136 assessment which is consistent with the previous quarter.

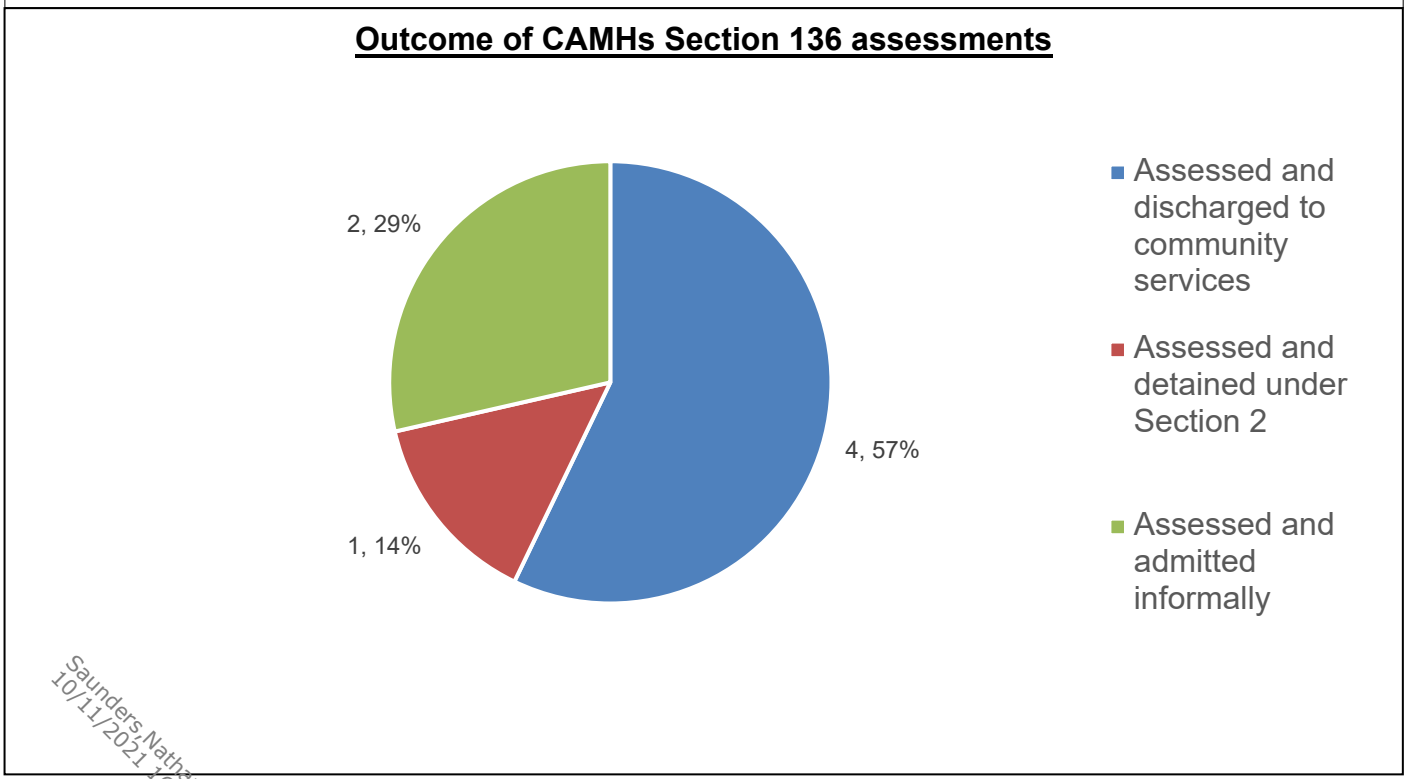
Period	% not admitted to hospital
July – September 2021	74.1%
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%
April – June 2020	70.4%
January – March 2020	62.8%



Section 136 - CAMHS

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





Saunders,Nathan
10/11/2021 16:00:31

Mental Health Review Tribunal for Wales (MHRT)
The MHRT have conducted a successful VC hearing which took place in August and have provided the following update in relation to the conduct of hearings going forward:

"The last year and a half has been testing for us all and unfortunately, this has certainly been the case for the holding of MHRT tribunals. As you will be aware the current process is that tribunals are being held by teleconference and whilst the system has worked for the majority of cases and has allowed us to continue the holding of tribunals throughout the pandemic, we accept that it will not be suitable for all. To this end, we are currently in the final stages of the Video Conferencing Pilot having contracted the use of the Kinly system for tribunals. This had not been an easy logistical task and unfortunately, finding a system that is accessible to all is far more difficult than it sounds. Individuals that need to access these hearings include individuals from the 7 Health Boards in Wales, 3 NHS Trusts, NHS hospitals, private hospitals, legal representatives, legal members of the tribunal, medical members of the tribunal and lay members of the tribunal, along with Welsh Government staff at times. All these different individuals and organisations from a combination of both private and public bodies have different firewalls and anti-virus software that restrict access to certain platforms and so finding a common platform and ensuring access to said platform has been extremely challenging. Whilst we have experienced issues during the pilot with some individuals being unable to access the system due to their own firewalls we are now in the final stages of the pilot and we hope to be in a position to update you over the coming weeks.

Face to face tribunals, however, will be far more difficult to implement and I have started work on the legal and logistical implications of this. As a general guidance however, I do not expect to be in a position to even be considering a return to face to face hearings for MHRT before the Spring of 2022. I will of course keep you all updated on this during MHAA meetings as the months progress."

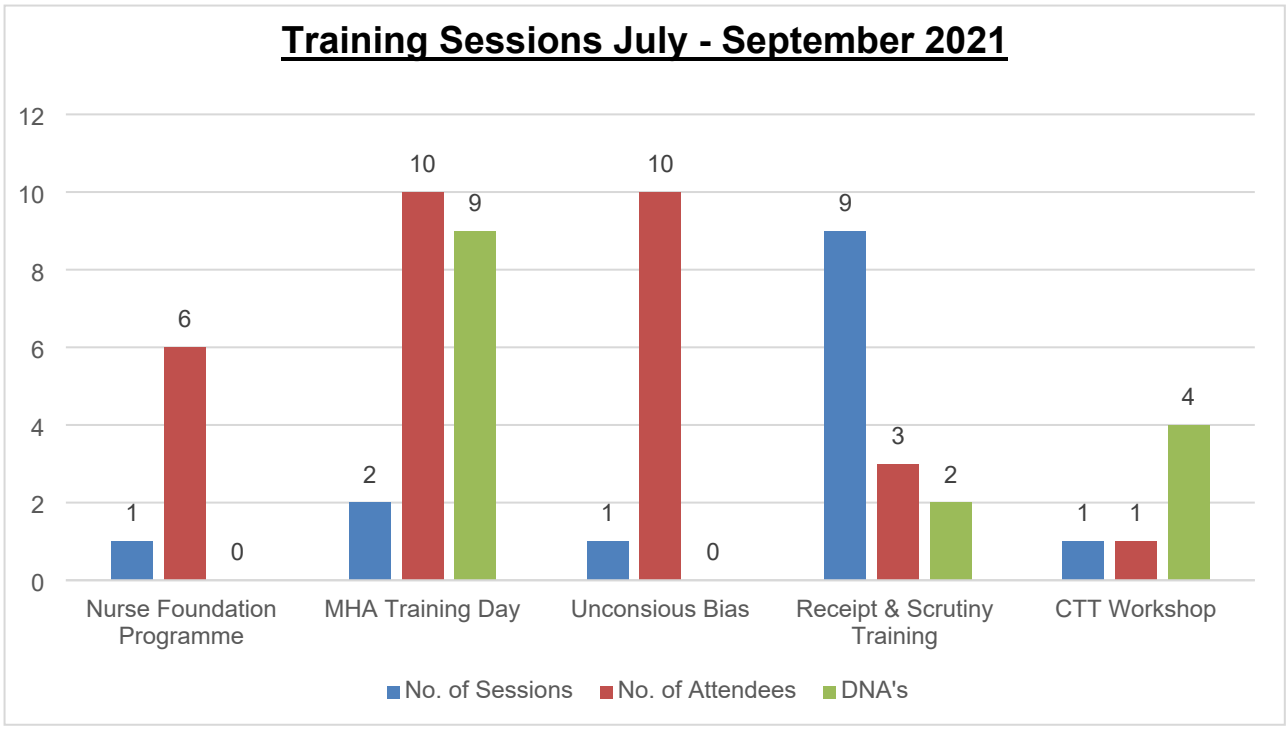
Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):
Fundamentally defective applications
Arrangements between the Local Authority and UHB continue to be working relatively well, communication in relation to receipt of applications for detention under the MHA continues to improve. 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.

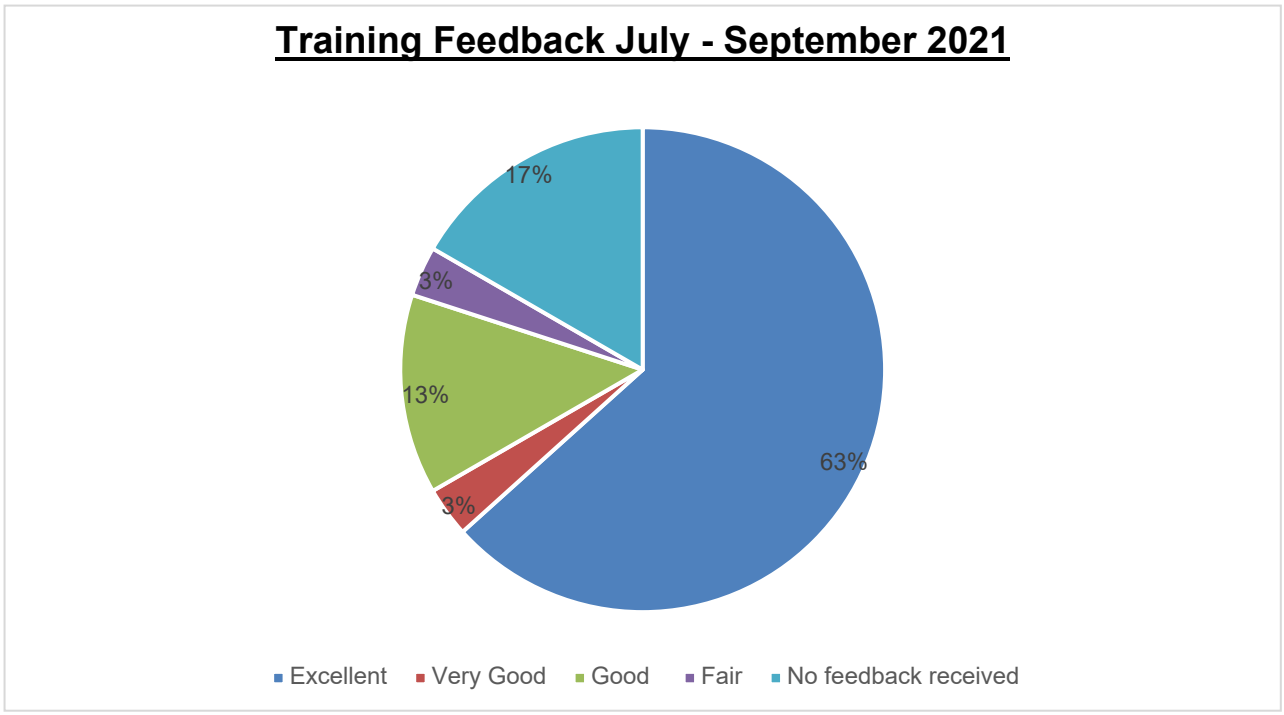
Section 136 in A&E
There continues to be a concern that UHB could exceed the detention period under certain circumstances, resulting in no authority to conduct a mental health assessment if the patient does not agree to it. For example when the time taken for medical treatment exceeds the 24/36 hour 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:





Saunders,Nathan
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Recommendation:

The Committee is asked to support the proposed approach taken by the Mental Health Clinical Board to ensure compliance with the MHA as set out in the body of the report and as follows:-

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

b) Section 136
Continue to monitor with colleagues in South Wales Police and ensure any incidents related to an assessment not being completed within the 24/36-hour period due to physical health issues are reported accordingly.

c) 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.

d) 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.

e) 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.

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

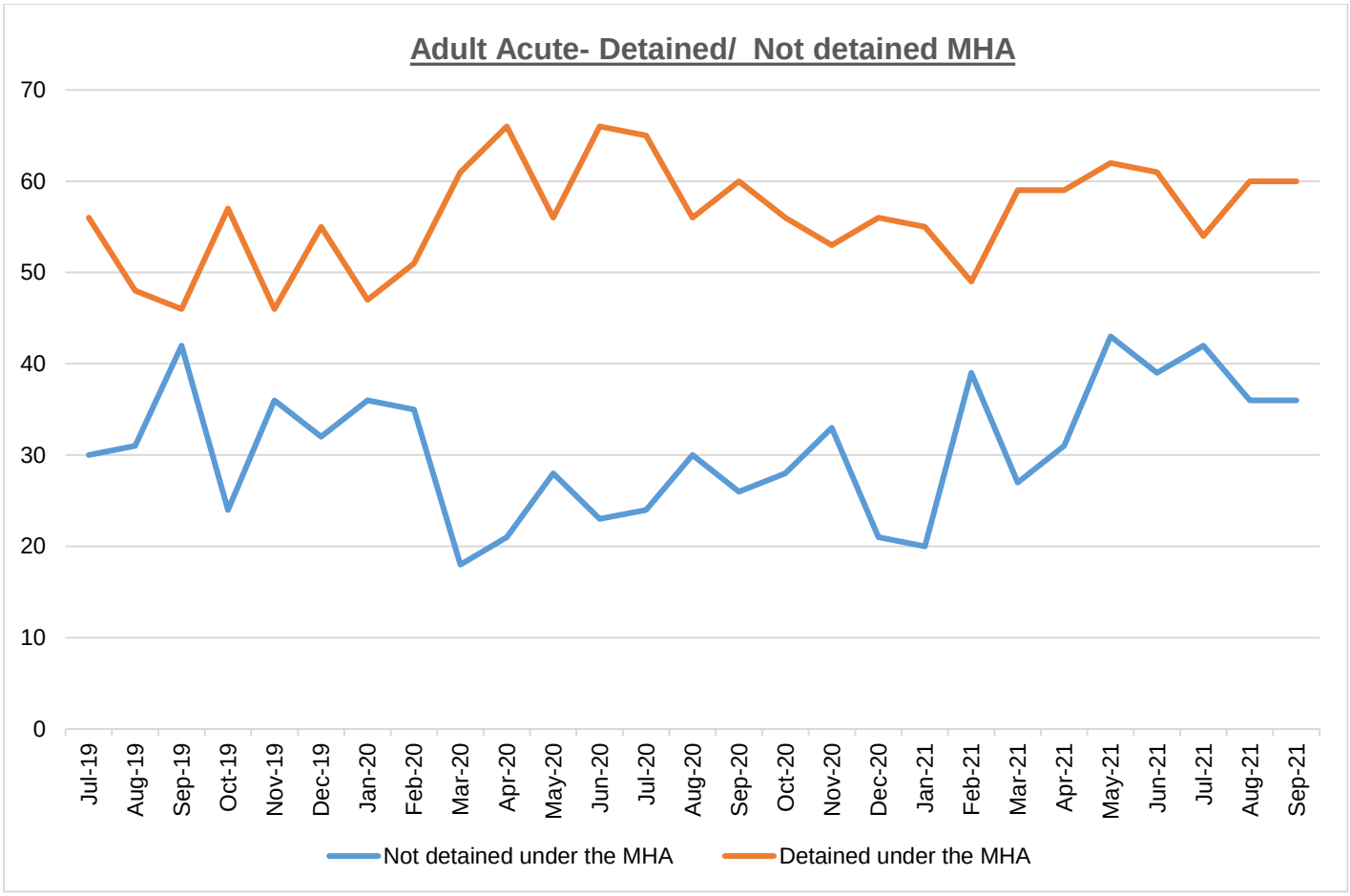
Report to the

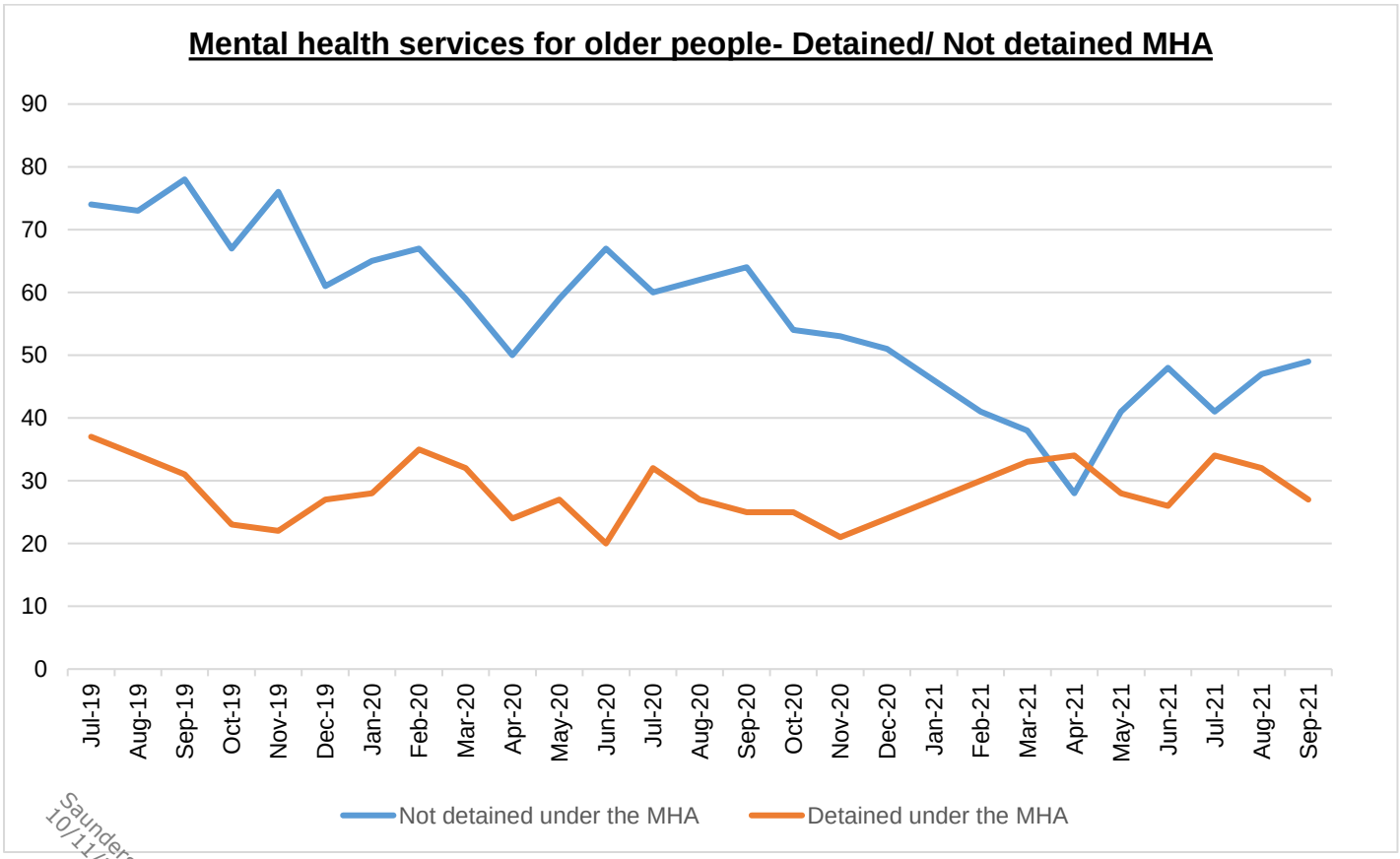
Mental Health and Capacity Legislation Committee

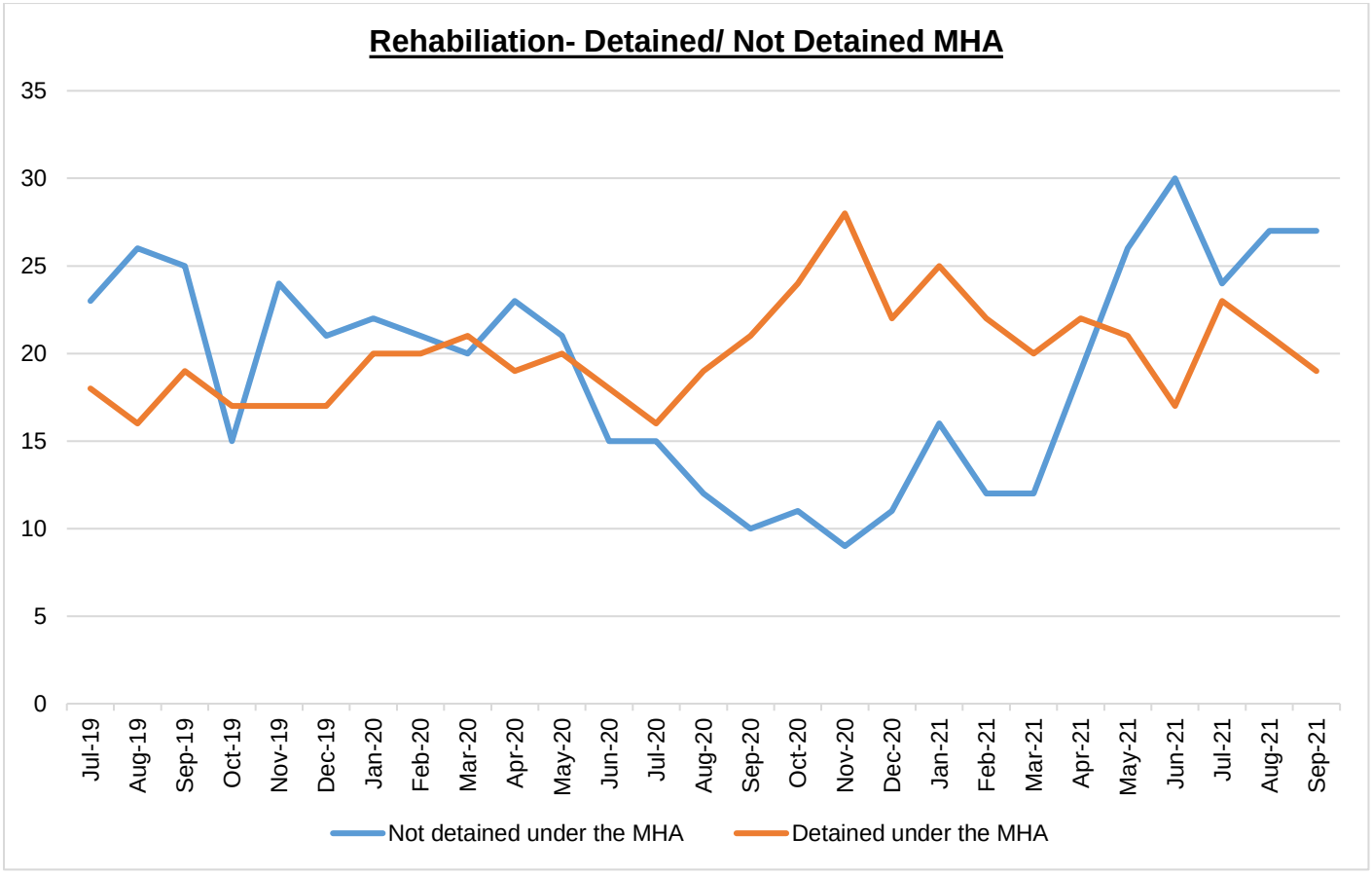
on the use of The Mental Health Act, 1983

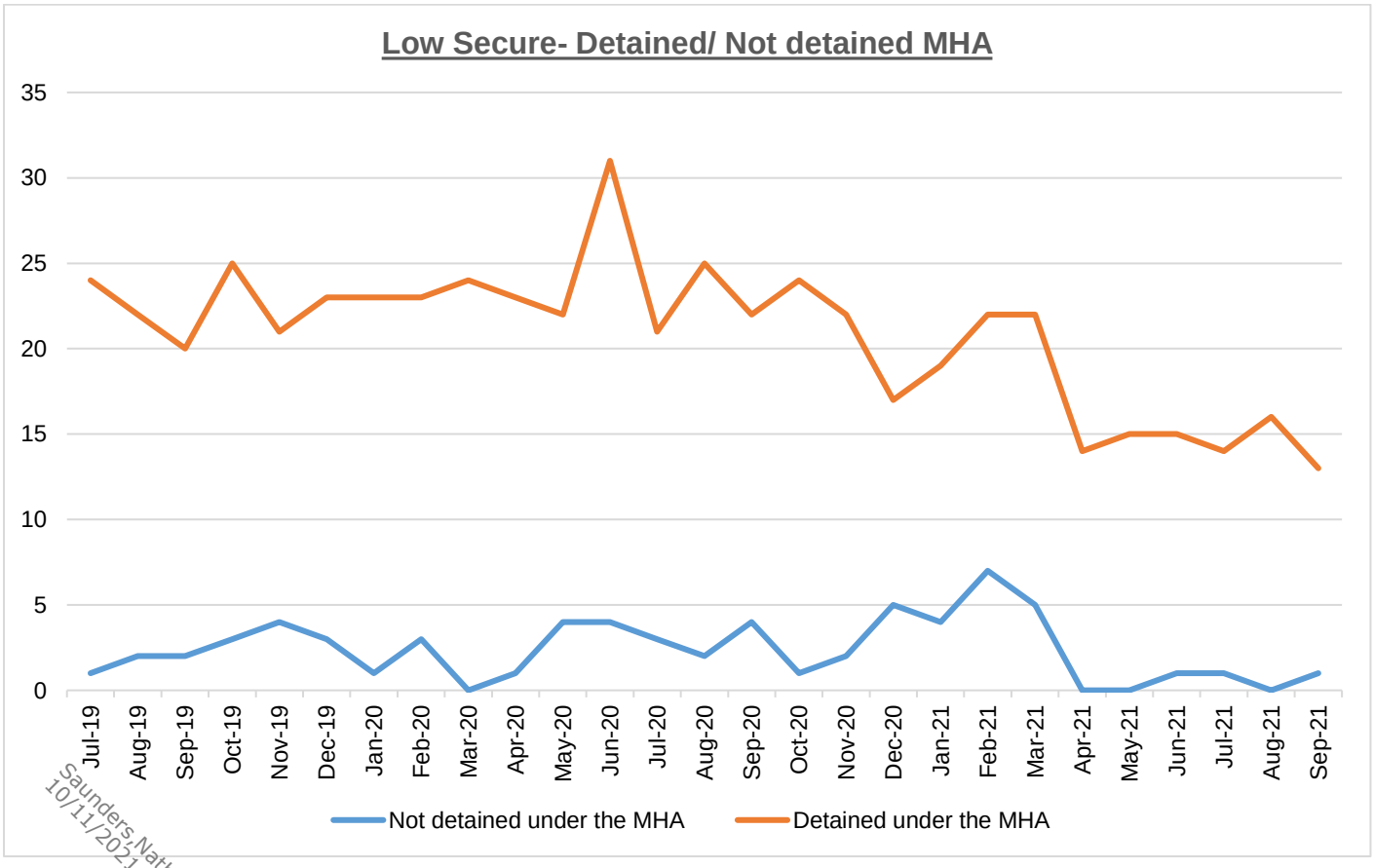
July- September 2021

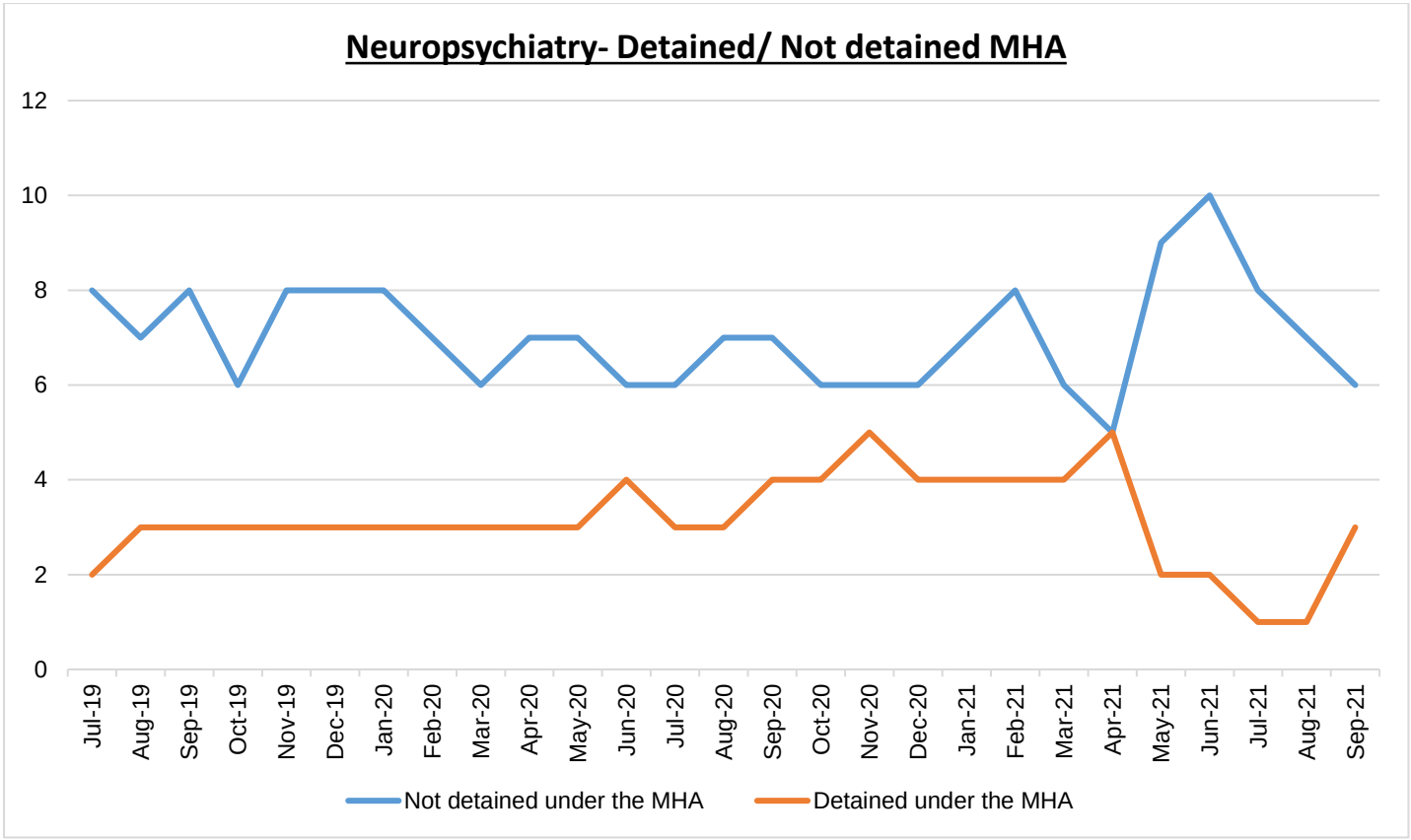
Contents **Page**

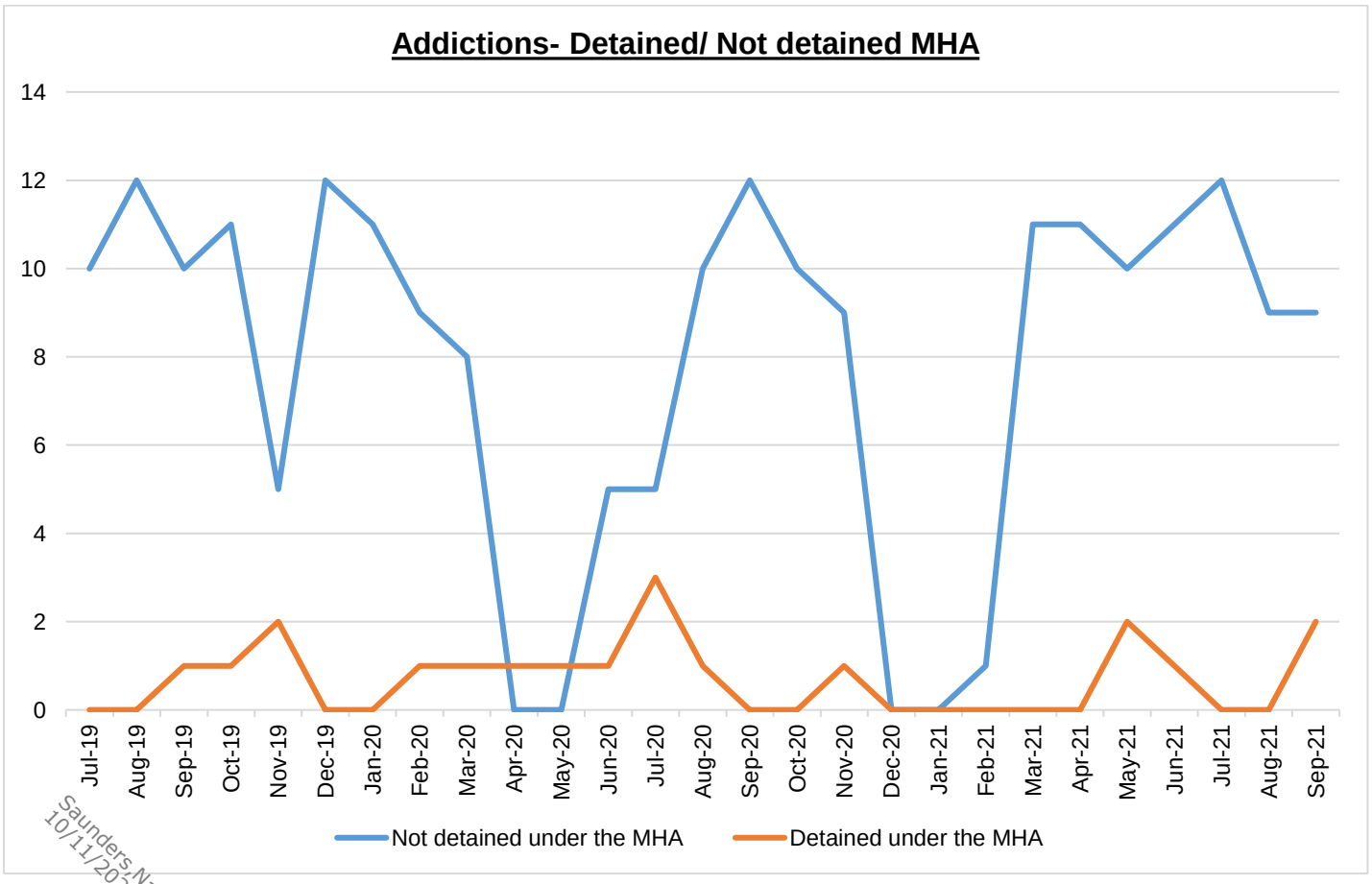




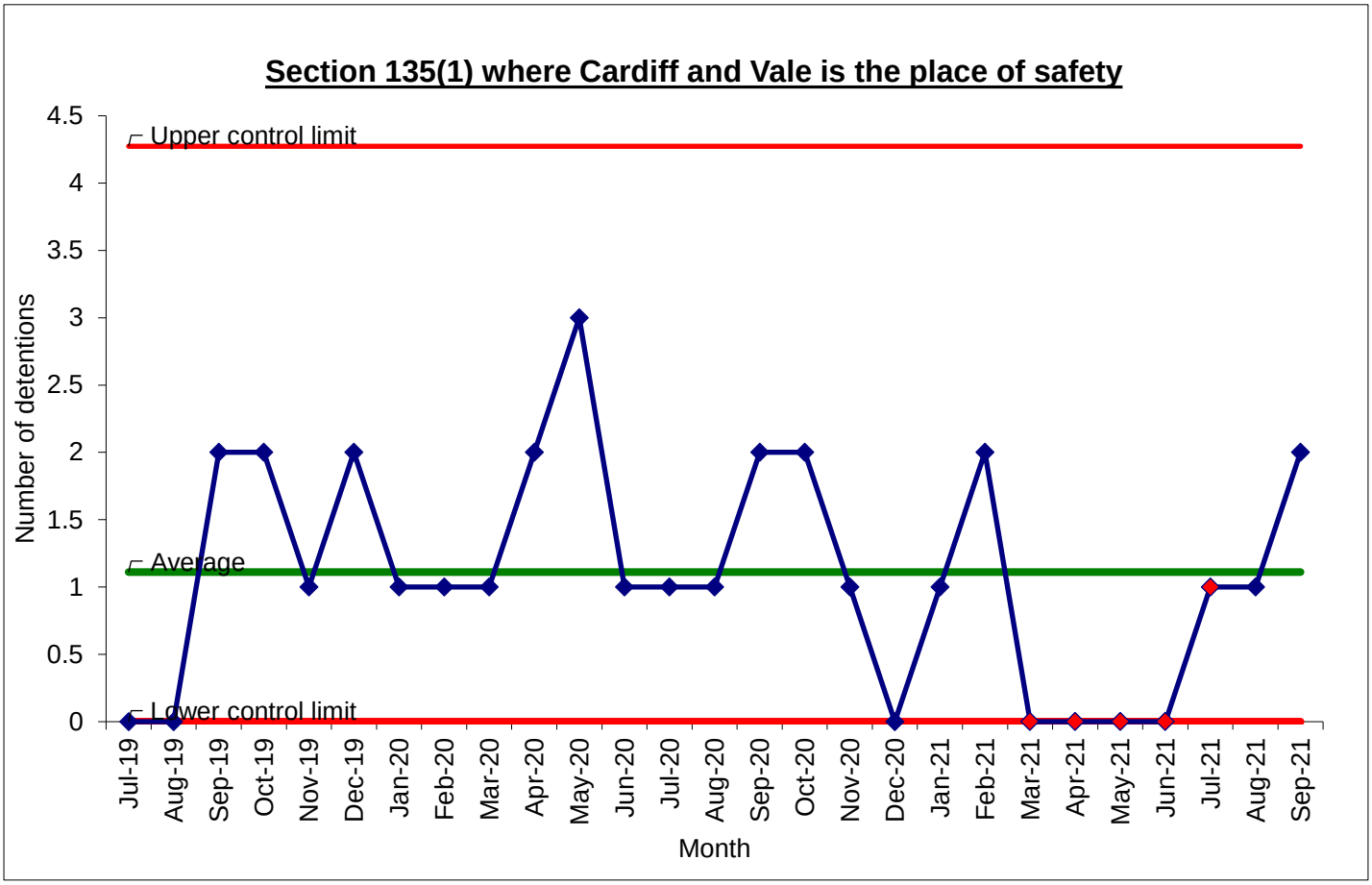








Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety



During the period Section 135 (1) powers were used three times. Two patients were placed on Section 2. One patient was discharged home.

