Mental Health Capacity Legislation Committee Meeting

Wed 09 February 2022, 10:00 - 12:00

Agenda

10:00 - 10:00
0 min

1. Welcome & Introductions

Ceri Phillips

10:00 - 10:00
0 min

2. Apologies for Absence

Ceri Phillips

10:00 - 10:00
0 min

3. Declarations of Interest

Ceri Phillips

10:00 - 10:00
0 min

4. Unconfirmed Minutes of the Meeting held on 19 October 2021

Ceri Phillips

04 MHCLC Minutes 19.10.21MD.NF. CP.pdf (12 pages)

10:00 - 10:00
0 min

5. Action Log from the meeting held on 19 October 2021

Ceri Phillips

05 DRAFT Action Log MHCLC MD.NF.pdf (2 pages)

10:00 - 10:00
0 min

6. Chairs Actions taken since last meeting

Ceri Phillips

10:00 - 10:00
0 min

7. Any Other Urgent Business Agreed with the Chair

Ceri Phillips

10:00 - 10:00
0 min

8.
Mental Capacity Act

8.1.
Mental Capacity Act Monitoring Report & DoLs Report – Update

Ruth Walker

- 8.1 MHCLC assurance report - JANUARY 2022.pdf (4 pages)
- 8.1a data 1.pdf (1 pages)
- 8.1b January data.pdf (1 pages)
- 8.1c February data.pdf (1 pages)
- 8.1d March data.pdf (1 pages)
- 8.1e April data.pdf (1 pages)
- 8.1f May data.pdf (1 pages)
- 8.1g June data.pdf (1 pages)
- 8.1h July data.pdf (1 pages)
- 8.1i August data.pdf (1 pages)
- 8.1j September data.pdf (1 pages)
- 8.1k October data.pdf (1 pages)
- 8.1l November data.pdf (1 pages)
- 8.1m December data.pdf (1 pages)

10:00 - 10:00
0 min

9.
Mental Health Act

9.1.
Mental Health Act Monitoring Exception Report

Dan Crossland

- 9.1 Mental Health Act Monitoring Exception Report February 2022.pdf (8 pages)
- 9.1.a Mental Health Act Monitoring Report October - December 2021.pdf (49 pages)

9.2.
Update on the Reform of the Mental Health Act

David Seward

10:00 - 10:00
0 min

10.
Mental Health Measure

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

Dan Crossland

- 10.1 MHLC - Mental Health Measure February 2022 AMS and CAMHS Final.pdf (12 pages)

10:00 - 10:00
0 min

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

11.1.
HIW MHA Inspection Reports

Dan Crossland

- 11.1 HIW Annual report Covering report for MHCLC feb 22.pdf (2 pages)
- 11.1a HIW Mental Health Annual Report 2020-2021.pdf (44 pages)

11.2.
Sub-Committee Meeting Minutes:

11.2.1.
Hospital Managers Power of Discharge Minutes

- 11.2.a PoD Minutes January 2022 Final.pdf (4 pages)

11.2.2.
Mental Health Legislation and Governance Group Minutes

- 11.2.b MHLGG Minutes January 2022 Final.pdf (7 pages)

11.3.
Corporate Risk Register

Nicola Foreman

- 11.3 MHCLC - Corporate Risk Register Covering Report - February 2022.pdf (3 pages)
- 11.3.a Detailed Corporate Risk Register - Board Meeting Jan 2022.pdf (4 pages)
- 11.3.b Detailed Corporate Risk Register Entries Jan 2022.pdf (1 pages)

10:00 - 10:00
0 min

12.
Items for Approval Ratification

12.1.
Committee Terms of Reference

Nicola Foreman

- 12.1 Terms of Reference - covering report.pdf (2 pages)
- 12.1.a MHCLC ToRs January 2022.pdf (9 pages)

12.2.
Committee Work Plan 2022/23

Nicola Foreman

- 12.2 Covering report - work plan 2022.23.pdf (2 pages)
- 12.2.a MHL& MCA Work plan 2022.23.pdf (1 pages)

12.3.
Committee Annual Report 2021/22

Nicola Foreman

- 12.3 Covering Report Draft Annual Report MHCLC.pdf (2 pages)
- 12.3.a Annual Report of MHCLC MD CP.pdf (7 pages)

12.4.
Policies/Procedures for approval:

12.4.1.
Section 5(2) Doctor's Holding Power Procedure

- 12.4.1 MHCLC Policy Approval Cover Report 5(2).pdf (3 pages)
- 12.4.1a Section 5(2) Doctors Holding Power Policy.pdf (40 pages)
- 12.4.1b Section 5(2) Doctors Holding Power Procedure.pdf (14 pages)

12.4.2.
Section 5(4) Nurse's Holding Power Procedure

- 12.4.2 MHCLC Policy Approval Cover Report.pdf (3 pages)
- 12.4.2a Section 5(4) Nurses Holding Power Policy.pdf (41 pages)
- 12.4.2b Section 5(4) Nurses Holding Power Procedure.pdf (14 pages)

10:00 - 10:00
0 min

13.
Review of the Meeting

Ceri Phillips

10:00 - 10:00
0 min

14.
To note the date and time of next meeting: April 26 2022 at 10am Via MS Teams

Unconfirmed Minutes of the
Mental Health and Capacity Legislation Committee
Held on 19 October 2021 – 10am
Via MS Teams

Chair:		
Ceri Phillips	CP	UHB Vice Chair and Committee Chair
Present:		
Sara Moseley	SM	Independent Member – Third Sector
In Attendance		
Caroline Bird	CB	Interim Chief Operating Officer
Jeff Champney-Smith	JCS	Chair, Powers of Discharge sub-Committee
Daniel Crossland	DC	Deputy Director of Operations – Mental Health
Steve Curry	SC	Deputy Chief Executive Officer
Nicola Foreman	NF	Director of Corporate Governance
Scott Mclean	SMc	Director of Operations – Children & Women
David Seward	DS	Interim Mental Health Act Manager
Rose Whittle	RW	Directorate Manager – Child Health
Observer:		
Marcia Donovan	MD	Head of Corporate Governance
Secretariat:		
Nathan Saunders	NS	Corporate Governance Officer
Apologies:		
Akmal Hanuk	AH	Independent Member - Community
Ruth Walker	RW	Executive Nurse Director

MHCL 21/10/001	**Welcome & Introductions** The Committee Chair (CC) welcomed everybody to the meeting.	**ACTION**
MHCL 21/10/002	**Apologies for Absence** Apologies for Absence were noted	
MHCL 21/10/003	**Declarations of Interest** The Independent Member – Third Sector (IMTS) advised the Committee that she was a member of the General Medical Council (GMC).	
MHCL 21/10/004	**Minutes of the Committee Meeting held on 20 July 2021** The minutes of the meeting held on the 20 July 2021 were received. **The Committee resolved that:**	

	a) The minutes of the meeting held on 20 July 2021 be approved as a true and accurate record of the meeting.	
MHCL 21/10/005	**Action Log 20 July 2021** The action log was received. The Deputy Chief Executive Officer (DECO) advised the Committee that a discussion would be required for a new action around waiting times and waiting list profiles for people with protected characteristics. It was noted that Cardiff and Vale University Health Board (CVUHB) had been considering the same when looking at overall access. The CC advised the Committee that the Director of Corporate Governance (DCG) and he would meet to discuss and embrace some of the data gathered around access. The Committee agreed to carry forward the action referenced MHCL 21/07/009 to the next meeting. **The Committee resolved that:** a) The Action Log taken from 20 July 2021 was noted.	**CC/NF**
MHCL 21/10/006	**Chair's Action taken since last meeting** The CC advised the Committee that no Chair's Action had been taken.	
MHCL 21/10/007	**Any Other Urgent Business Agreed with the Chair** a) Compliance with MH Measure relating to Children and Young People It was noted that a discussion regarding compliance with the Mental Health Measure relating to Children and Young People would be had when discussing the agenda item 10.1 - Mental Health Measure Monitoring Reporting including Care and Treatment Plans Update Report.	
MHCL 21/10/008	**Patient / Staff Story** The Patient Story – 'My Battle with Food' was received. Following the patient story, the Director of Operations – Children & Women (DOCW) advised the Committee that the	