Section 135(2) powers were used once during the period. The patient was then brought back to hospital under Section 2.

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;-

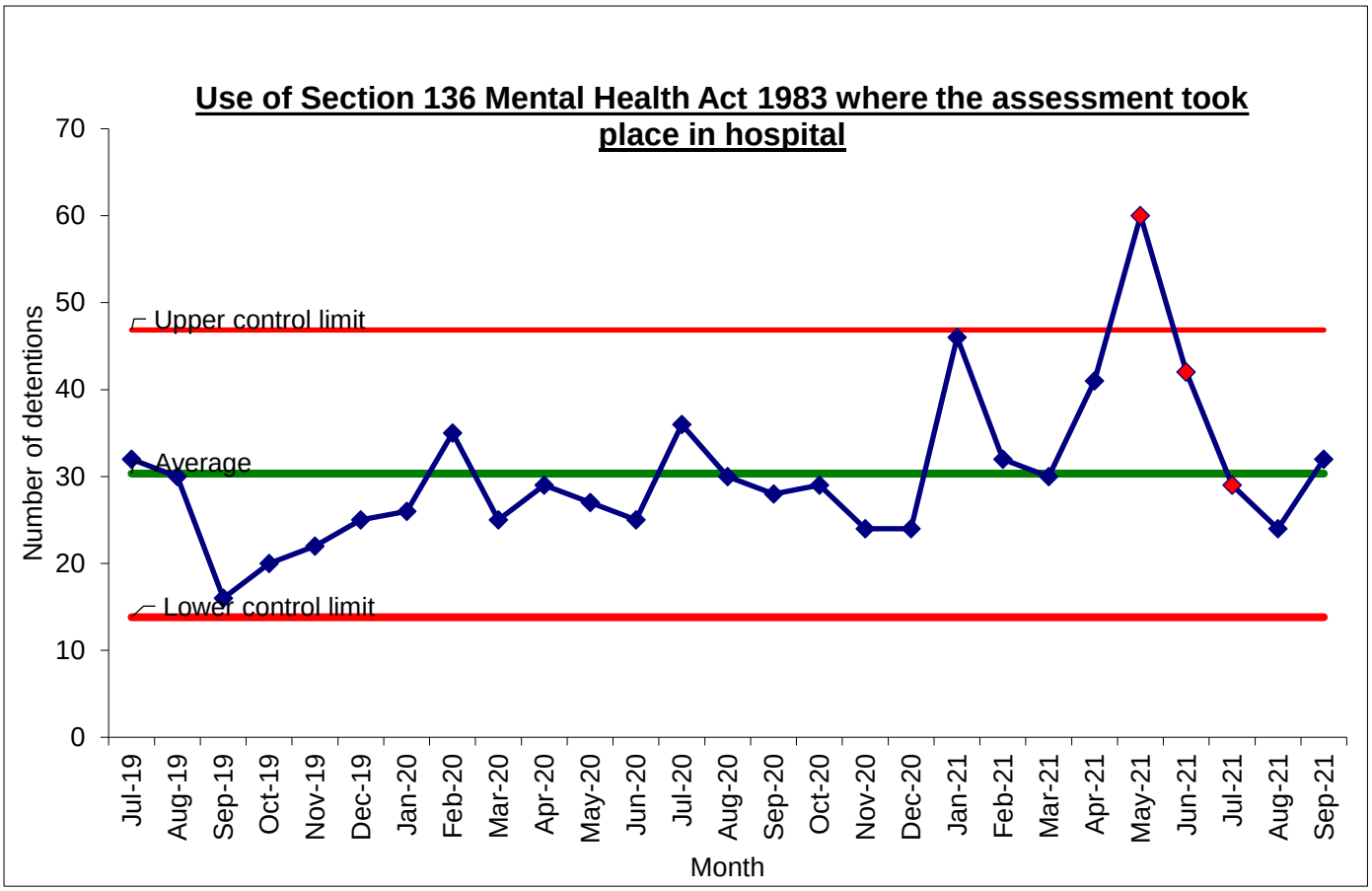
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

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.

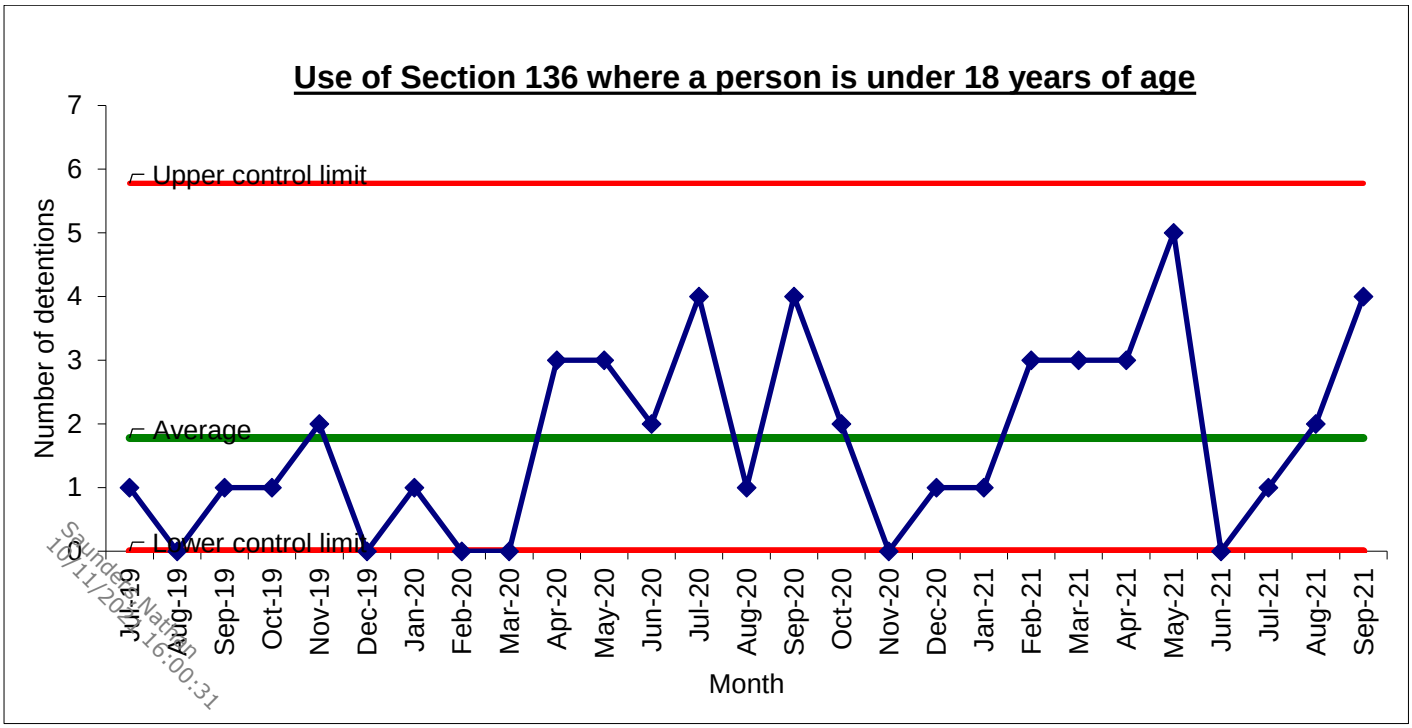
For this period we have seen seven people for a Voluntary Assessment and two were brought into hospital under the Mental Capacity Act.

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

During the period a total of 85 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.

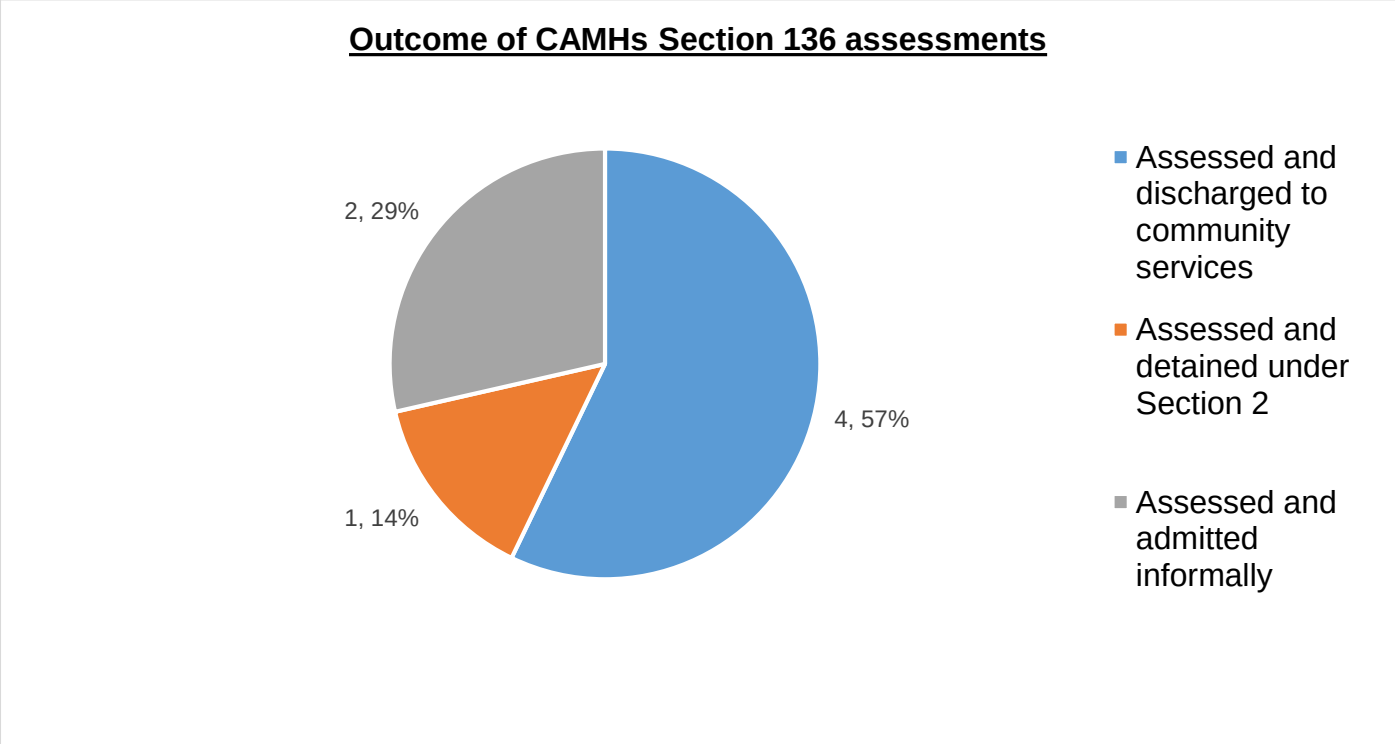


Seven of those assessments were carried out on patients under the age of 18. Included in the above data are those under 18 years of age. This is extracted below;-

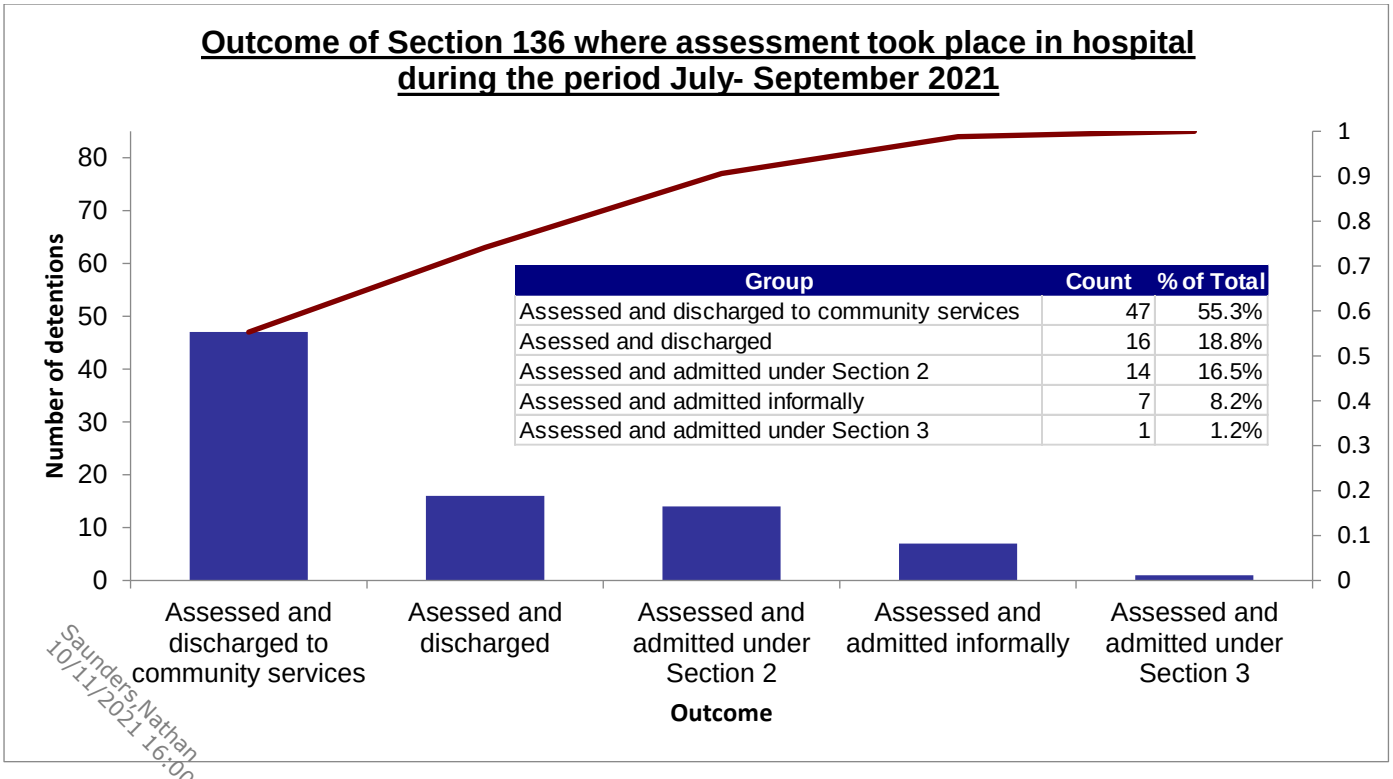


The pareto chart highlights that 74.4% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

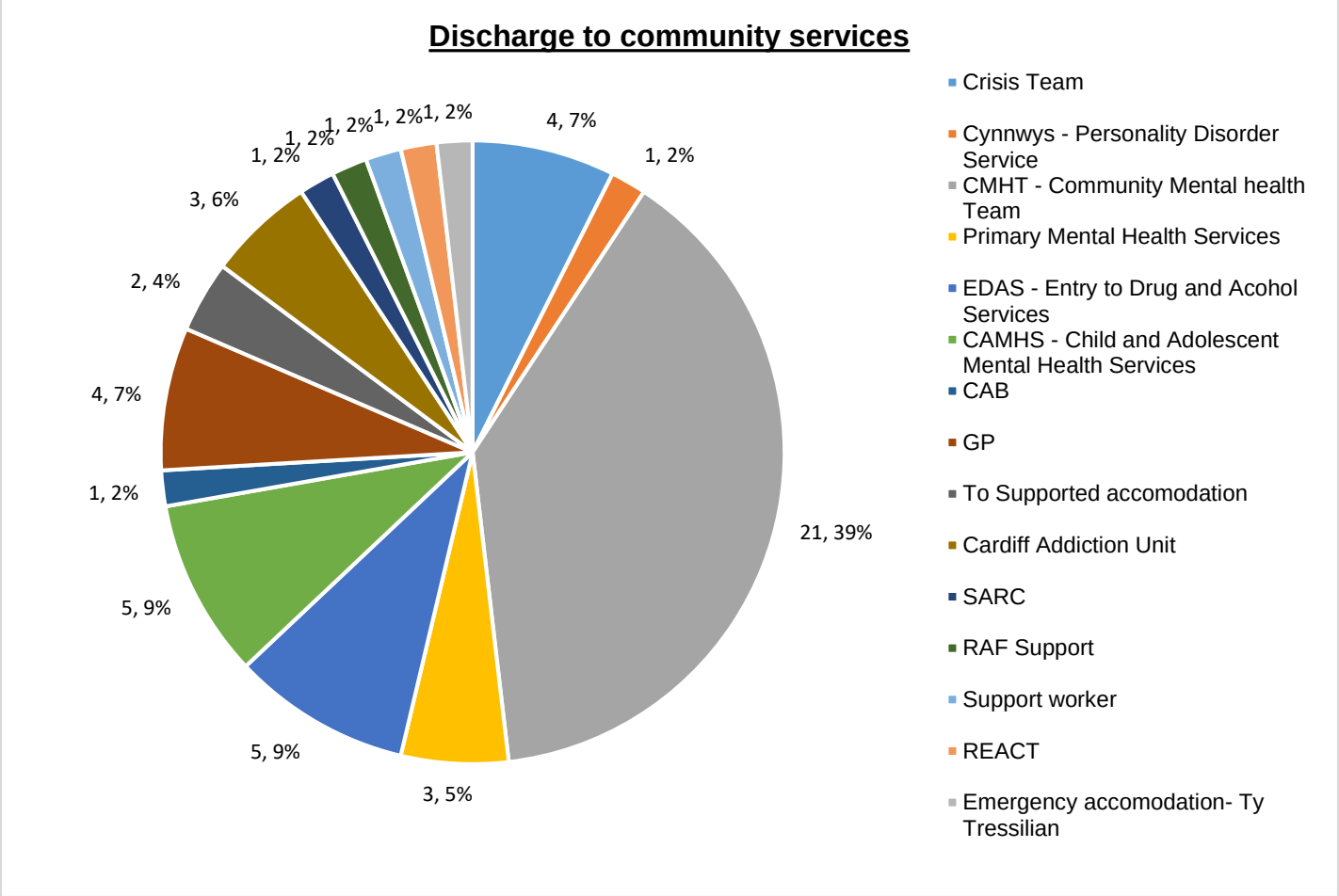
Included in the above data are the outcomes for those under 18 years of age. Those outcomes are as follows;-



All but one of these presentions were in relation to the same patient.



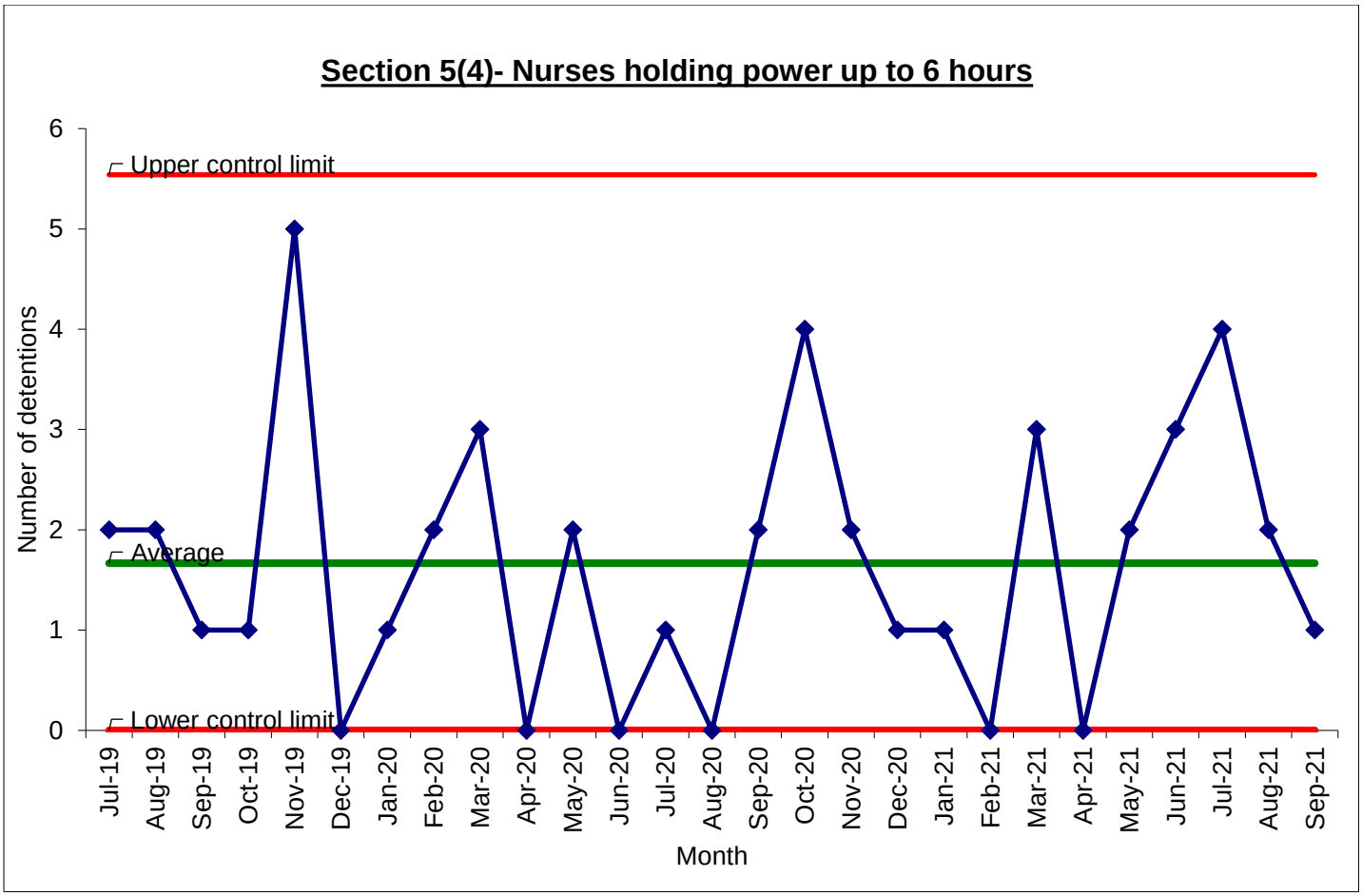
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

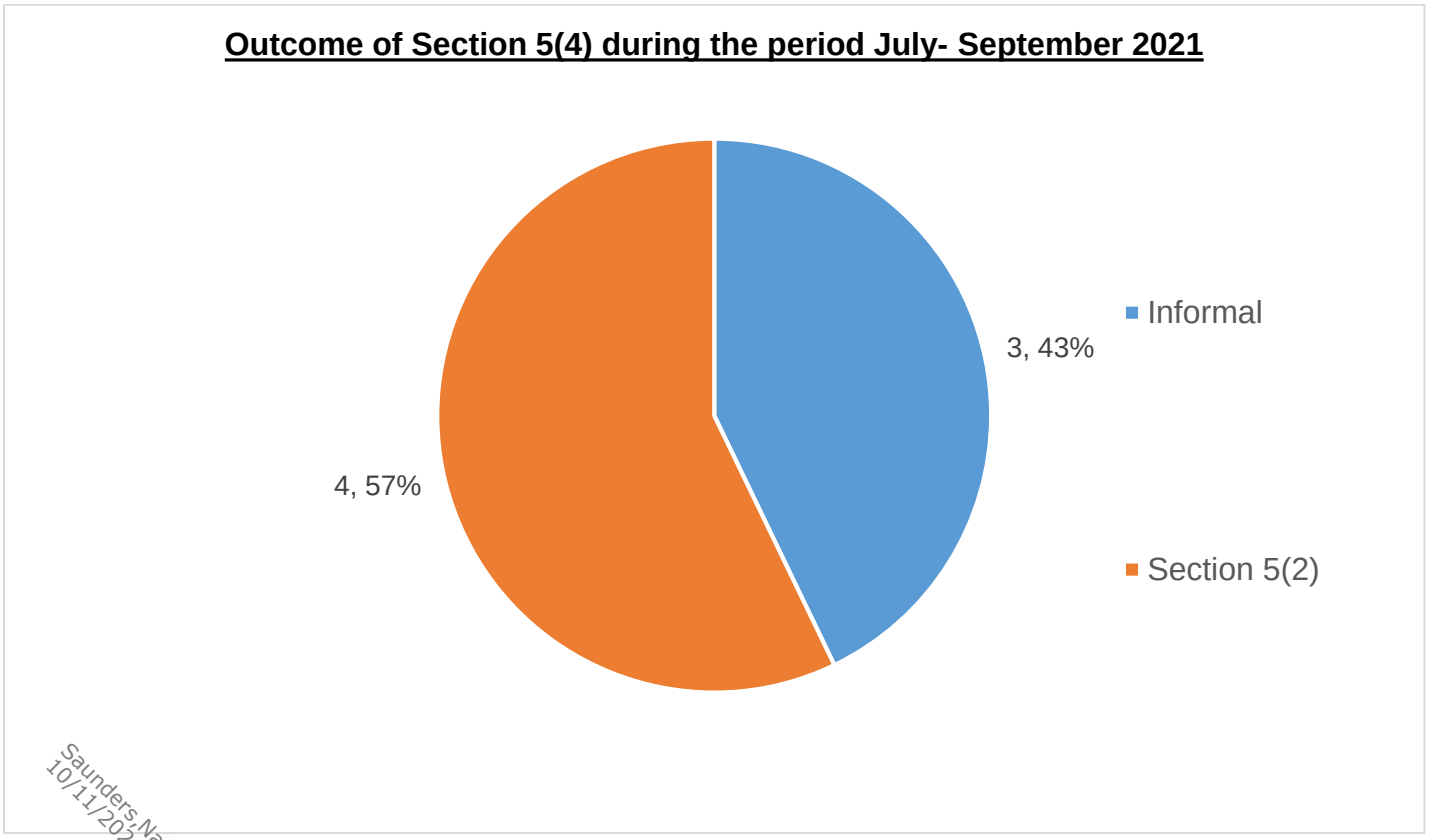


Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

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





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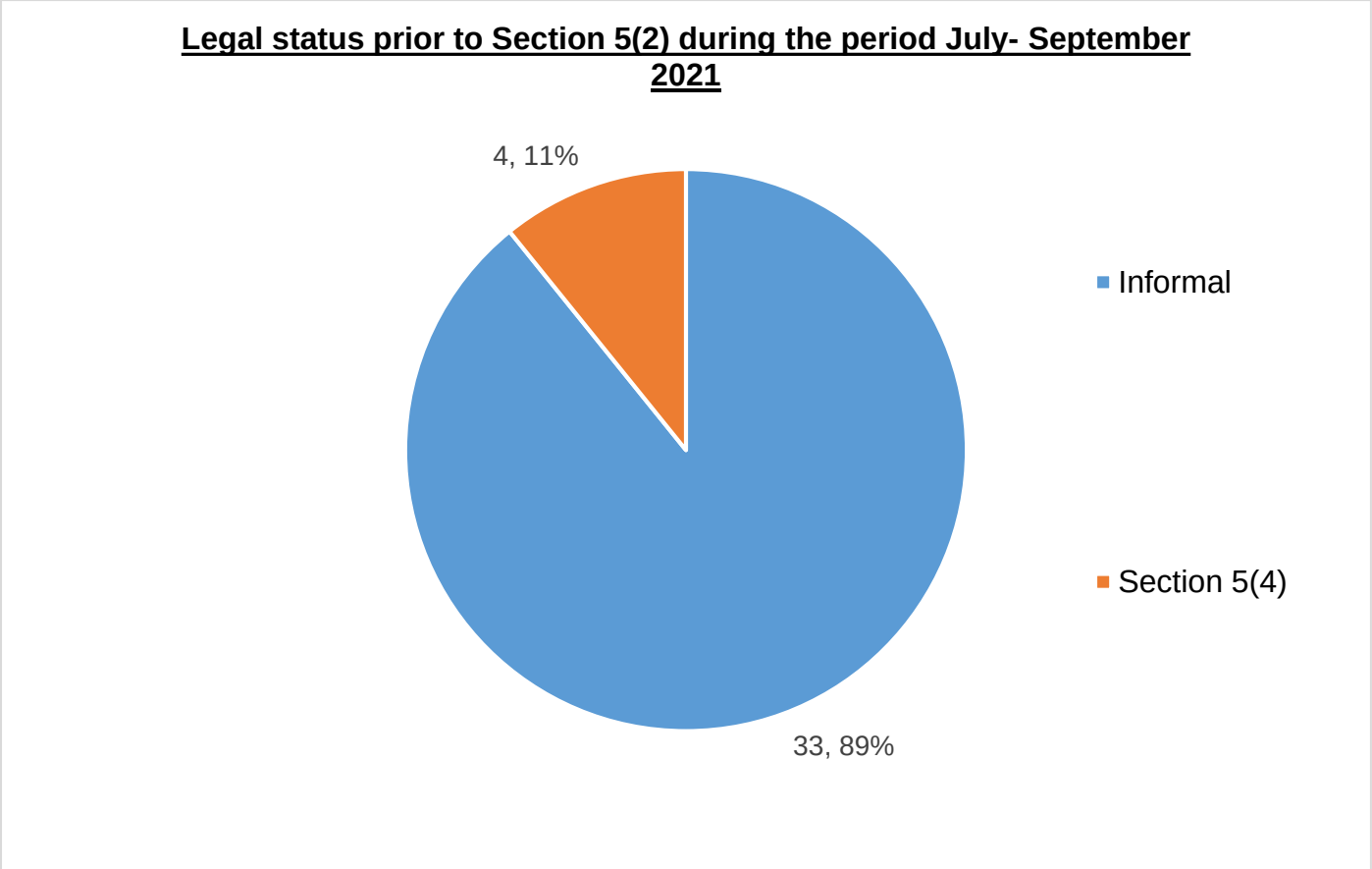
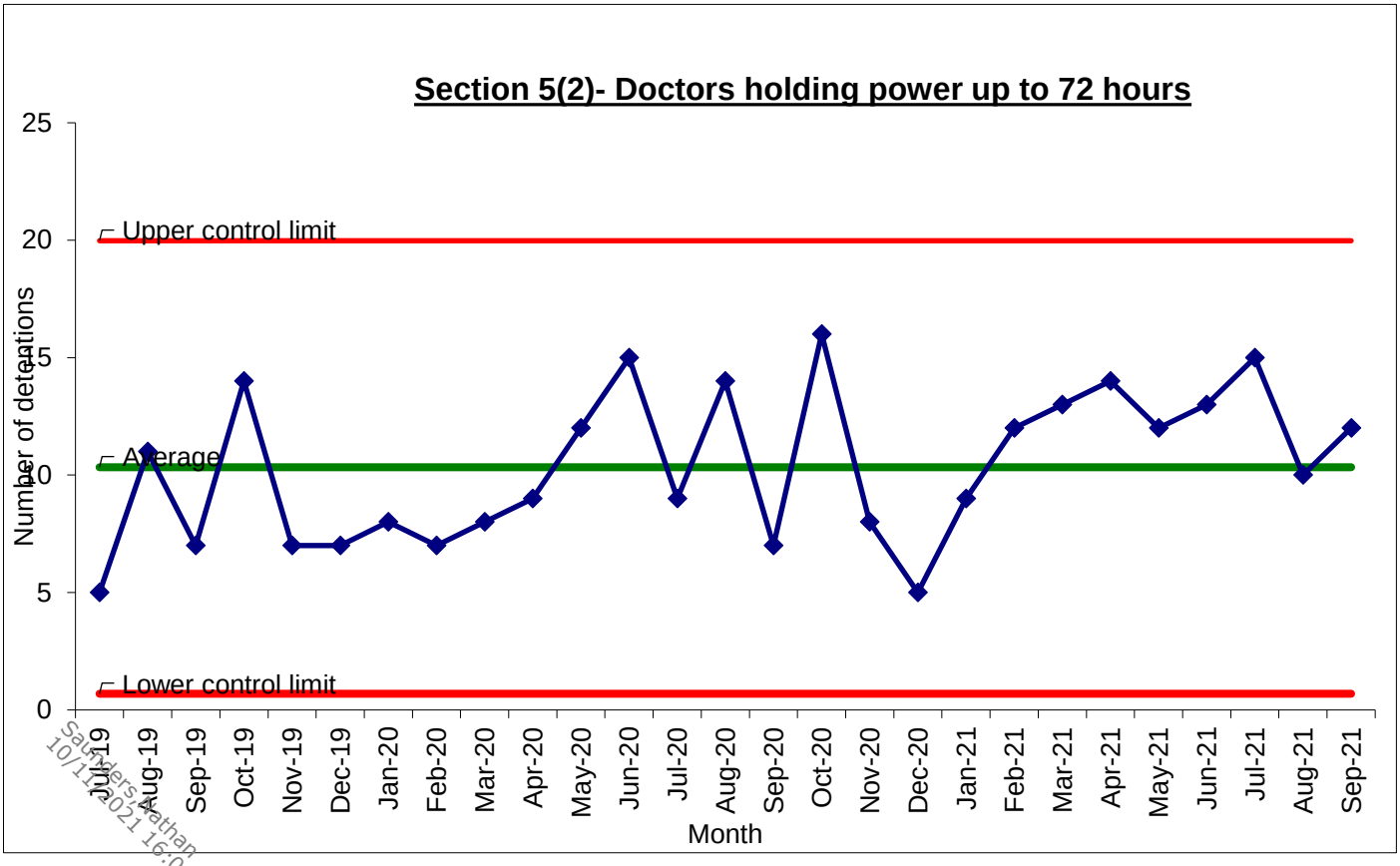
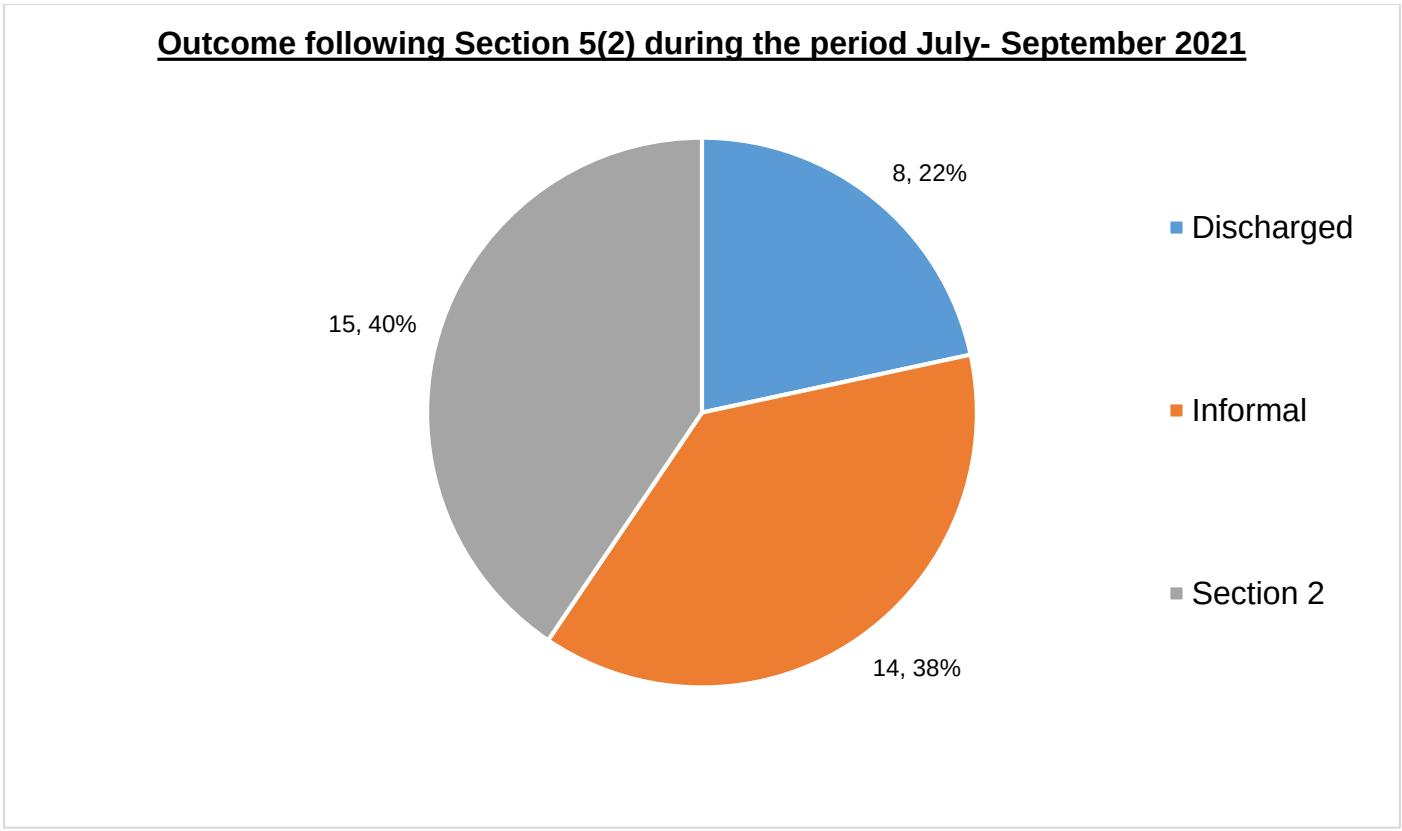
Section 5(2) - Doctors holding power