	medical model would never have worked for the patient in the story because over medicalising the condition at the start of the patient's journey had been the wrong thing to do. It was noted that through investment, recruitment and transformation, the Health Board would seek to make the improvements required right across the Mental Health spectrum. The Independent Member – Third Sector (IMTS) noted that it was clear that the patient required a multidisciplinary approach and was thankful that he had received that, but she highlighted that the access routes for the patient's Mother had proved difficult and queried why that was. The Directorate Manager – Child Health (DMCH) responded that the patient was from a neighbouring Health Board and so could not answer to that specific case. However, the DMCH confirmed that the access routes were varied into the Child and Adolescent Mental Health Services (CAMHS) and consideration was required in relation to how to manage the various approaches into CAMHS. The CC asked if data could be provided to support what had been identified with regards to making access a more multidisciplinary approach. The DMCH responded that it would be difficult to deliver data at its current stage but noted that the whole programme relating to the school in reach programme and the work that was being undertaken with the Regional Partnership Board (RPB) would start to demonstrate that and advised the Committee that an update report could be brought to a future meeting. The Deputy Chief Executive Officer (DCEO) advised the Committee that it formed part of the transformational work and hence suggested that the matter should go to the Strategy & Delivery Committee as part of the "deep dives" being provided to that Committee. He added that the patient story should be shared with the Welsh Health Specialised Services Committee (WHSSC) because it was a commissioned service. The CC responded that he would speak to WHSSC colleagues regarding this particular case. **The Committee resolved that:**	

	a) The Patient Story was noted.	
MHCL 21/10/009	**Mental Health Act Monitoring Exception Report** The Mental Act Monitoring Exception Report was received. The Mental Health Act Team Lead (MHACTL) advised the Committee that there were 2 main items from the Exception Report to highlight. The first was that the the Mental Health Clinical Board had confirmed that "the clock would start ticking" in Accident & Emergency (A&E) in the majority of Section 136 cases, following recent legal advice. It was noted that the clock would start ticking if a patient was taken to A&E for a physical issue which was related to their mental disorder but noted that the appropriate shift coordinators would decide whether the physical illness was related to the mental disorder or not. It was noted that in circumstances where the physical treatment was unrelated to the mental disorder the clock would not start ticking until the patient was fit for a Mental Health Act assessment. He added that it had been agreed that the shift coordinator would be responsible for making the determination as they were responsible for coordinating the Mental Health Act assessment. It was noted that in all instances where the Section 136 had lapsed due to the patient not being fit for a Mental Health Act assessment, a DATIX would be completed. The MHACTL advised the Committee that the use of Section 136 had decreased since the high record seen in May 2021. It was noted the police had received further training regarding Section 136 powers and how they should be used as a last resort rather than a first resort and hence that could be part of the reason for the identified decrease in use. The second item from the Exception Report which was highlighted was that the Mental Health Review Tribunal for Wales (MHRT) had conducted a successful video conference which took place in August 2021.	

	The MHACTL advised the Committee that he had attended an All Wales Mental Health Act administrator's forum last week and noted that the MHRT had been present and had updated administrators that they had conducted a video conferencing pilot throughout Wales. It was noted that, moving forward, (i) MHRT should be offering all patients' video conferencing, (ii) not all Health Boards were able to facilitate video conferencing, and (iii) hence the Tribunal Panel would decide whether to move forward with video conferencing or telephone conference. It was noted that the Senior Operations Manager for the Mental Health Review Tribunal would issue a general statement in relation to their progress moving in relation to video conferencing and face to face tribunals as well. The IMTS asked if staff had been provided with training for the decisions that were required regarding Section 136 patients and the implications of that in relation to statutory compliance. The MHACTL responded that the shift coordinators would be trained and noted that shift coordinators were completely involved in the process of arranging 136 assessments. The DCEO responded that A&E was one of the most monitored places within the Health Board and noted that staff were used to the kinds of decisions that were required. The IMTS advised the Committee that she had found it extraordinary that it had taken the MHRT so long to allow people, who were detained against their will, to be able to challenge that via video and to still say it may not be possible in some areas was extraordinary. She added that the Health Board should monitor the number of people who want to use video facilities and how the Health Board can support those patients together with the changes that might occur when the legal changes were made. The CC commented that every other area of society had moved across to video conferencing due to the pandemic. The CC asked if anything had been mentioned at the All Wales Mental Health Act administrator's forum with regards to that.	