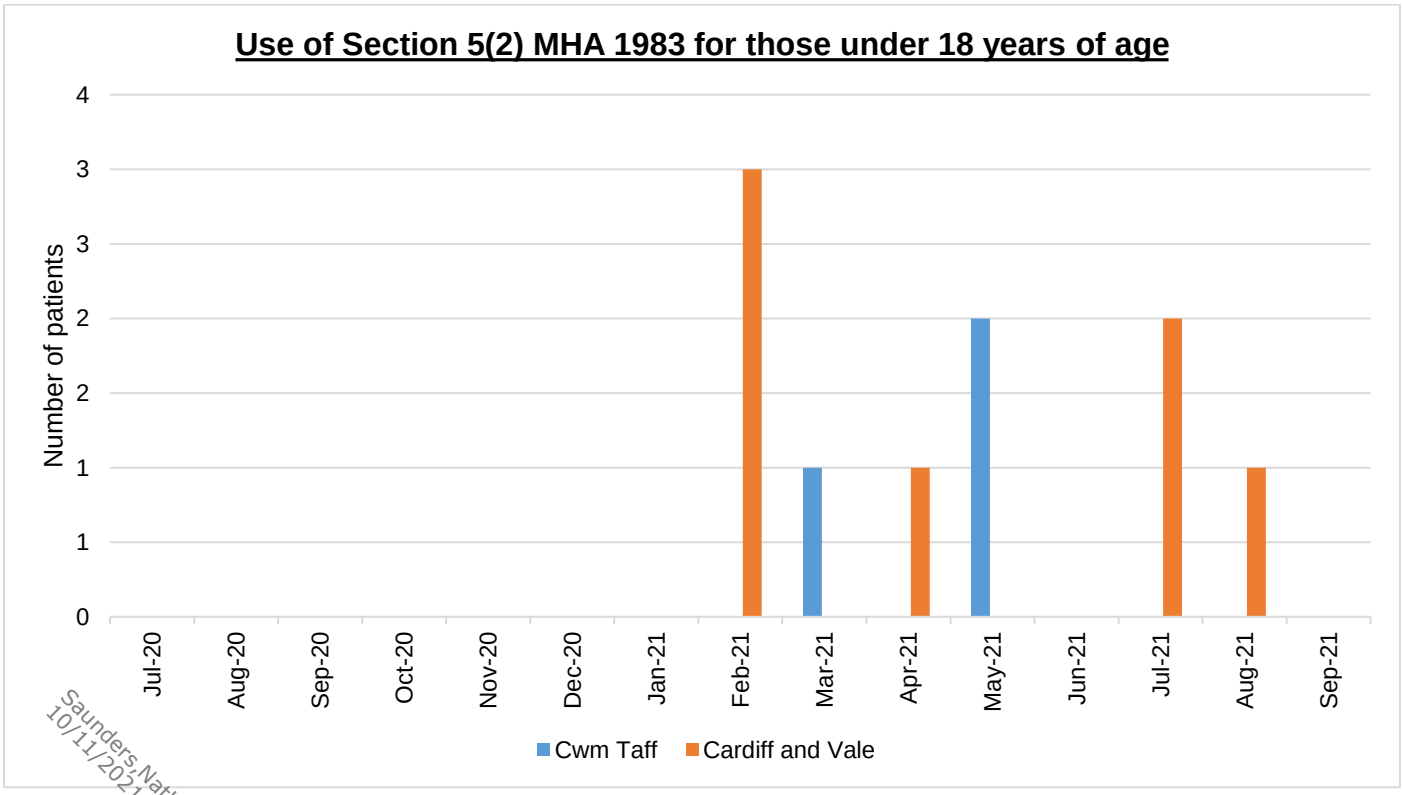


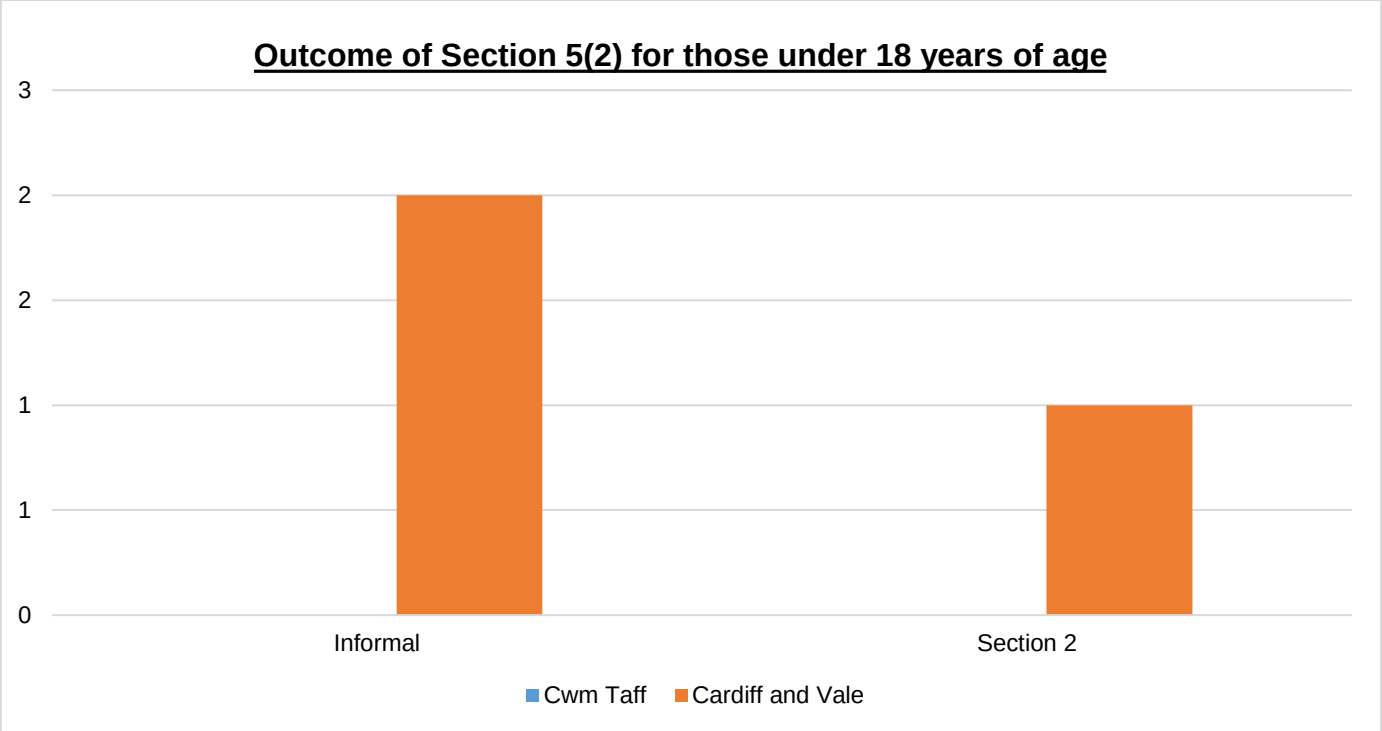


CAMHS Commissioned Inpatient Data

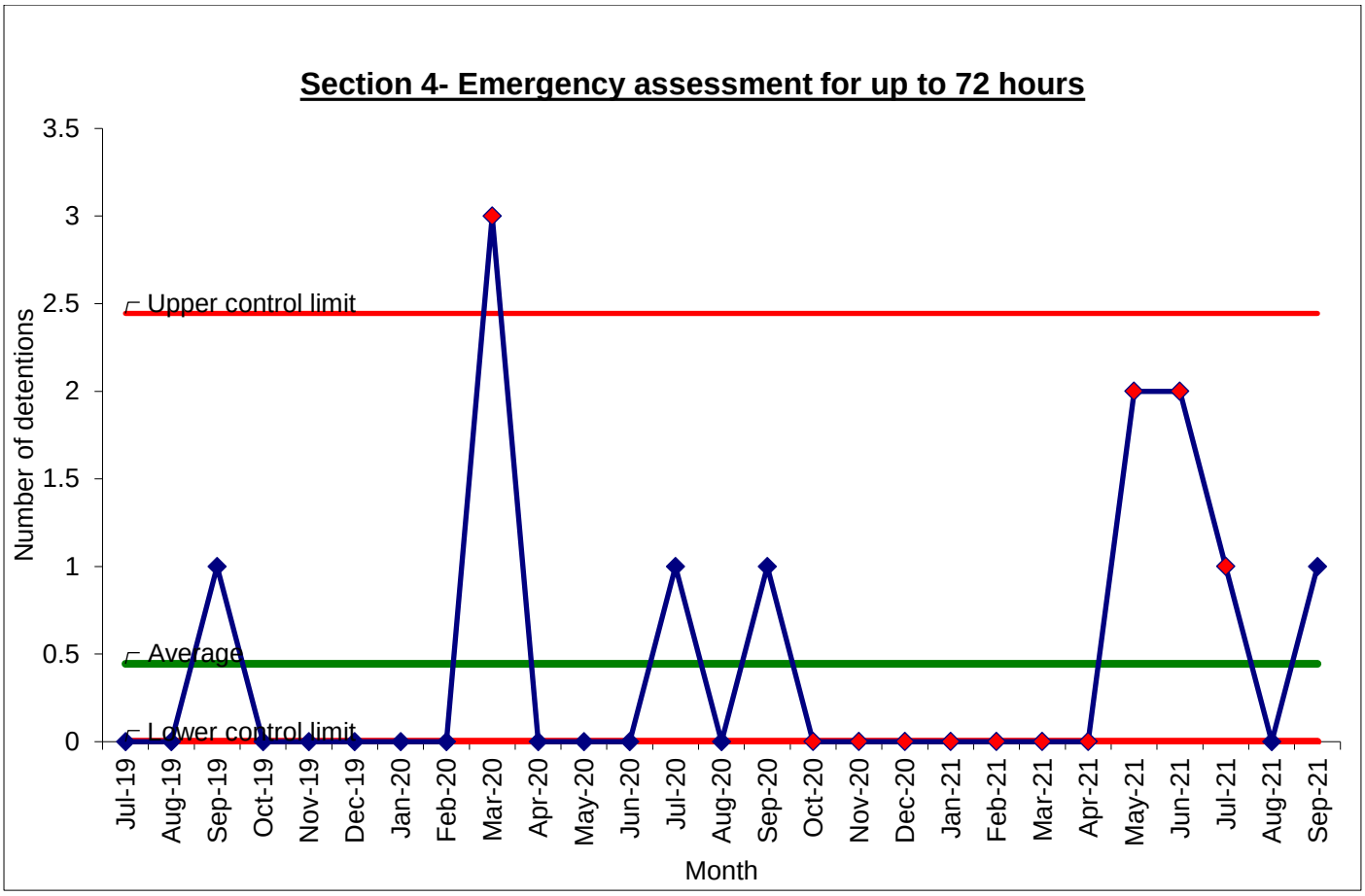
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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





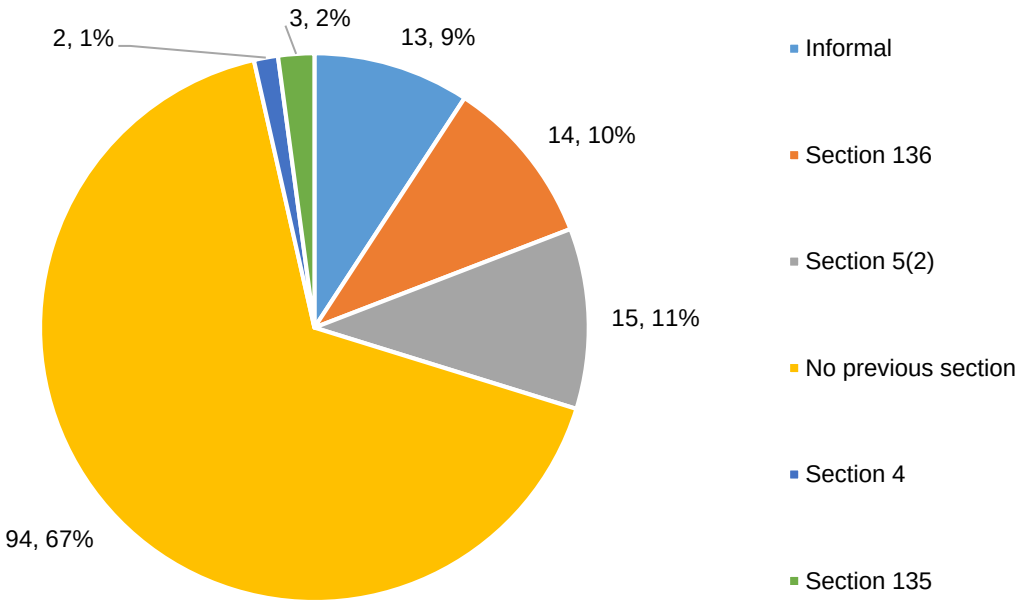
Section 4 - Admission for Assessment in Cases of Emergency



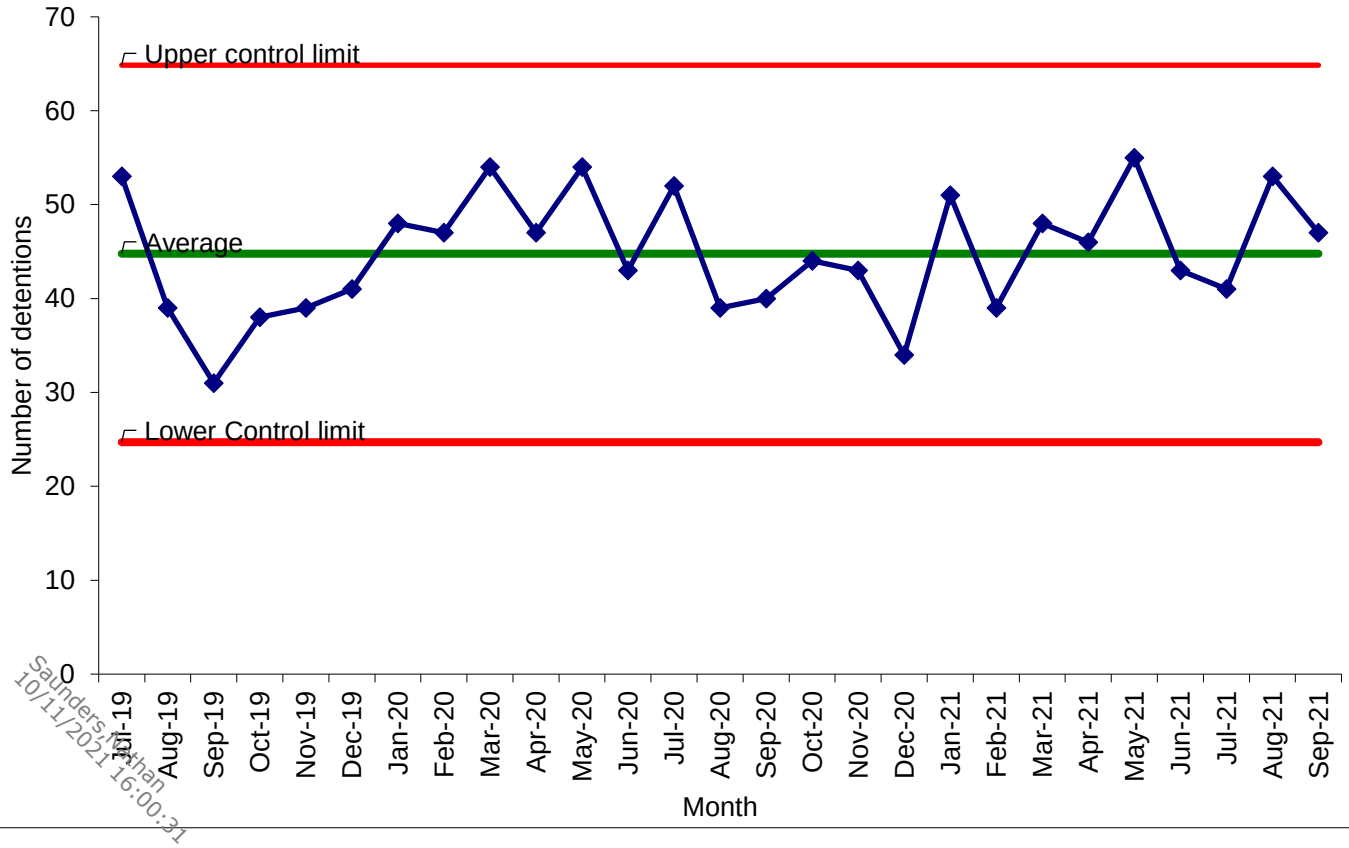
Section 4 was used on two occasions during the period due to an immediate and significant risk of mental or physical harm to the patient or others. Both patients were detained under Section 2.

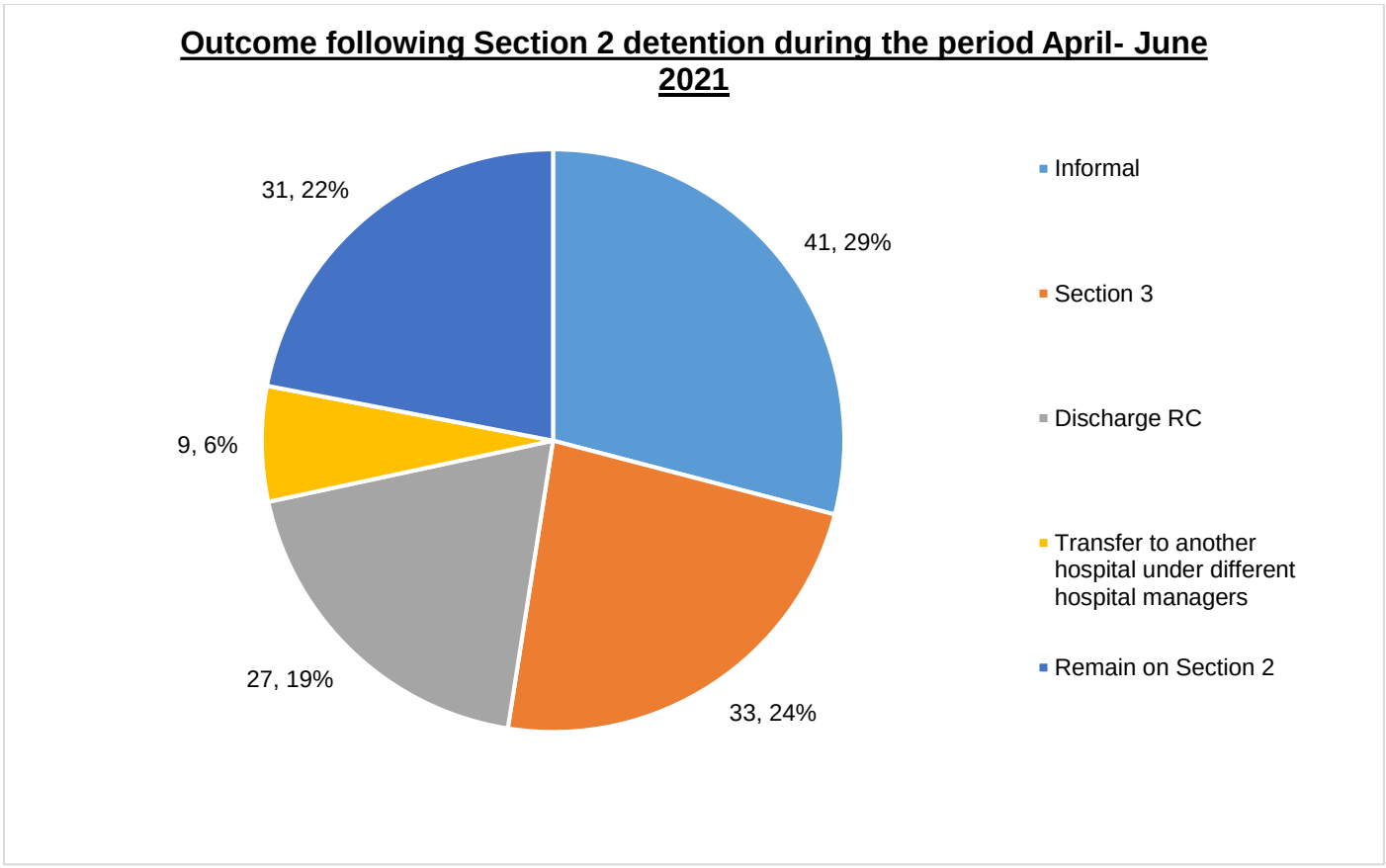
Section 2 – Admission for Assessment

Legal status prior to Section 2 during the period July- September 2021



Section 2- Admission for Assessment up to 28 days

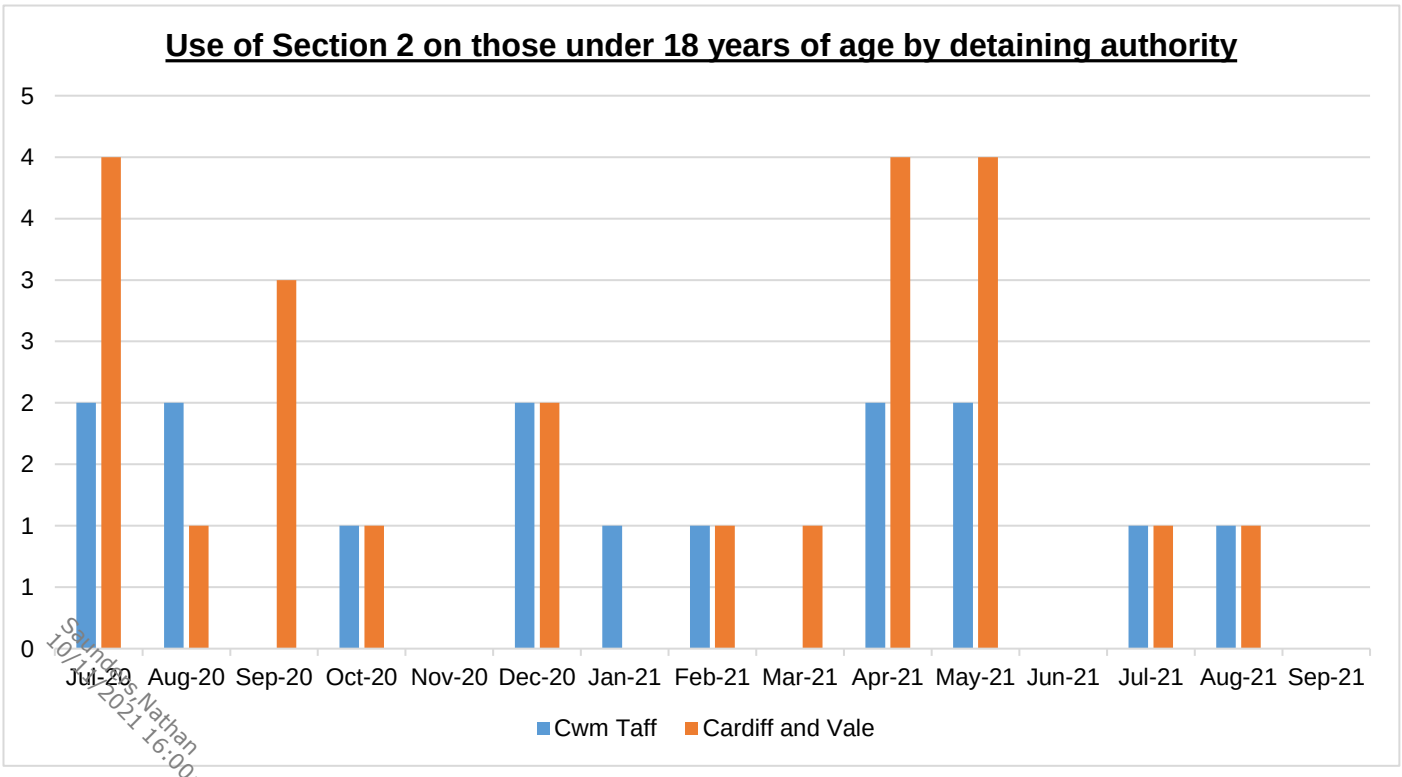


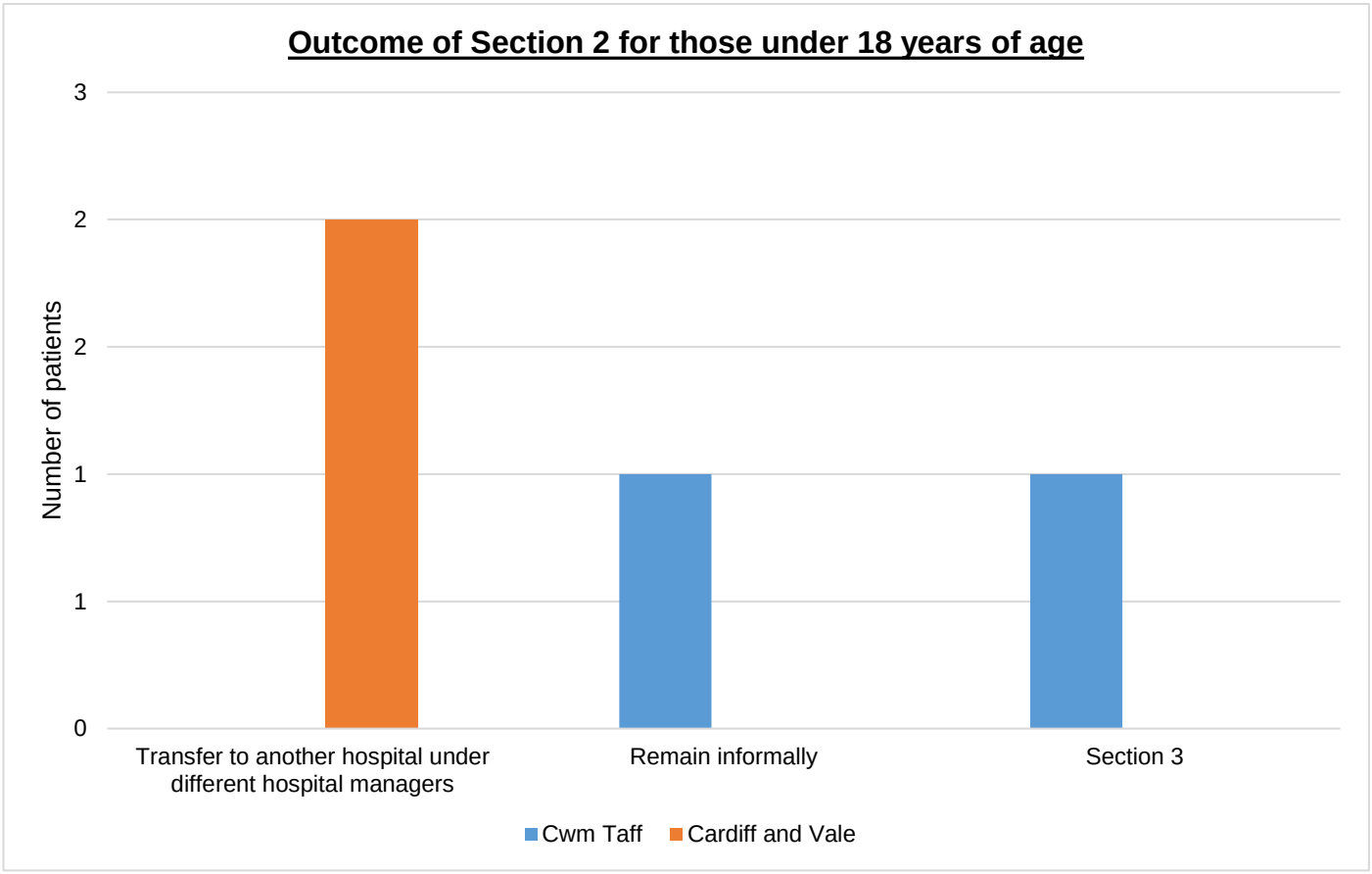


CAMHS Commissioned Inpatient Data

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

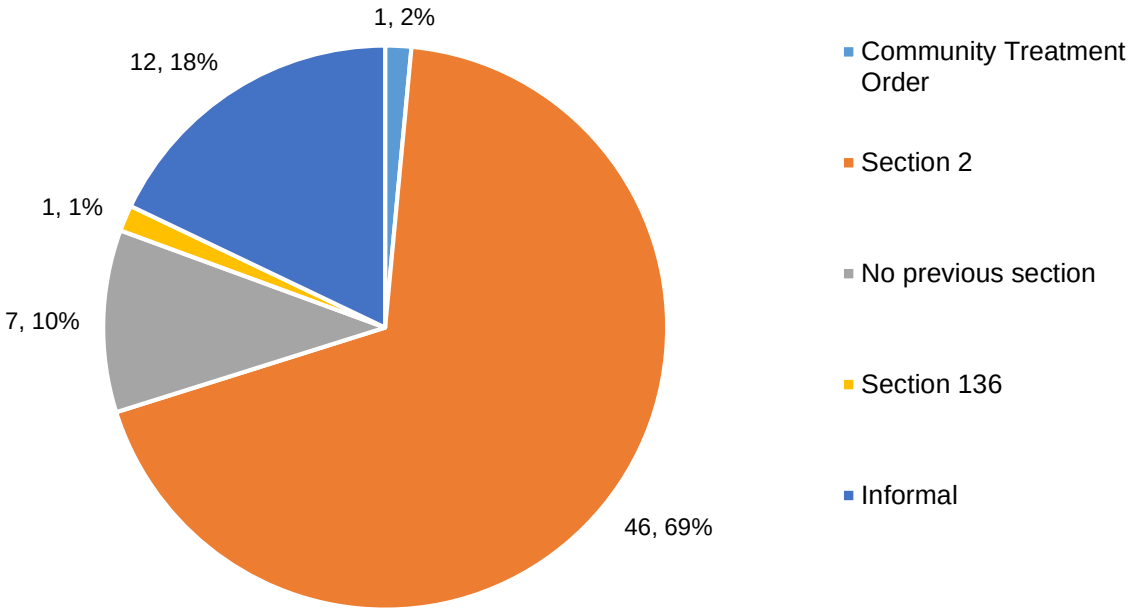
Included in the above data are those under 18 years of age. This is extracted below;-



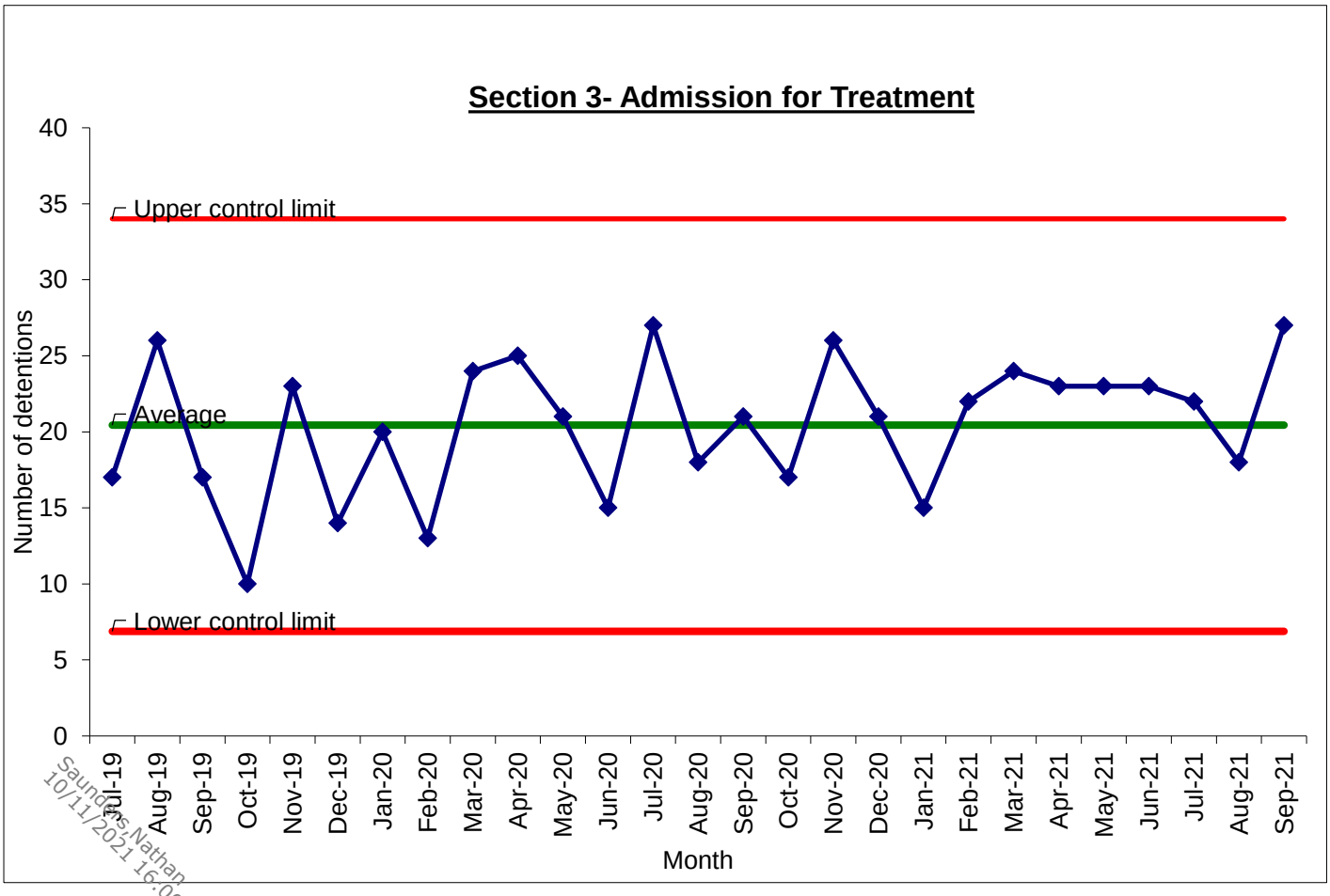


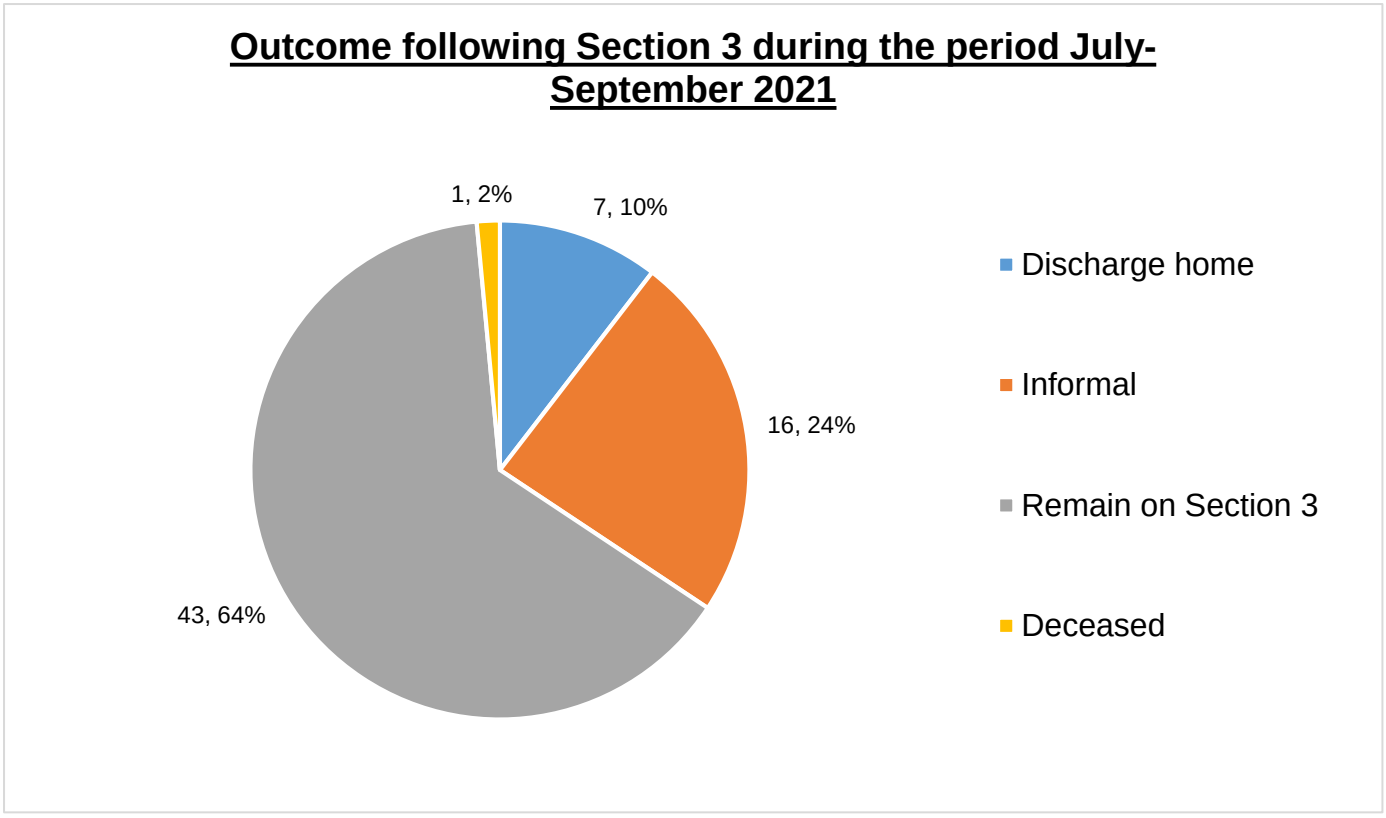
Section 3 – Admission for Treatment

Legal status prior to Section 3 during the period July- September 2021



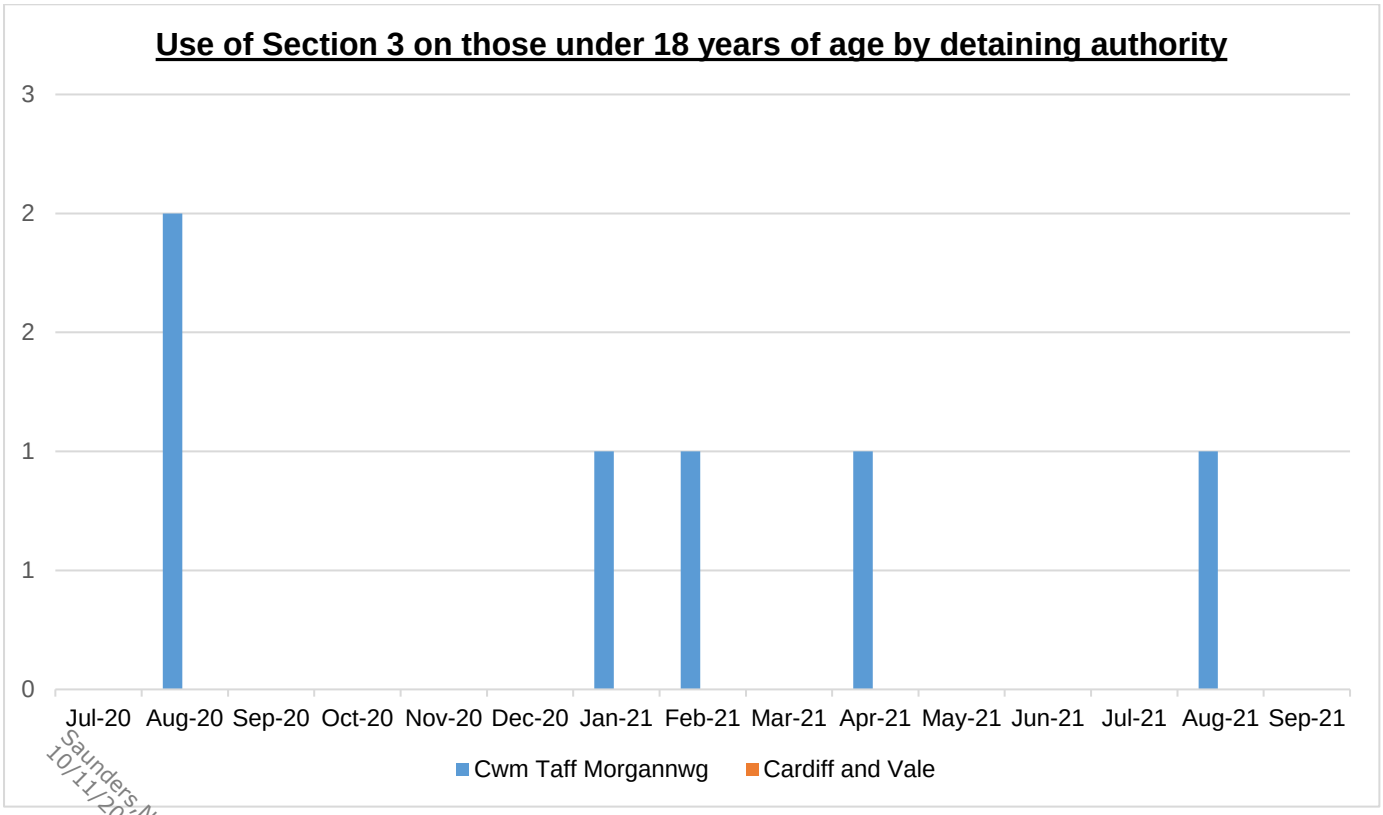
Section 3- Admission for Treatment



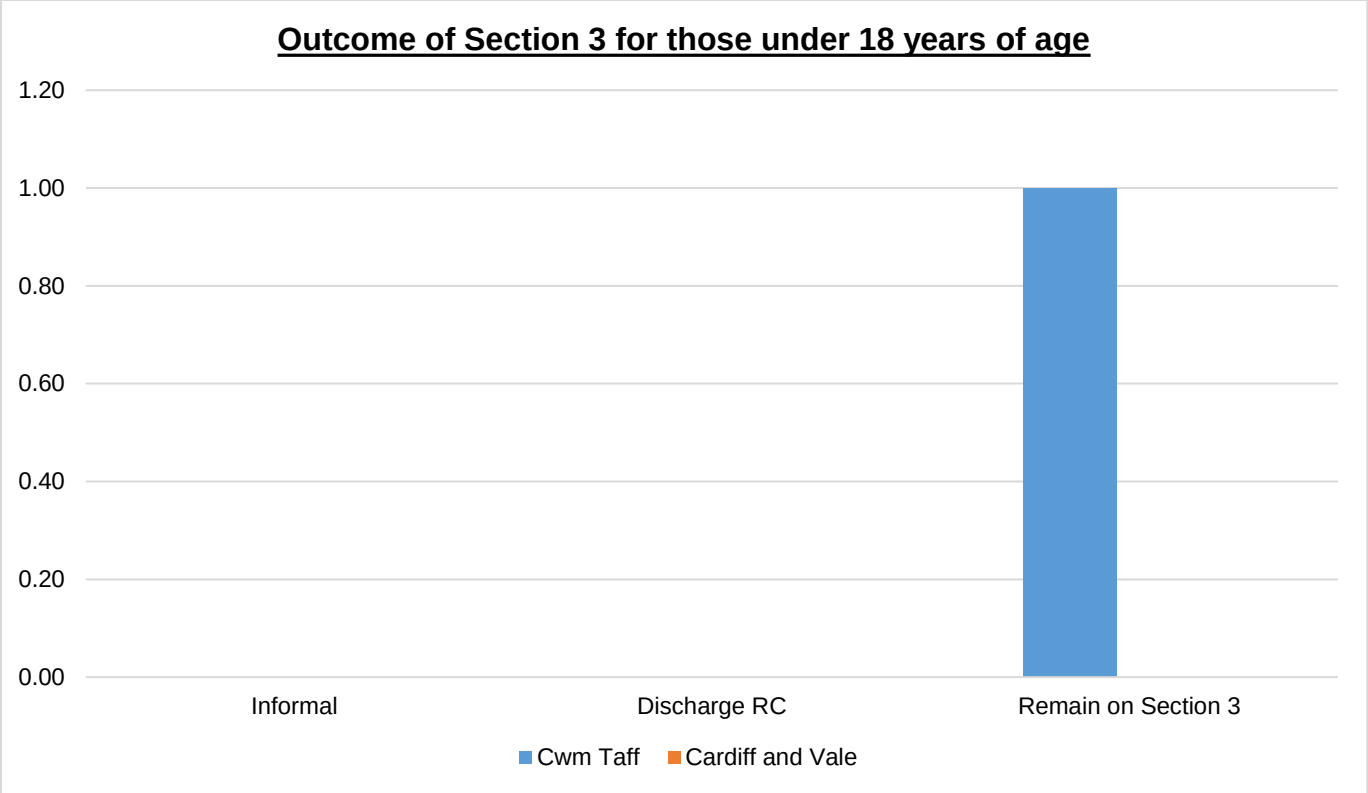


CAMHS Commissioned Inpatient Data

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



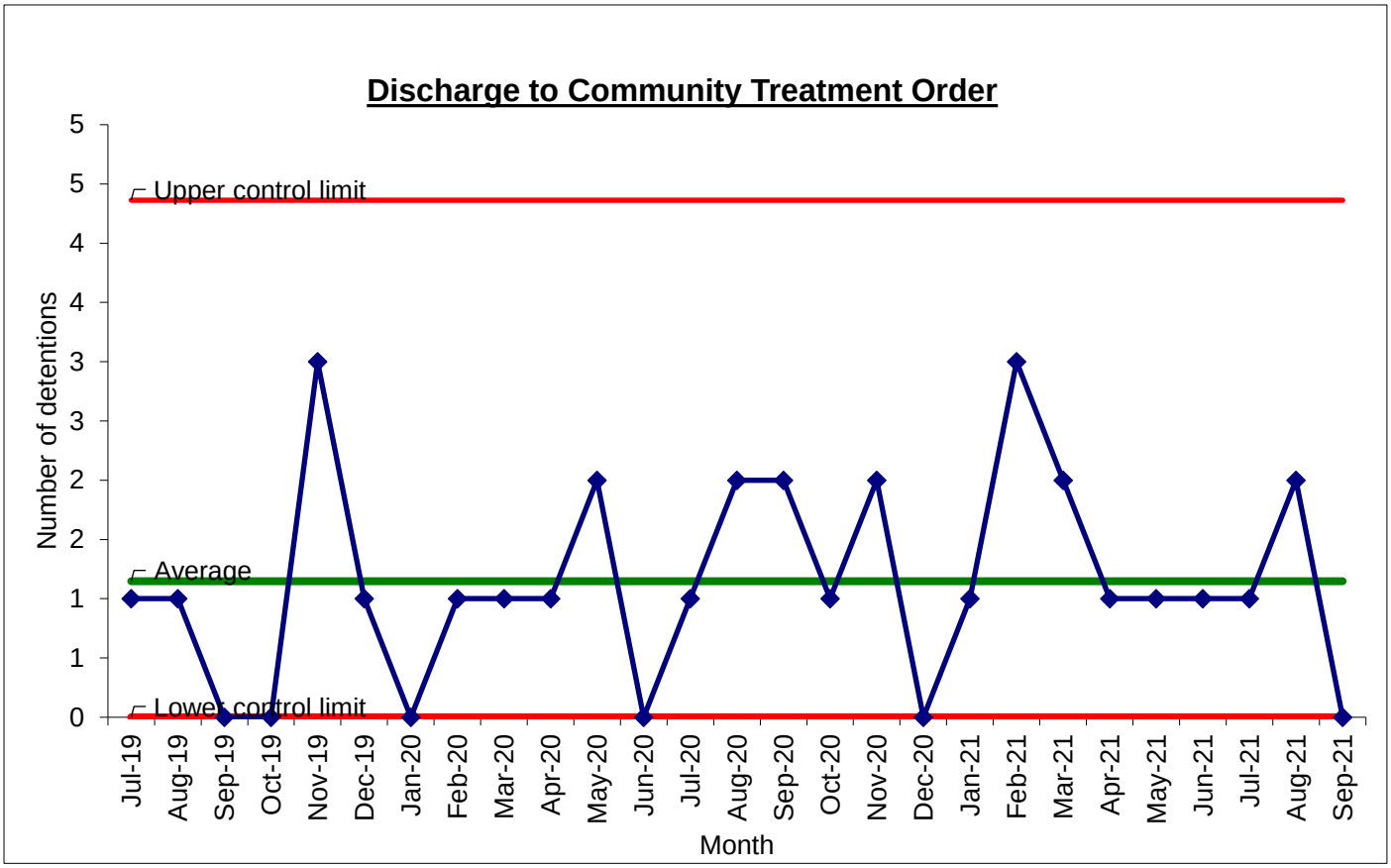
The above data would include those under 18 years of age.

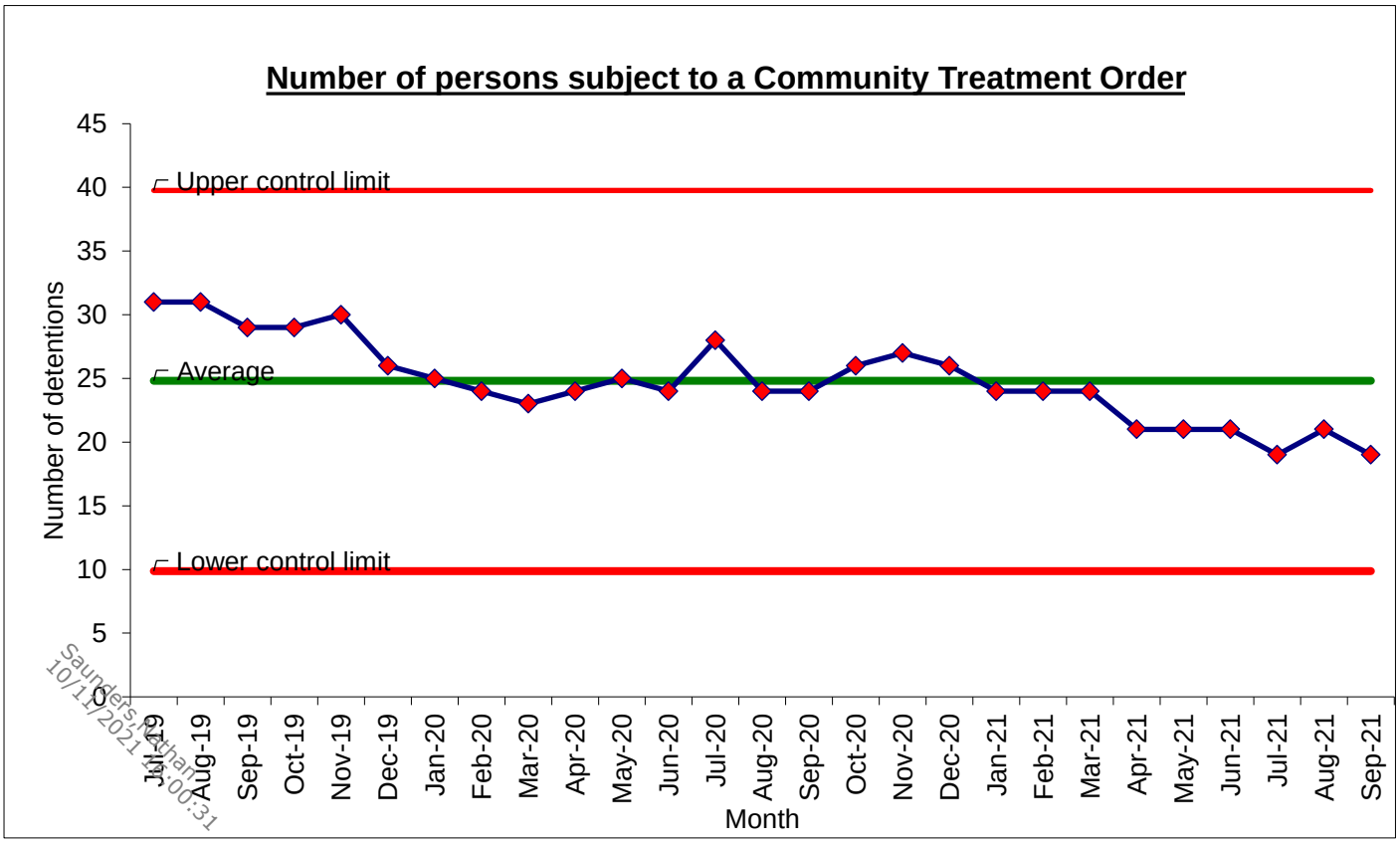


Community Treatment Order

During the period July- September 2021 three patients were discharged to Community Treatment Order.

As at 30 September 2021, 19 patients were subject to a Community Treatment Order (CTO).





Recall of a community patient under Section 17E

During the period, the power of recall was used on two occasion occasions. The patient's CTO's were subsequently revoked.

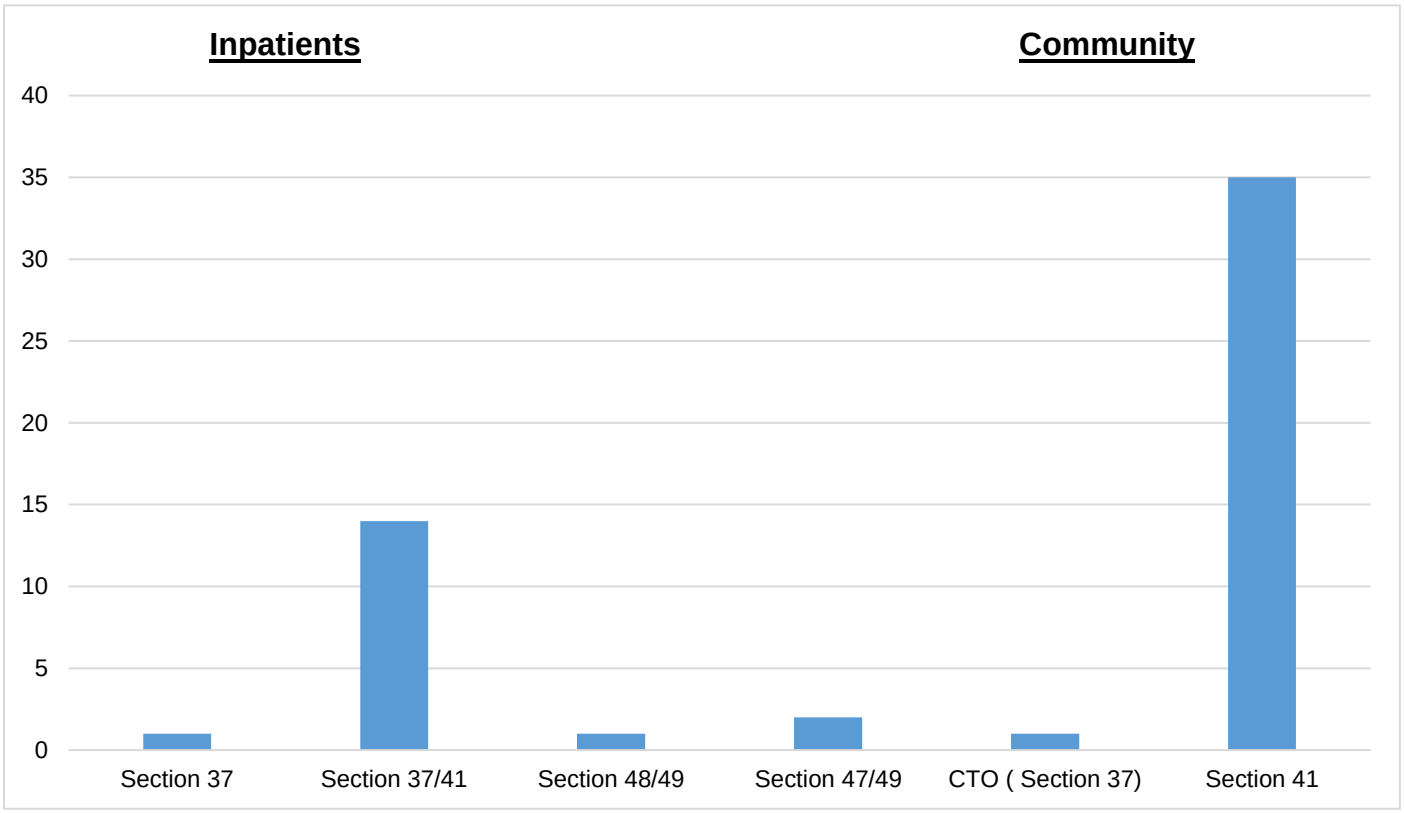
CAMHS Commissioned Inpatient Data

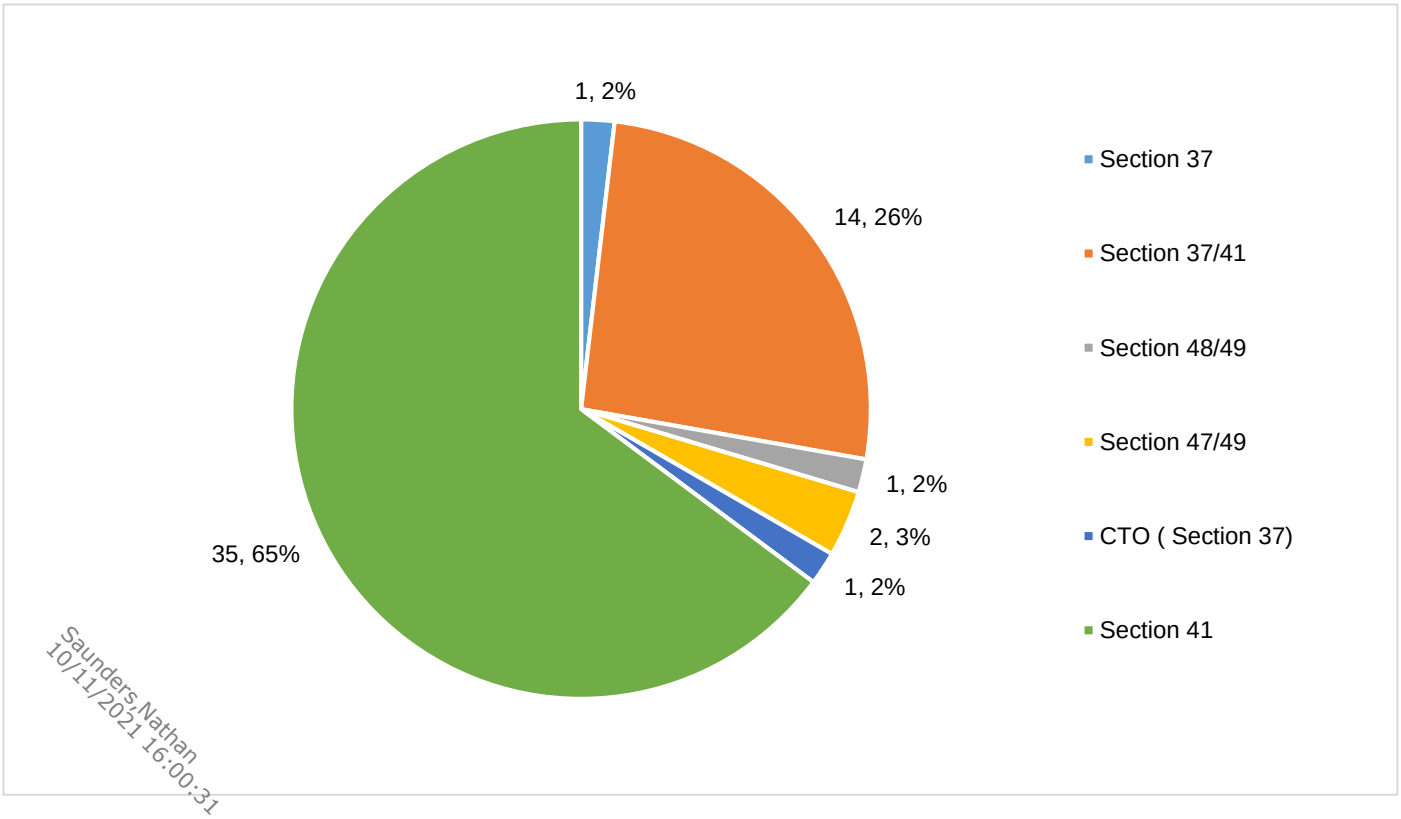
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

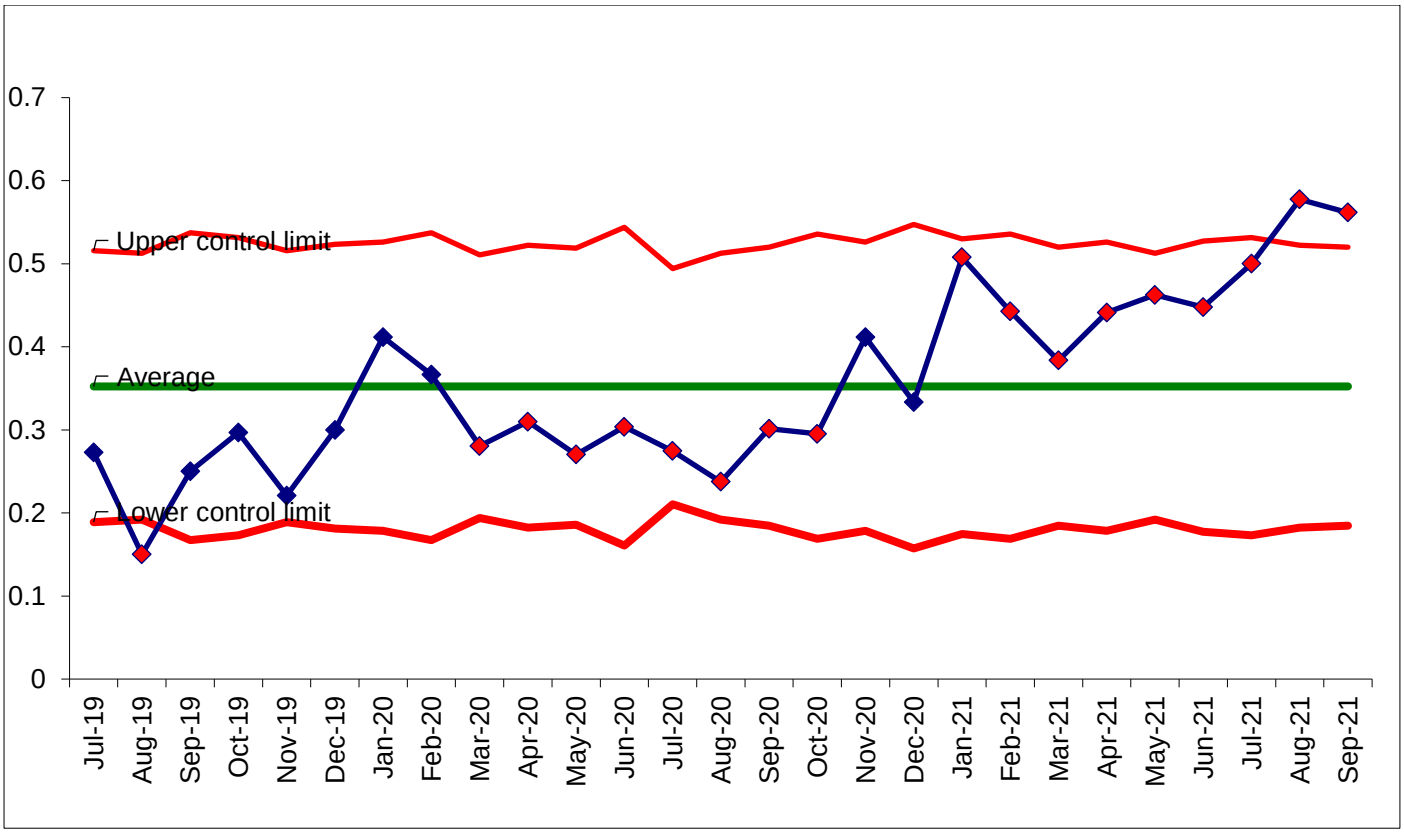
Part 3 of the Mental Health Act 1983

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 September 2021.