	The MHACTL responded that the MHRT had identified that firewalls had caused issues in being able to perform video conferencing because all Health Boards in Wales and England used different firewalls. The CC advised the Committee that it was the Independent Member – Legal (IML)'s view that the MHRT should be challenged and asked if the Committee should respond to the MHRT and state that their response was unsatisfactory. The CC advised the Committee that the MHRT should be approached. He asked for support from the MHACTL and Deputy Director of Operations – Mental Health (DDOMH) to assist with that. The IMTS asked what happened to the under 18 year olds regarding Section 136 as the tolerance threshold was still quite high. She had understood that many of these under 18 year olds were discharged and she wanted to know if they were being detained under Section 136 and/or then released back into the community. The DMCH responded that from looking at the data, some of the under 18 year olds had come back and forth and noted that the issues experienced by young people remained complex. It was noted that a lot of work was being done with the Children's Commissioner to review cases. The Deputy Director Operations – Mental Health (DDOMH) advised the Committee that some of the data may not be accurate due to repeat admissions and he commented that the same was also being reviewed. It was noted that risk management plans would be developed which would give quite clear instructions to various services about how to manage individuals who present frequently. **The Committee resolved that:** The proposed approach taken by the Mental Health Clinical Board to ensure compliance with the MHA was supported as set out in the body of the report and as follows:- <u>a) Fundamentally defective applications</u>	

	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.	
MHCL 21/10/010	**Update on the Reform of the Mental Health Act** The MHACTL advised the Committee that the UK Government had prepared a response following the consultation undertaken in relation to its White Paper relating to the review of the Mental Health legislation. It was noted the Welsh Government (WG) had been present at the All Wales Mental Health Act administrator's forum and a response from Welsh Government was awaited. The IMTS noted that, from a devolution perspective, it would be interesting because a lot of the Mental Health Act would impact upon Welsh legislation and hence could lead to some confusion.	

	The CC queried when the WG response to the UK Government's review, was likely to be issued. The DCEO responded that from the feedback he had received, WG were still working through the detail. He queried where could the Health Board influence that and whether the Mental Health Clinical Board could have a part to play. The DDOMH responded that several discussions had taken place, in the network board, regarding the proposed legislation, and in regular meetings with Directors of Operations and WG. The IMTS asked if there were any timescales for the legislation. The MHACTL responded that no timescales had been given at present. The CC mentioned that the proposed recommendation should be changed slightly so that it was clear that the word "Government" referred to the "UK Government". **The Committee resolved that:** a) The UK Government's response to the Independent Review of the Mental Health Act 1983, as summarised in the covering report, was noted.	
MHCL 21/10/011	**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 advised the Committee that, with reference to the covering report, he would highlight Part 1a of the Measure for Adults and that the Director of Operations – Children & Women (DOCW) would highlight Part 1a of the Measure of Children and Young People. **Part 1a – Adults** It was noted that the referral activity for Quarter 4 of 2020 and Quarter 1 of 2021 had seen a gradual decrease in referral rates following the initial steep rise in referrals during the first two quarters after the first lockdown, but with a notable spike in referrals in March 2021.	

	It was noted that completed assessment rates had risen with a high peak of over 600 assessments in September 2021 and that assessment rates had dropped during August due to staff annual leave and term time working arrangements. The DDOMH advised the Committee that a recent successful recruitment drive, had shown a gradual reduction in "over 56 days" waiting, and that from 26th October 2021 all booked appointments were under 56 days, with the most recent waiting time for assessment reduced from 100 days in July 2021 to 43 days on 29th September 2021. It was noted that, In total, 1197 were currently waiting for assessment with 342 waiting over 56 days. It was noted that referrals were now screened and triaged by the merged Single Point of Entry (SPOE) which had resulted in counselling waiting times improving significantly. **Part 1a – Children and Young People.** The DOCW advised the Committee that compliance against the Part 1 target had not been achieved since October 2020. It was noted that 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 had sharply increased from March 2021 and had remained significantly higher than pre-Covid levels. It was noted that the average wait for assessment was currently 37 days. It was noted that capacity had been a challenge for the team, with a mixture of short and long-term sickness, and the team had been operating on approximately 66% capacity since the beginning of December 2020. The DOCW advised the Committee that the service was continuing to deliver its full service both virtually (via telephone and video) and face-to-face. He expected that to continue as part of a blended service post-Covid in order to better meet the needs of children and young people who required support from the service.	

	The DDOMH advised the Committee that compliance for Part 1b of the measure remained at 90% for both Adults and Children and Young People. It was noted that there were an additional 200 spaces created by the team to ensure that the target was maintained. **Part 2 – Care and Treatment Planning** The DDOMH advised the Committee that there had been a slight reduction in adult services with a large spike seen in adults with learning difficulties. It was noted that the large spike identified related to 53 patients. It was noted that Mental Health services for older people were maintaining the steady and increased improvement over time. It was noted that there had been an issue concerning the quality of the care and treatment plans, and a number of actions were being put forward to address the same, such as the "Care Aims" training. The DOCW advised the Committee that there had been a discussion regarding some areas of the Mental Health System for under 18 year olds and noted that 3 formal sessions were held each year with the delivery unit. It was noted that there had been independent national scrutiny against the Measure and he was pleased to note that the Health Board had done very well against Parts 1a and 2, with no action needed based upon 7 external reviews. **Part 3 - Right to request an assessment by self –referral.** The DDOMH advised the Committee that in August 2021 there had been a spike in number of self-referrals. That represented an adjustment of the data gathering process to more accurately reflect compliance. It was noted that each Adult Community Mental Health Team (CMHT) had an automated email sent to the team manager on a Monday morning every week that listed various things that were upcoming for patients on their caseloads, including patients who were due to receive an Outcome Letter which included a due date. **Part 4 – Advocacy – standard to have access to an IMHA within 5 working days**	

	The DDOMH advised the Committee compliance remained at 100% and that the only addition to the Part 4 measure update was in relation to the procurement of the advocacy service. The IMTS asked which areas were seeing the most pressure with regards to the volume of patients. The DDOMH responded that the Part 1a target was where most pressure was being seen for individuals who had presented with moderate mental health problems, and that the clinical acuity tended to be lower. However they had noticed some increase in activity in the system with regards to CMHTs and an increased demand for secondary care services. It was noted that additional resource had been supplied to the Emergency Unit (EU) which had resulted in a slight decrease regarding liaison activity. It was noted that 4 additional staff had been provided to the Part 1 services. A drop in staff numbers had been noted in August as staff took leave, although it was noted that the managers had been working with the team to provide the support needed. The DOCW advised the Committee that the system as a whole was configured to have a Part 1a assessments with the least unwell right through to moderate and crisis, and noted that what had been seen was lifted acuity in all three areas. The IMTS asked if there was any reason for the increased complexity and was there anything that should be looked at outside of the system. The DOCS responded that there was a general mental health need in light of the Covid-19 pandemic. **The Committee resolved that:** a) The content of the Mental Health Measure (Wales) 2010 including the Part 2 update, was noted.	
MHCL 21/10/012	**HIW MHA Inspection Reports** There were no HIW MHA Inspection Reports for the period.	

MHCL 21/10/013	**Sub-Committee Meeting Minutes:** **a) Hospital Managers Power of Discharge Minutes** **b) Mental Health Legislation and Governance Group Minutes** **The Committee resolved:** a) The Hospital Managers Power of Discharge Minutes dated 5 October 2021 were noted. b) The Mental Health Legislation and Governance Group Minutes dated 7 October 2021 were noted.	
MHCL 21/10/014	**Review of the Meeting** The CC asked to note the Committee's thanks to Sunni Webb, who had recently left the post of Mental Health Act Manager and thanked the Mental Health Act Team Lead for stepping in. The DCEO advised the Committee that the Mental Health and Capacity Legislation Committee workshops that had been provided in previous years had proved helpful and asked if there would be plans to reintroduce those in order to provide educational refreshers for new Members. The CC advised the DCEO that he would speak with the DCG outside of the meeting.	
MHCL 21/10/015	**15. Date & Time of next Committee Meeting** February 9th 2022 at 10am	

ACTION LOG
MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE
UPDATE FOR 9th FEBRUARY MEETING