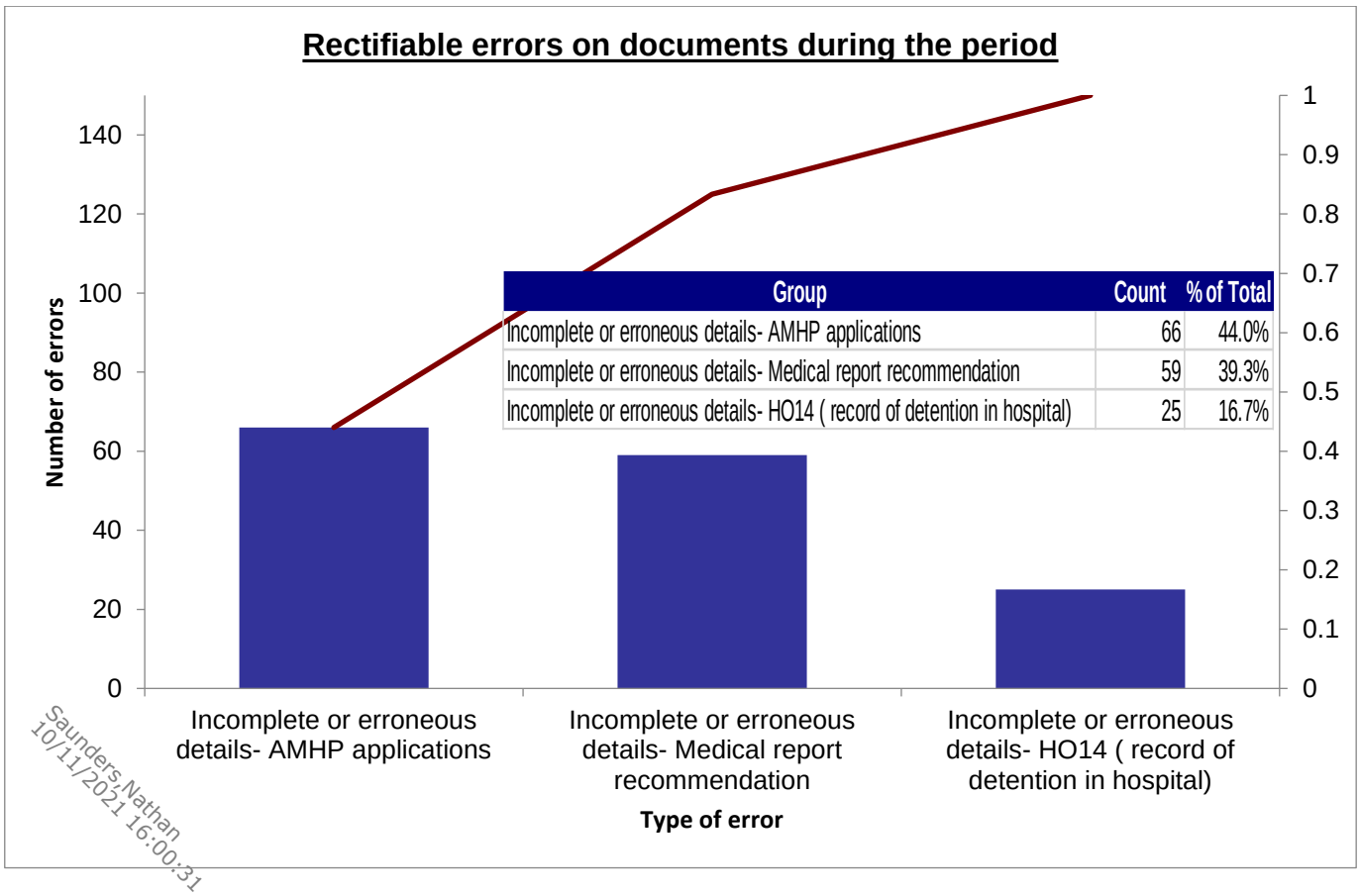


Scrutiny of documents during the period

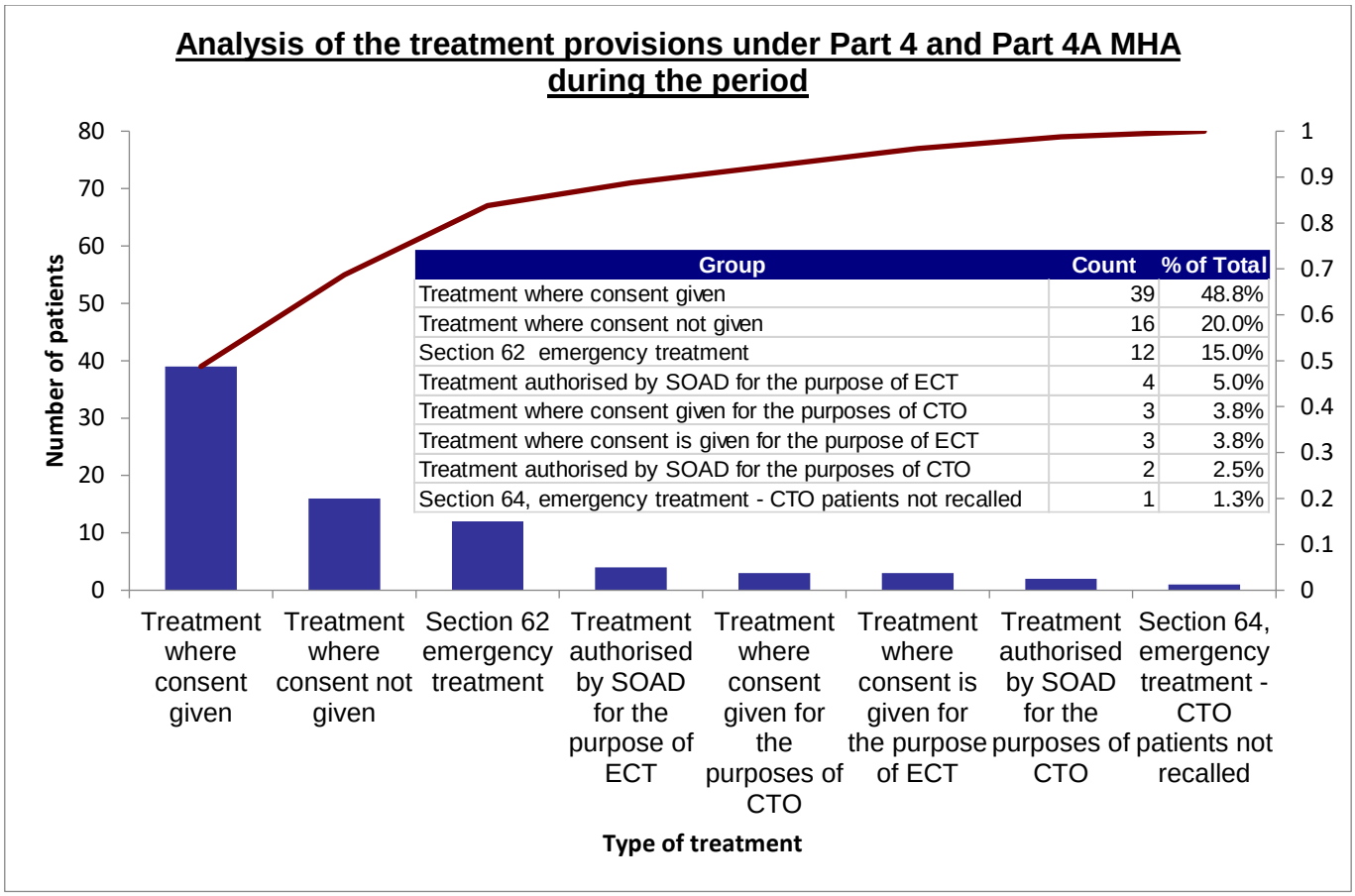


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.

Rectifiable errors on documents during the period



Consent to Treatment



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:

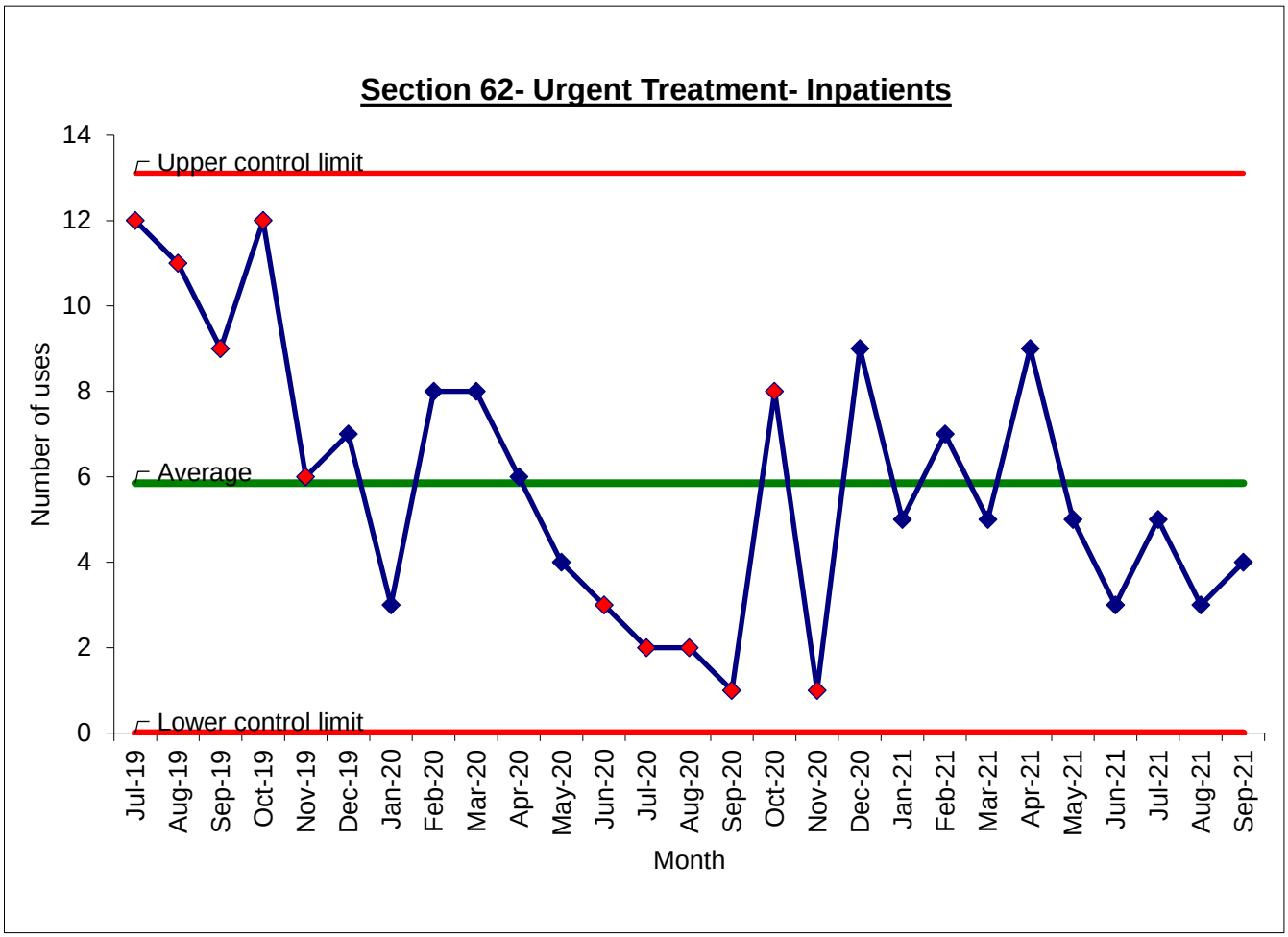
- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That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

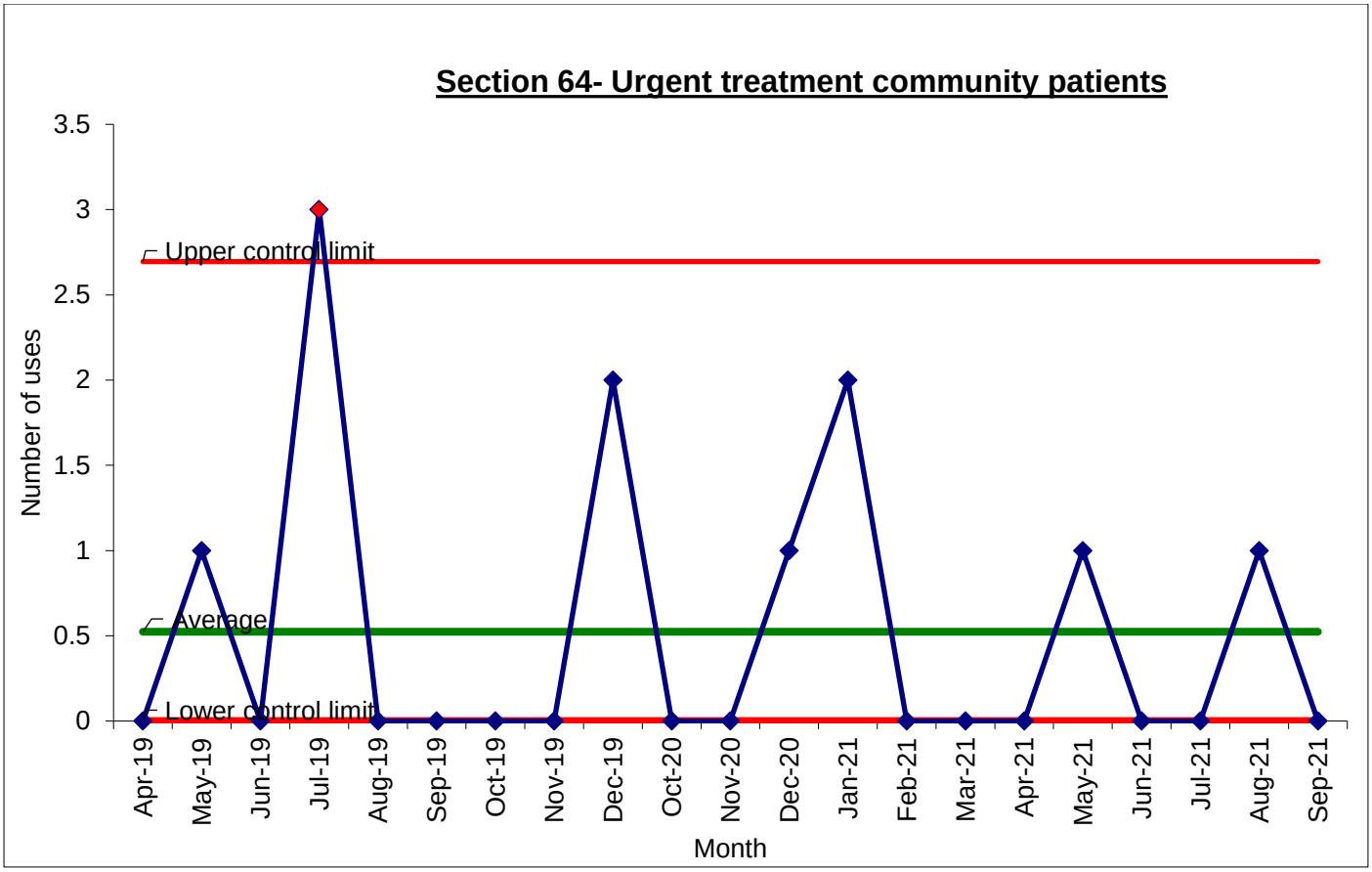
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.

- 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 twelve occasions for the following reasons:

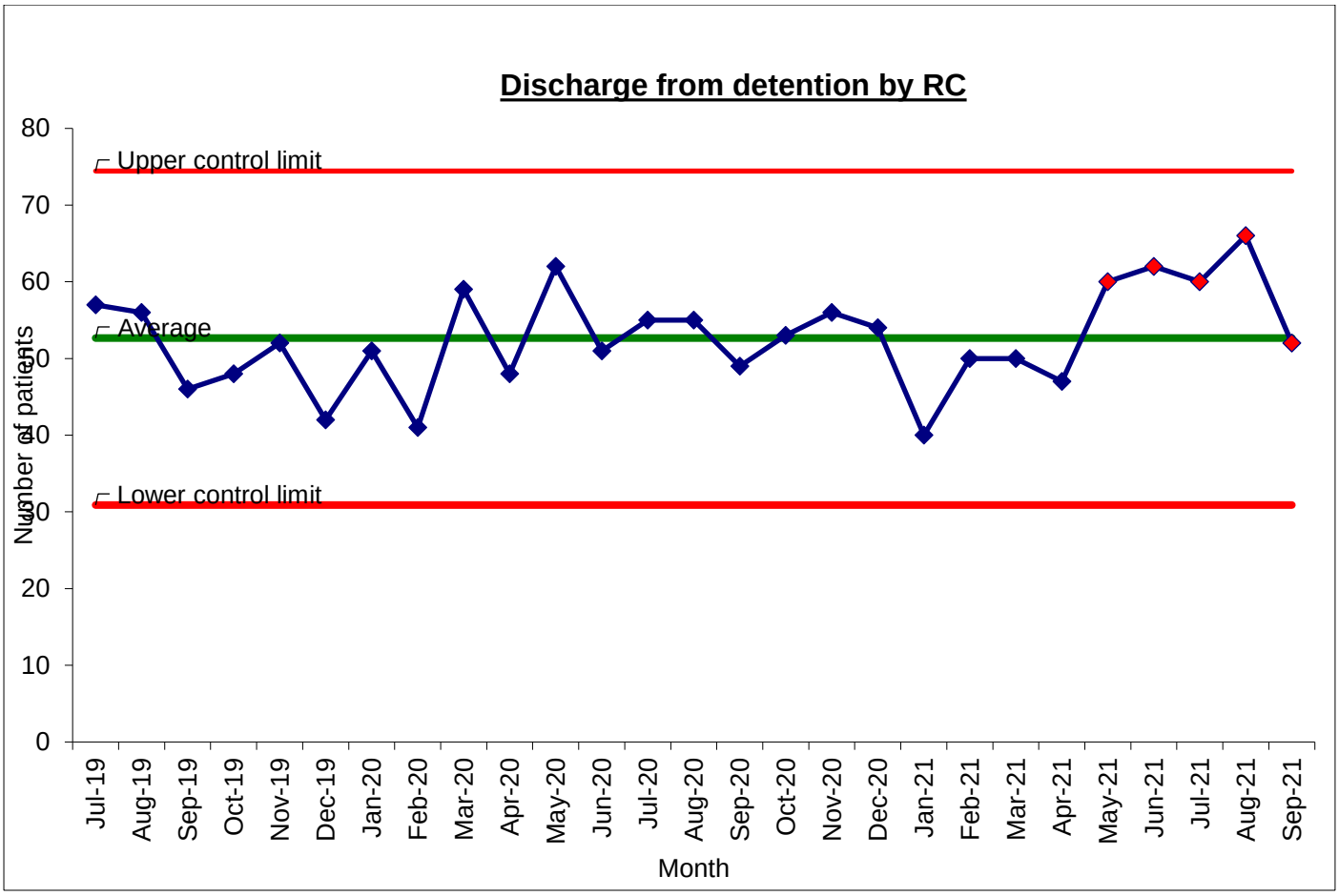
- Pending SOAD – 3 month rule x 7
- Change of capacity to consent x 1
- Awaiting new certificate due to time limited certificate x 2
- Change of medication x 2

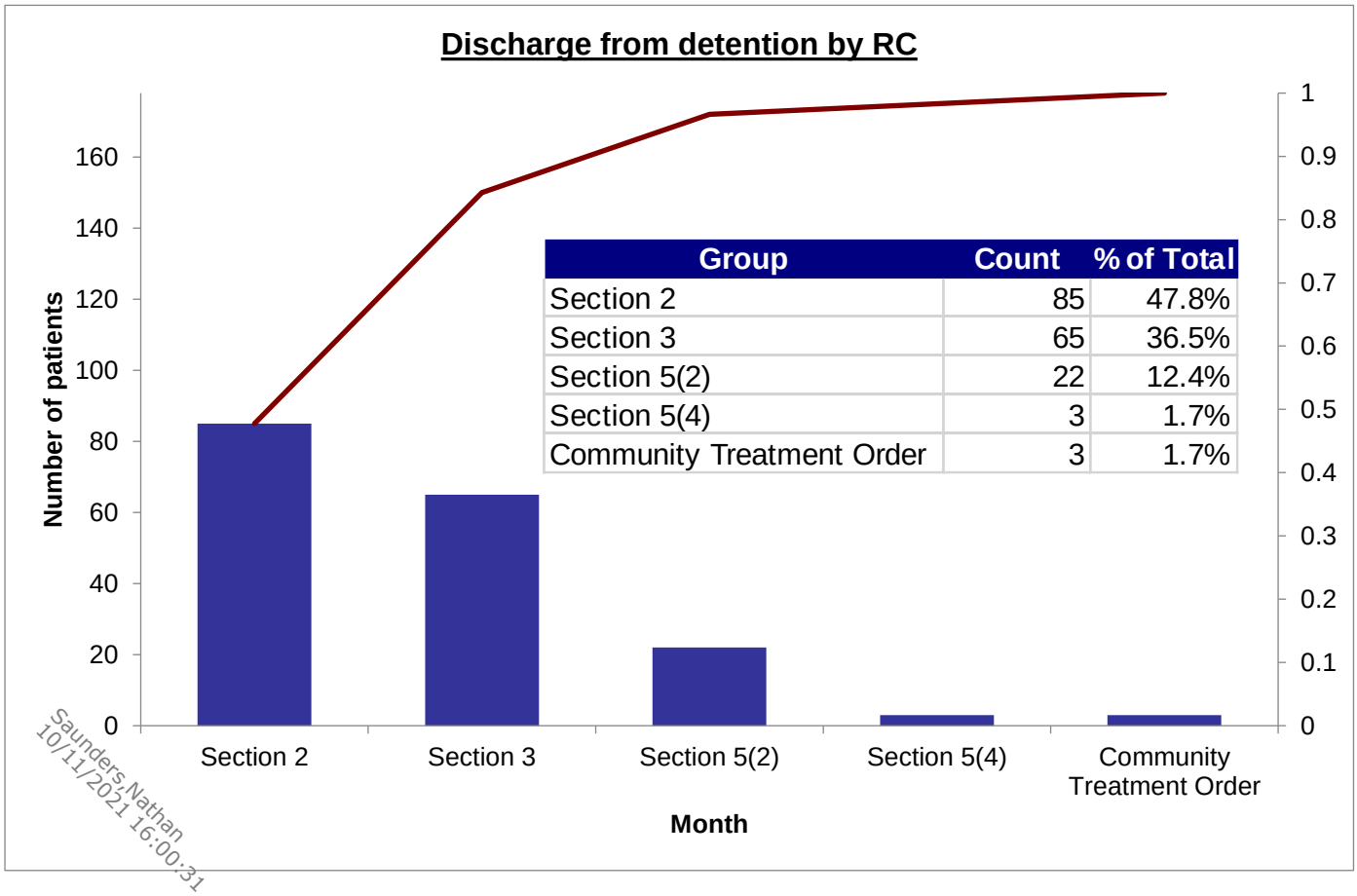


The above chart highlights that Section 64 was used on one occasion during the period for following reason:

- One month rule x 1

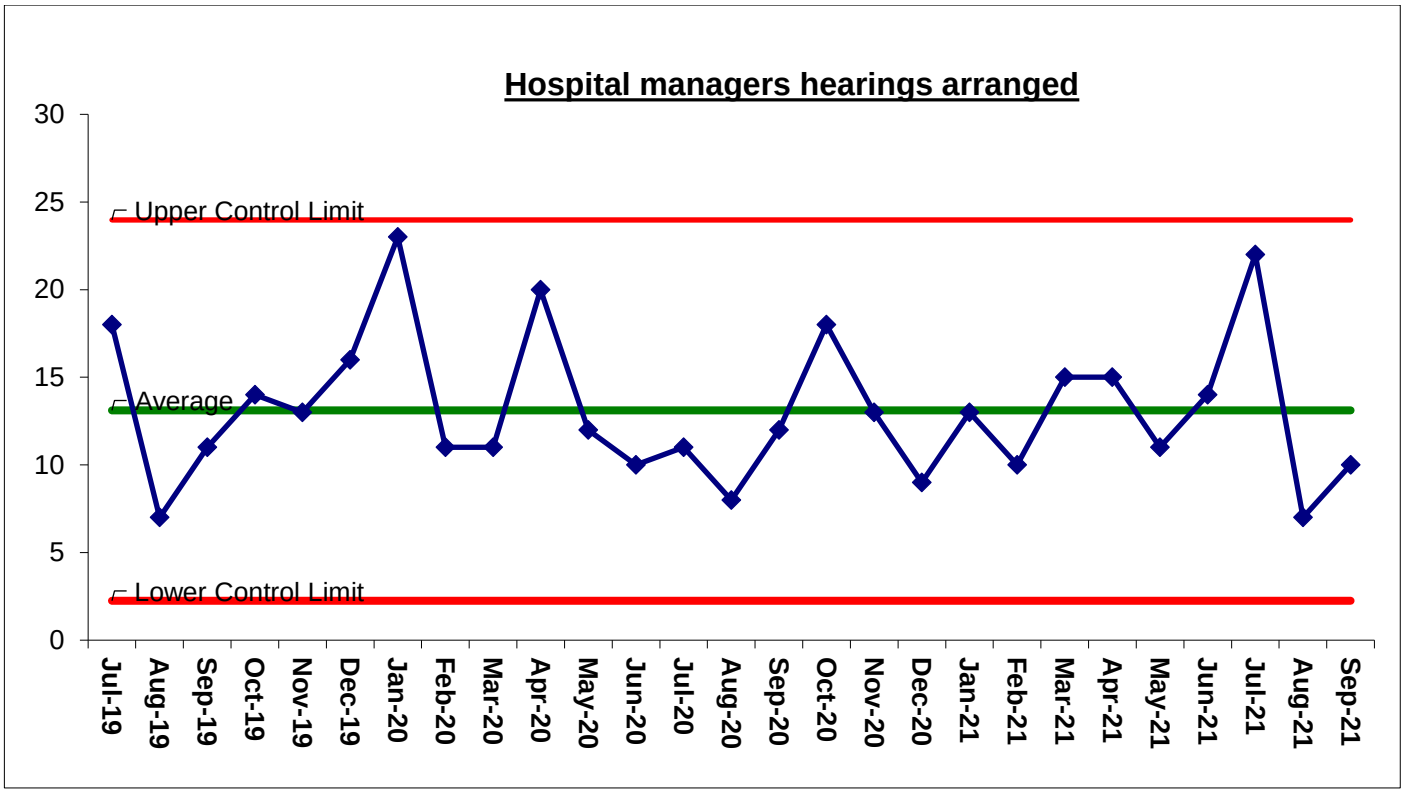
Discharge

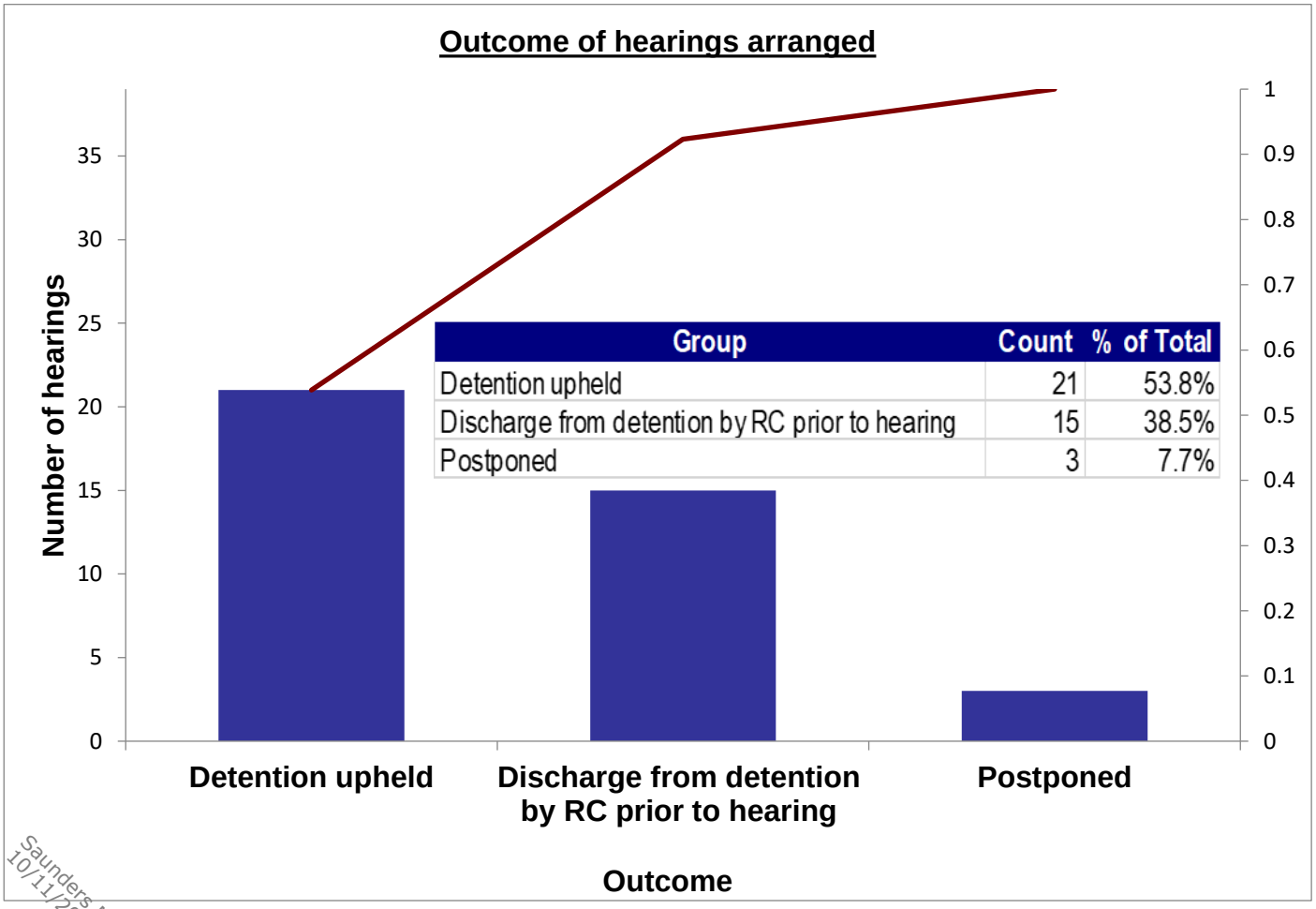




Group	Count	% of Total
Section 2	85	47.8%
Section 3	65	36.5%
Section 5(2)	22	12.4%
Section 5(4)	3	1.7%
Community Treatment Order	3	1.7%

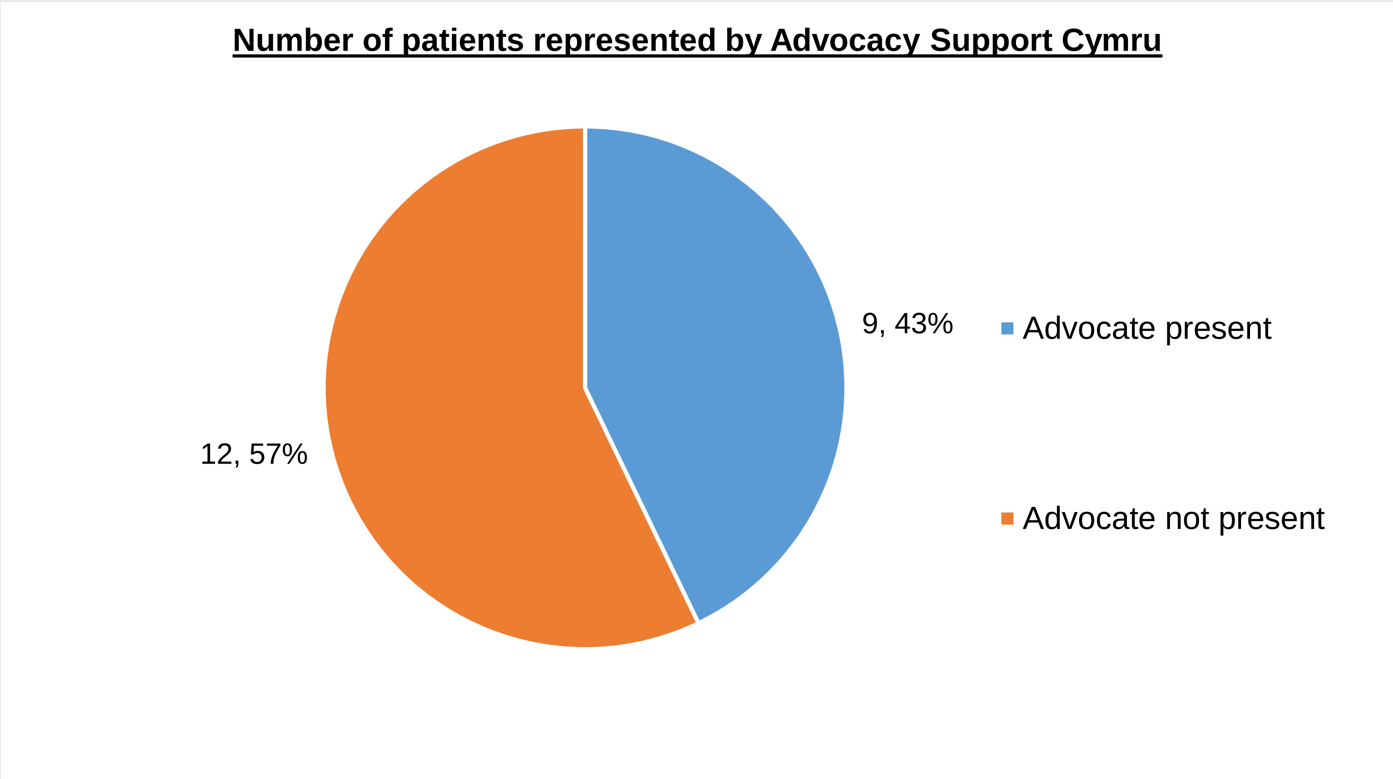
Hospital Managers – Power of Discharge

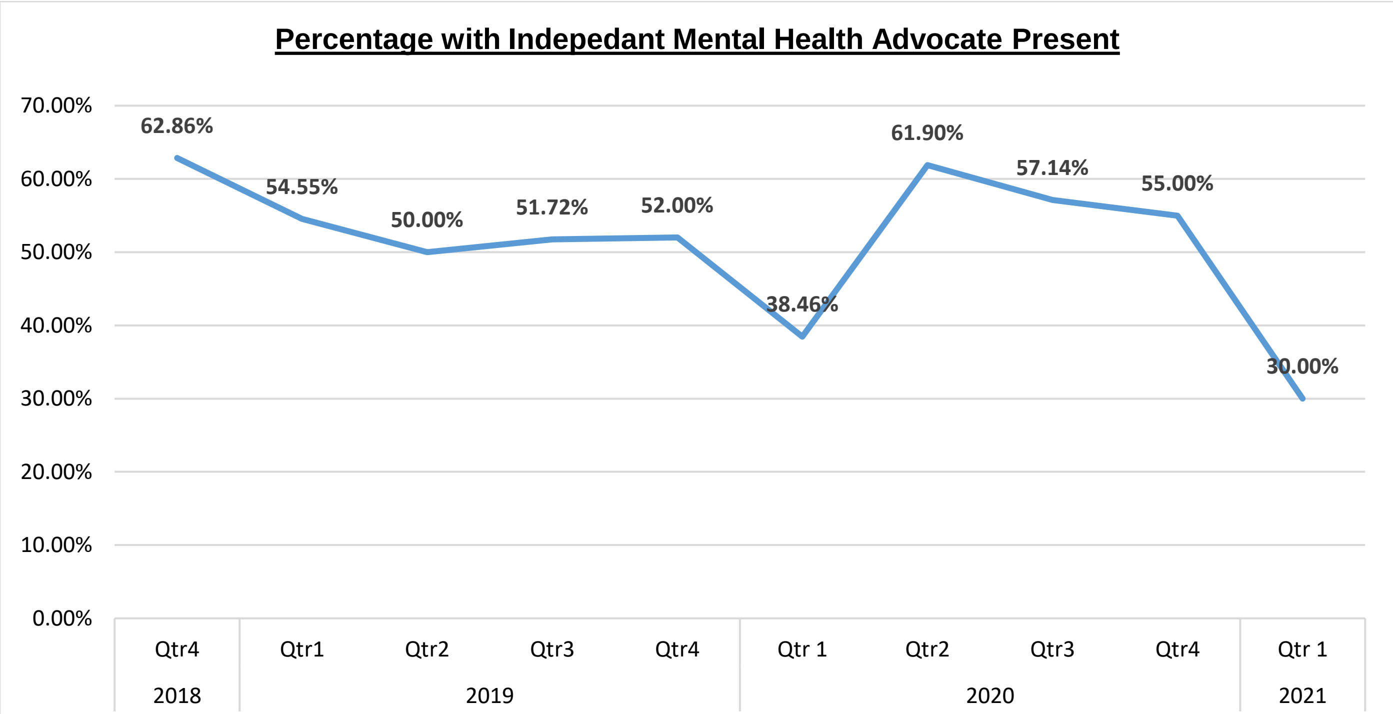




Three hearings were postponed for the following reasons:

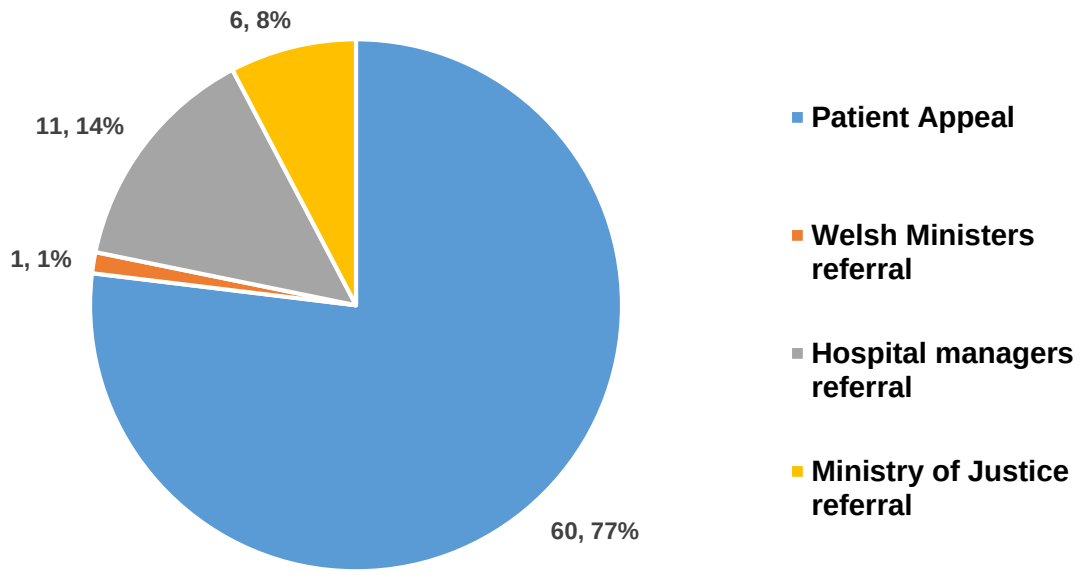
- RC availability
- The patients CTO was recalled
- The patient was placed on a CTO