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
Actions Completed					
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	**TAKEN OFFLINE** Ongoing discussions to be had following departure of the EDWOD To be taken offline and discussed. COO, DCG & CC
Actions in Progress					
MHCL 21/07/009	Liberty Protection Safeguards SBAR	The SBAR item be added as a standing item on the agenda.	**09/02/2021**	Ruth Walker	**Completed.** Added to February Agenda Future Standing Item
Actions referred to committees of the Board					
MHCL 21/10/008	Transformation & RPB Approach – Access to CAMHS	A report could be brought around the whole RPB to a future meeting. The Deputy Chief Executive Officer noted it should go to the Strategy & Delivery Committee as part of the deep dives being provided.	**11/01/2022 (S&D meeting)**	Abigail Harris	**Completed**. On the agenda for the Strategy and Delivery Committee meeting on 15 March 2022.
MHCL 19/06/008	Mental Capacity Act Monitoring Report	To discuss at HSMB whether it would be sensible to link up mandatory training (including MCA) compliance with doctors' access to study leave.	Date to discuss at HSMB	Stuart Walker	Agreement not reached with LNC at present. Discussions are ongoing.

MINUTE REF	SUBJECT	AGREED ACTION	DATE	LEAD	STATUS/COMMENT
MHCL 20/02/005		The issue regarding poor compliance on Medical Training be reviewed by the Strategy and Delivery Committee.			This item will be reviewed by the S&D Committee and reported back to a future meeting.

Report Title:	**Mental Capacity Act (MCA) and DoLS monitoring report**								
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	09.02.2022	
Status:	**For Discussion**		**For Assurance**	**x**	**For Approval**		**For Information**		
Lead Executive:	**Executive Nurse Director**								
Report Author (Title):	**Deputy Executive Nurse Director Director of Nursing for Professional Standards, Governance and Improvement**								

Background and current situation:

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

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

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

In 2019 the Law Commission's review of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (2009) (DoLS) resulted in new legislation; the Mental Capacity [Amendment] Act 2019 (MC(A)A). This legislation was expected to come into force from 1st April 2022. However, this date has been delayed and yet to be confirmed. The Legislation will replace the Deprivation of Liberty Safeguards with the new Liberty Protection Safeguards scheme (LPS).

The LPS Code of Practice and Welsh Regulations, which will provide the detail required to support implementation of LPS, have not been published, although a consultation version is expected in Spring 2022, the outcome of the consultation will likely inform the time frame for Health Boards to implement LPS and comply to the Legislation.
However, it is essential that the Health Board commences planning well in advance of that date, due to the significant scale of the project.

Cardiff & Vale currently has no staff resource to manage the implementation of LPS.
The staff resource model will be clear following publication of the LPS Code of Practice and Welsh Regulations, Spring 2022.

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

ASSESSMENT

Liberty Protection Safeguards (LPS)

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

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

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

A detailed SBAR on the Implementation of the Liberty Protection Safeguards (LPS) & transition from Deprivation of Liberty Safeguards (DOLS) across Cardiff & Vale UHB which outlines the key areas of implementation and risks are due for presentation and Management Executive meetings in the coming weeks.

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

Mental Capacity Act Manager

The UHB has recently recruited to this post following the resignation of the previous post-holder.

Independent Mental Capacity Act (IMCA) referrals

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

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

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

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

Total number of referrals received from July 2021 – September 2021 – 85 Referrals

- Serious Medical Treatment – 6
- Long Term Move of Accommodation – 8
- Adult Safeguarding – 11
- Care Review – 3
- Relevant Person's Representative (RPR) – 40
- IMCA 39d – 13
- IMCA 39C – 0
- IMCA 39a – 4

Awaiting data October – December 21

Recommendation:

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

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

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

care, in the right place, first time		provide an environment where innovation thrives	