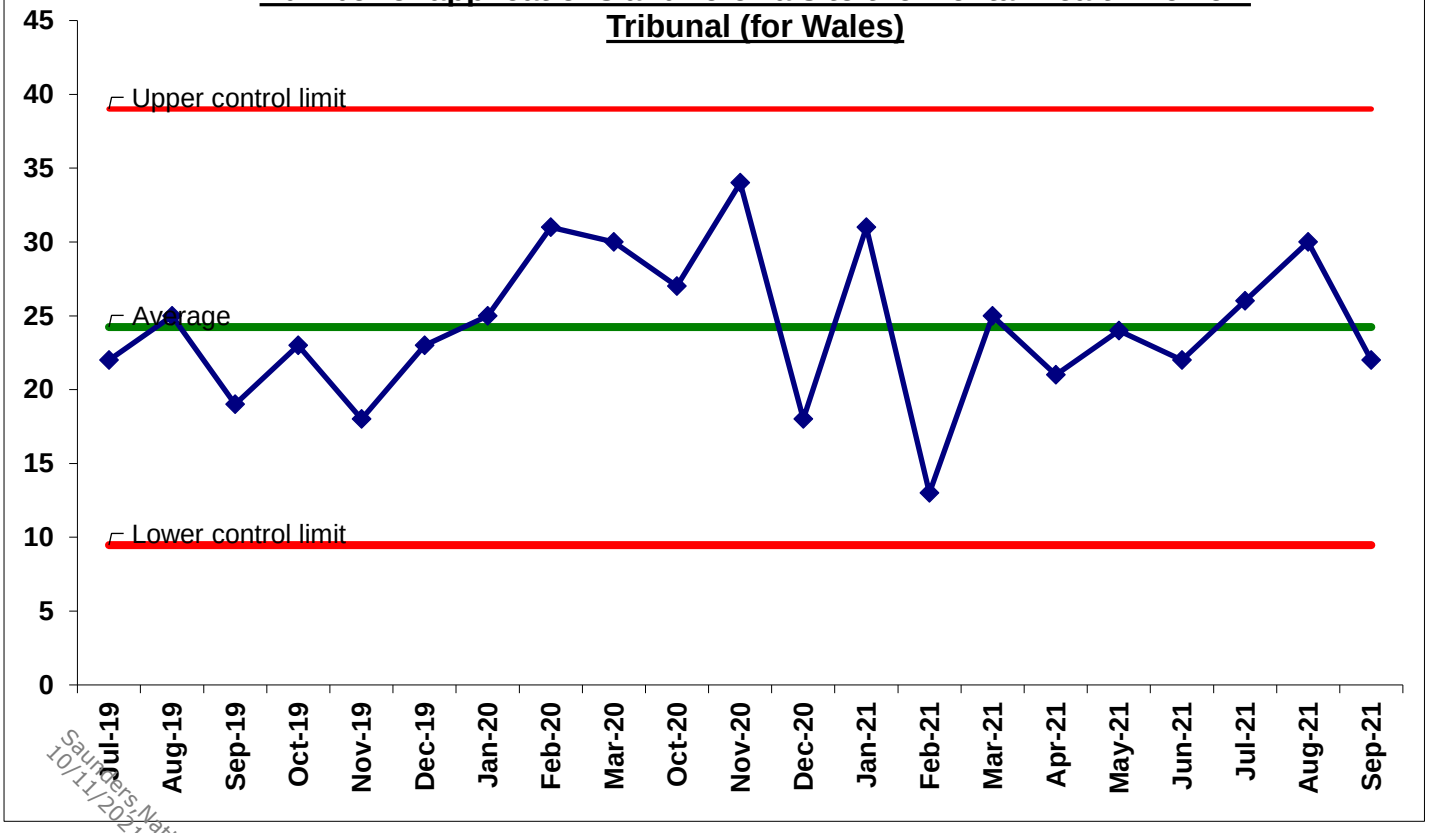


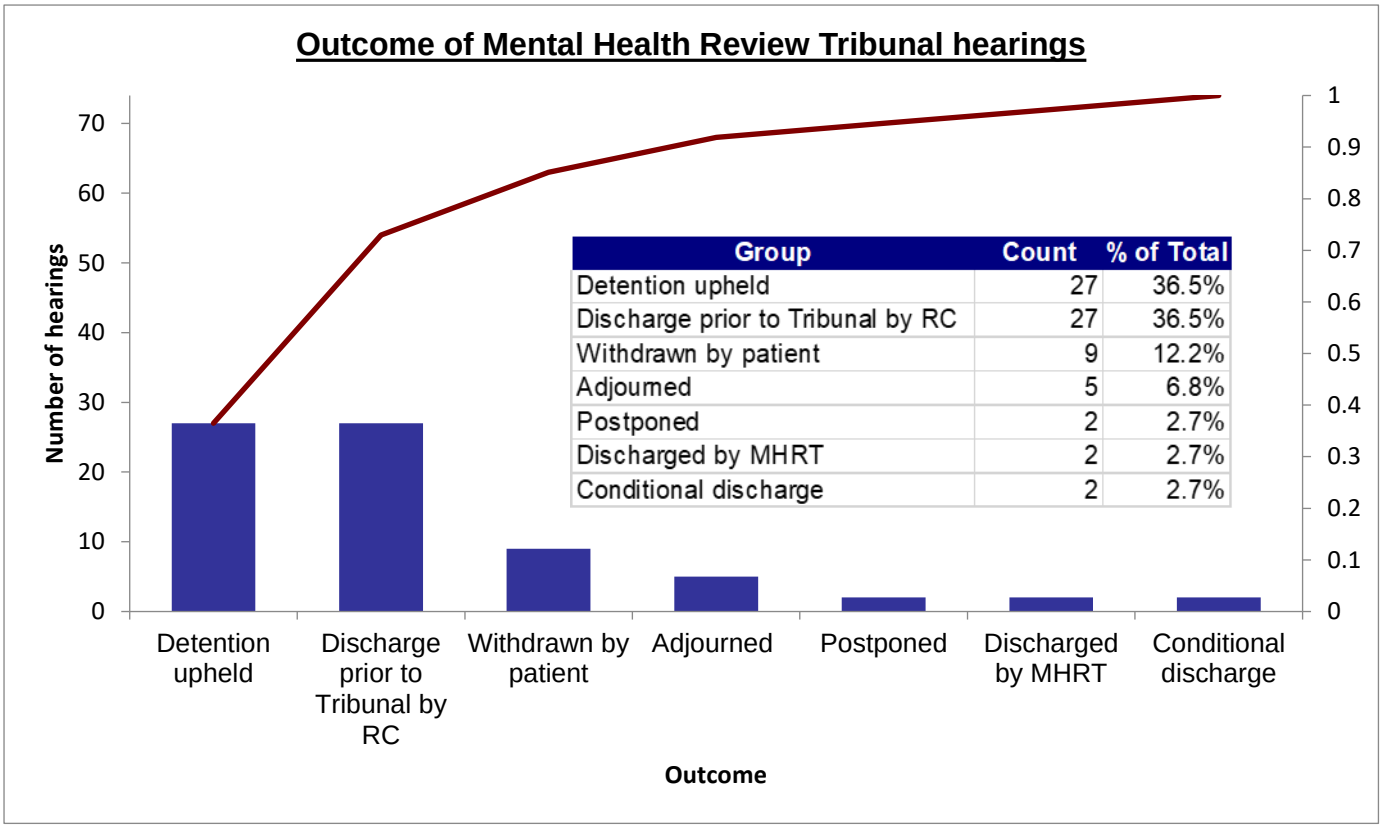
During the period the Mental Health Act Office made eight referrals to Advocacy Support Cymru where the patient was deemed not to have capacity make this decision. One of the hearings were either postponed/ cancelled and therefore weren't attended by an advocate On three occasions an advocate was instructed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





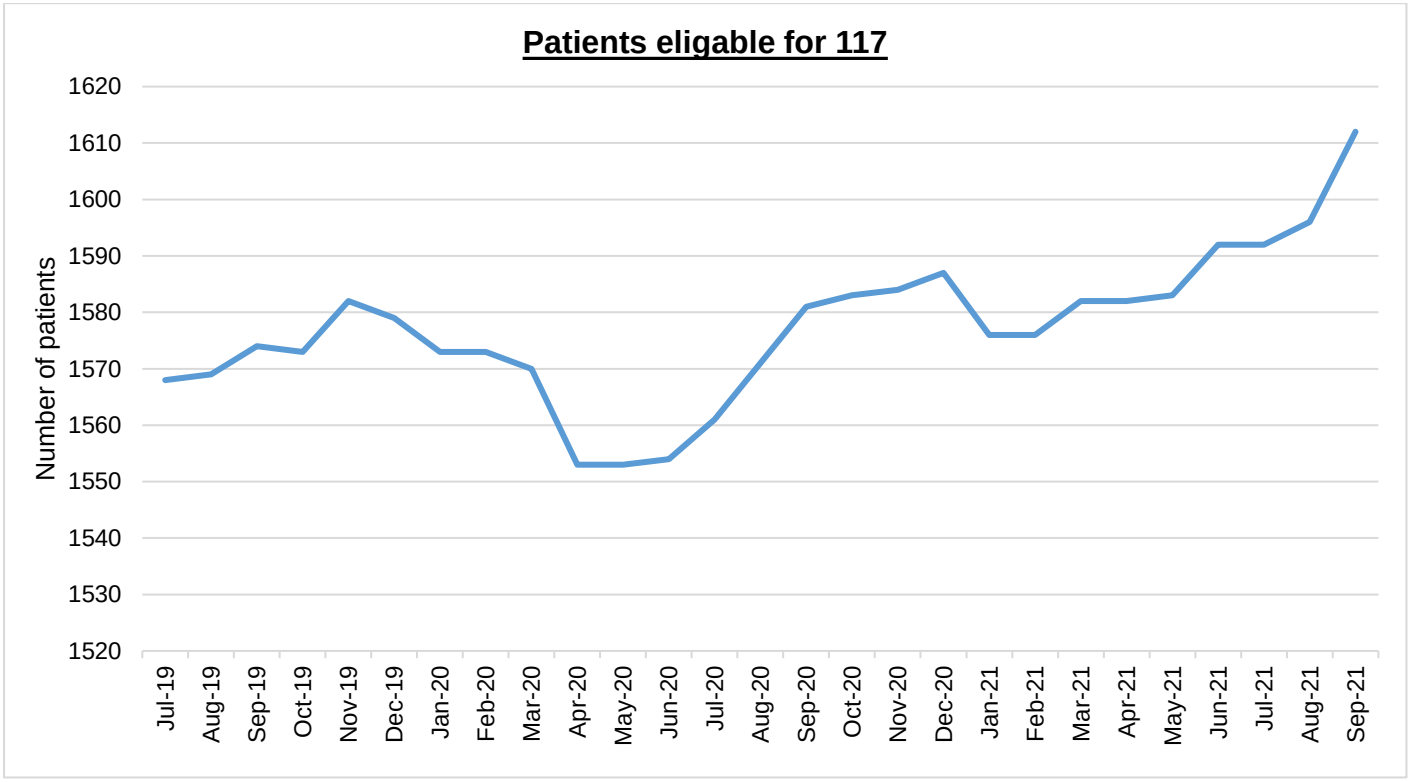
Five hearings were adjourned for the following reasons:

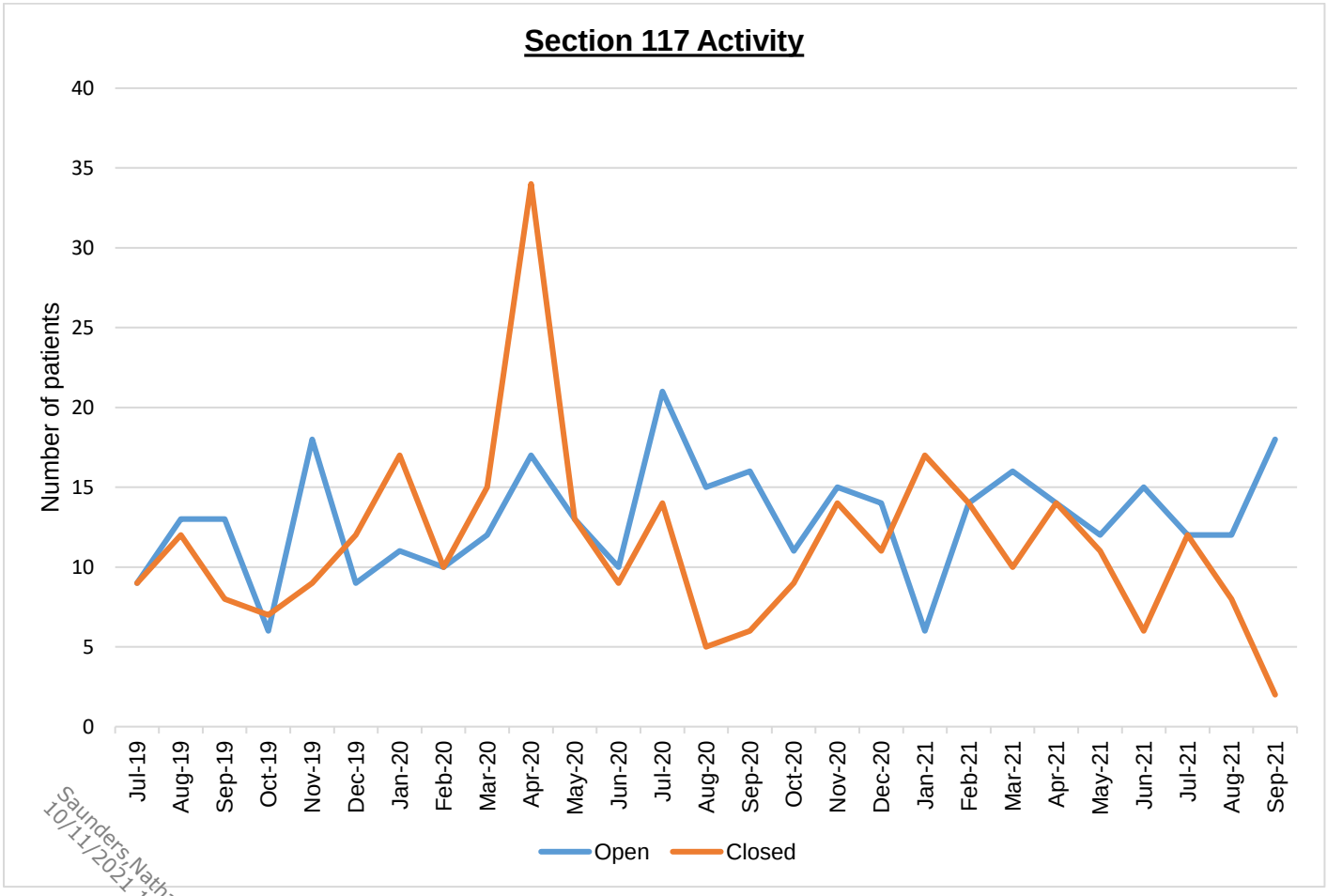
- More information needed x 4
- Legal representation not appointed prior to hearing unavailable x 1

Two hearings were postponed for the following reasons:

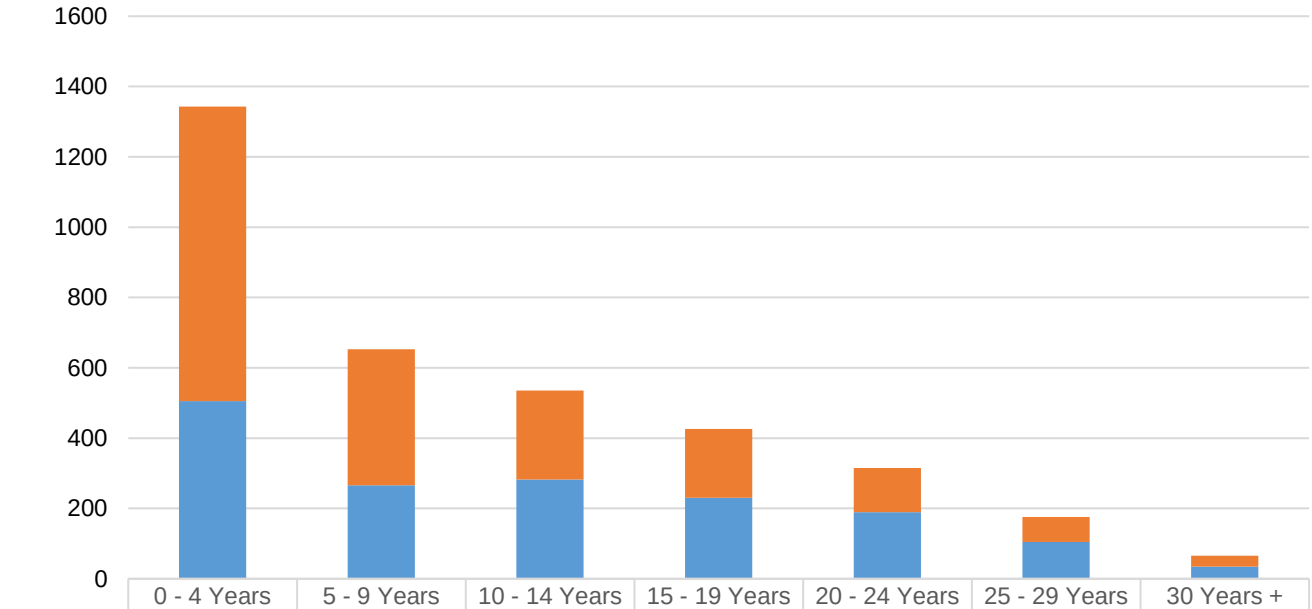
- Further evidence required x1
- Social worker unavailable to attend x 1

Section 117 Aftercare





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	838	387	253	196	126	71	31
Ongoing	505	266	282	230	189	105	35

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

July- September 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 5 months.

As of 07/10/2021 only visits in exceptional circumstances will be permitted. This is due to the ongoing global pandemic.

Section 19 transfers to and from Cardiff and Vale UHB

During the period:

- 10 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:

    - Four to return to their home area
    - Two to CAMHS
    - Four to a private PICU bed

Seven 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
- To go a specialist placement

One patient detained under Part 3 of the Mental Health Act was transferred from Cardiff and Vale UHB from a hospital under a different set of managers in order to go to a specialist placement.

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.

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

Report Title:	**Reforming the Mental Health Act – Government response to consultation**								
Meeting:	**Mental Health & Capacity Legislation Committee**					**Meeting Date:**	**19 October 2021**		
Status:	**For Discussion**		**For Assurance**		**For Approval**		**For Information**	**x**	
Lead Executive:	**Chief Operating Officer**								
Report Author (Title):	**Mental Health Clinical Board Director of Operations**								

Background and current situation:

In 2017, the government asked Professor Sir Simon Wessely to lead the Independent Review of the Mental Health Act 1983 (MHA), to propose recommendations for modernisation and reform. The final report was published in December 2018 and made over 150 recommendations.

The government has now published its response in the form of a White Paper, which went out for a 14-week public consultation, receiving more than 1700 responses. Following consultation, the government has set out its response to bring forward a Mental Health Bill, which will be introduced when Parliamentary time allows. The following summary sets out how the government plans to take forward their proposals:

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

1. Guiding Principles	
Proposal	**Response**
The government proposes to seek to include four principles "up front" in the MHA, as well as in the code of practice (in which there are currently five principles). The proposed principles are: • choice and autonomy – ensuring patients' views and choices are respected, • least restriction – ensuring MHA powers are used in the least restrictive way, • therapeutic benefit – ensuring patients are supported to get better and discharged as quickly as possible, and • the person as an individual – ensuring patients are viewed and treated as individuals.	Many responses suggested the principles should be applied throughout the mental health system to ensure they are embedded in practice. This included proposals to make them more prominent to practitioners, service users and carers. The Government will continue to work to take forward the principles and seek to incorporate the feedback received from the consultation as they consider how the principles are embedded in everyday practice and application of the Act.
2. Detention Criteria	
Proposal	**Response**
The government also proposes to tighten the criteria for detention under the MHA to address the rising rates of detention and its disproportionate use among certain ethnic groups. First, the section 3 detention criteria for admission for treatment will	There were 1352 responses to this question. Overall, 74% of responses agreed/strongly agreed with the proposal; while 14% disagreed/strongly disagreed and 12% were not sure. Respondents were strongly supportive that

be amended to clearly stipulate that, for someone to be detained, it must be demonstrated that: • the purpose is to bring about a therapeutic benefit; • care and treatment cannot be delivered to the individual without their detention; and • appropriate care and treatment is available. Second, the section 2 (admission for assessment) and 3 detention criteria will be amended to require that there must be a "substantial likelihood of significant harm" to the health, safety or welfare of the person, or the safety of any other person.	the requirement for a 'substantial likelihood of significant harm' was a good proposal, agreeing that risk ought to be significant to justify depriving someone's liberty. Some respondents also requested clarity around the definition of some of the terms, particularly 'substantial' and 'significant'. There is wide support for reforming the detention criteria as set out in the White Paper. The proposals on introducing the tests of therapeutic benefit and 'a substantial likelihood of significant harm' were well received. Respondents have also raised some important considerations, which the Government will bear in mind as they develop the draft Bill.
GIVING PATIENTS MORE RIGHTS TO CHALLENGE DETENTION	
3. Increasing the frequency of automatic referrals to the Tribunal	
Proposal	**Response**
The government wants to introduce more tribunal hearings to check on whether a patient's detention continues to be appropriate. Under the proposals: • For patients subject to a Section 3, referral would instead take place 4 months after the detention started, if the Tribunal has not considered the case in the first 4 months. Thereafter, referral would take place 12 months after the detention started, if the Tribunal has not considered the case in the intervening months. After the first 12 months of detention, referral would take place annually. • For patients on a CTO, referral would take place 6 months after the patient was put on the CTO, if the Tribunal has not considered the case in the first 6 months. However, thereafter, referral would take place 12 months after the patient was put on the CTO, if the Tribunal has not considered the case in the intervening months. After the first 12 months of detention, referral would take place annually. • For patients subject to Part 3, referrals would take place every 12 months. • For patients on a conditional discharge (Part 3, restricted), referral would take place 24 months following receipt of the	The majority of respondents agreed that the proposals for automatic referrals to Tribunals were sensible, and that their frequency should be increased to provide more robust scrutiny to ensure patients' rights are protected. However, some responses voiced specific concerns on the timings for each group of patients, in addition to comments on practical implications for the Tribunal, the role of the Tribunal, and the experience of patients. The intention is to take forward the proposals to increase the frequency of automatic referrals to the Tribunal and ensure that detentions under the Act are more regularly scrutinised. They are an important safeguard, ensuring that many detentions are reviewed independently from the detaining authority on a regular basis, rather than relying on the patient or their representative to request a review. Concerns with the proposed frequency of automatic referrals and the impact these could have on patients and the Tribunal system were acknowledged. However, the Government believe that the proposed timings are broadly appropriate. Further consideration will be given to the judiciary and how best to manage these referrals to ensure they can be administered in the least intrusive and effective way. The implementation of the proposed more frequent automatic referrals will need to be

conditional discharge by the patient. Thereafter, referral would take place every 4 years.	carefully planned to ensure that access to justice is maintained effectively. Consideration will be given to phasing in any changes over time so the Government can carefully assess resource and capacity constraints for the Tribunals services relating to reforms to the Act and ensure sufficient capacity and funding to enable the Tribunal to deliver on the reforms to the Act.
4. Removing automatic referrals to the Tribunal following a revocation of a Community Treatment Order	
Proposal	**Response**
While the overall intention is to increase the scrutiny of detention, including by the Tribunal, the Government also want to ensure that the process for reviewing an individual's detention works effectively. Currently, there is an automatic referral to the Tribunal when someone's CTO is revoked. The Independent Review made the case that this is an ineffective safeguard, as often by the time the Tribunal sits, the patient is back in the community, on another CTO, or where the CTO has been revoked, they have reverted to a Section 3 patient. This makes the automatic referral to the Tribunal redundant, as the outcome of the Tribunal will not have a material impact on the patient. In the White Paper, it was proposed to remove the automatic referral to a Tribunal received by service users when their CTO is revoked. This will also help create capacity in the Tribunal system, to take on other reforms for the more frequent automatic referrals we are proposing in relation to other detained patients.	Whilst concerns were acknowledged around the removal of a safeguard for those whose CTO has been revoked, it is believed that the White Paper proposals to increase the frequency of automatic referrals to the Tribunal system including those on CTOs, provides more regular access to the Tribunal to scrutinise detention. Additionally, it is important to recognise that patients who are detained for assessment under Section 2 or for treatment under Section 3 following a revocation of a CTO, would still have the right to appeal to the Tribunal. It is agreed that that revocation decisions should still be subject to scrutiny. The Government is committed to working with stakeholders to discuss how best to achieve this, but feel this is for the Code of Practice and not the statue book. The removal of an automatic referral to the Tribunal following a revocation of a CTO will need to be carefully implemented to ensure that a patient's ability to challenge their detention is not negatively impacted. A phased approach is the best route to implement this policy. As the frequency of automatic referrals to the Tribunal increases over time, the Government must fully assess resource constraints and ensure sufficient capacity in the system before removing other safeguards.
5. Giving the Tribunal powers to make directions	
Proposal	**Response**
Under Section 72 of the Act, the Tribunal can already make recommendations relating to a patient's leave or transfer, but such recommendations are not binding. It is proposed: • To extend the role of the Tribunal so it is able to grant leave and transfer, and to direct services in the community.	The balance of responses was in favour of the proposal. However, contributions highlighted a number of issues which will need to be worked through. These include reviewing the position on the proposed time requirement for health and local authorities to deliver on directions made by the MHT, considering further the relationship between a Tribunal direction and independent

• That there should be an obligation in legislation on health and local authorities to take all reasonable steps to follow the Tribunal's decision. If the authority is not able to give effect to the Tribunal's decision, it must provide an explanation to the Tribunal, setting out the steps it took and why it was not possible to follow the decision. • That healthcare bodies and local authorities should be given a period of five weeks to take reasonable steps to deliver the Tribunal's direction.	clinical decision making, and how obligations and duties should be discharged and monitored. Matters will be considered further with stakeholders. The most important aspect of these considerations must be that all agencies, including the Tribunal, work together to ensure that patients get plans for care and discharge which work for them.
6. Associate Hospital Managers' panel hearings	
Proposal	**Response**
The White Paper recommended removing the role of the associate hospital managers' panel in discharging patients from detention, a power delegated from hospital managers to associate hospital managers, as a result of stakeholder concern about the effectiveness of this safeguard. The White Paper proposed that the Mental Health Tribunal is better placed to assess whether a patient continues to meet the criteria for detention under the Act, and that the better policy is for an increase in access to the Tribunal which would allow for the removal of associate hospital mangers' panel hearings.	The response to this question was far more mixed than the Government anticipated, with a lot of support in favour of keeping the panels in place. The Government understands this view and has committed to extend patient rights and opportunities to access the Mental Health Tribunal. It may be that increased pressure on clinical time, to service a greater number of Tribunal hearings, will become reason enough for panels to be removed or phased out. The Government will consider this matter further.
STRENGTHENING THE PATIENT'S RIGHT TO CHOOSE AND REFUSE TREATMENT	
7. Advance Choice Documents	
Proposal	**Response**
The introduction of Advance Choice Documents as a means of providing people with the opportunity to set out in advance the care and treatment they would prefer, the name of their chosen nominated person, and any treatments they wish to refuse, in the event they are detained under the Act and lack the relevant capacity. The White Paper proposed that the Advance Choice Document should adhere to a standard format and approach, and it should include the following information about the individual's preferences, as well as any other information deemed relevant by the individual: • any treatments the person does not wish to consent to as well as their preferred clinically appropriate treatments	Work will continue closely with stakeholders to establish how advance choice decision making can align under the MHA with the MCA. Valuable feedback has been received from stakeholders with regard to the complexities associated with children. Proposals to ensure that children benefit from using Advance Choice Documents as a tool to inform their care and treatment will continue to be developed. It has been recognised that the efficacy of Advance Choice Documents depends upon a number of practical considerations. As stated in the White Paper, the Government are seeking to ensure that these documents can be made and stored in a secure digital database so that they can be readily accessed by service users and health professionals. Training and guidance is needed to ensure that health and

• preferences and refusals on how treatments are administered (for example refusal of suppositories, and preference for care staff of a particular gender, to avoid retraumatising them, given the relationship between gender-based violence and trauma) • name of their chosen nominated person • names of anyone who should be informed of their detention, care and treatment (including specific instructions on which individual should get what information) • communication preferences • behaviours to be aware of which may indicate early signs of relapse • circumstances which may indicate that the person has lost the relevant capacity to make relevant decisions • religious or cultural requirements • crisis planning arrangements, including information about care of children/other dependents, pets, employment, housing etc. • other health needs and/or reasonable adjustments that might be required for individuals with a disability or learning disability and for autistic people	care professionals can support people to make Advance Choice Documents and are equipped to use them in decision making.
8. Care and Treatment Plans	
Proposal	**Response**
To make Care and Treatment Plans statutory and we set out when and how the Plan should be developed and who should oversee the process. We said that a Care and Treatment Plan should include the following information: • the full range of treatment and support available to the patient (which may be provided by a range of health and care organisations) • for patients who have the relevant capacity and are able to consent, any care which could be delivered without compulsory treatment • why the compulsory elements of treatment are needed • what is the least restrictive way in which the care could be delivered • any areas of unmet need (medical and social), for example where the patient's	We will seek to ensure that the new statutory Plan takes into account existing requirements around care planning, that it encourages joint working, and that there is flexibility regarding the contents of the Plan so that it is truly patient led. We think that the required contents, set out in the White Paper, are an essential part of the patient's Care and Treatment Plan. We appreciate that it may not always be feasible for clinicians to cover off all the required elements of the Plan by day 7 of an individual's detention. We also recognise that placing unrealistic deadlines on clinical staff, regarding its completion and sign off, may result in the Plan becoming a box-ticking exercise. We will work with stakeholders to review the proposed timelines and governance structure to ensure that any statutory requirements placed on staff are aimed at facilitating a culture of high

preferred treatment is unavailable at the hospital • planning for discharge and estimated discharge dates (with a link to s117 aftercare) • how advance choice documents and the current and past wishes of the patient (and family and/or carers, where appropriate) have informed the plan, including any reasons why these should not be followed • for people with a learning disability, or autistic people, how Care (Education) and Treatment Reviews, where available, have informed the plan, including any reasons why these should not be followed • an acknowledgement of any protected characteristics, for example any known cultural needs, and how the plan will take account of these • a plan for readmittance after discharge for example informal admission, use of civil sections, or recall by the Justice Secretary	quality, co-produced care and treatment planning for all patients detained under the Act.
9. Refusal of treatment for those with capacity	
Proposal	**Response**
We proposed to change the criteria for administering urgent compulsory treatment under the Act so that it can no longer be given to patients with the relevant capacity, against their wishes, on the basis of the alleviation of serious suffering. This would result in no longer being able to treat under s62(1)(c).[1]	While there was broad support for this proposal, many respondents raised potentially negative, unintended consequences, as well as practical considerations associated with implementing this new safeguard. Some of these concerns may be resolved through clearer guidance around assessing mental capacity, ensuring that mental health professionals are appropriately trained to carry out these assessments, and by strengthening governance structures around the use of urgent treatment, so that it is only used when absolutely appropriate. We will work closely with stakeholders to explore how we can develop our proposal to mitigate these concerns.
10. A new right to challenge a treatment decision at the Tribunal	
Proposal	**Response**
In order to improve the rights of patients and give them greater choice and autonomy when it comes to their care and treatment, we proposed to give people detained under the Act the ability to appeal treatment decisions with the Mental Health Tribunal, if they are receiving treatment that they	The consultation process has confirmed that, as highlighted by the Independent Review, judicial review is not an effective route of appeal for patients who are receiving compulsory treatment. We maintain that expansion of the Tribunal's powers would improve the patient's rights in this

(a) which is immediately necessary to save the patient's life,
(b) which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition,
(c) which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
(d) which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to other

have not consented to. The challenge could also be brought by the patient's IMHA or nominated person (NP), if the patient lacks the relevant mental capacity but has an Advance Choice Document stating their treatment refusal. There would be a permission to appeal stage and, if a hearing was granted, then a Tribunal judge (sitting alone) would consider the evidence and decide whether to uphold the responsible clinician's decision, order that they reconsider their decision or potentially order that the specific treatment is no longer administered to the patient.	regard, however, the consultation process has identified concerns, in particular regarding the power sitting with a single judge acting alone and the need for clinical input into the decision-making process, in the interests of patient safety. We will continue to work closely with stakeholders to develop this policy and identify potential means of mitigating the concerns raised by stakeholders.
11. Advance Consent to Admission	
Proposal	**Response**
The Independent Review recommended that we consult on whether the Act should give individuals the right to consent in advance to admission to hospital for treatment for a mental illness. This would mean that, if an individual had given prior consent and they later become unwell and lose the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the Act (or subject to the DoLS/LPS). The White Paper set out our concerns with this proposal around access to safeguards, whether individuals would be fully aware of what they were consenting and whether they would feel they could later object. However, it also set out that the principle that people should be able to make decisions which will endure in the event of future incapacity, including advance consent, is already recognised in law. The White Paper consulted on whether the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act and its Code of Practice to make clear the availability of this right to individuals.	Whilst 64% of respondents supported making clearer the right to give advance consent to admission, concerns were raised about how this would work in practice and what safeguards would be put in place to protect patients informally admitted. As the right to give advance consent is already recognised in law, we will continue to explore how advance consent could be implemented within the patient journey, and how this would work in practice, including what safeguards we would need to be put in place to support patients informally admitted on this basis.
12. Nominated Person	
Proposal	**Response**
To replace the Nearest Relative (NR) with a new statutory role, known as the Nominated Person (NP), who the patient can personally select to	As set out in the White Paper, we will take forward legislative changes to replace the Nearest Relative role with the Nominated Person role so that individuals can choose who

represent them and exercise certain rights on their behalf. The new Nominated Person will have the same rights and powers to act in the best interests of the patient as Nearest Relatives have now. These include rights to apply for, or object to, the patient being detained under the act, to apply for the person's discharge and to appeal to the Tribunal if this is denied. The NR may also receive information from the hospital about the person's care, detention or CTO, unless the person objects to this. In addition to these rights and powers, the NP will have the right to be consulted on statutory care and treatment plans, to be consulted, rather than just notified, when it comes to transfers between hospitals, and renewals and extensions to the patient's detention or CTO, to be able to appeal clinical treatment decisions at the Tribunal if the patient lacks the relevant capacity, and to object to the use of a CTO if the patient lacks the relevant capacity to do so themselves.	represents them. We will provide additional support and guidance for those involved in the person's care to address stakeholder concerns, introduce safeguards, and clarify how these new powers interact with existing legal rights, including those of parental responsibility.
13. Advocacy	
Proposal	**Response**
Independent Mental Health Advocates (IMHAs) are specialist advocates who are trained specifically to work within the framework of the Act and are independent of mental health services. The following proposals were made in the White Paper: • To extend the statutory right to an IMHA to all mental health inpatients, including informal patients, patients awaiting transfer from a prison or an immigration detention. This recognises how important it is for all patients to understand and exercise their rights in mental health inpatient settings. • To expand the role of IMHAs to support patients to access additional safeguards including helping patients to contribute to their statutory care and treatment plan and prepare their advance choice document, supporting patients to exercise their increased rights to challenge detention, and supporting patients to appeal treatment decisions.	As set out in the White Paper, we will take forward legislative changes to extend eligibility of IMHA services to all mental health inpatients, including informal patients, and to add the proposed additional rights and powers relating to supporting service users with advance choice and care planning, and applying to the Tribunal on behalf of the service user. We will also consider the requirements needed for an opt out service. As committed to, we will further explore with stakeholders the best way to improve the quality of IMHA services, whether through enhanced standards, accreditation, regulation, or increased training requirements. We will continue to prioritise the development of culturally appropriate advocacy and work with stakeholders to ensure that ethnic minority backgrounds are considered as the reforms are implemented.

14. Mental Health Act (MHA) and Mental Capacity Act (MCA) interface	
Proposal	**Response**
In certain circumstances, where a person has a mental disorder, lacks the relevant capacity and is not objecting to detention or treatment, a practitioner may need to consider whether that person should be detained under the MHA or instead made subject to the Deprivation of Liberty Safeguards, under the MCA (to be replaced by Liberty Protection Safeguards). The White paper set out to take forward the Independent Review's recommendation that a clearer dividing line be introduced in legislation between the two Acts, based on whether or not a patient is clearly objecting to detention or treatment. The effect would be that all patients without the relevant capacity, who do not object, would be subject to the the DoLS/LPS and not under the MHA. The Independent Review found that within this interface it is not always clear for practitioners whether the MHA or DoLS should be used if a person lacks the relevant capacity and does not appear to be objecting, and that the MHA is still used in cases where it may be preferable to use DoLS. In parallel to reforms of the MHA, the Government is replacing DoLS with a new LPS framework, which will itself address these issues. The White Paper also agreed with the Independent Review that it is important to assess the impact of implementation of the new LPS, before introducing these reforms to the MCA/MHA interface.	In light of the feedback received, we do not intend to take forward reform of the interface, as set out in the White Paper, at this time. We will seek to build the evidence base on this issue through robust data collection, to better understand the application of the interface. In addition, we will continue to engage with stakeholders to understand what support and guidance could help improve application of the current interface. The Government will shortly publish its consultation on a draft, updated, Code of Practice for the MCA, including the LPS, and the draft LPS regulations. This will set out how we think LPS will operate in detail and invites feedback on that. The LPS system will be more streamlined and will put the person at the centre of the decision-making process. The LPS will introduce an explicit duty to consult with the person, and those interested in their welfare, to establish the person's wishes and feelings about proposed arrangements. Those who are close to the person will also be able to provide representation and support to them via a new 'Appropriate Person' role. People can also be represented, supported and afforded their rights throughout the process by an Independent Mental Capacity Advocate (IMCA). Furthermore, the rights of people at the heart of the most complex cases will be considered and upheld by new the new 'Approved Mental Capacity Professional' role. We will review the interface once the new LPS arrangements are embedded, based on a clearer evidence base around application of the interface, and the impact of implementation of the LPS.
15. A&E Holding Powers	
Proposal	**Response**
The White Paper identified that too often police are relied on to hold individuals who are in crisis and are attempting to leave accident and emergency departments (A&E). It therefore set out our intention to improve the powers available to health professionals in A&E so that individuals in need of urgent mental health care stay on site, pending a clinical assessment. The White Paper	We will seek to give powers in legislation to health professionals in accident and emergency departments so that individuals in need of urgent mental health care stay on site, pending a clinical assessment. We will carefully consider the points raised by those who responded to the public consultation

consulted on which legal framework would be most suitable to provide for this giving the following choices: • Rely on Section 4B of the Mental Capacity Act only. • Extend Section 5 of the MHA so that it also applies A&E, accepting that Section 4B is still available and can be used where appropriate.	about how this should be implemented, including how best to address the limitations of Section 5 of the MHA and Section 4B of the MCA, as highlighted through consultation.
CARING FOR PATIENTS IN THE CRIMINAL JUSTICE SYSTEM	
16. Independent role to oversee secure transfers from prison and immigration removal centres (IRCs)	
Proposal	**Response**
We proposed to establish a new designated role for a person independent of the health or criminal justice systems to manage the process of transferring people from prison or immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health. The options given were: • To expand the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers. • To create a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service (HMPPS) to manage the prison or IRC transfer process. • An alternative approach.	We will continue work to introduce the independent role, utilising feedback received through the consultation when deciding where the role should sit. We will use this feedback to create draft job descriptions, which will then enable us to test out the duties, scope and placement of the role from an operational perspective and with key stakeholders. We also recognise the key differences between prisons and IRCs, which we will take into account as part of this work.
17. Introducing a 28-day limit from immigration removal centres and prisons to a secure hospital	
Proposal	**Response**
As set out in the White Paper, we propose introducing a 28-day time limit to speed up the process of transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings. This time limit will be split into two sequential, statutory time limits of 14 days each: first from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place. We will commence this provision once the	We recognise that the average wait is above 28 days at present, and that this is a longstanding problem, but note that introducing a limit with no additional resourcing, or addressing the reasons for current delays, may result in further issues such as: • the availability of beds, which at times can be a barrier to timely transfers • sufficient levels of appropriately trained healthcare staff

recently published NHSEI guidance on transfers and remissions is properly embedded.	• the requirement for clearer responsibility for the transfer process and strong reporting mechanisms • advocacy and representation for patients awaiting transfer • ensuring appropriate care is available in prison prior to transfers taking place to avoid worsening of mental health. We will take forward legislative change to introduce the 28-day time limit. However, this will only be commenced once the NHSEI guidance on transfer and remissions has been fully embedded, and we will take into account other reforms such as the introduction of the independent role to help in meeting the new time limit.
18. Supervised Discharge	
Proposal	**Response**
The introduction of a new power of "supervised discharge" which would enable a small group of restricted patients who are no longer therapeutically benefitting from treatment in hospital, but continue to pose a risk that could not be safely managed in the community without constant supervision, to be discharged from hospital with conditions amounting to a deprivation of liberty and that individuals would only be eligible to be discharged in this way if it posed the least restrictive option for them.	We will move forward with our plans to provide the Tribunal and the Justice Secretary with the power to grant a supervised discharge to restricted patients where they are satisfied that this is the least restrictive option when: • The patient is no longer therapeutically benefitting from treatment in hospital; but • Continues to pose a level of risk which would require a degree of supervision and control amounting to a deprivation of their liberty; and so, could not be managed via a conditional discharge. As noted in the White Paper, we propose that patients on a supervised discharge would be subject to annual review by the Tribunal. We will continue to engage with experts to consider further the role for the Tribunal and other appropriate safeguards which should accompany this new power to ensure that its use is limited and proportionate, for the small number of cases for which it is intended. In order for the proposed measures to work well, appropriate and well-resourced community provision must be available.
19. The role of social supervisor	
Proposal	**Response**

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. Social supervision is an important role, balancing public protection with the care and support of conditionally discharged patients. Social supervisors work closely with the Ministry of Justice Mental Health Casework Section and can request recall of patients to hospital. Despite this important function, there is some confusion about where this role should sit and a lack of national guidance about how it should operate, leading to local divergence in practice and standards. The Government wishes to strengthen and further develop the role of social supervisor and has consulted with stakeholders on how best to achieve this.	The Government will continue to work with stakeholders to understand how to best redefine the role of social supervisor in order to drive improvement of the service at a national level, and to reduce the regional disparities currently observed. The Government will explore updating the guidance with the aim of clarifying the institutions responsible for the role's delivery, the professionals eligible to discharge it, and the training required of professionals, including training required to supervise patients with a restriction order. The Government will also survey the increased support and resources that may be necessary as a result of a redefinition of the role of social supervisor.
PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
20. Limiting the scope to detain people with a learning disability and autistic people under the Act	
Proposal	**Response**
The White Paper recognises the considerable concern about inappropriate admission and long lengths of stay for some people with a learning disability and autistic people to mental health hospitals under the Mental Health Act. Therefore, the White Paper proposes to reform the Act to be clearer that for the purposes of the Act, neither a learning disability or autism can be considered to be mental disorders warranting compulsory treatment under Section 3 of the Act. This is because learning disabilities and autism are conditions which cannot be removed through treatment, although some autistic people and people with learning disabilities may require treatment for mental illness. Under the proposals, people with a learning disability and autistic people could be detained under Section 2 of the Act when their behaviour is so distressed that there is considered to be a substantial risk of significant harm to self or others and there is a probable mental health cause to that behaviour that warrants investigation. If detained, the assessment process under Section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the	We will continue to consider the best way to take forward these reforms, taking into account the potential risks and practical implications respondents raised and identifying how to ensure appropriate safeguards are in place for individuals. We recognise the link between some of the responses to this question and part 7 of the White Paper on the interface between the Mental Health Act and the Mental Capacity Act. We have noted the link between the responses to this question referencing community support provisions and the White Paper proposal to create a new duty on local commissioners to ensure adequacy of supply of community services. We also recognise the need for clear guidance and training to ensure the reforms and safeguards work as intended.

patient may follow a treatment pathway for the mental health condition under Section 3 of the Act. They should only be detained after all alternatives have been considered. A Care (Education) and Treatment Review (CETR) is also expected to be conducted before a detention to provide evidence as part of any decision made. If, however, if no mental health condition is identified then the individual could no longer be detained under the Act and detention should cease.	
PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
21. Unintended consequences of reforms	
Proposal	**Response**
The White Paper recognises the considerable concern about inappropriate admission and long lengths of stay for some people with a learning disability and autistic people to mental health hospitals under the Mental Health Act. Therefore, in order to reduce admissions of people with a learning disability and autistic people, the White Paper proposes to reform the Act to be clearer that for the purposes of the Act, neither a learning disability or autism can be considered to be mental disorders warranting compulsory treatment under Section 3 of the Act. This is because learning disabilities and autism are conditions which cannot be removed through treatment, while some people with autism and learning disabilities may require treatment for mental illness. Under the proposals, people with a learning disability and autistic people can be detained under Section 2 of the Act when their behaviour is so distressed that there is considered to be a significant risk of harm to self or others. The assessment process under section 2 should seek to find the driver of this distressed behaviour and if a mental health condition is identified as the driver then the patient may follow a treatment pathway for the mental health condition under Section 3 of the Act. They should only be detained after all alternatives have been considered. A Care (Education) and Treatment Review (CETR) is also expected to be conducted before a detention to provide evidence as part of any decision made. If, however, if a mental health condition is not identified as the driver then the	We have noted the concerns raised in relation to the proposed reforms, as well as the link between these responses and other consultation responses. We will take these into account when further developing our proposals. We will also consider implications for the LPS in any reform and the design of which will be consulted on.

individual could no longer be detained under the Act and detention should cease. The White Paper proposes that these changes will only be made for civil patients to ensure that accused people and offenders who may currently be diverted to an inpatient setting are not forced into the criminal justice system which cannot cater for their needs	

PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
22. The criminal justice system	
Proposal	**Response**
Changes to limit the scope to detain people with a learning disability or autistic people under the Act to only apply to civil patients. The rationale for this position was to ensure that accused people and offenders whom the courts, or the Secretary of State for Justice, might currently divert to an inpatient setting are not forced into the criminal justice system, which is not able, or indeed intended, to cater for their needs.	We recognise the importance of ensuring that reforms to the Act for people with learning disabilities and autistic people strike an appropriate balance in terms of application to the criminal justice system. We will therefore commit to exploring this issue further, including through an expert group. More widely, the MoJ is committed to improving support and outcomes for neurodivergent offenders. This includes our independent Call for Evidence on neurodiversity in the criminal justice system, which has been led by HM Inspectorate of Prisons and Probation, and will help us to bring forward key improvements in how we recognise, understand and support this cohort.

PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
23. Care (education) and treatment reviews	
Proposal	**Response**
The White Paper recognises that if a person with a learning disability or an autistic person is detained under Section 3 of the Act due to a co-occurring mental health condition, then this could lead to a lengthy detention. The White Paper sets out that it wants to ensure that discharge is a priority from day 1 of detention under Section 3 of the Act. To ensure this happens, the White Paper proposes putting recommendations from Care, Education, and Treatment Reviews (C(E)TRs) for children and Care Treatment Reviews (CTRs) for adults on a statutory footing because C(E)TRs have been proven to reduce hospital admission when they are undertaken correctly and acted upon. It also proposes the introduction of a	While most respondents agreed with this proposal we have noted their thoughts and concerns around the practicalities of the proposal. We will continue to explore how this duty can be put into practice accounting for the feedback given.

statutory requirement for the Responsible Clinical (RC) to consider the findings and recommendations made as part of the C(E)TRs and CTRs in the patients care and Treatment Plan and that any deviation from the recommendations made in the C(E)TRs should be justified by the RC.	

PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
24. Duties on local commissioners	
Proposal	**Response**
In order to ensure the right services are available in the community, for people with a learning disability and autistic people to prevent unnecessary admission into hospitals and to speed up discharges, the White Paper proposes to create a new duty on local commissioners to ensure adequacy of supply of community services for people with a learning disability and autistic people. It recognises that this could create new funding requirements on local authorities and so also proposes to undertake a formal new burdens assessment to establish implications for local government, informed by the consultation responses. To support this duty, we committed to creating a related duty on commissioners that would ensure every local area understands and monitors the risk of crisis at an individual level for people with a learning disability and autistic people in the local population. The White Paper sets out that commissioners will do this through the creation of a local “at risk” or “support register”, where they will have to work with local authorities to identify and monitor the support needs of individuals.	Based on strong support we intend to proceed with the proposal on adequacy of supply. Work will consider what guidance might need to sit alongside the duty and there will need to be more detailed work on the impact assessment to consider resource implications for local government and the NHS. With regards to “support registers”, we have noted the concerns and suggestions raised by respondents and will continue to explore how this proposal could work in practice to ensure the best outcomes for people with a learning disability and autistic people.

PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE	
25. Pooled budgets	
Proposal	**Response**
Section 75 of the NHS Act 2006 is the existing mechanism for pooling budgets between an NHS body and local authority. The White Paper does not have a specific proposal to improve pooling budgets for services for people with a learning disability and autistic people and asks for views on this.	We will continue to consider the options for pooled budgets, taking into consideration the challenges and solutions proposed by respondents. We will also look at how best to report spend on these services and for spend to be made transparent. Respondents were broadly receptive to the increased use of pooled budgets, although some pointed to these not being useful for children or felt that learning disability, autism

	and mental health services should be funded separately. Respondents were realistic about the challenges associated with pooled budgets and many felt they needed more information to properly respond.
26. The role of the Care Quality Commission	
Proposal	**Response**
The Government wishes to strengthen the role of the Care Quality Commission (CQC) in monitoring the use of the Act, and has consulted with stakeholders to consider extending monitoring powers to cover all those who commission and provide services under the Act.	We will continue to consider this proposal as the reforms are implemented, and within the context of broader changes to the CQC's role being considered as part of the NHS Bill, including their role in overseeing the new Integrated Care Systems and Local Authority assurance.
27. Community Treatment Orders (CTOs)	
Proposal	**Response**
The White Paper set out to reform CTOs, including strengthening the requirement for evidence and justification for use; increasing the number of decision makers before someone is put onto a CTO; introducing a time limit and increasing the frequency of review; and requiring that they provide a genuine therapeutic benefit to those who are subject to them.	The consultation process has confirmed that stakeholders remain divided on the use of CTOs but agree on the need for change. The Government is committed to reforming CTOs and we believe our proposals will limit the number of CTOs and ensure they are only used where there is strong justification and where they provide therapeutic benefit to the individual. While there was broad support for this proposal, many respondents raised potentially negative, unintended consequences, as well as practical considerations associated with implementing our proposals. Some of these concerns may be resolved through clearer guidance in the Code of Practice and strengthening governance structures around the use of CTOs, so they are only used when absolutely necessary and when communicated to all parties involved. We will continue to work closely with stakeholders to develop this policy and identify potential means of mitigating the concerns raised by stakeholders.
28. Use of remote technology	
Proposal	**Response**
The White Paper discussed the use of video technology and whether digital and online methods can suffice to make medical assessments for the purpose of the Act. At the time, the position of the Government and NHSEI was that the Act may be interpreted to allow for this. However, the High Court found otherwise in the case Devon Partnership NHS	In parallel to the consultation process, the Government held discussions with stakeholders to consider whether the Act should be amended to allow an interpretation of these terms which allow for the use of remote assessments. We have decided not to do so. The broad consensus was that the presence of professionals in the room with people is required. It is in the

Trust v Secretary of State for Health and Social Care in January 2021. The Court found that the terms “personally seen”, as required of an AMHP under Section 11, and “personally examined2, as required of a medical practitioner under Section 12, cannot be satisfied by the use of remote technology.	interest of patients, and preserves established good practice.
29. Section 117	
Proposal	**Response**
In parallel to the consultation process, the Government held discussions workshops with stakeholders about the future of Section 117 aftercare. There are two particular areas that are being considered. Firstly, how responsibilities under Section 117, which are an obligation for both health and social services, should be split between those systems. Stakeholders were clear that there is a need for the Government to work with the Local Government Association (LGA), ADASS and with NHSEI to produce national guidance. Secondly, this year’s High Court judgement in the case of R (Worcestershire County Council) v Secretary of State for Health and Social Care and Swindon Borough Council (‘the Worcestershire case’), has in the Government’s view, highlighted the need for greater clarity with the Act about how the concept of Ordinary Residence should be interpreted in practice.	We have explored initial proposals to make it more straightforward in some cases to establish which local area is responsible for the aftercare of a person, particularly in more complicated personal histories which have included placements out of area. Initial feedback from stakeholders we have engaged with has been positive. We will continue to develop proposals in close liaison with stakeholders in local Government and NHSEI.
30. Impact Assessment	
Proposal	**Response**
The Government published a consultation impact assessment alongside the White Paper. This document sets out the analysis of the impact the White Paper proposals might have, if taken forward, in terms of economic, social and health impacts.	As part of this consultation, the Government sought views on the impact assessment and asked people to submit any further evidence which could help accurately assess the impact of the proposals. The evidence received was considered when updating the impact assessment, which has been published alongside this document. A further iteration will be published alongside the draft Bill.

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

Concerns have been raised in relation to the substantial increase in work demand and how this will impact on staff in terms of meeting the targets, applying the principles effectively and the subsequent impact of increasing workload and missing the priorities on staff wellbeing (which is directly linked to performance and patient outcomes)".

The demand on the Second Opinion Appointed Doctor service provided by Healthcare Inspectorate Wales and the Mental Health Review Tribunal for Wales will significantly increase. Careful consideration to the current workforce arrangements will be required to manage the substantial increase in workload to our partner agencies and the UHB as a whole.

The Mental Health Act Department will require significant additional resource to manage the substantial increase in the number of Tribunal hearings alone.

Recommendation:

The Committee is asked to **NOTE** the Government's response to the Independent Review of the Mental Health Act 1983, as summarised in the covering report**.**

Shaping our Future Wellbeing Strategic Objectives *This report should relate to at least one of the UHB's objectives, so please tick the box of the relevant objective(s) for this report*			
1. Reduce health inequalities	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.*

REPORT TITLE:	Mental Health Measure (Wales) 2010 incl. Part 2								
MEETING:	Mental Health Legislation Committee						**MEETING DATE:**	**19 October 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								

PURPOSE OF REPORT:

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

REPORT:

SITUATION

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

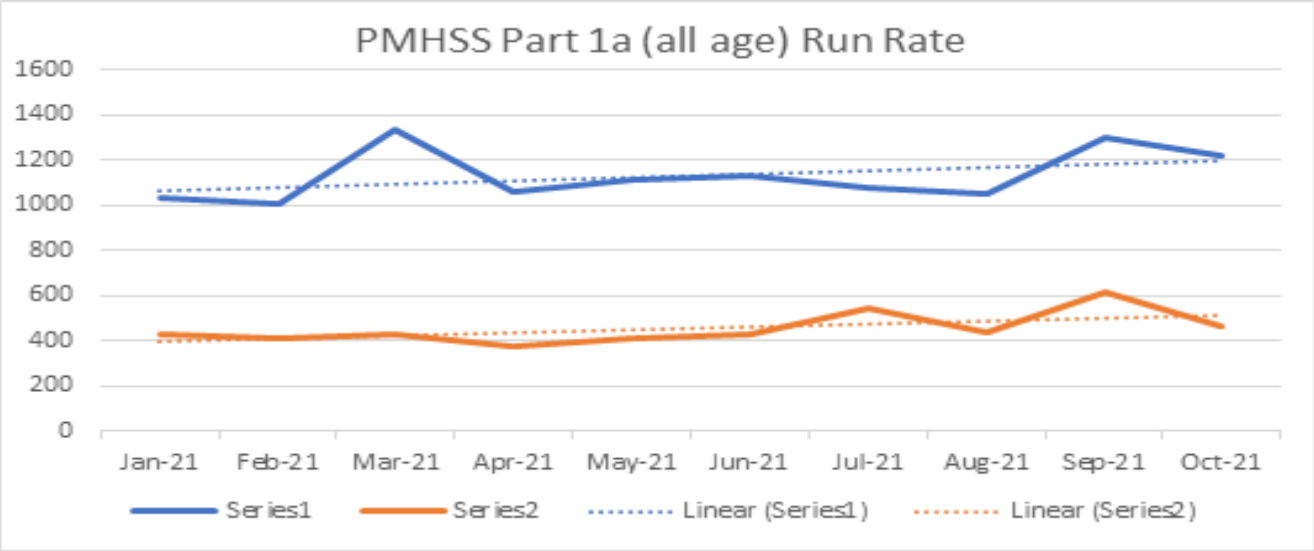
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

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

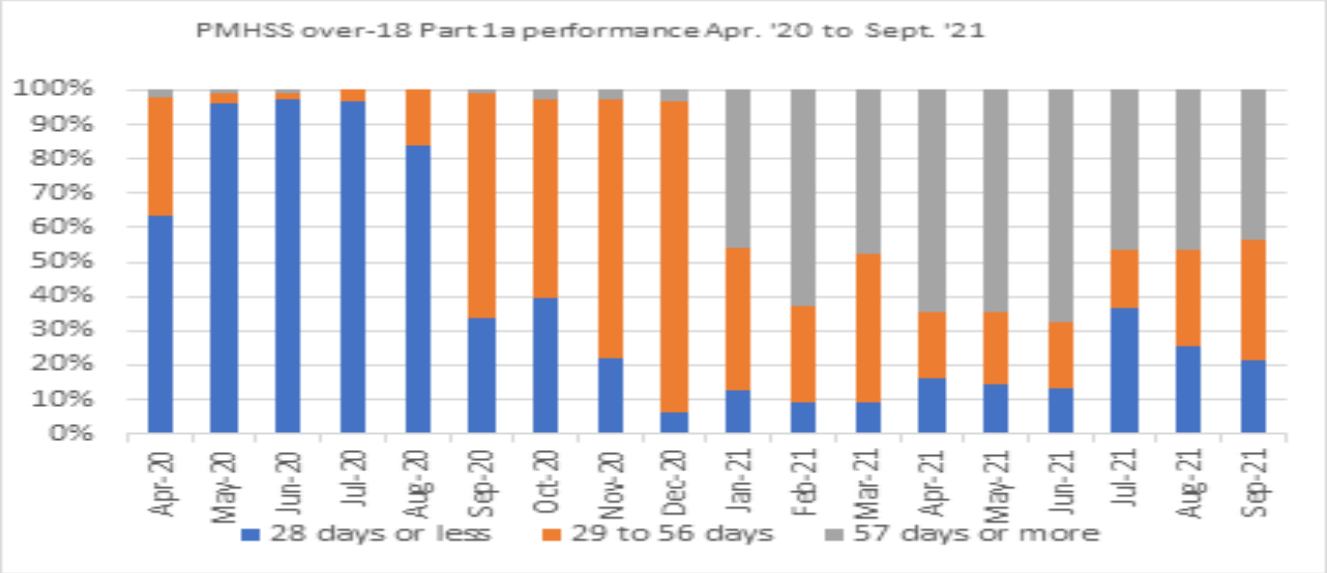
Referral activity for Q4 2020 & Q1 2021 has seen a gradual decrease in referral rates following the initial quite steep rise in referrals the first two quarters after the first lockdown but with a notable spike in referrals in March '21. Completed assessment rates are rising with a high peak of over 600 assessments in September 2021(See Graph 1). Assessment rates dropped during August due to staff annual leave and term time working arrangements.

Graph 1



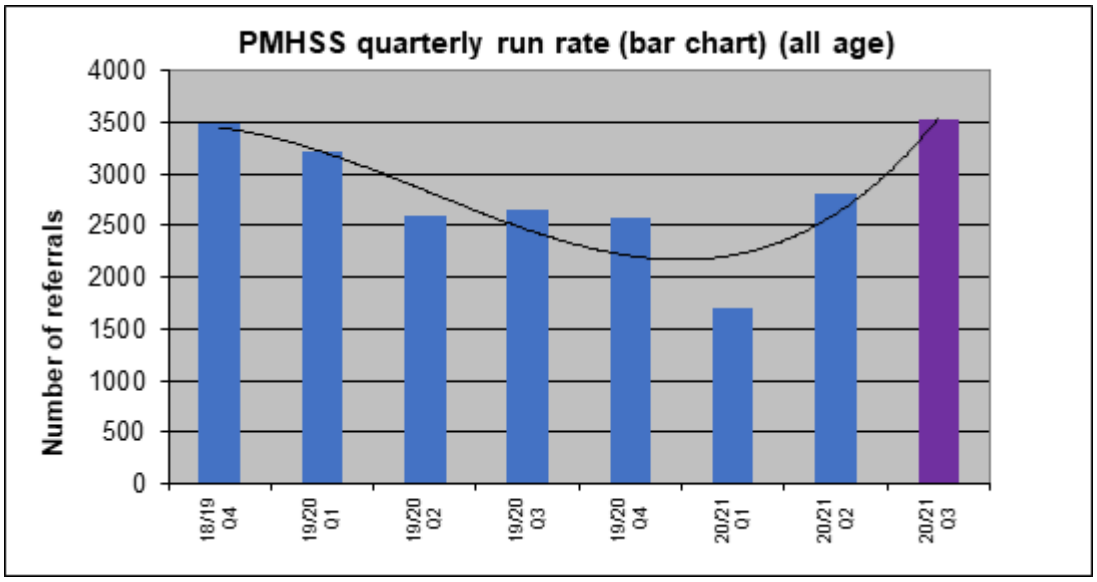
Regarding the over-18 Part 1a performance (see Graph 2), recent successful recruitment drive, has shown a gradual reduction in over 56 day waiting. From 26th October 2021 all booked appointements are under 56 days with the most recent waiting time for assessment down from 100 days in July 2021 to 43 days on 29th September 2021. In total, 1197 are currently waiting for assessment with 342 waiting over 56 days. October and November will see an increasing return to compliance, first with under 56 days and then under 28 days predicted for between the end of November and the middle of December 2021. However, trajectory data indicates a possible surge or referrals in October 2021 (with a predicted 1500 new referrals) which may delay return to compliance depending on the actual numbers.

Graph 2



Despite a quite dramatic decrease in referral numbers in Q1 2020/21 Q2 and Q3 indicate a steady increase in referrals and consistent rising demand. (See Graph 3).

Graph 3



Since referrals are are now screened and triaged by the merged Single Point of Entry (SPOE), counselling waiting times have improved significantly.
The impact of the SPOE has:

- Reduced waiting times for counselling, down from 6 months to 4-6 weeks which remains. The numbers waiting in different localities has decreased significantly.
- Option for extending counselling time for people where clinically indicated in response to stakeholder engagement in IMTP process.

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 three new starters in place from 27th September 2021.

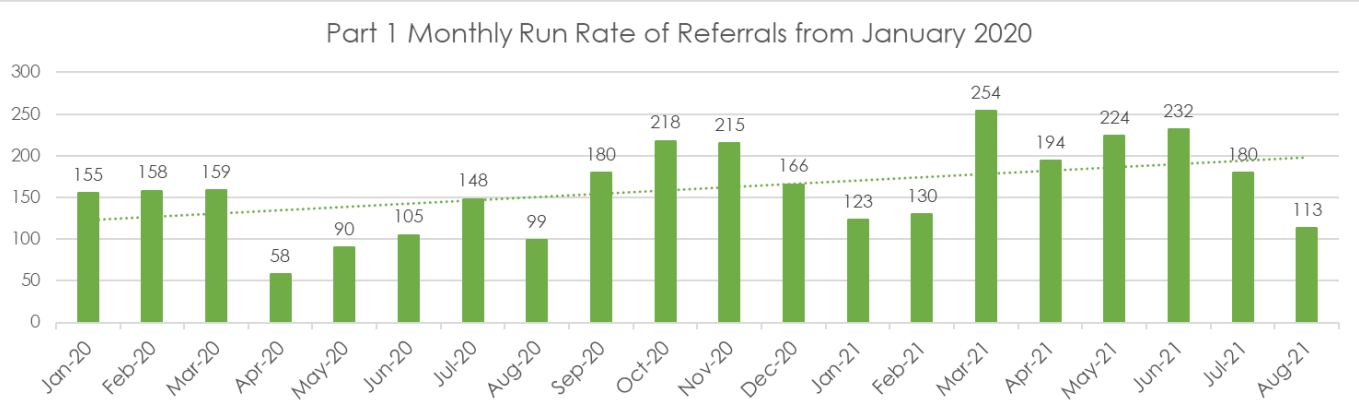
Revised trajectories currently being developed in light of the impact of the above measures. Currently referrals are being booked in at 43 days, the expectation is for this to decrease further with new assessors going live from 4th October 2021.

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

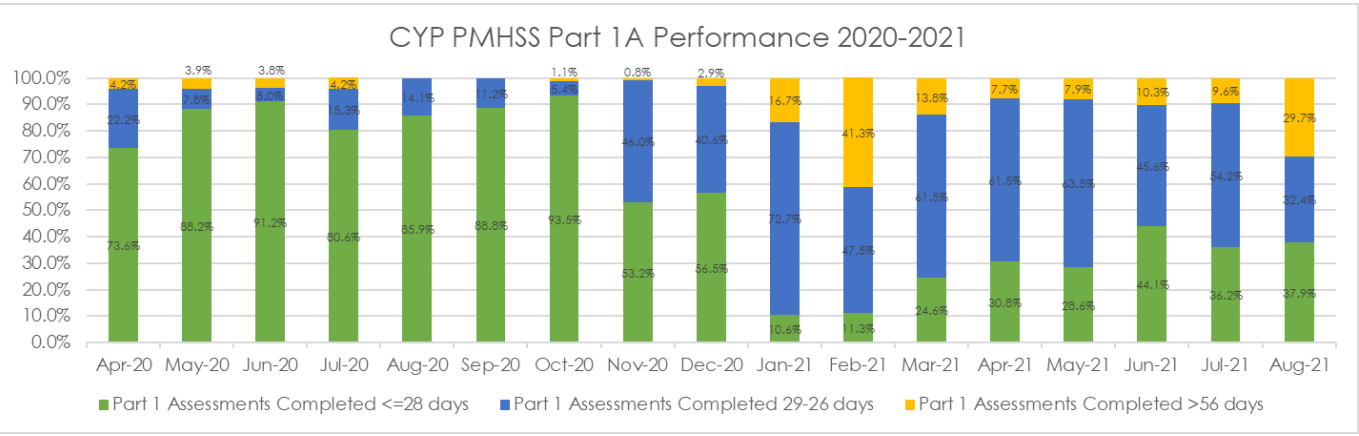
Compliance against the part 1 target not been achieved since October 2020. Following a decline in referrals during the height of Covid, referral levels significantly increased during October 2020 and November 2020 following the re-opening of schools, and whilst there was a decrease between December and February, referrals have sharply increased from March and have remained significantly higher than pre-Covid levels. As expected, there has been a decrease in referrals during July and August which is as a result of the school summer holidays.

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

Graph 4



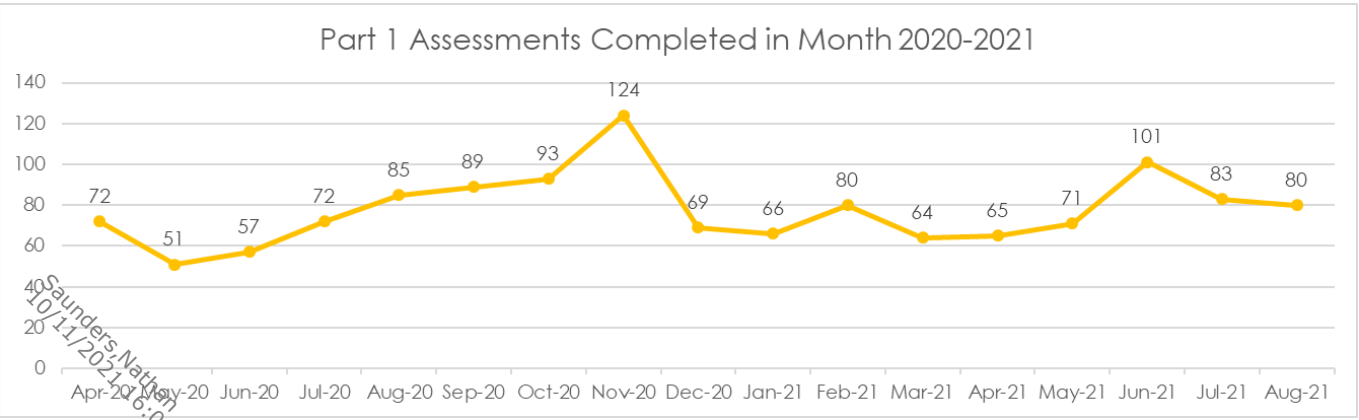
Graph 5



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 it's full offer via virtual (telephone and video) and face-to-face means and expects to continue to utilise these mediums as part of a 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.

Graph 6



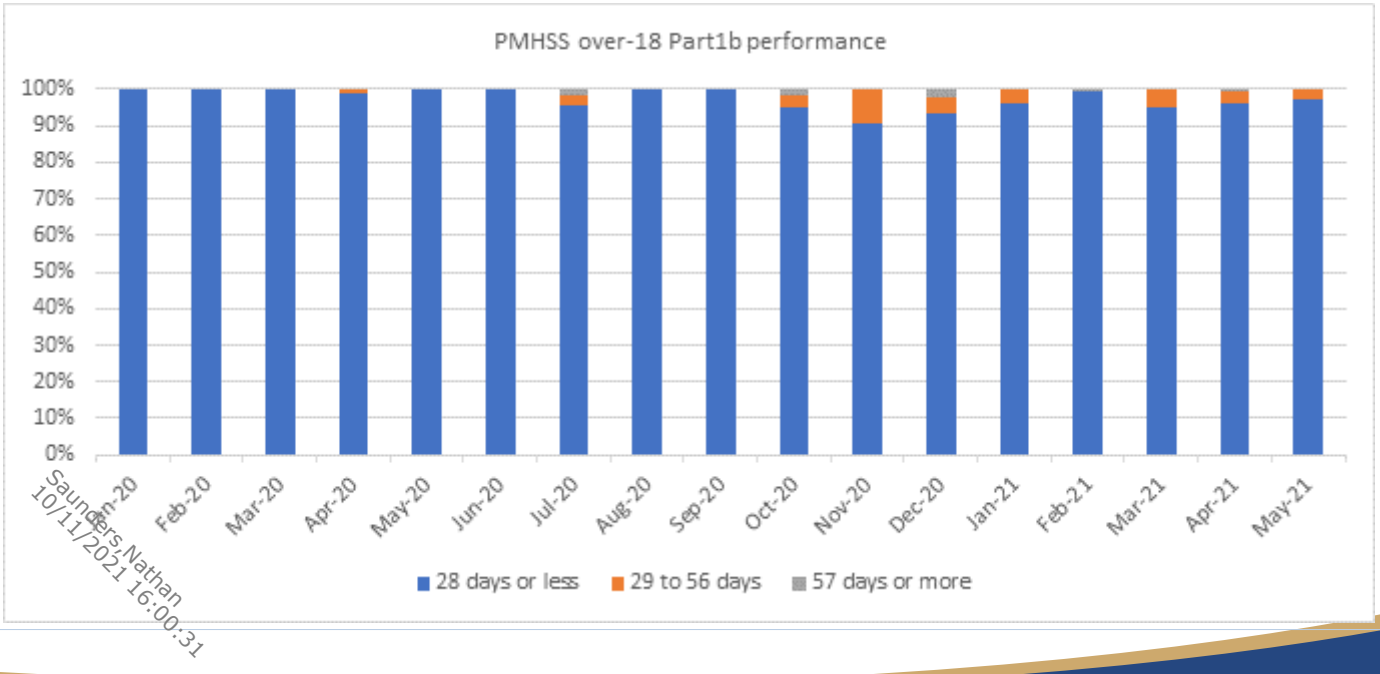
Actions to improve compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of partnership working with Healios to deliver Part 1 assessments.
- 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. It is anticipated that the joint assessment team will have a soft launch in January but will be fully operationalised from April 2022.

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 7). This has continued during the Covid 19 period.
A new therapeutic course (Understanding Me) has been developed and is being piloted. This course aims to support people presenting with emotional distress. In total for courses starting in September, PMHSS are delivering groups for up to 100 service users, supporting ongoing compliance with the Tier 1b target.

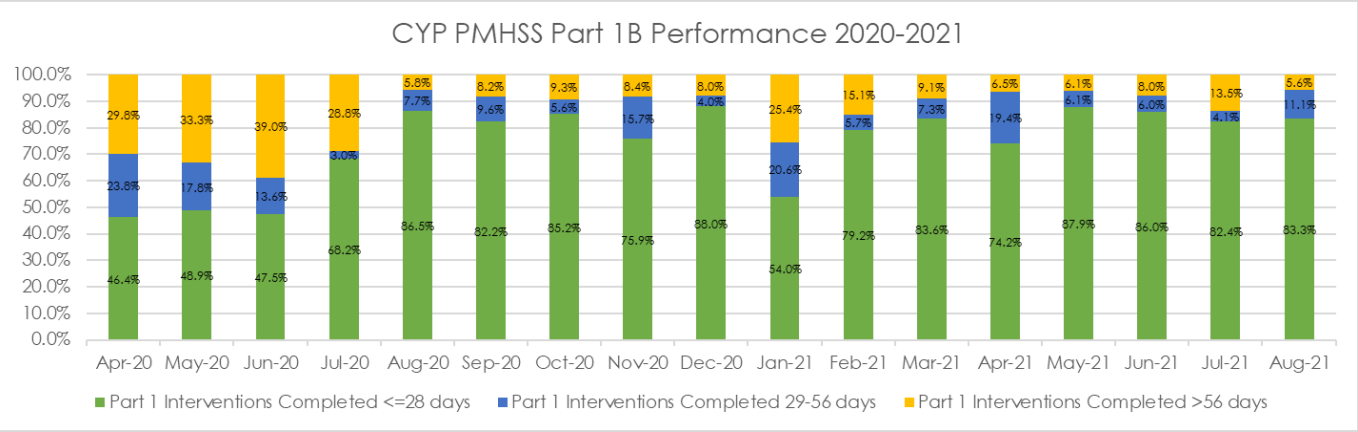
Graph 7



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

Compliance against Part 1B of the target has been achieved since May 2021. 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 of the commencement of their treatment, following assessment.

Graph 8



<u>Part 2 – Care and Treatment Planning (Adult)</u>

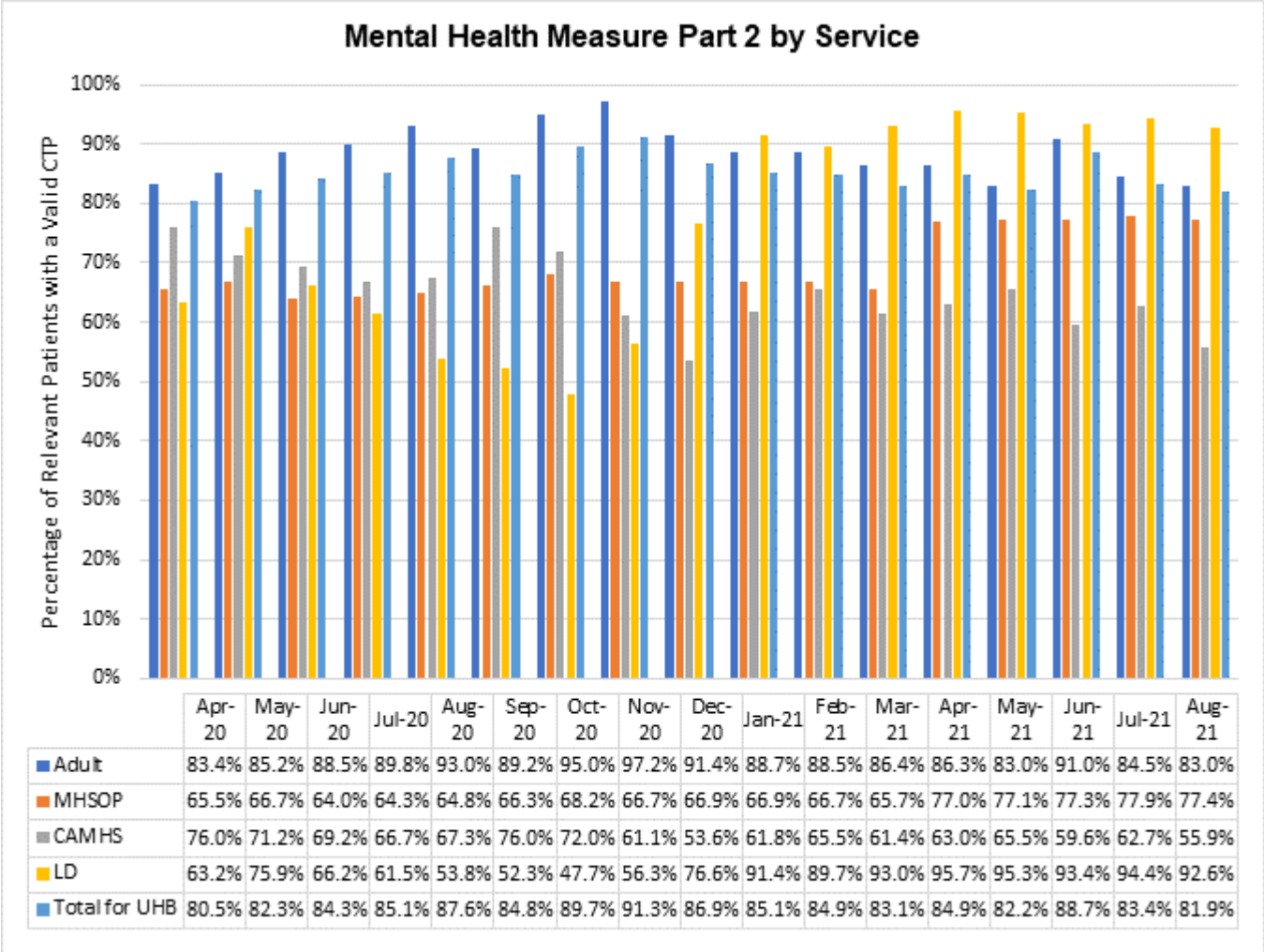
Standard for all relevant service users in secondary care to have an outcomes based holistic co-produced care plan

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, Care Aims training is drawing to a close on the week of 11th October with evaluation and a meeting between the Care Aims trainer and the Clinical Board in January 2022. Two implementation groups will commence (in Adult and MHSOP) to apply the learning to the clinical context. In addition to this, a course has been developed in the Recovery and Wellbeing College for service users, carers and staff members to attend to learn how to develop co-produced Care and Treatment Plans. The training has been developed by a staff member who has experience in auditing and developing Care and Treatment plans and a Peer trainer with lived experience of Part 2 services.

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 continues with Dr Neil Jones leading the work stream and the Director of Operations supporting. Included in this is a survey for service users asking about their experience

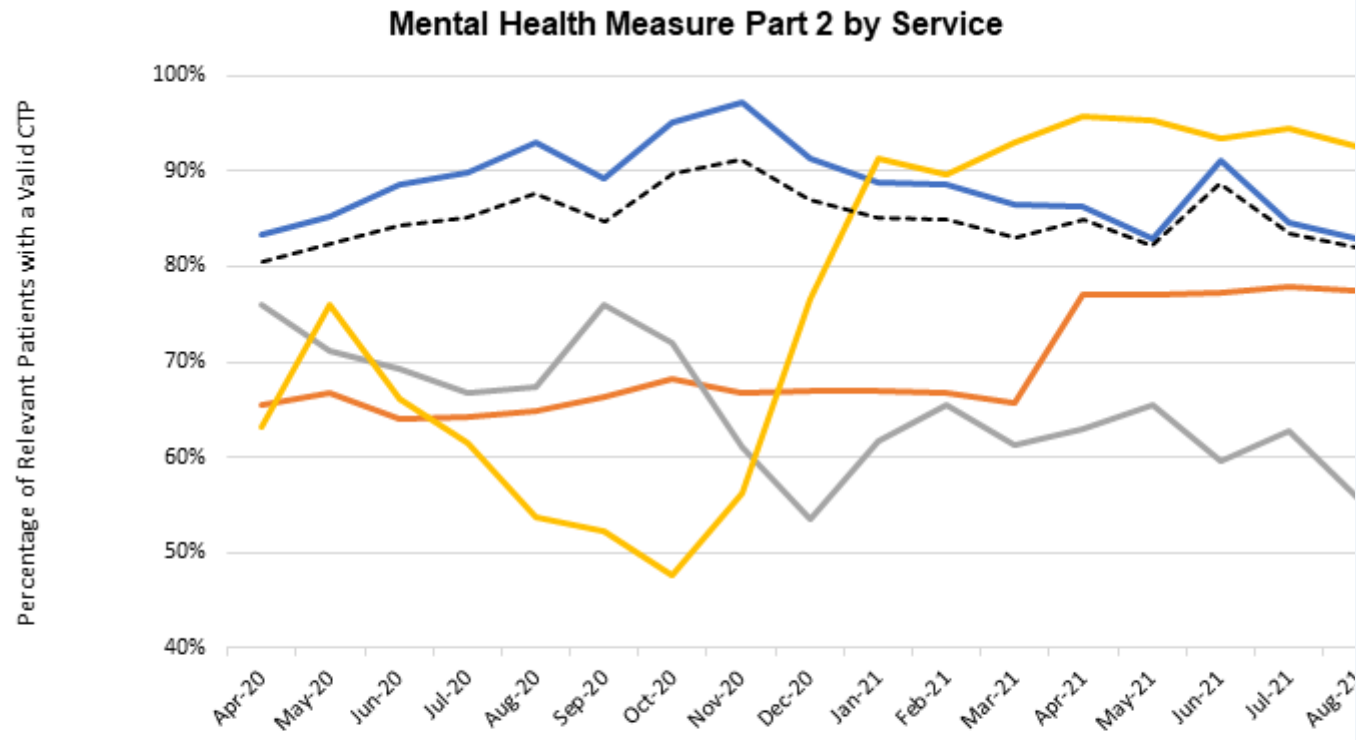
Compliance has reduced by 0.3% since May 2021, and overall by 5.7% since August 2020. This may be partially due to a 0.8% increase in caseload numbers compared to April 2021 and a 25% reduction in discharges compared to April 2021. This is likely to be creating additional demands to maintain compliance as well as commencing new planning with allocated service users. MHSOP Care and Treatment plans have risen to 77.4% from 65.4% in May, at 10.9% increase on August 2020. Adult compliance remains at 83%, down 10% since August 2020, however compliance was as high as 91% in June 2021.

Graph 9



	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	May-21	Jun-21	Jul-21	Aug-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%	86.3%	83.0%	91.0%	84.5%	83.0%
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%	77.1%	77.3%	77.9%	77.4%
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%	63.0%	65.5%	59.6%	62.7%	55.9%
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%	95.7%	95.3%	93.4%	94.4%	92.6%
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%	84.9%	82.2%	88.7%	83.4%	81.9%

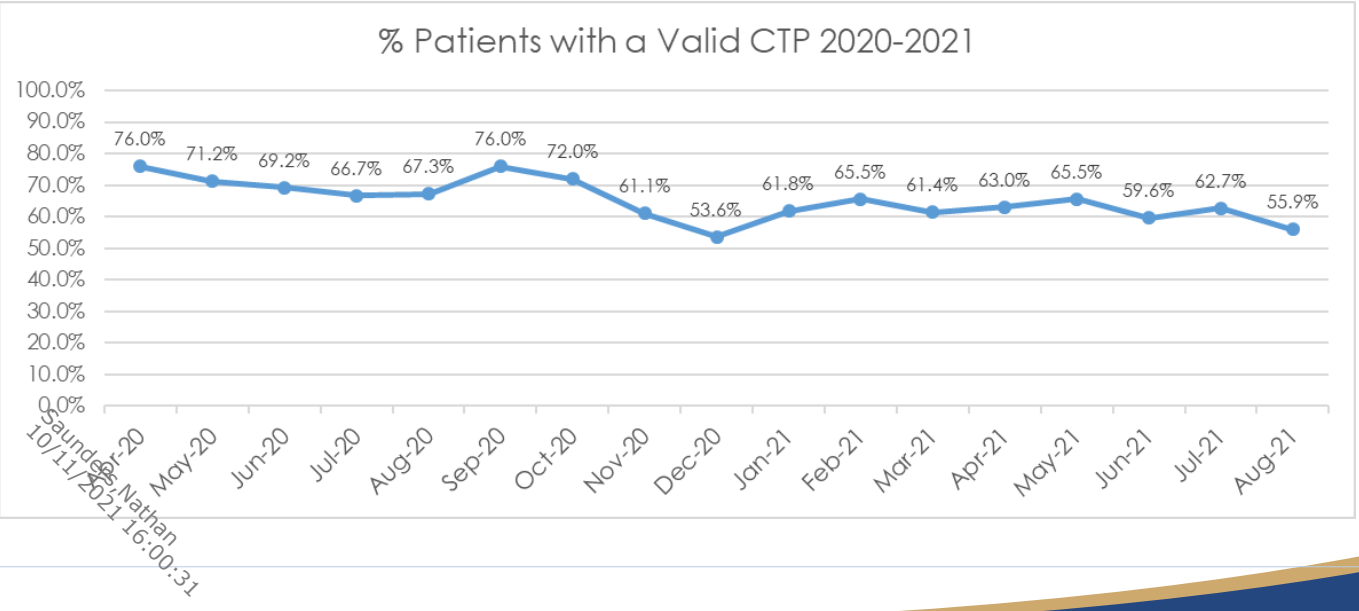
Graph 10



	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	May-21	Jun-21	Jul-21	Au
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%	86.3%	83.0%	91.0%	84.5%	83.
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%	77.1%	77.3%	77.9%	77.
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%	63.0%	65.5%	59.6%	62.7%	55.
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%	95.7%	95.3%	93.4%	94.4%	92.
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%	84.9%	82.2%	88.7%	83.4%	81.

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

Graph 11



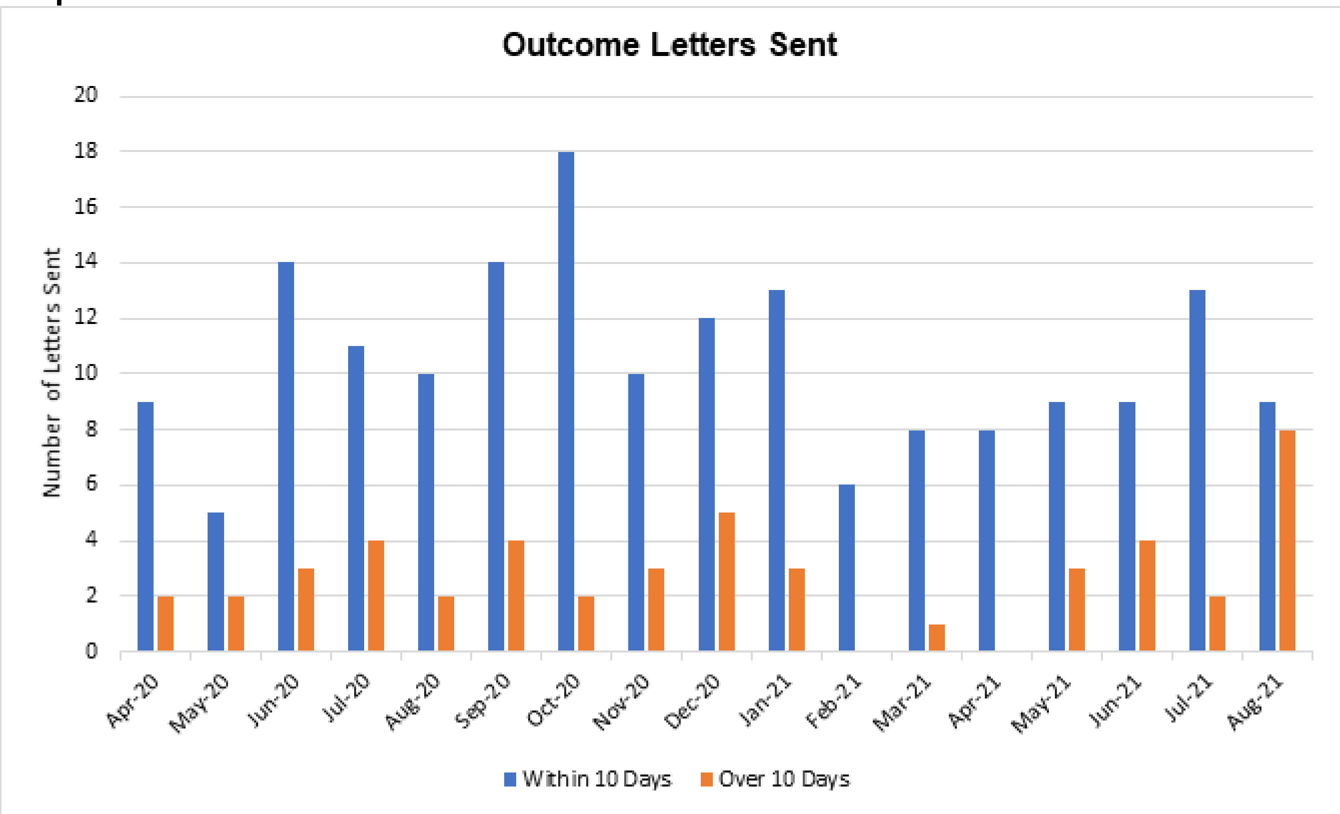
Saunders, Nathan 10/11/2021 16:00:31

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 chart (Graph 12) details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 12



The spike in August represents an adjustment of the data gathering process to more accurately reflect compliance. Previous reports did not include Part 3 patients who received no letter at all. This significant increase in over 10 days shows the impact of a new process that was put into place at the end of July 2021 in Adult CMHTs. Each Adult CMHT has an automated email sent to the team manager for Monday morning every week that list various things that are upcoming for patients on their caseloads. A new section was added to show patients who are due to receive an Outcome Letter which includes a due date. This increase in over 10 days is showing

the impact of this, and we are expecting that as this process improvement develops, the number of Outcome Letters sent will increase significantly, and be within the 10 day time limit.

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.

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

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MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMMITTEE HELD AT 10 AM ON 5th October 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
Mike Lewis PoD member
Sarah Vetter PoD member
Sharon Dixon PoD member
Mair Rawle PoD member
Peter Kelly PoD member

In attendance:
Sunni Webb - Mental Health Act Manager
David Seward - Deputy Mental Health Act Manager
Morgan Bellamy - Mental Health Act Team Lead
Georgia Walsh – Assistant Mental Health Act Administrator

Apologies:
Huw Roberts PoD member
Wendy Hewitt-Sayer PoD member
Rashpal Singh PoD member
Dr John Copley PoD member
John Owen PoD member
Amanda Morgan PoD member
Teresa Goss 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.

2 New Members and Independent Members
There were no new members.

3 Apologies
Apologies were received and noted.

4 Members points for open discussion
There were none

5 Minutes of Meeting held on 6th July 2021
These were agreed as an accurate record of the meeting with no amendments other than the date of this meeting 5th October 2021.

6 Matters Arising

Consultation response – After discussion it was agreed the Deputy MHA Manager would share the response created for the Clinical Board with the group. **Action Deputy MHA Manager**

Arranging Panels – this had been reviewed by the MHA office and unfortunately nothing further could be done. Panels and Hearings need to be set up well in advance to ensure their smooth running.

Face to face Hearings – comments noted. There are no immediate plans to introduce them and it is likely to be mixture of face to face and video link Hearings in the future. Patients have been asked for their views with unfortunately very little feedback to date.

Unconscious Bias Training – it was noted that all but two people had completed the training. There was a positive response from those who had taken part. This would be on-going annual training for PoD members. Those who had not completed the evaluation were asked to do so. Deputy MHA Manager agreed to send out the evaluation forms to those who had yet to complete them. **Action Deputy MHA Manager and PoD members.**

7 Operational Issues

Power of Discharge Hospital Managers Hearing Conduct Protocol – this has been through the various committees and been ratified. The Chair suggested it could probably do with a re-write and asked for volunteers. **Action All**

Feedback on the Annual Review Process – Chair thanked everyone for their contribution to the process, it will be fed back to the working group with a view to amend the documentation in time for the 2022 reviews. **Action Chair**

8 Lessons Learnt

The Chair has reviewed the feedback at the end of the minutes and was pleased to note that Panels have taken time to reflect on their performance after each hearing.

9 MHA Activity Monitoring Reports

The reports were noted. It was acknowledged that the number of hearings and tribunals were below average for the last quarter.

Advocates were present in 43% of Hearings and the MHA office continue to do all they can to promote the service.

10. Concerns/compliments from Power of Discharge group Hearings

These were noted. Again, the issue of CTPs dominated the comments. This issue to be raised at MHLGG. **Action – Chair**

The annual report on compliments and concerns was noted. The issue of CTP and risk assessments seem to be the dominant reasons for managers to comment. **Action Chair to raise at appropriate forums.**

11. Committee and Sub-Committee Feedback

The Chair informed the group that there was nothing to report as both meetings were due to be held in the coming week. Minutes of the previous meetings included in the papers for this meeting.

12. Training

The National Conference is scheduled for the spring of 2022 but further information will be provided. **Action Deputy MHA Manager**

Working with interpreters –unfortunately little progress has been made on this area of training. Both the Deputy MHA Manager and Carol Thomas agreed to re-look at this. **Action Deputy MHA Manager and Carol Thomas**

ECT – Deputy MHA manager is awaiting dates from the ECT department. **Action Deputy MHA manager**

13. Mental Health Act Office Update -The Mental Health Act Manager advised of the changes within the MHA office. David Seward will be "acting" as the Mental Health Act Manager whilst a recruitment process is completed. The MHA Manger starts her new post on the 11th October 2021. Georgia, Nicola and Laura had been appointed to undertake the assistant administrative roles in the office alongside Beth. The Chair on behalf of the PoD congratulated Sunni on her appointment and wished her well for the future. In his role as Chair, he valued her pragmatic approach to dealing with issues and problems. She will be much missed. There will be an opportunity to say goodbye to Sunni in the coming weeks. The Chair wished David well in his new role and looked forward to working with him.

A.O.B

Late Minutes – Hospital Managers were reminded of the timescale to complete minutes following a Hearing **Action – All**

Contested/Uncontested Hearings – there was a discussion regarding a recent Hearing where the minutes had reflected that it was to be an uncontested Hearing. However, the patient had changed his mind. In those circumstances either the text could be changed or the fact that the patient had changed his mind could be reflected in the minutes. **Action All**

CTO/DoLs – at a recent Hearing it was brought to the attention of the Managers that a patient, on a CTO, was being allowed only escorted leave. This is a clear deprivation of liberty. At the end of the Hearing the Chair discussed the situation with the R.C and the supported accommodation nurse and a way forward was agreed between them. The Chair thanked the MHA office for bringing this to the attention of the panel. Action – **All to note**

Date of next meeting: 4th January 2022

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 7th October 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
Jeff Champney Smith	Chair, Power of Discharge Group
Alex Alegretto	Independent Mental Health Advocacy Manager
Katherine Lewis	Consultant Social Worker DOLS/ AMHP
Lynda Woodley	Operational Manager, Vale of Glamorgan, Local Authority
Morgan Bellamy	Mental Health Act Team Lead
Susan Broad	DOLs lead
Emma Powderhill	Crisis Team Leader
Dr Jane Jones	Clinical Director, CAMHs
DS Tom Holden	Police Service representative
Claire Thomas	Police Service representative
Ceri Lovell	Team Leader- CAMHS Crisis Liaison Team
Katherine Lewis	Consultant Social Worker DOLS/ AMHP

Apologies

Peter Thomas	Police representative
Katie Fergus	Consultant representative
Emily Harrington	Consultant representative
Stephen Clarke	Welsh ambulance service
Tara Robinson	Lead Nurse for adult mental health
Jayne Thomas	Police representative

Kara Hanningan	Clinical nurse specialist for physical health and ECT
Andrea Sullivan	Clinical governance lead, Mental health
Dr Michael Ivenso	Consultant representative
Catherine Morris	Emergency unit representative
Carys Buss	Emergency unit representative

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 8 July 2021

Not discussed at this meeting. Any points to be amended should be emailed to the minute taker.

4 MHA Activity

The monitoring reports from April- June and July- September were distributed for information only and were not discussed.

The exception report from October 2021 was discussed. The following points were of note.

The Health Board had previously sought legal advice and has agreed that the 24 hour clock for assessing a person under Section 136 MHA will start from the time they arrive in A&E if the physical issue they attended A&E for is related to their mental health. It will be the shift coordinators that deem whether this is the case or not.

The number of Section 136's has decreased since the unprecedented high last quarter.

The recording of voluntary/ mental capacity Act attendances at both A&E and Hafan Y Coed is still a struggle as the data is not consistently submitted to anyone within the Health Board. The numbers we have are very low and cannot be relied upon.

Claire Thomas confirmed there is a compliance issue within the police force in that some officers are unaware that they need to complete the electronic form for voluntary/ MCA patients. Training has been provided but the police are yet to reach everyone. The police have requested that both A&E and the crisis team take note of when patients come for voluntary/ MCA assessments until a more permanent solution is found.

Action- Vale LSM to request shift coordinators insist SWP use an electronic form for VA's.

The chair of the meeting voiced his concern that patterns of admissions may not be picked up on/ reflected properly without this information being collated properly.

The digital lead confirmed that there is a specific PARIS case note that should be being completed every time a police officer rings with assessment queries.

One of the police service representatives queried whether Health Board staff could be prompted to ensure police officers complete the electronic form for everyone they bring in, irrelevant of them being detained under the MHA or not.

The MHA manager has requested that the MHA office attempt to reconcile voluntary/ MCA assessments each month in the same way that they do with Section 136's. The police service representative confirmed this would be possible but that the data she has is unlikely to be particularly accurate as the police forces own recording of these is also inconsistent.

The number of young persons detained under Section 136 has also decreased. There were no operational issues to note however the Vale AMHP lead did feel there was a lack of understanding about the Mental Capacity Act and the use of the transitional team for young persons who are nearly at the age when adult services will take over.

The Mental Health Review Tribunal has so far carried out two successful video conference calls but this is still being trialled and there is no set date for them to go live. Face to face hearings will not begin to be considered until Spring 2022.

The clinical director for CAMHs voiced her concerns that this is still how MHRTs are being conducted and feels that this issue should be escalated at the earliest chance. The MHA manager confirmed that the issue has already been strongly raised with the MHRT.

It was confirmed that the Mental Health Legislation and Capacity Committee also feel uncomfortable about the continued use of teleconferences. The MHA manager will request that the committee formally write to the Mental Health Review Tribunal to ask for the item to be at the forefront so that the issue can be resolved as soon as possible.

Action- MHA Manager to liaise with MHLCC to write to MHRT office

The chair of the group highlighted that the structure of adult services will be changing. This may impact on how the exception report and this meeting as a whole may be scrutinised going forward.

One other very recent exception was discussed whereby a patients Section 117 eligibility was reinstated without them having been re- detained under an eligible section. One of the AMHP leads explained that having looked at the picture holistically it was felt that reinstating was the correct thing to do and that the initial discharge process had not been followed correctly. The CoP supported re-instating

117 in exceptional circumstances which the UHB and LA agreed this was. All agreed that the case should be learnt from and that following the correct discharge procedure is of utmost importance for both the UHB and LA. The consultant representative agreed to take the issue back to the MAC meeting.

There is no further update with regard to the review of the Mental Health Act.

5 Matters Arising

There is still no change in the use of telephone consultations for SOADS. They were considering the use of attend anywhere software. This was of concern and similarly to the MHRT. MHA Manager/chair to liaise with MHLCC to write to HIW to escalate the matter.

The recording of repeat Section 136's is still problematic as PARIS will not easily allow us to capture this. The local data repository is being looked into but there is no certainty as of yet. It was agreed that this agenda item needs to remain high up on the digital leads priority list.

Action- Chair to liaise with digital lead and his manager

There hasn't been any further formal meetings in regard to the MHA/MCA/Suicide issues however the roll out of the connecting people suicide awareness training has piloted and will continue to be rolled out.

The type of risk assessment that the Health Board uses is going to change. The code of practice is clear that patients need to have a structured risk assessment. An all Wales nursing risk assessment is in production. There are concerns that which ever assessment is used must capture the needs of mental health patients properly. There is no clarity at present as to which structure will be used. There are obviously training implications to any changes.

The chair of the group confirmed he would be approaching the director of mental health nursing to request the use of a scheme B transport provider.

The AMHP leads both reiterated that the use of St Johns ambulance has helped substantially with the conveyancing of patients however they are now stretched as a service too. There are also still ongoing issues with accessing secure care for patients who are aggressive or unwilling to come to hospital. At present DATIX forms are not being completed for instances where AMHPs are having difficulty conveying patients. It was agreed that submitting DATIX forms would assist with getting figures surrounding this and it was eventually decided that the issue should be discussed between the three new locality managers to ascertain who would be best to submit the DATIX forms. It's aimed that gathering DATA will hopefully allow the Health Board to identify any further gaps in the service.

Action- Current MHA Manager to discuss with new colleagues once role has changed.

The scrutiny of consent to treatment certificates was further discussed and the group were informed that the director of mental health nursing was due to take the proposal

to the nursing board but unfortunately it didn't go ahead. It was queried whether ward managers would be most appropriate to do this. We are waiting on a response.

There continues to be a shortage of Section 12 doctors. The chair of the group agreed to keep chasing this issue up and raise it within workforce planning.

6 Feedback on operational issues and incidents:

There have been no significant changes in regard to Covid 19. Local authority staff are starting to return to offices but will continue to work in a hybrid fashion.

The chair of the PoD group mentioned a potential deprivation of liberty for a CTO patient partly due to Covid 19 restrictions, but confirmed that the matter had been taken fully on board by the professionals caring for the patient and the PoD group were happy with the response at the hearing.

There has been no further update with regard to who takes over RC responsibility for CAMHs patients in Hafan Y Coed.

There has been no further progress with regard to the use of digital signatures.

The MHA Manager confirmed that when legal advice is sought it is on behalf of the UHB and that everyone needs to be very clear as to this. Colleagues in the local authority may seek their own legal advice but this is not the Health Boards legal advice to rely upon.

This issue was discussed earlier in the meeting but it was reiterated that shift coordinators will be the responsible person for making the routine clinical judgement as to whether the persons presentation in A&E was in relation to their mental health or not and therefore when the 24-hour clock will commence. We are aiming for this issue to now be resolved and therefore not go to the committee. It was also confirmed that the Health Board is seeking further legal advice on situations where people detained for over 36 hours without having a MHA assessment and incidents of this should be reported to the Welsh Government.

The senior nurse for adult services will be managing the crisis team and liaison psychiatry which will hopefully allow better cohesion going forward.

It was queried whether a brief could potentially be sought from the senior nurse.

Simon Amphlett raised concerns that sometimes its not clear whether patients are detained under Section 136 or not. From a police perspective an officer shouldn't leave a Section 136 patient at A&E until they have been formally accepted for treatment by the Health Board. The police have recruited new officers and training is being undertaken. The bronze inspector's contact details will be distributed to the crisis team which will hopefully help alleviate any confusion. The chair of the group suggested that a flow chart could be created by the MHA Office which can be used by both the police and Health Board staff to help guide them through the new process for Section 136's. The intranet page will be updated and a flow chart will be further considered between the police service/ MHA department.

Action- MHA Manager to discuss creating flowchart with SWP.

An incident when a person was de-arrested from a Section 136 and refused at A&E was briefly discussed. It was noted that A&E is a place of safety for the purposes of A&E. The police service representative reassured the group that communication has been circulated to let police officers know this cannot happen.

7 Feedback

The main issues that came out of the AMHP forums were surrounding conveyancing of patients which had already been discussed and the coordinating of professionals/ police to action Section 135 warrants. We are also experiencing a number of unsigned Section 135's by the police.

The difficulties obtaining Section 12 doctors was also raised and there are now two of our main doctors out of action for a temporary period. The chair of the group will escalate this matter.

Section 140 of the MHA 1983 was briefly mentioned by one of the lead AMHPs. This part of the Act places a duty on the Health Board to provide somewhere for patients to wait whilst a bed is being sought for them. The chair of the group will investigate this further.

Action- MHA Office/ Chair of group to escalate the HB's responsibility of Section 140.

Feedback from the consultants meeting was that teams do try to coordinate joint MHA assessments if at all possible but that some teams cannot easily facilitate this.

The lack of beds following emergency MHA assessments was also briefly discussed- it was agreed by the clinical director that a procedure would need to be created by various professionals but no further progress has been made with this at present.

The chair of the PoD group voiced his disappointment that the problems surrounding care and treatment plans are still ongoing. His main concerns were that CTPs have a failure of ownership, are sometimes out of date and don't reflect the high standard of care that patients are receiving. The digital lead confirmed that the community mental health team's automatic PARIS reports should now highlight patients who need a CTP review. This is hoped to encourage improvement on this front but issues surrounding CTPs being updated in a timely manner may be more difficult to resolve. It was suggested that the chair of the PoD group attend the quality and safety meetings for Adult, MHSOP and Community to discuss the problems there as well. An invite will be sent.

Police feedback concerned the way in which electronic forms are being forwarded back to them. This will be looked into further by the MHA office/ the police service representative.

There are no concerns regarding the advocacy service. The advocates are now feeling comfortable going back onto wards and are happy their role is being fulfilled.

8 Power of Discharge Group comments, compliments and feedback

These are to be looked at by group members in their own time.

9 External reviews

None that the group are aware of.

10 Interface MHA/MCA/DOLS

The chair of the group decided that due to time constraints of the meeting that day and the fact that the introduction of the LPS' is likely to be delayed that this should be discussed in more detail at the next meeting.

11 Quality indicators and audit activities

Nothing to report

Any other business

The chair of the group wished to thank the MHA Manager for her service to the directorate over a number of years and wished her good luck in her new role. It was noted that David Seward will be acting up as MHA Manager from Monday 11th October.

Date of future meetings

06 January 2022