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

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

MENTAL HEALTH & CAPACITY LEGISLATION COMMITTEE INDICATORS

	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Jan-21	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**
DoLS												
1. Number of DoLS applications made	80	90	101	96	89	121	84	63	84	83	79	91
2. No of DoLS applications completed	*74 (5)	*76 (28)	77 (43)	23 (11)	13 (10)	107 (49)	117 (23)	92 (17)	78 (23)	57 (20)	122 (30)	79 (21)
a. No of DoLS applications assessed	*12 (5)	*20 (8)	22 (15)	91 (47)	61 (21)	27 (16)	29 (14)	17 (7)	27 (11)	23 (16)	41 (21)	24 (6)
b. No of DoLS applications withdrawn	*62 (33)	*56 (20)	55 (28)	114 (58)	74 (31)	80 (33)	88 (9)	75 (10)	51 (12)	34 (4)	81 (9)	55 (15)
4. Breach of timescales including length of breach												
a. Urgent authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
b. Standard authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
c. Further authorisation	January Tab	February Tab	March Tab	April Tab	May Tab	June Tab	July Tab	August Tab	September Tab	October Tab	November Tab	December Tab
5. Requests for reviews of the DoLS authorisation	1	0	1	0	1	0	1	0	0	0	0	0
6. Appeals made to Court of Protection												
a. No of 21a Application	0	0	0	0	0							
b. No of Joined as Party / Welfare order	1	2	0	0	1							
8. Appointment of IMCA as RPR	10	16										
MCA												
9. Number of queries to MCA Manager	10	10	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4	5
10. Number of IMCA referrals				Figures April to June 79			Figures July to September - 85			Awaiting figures October to December		
11. Number of monitoring reports from the IMCA service						1			1			
12. Appointment of IMCA under:												
a. s39a						5			4			
b. s39c						0			0			
c. s39d						10			13			
13. Number of HIW reports received regarding compliance of clinicians	0	0	0								0	0
14. Number of complaints received from patients/carers regarding compliance of clinicians	0	0	0								0	0
15. Number of Public Service Ombudsman for Wales Reports citing issues around MCA	0	0	0								0	0
16. Number of staff who have undertaken MCA training												
a. Children & Women Clinical Board	Not available as yet											
b. CD&T Clinical Board												
c. Medicine Clinical Board												
d. Mental Health Clinical Board												
e. PCIC Clinical Board												
f. Specialist Clinical Board												
g. Surgery Clinical Board												

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Urgent July 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
14/06/2021	14/06/2021	15/07/2021	15/07/2021	26 Days
17/06/2021	17/06/2021	13/07/2021	14/07/2021	20 Days
18/06/2021	18/06/2021	22/07/2021	26/07/2021	31 Days
24/06/2021	24/06/2021	21/07/2021	21/07/2021	20 Days
01/07/2021	01/07/2021	14/07/2021	14/07/2021	6 Days
07/07/2021	07/07/2021	22/07/2021	27/07/2021	13 Days

Standard/Further July 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
04/05/2021	04/05/2021	19/07/2021	19/07/2021	56 Days
01/06/2021	01/06/2021	19/07/2021	21/07/2021	28 Days

Urgent Withdrawn July 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
14/05/2021	02/07/2021	11/06/2021			16 Days	x		
25/05/2021	02/07/2021	16/06/2021			15 Days	x		
06/06/2021	02/07/2021		15/06/2021		1 Day	x		
08/06/2021	07/07/2021	02/07/2021			17 Days	x		
22/06/2021	14/07/2021	09/07/2021			10 Days	x		
14/06/2021	26/07/2021	26/07/2021			35 Days	x		
15/06/2021	26/07/2021		23/06/2021		1 Days			x
24/06/2021	26/07/2021			07/07/2021	6 Days	x		
20/06/2021	26/07/2021	03/07/2021			6 Days	x		
27/06/2021	26/07/2021	20/07/2021			16 Days	x		
04/07/2021	26/07/2021		22/07/2021		11 Days	x		
30/06/2021	26/07/2021		12/07/2021		5 Days			x
11/07/2021	26/07/2021	20/07/2021			2 Days	x		

Standard/Further Withdrawn July 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
25/05/2021	02/07/2021	25/06/2021			10 Days	x		

Urgent August 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
06/05/2021	06/05/2021	18/08/2021	18/08/2021	97 Days
14/06/2021	14/06/2021	11/08/2021	11/08/2021	50 Days
22/06/2021	22/06/2021	11/08/2021	11/08/2021	42 Days
23/07/2021	23/07/2021	24/08/2021	24/08/2021	25 Days
22/07/2021	22/07/2021	10/08/2021	10/08/2021	12 Days

Standard/Further August 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
29/06/2021	29/06/2021	20/08/2021	20/08/2021	45 Days
30/06/2021	30/06/2021	20/08/2021	20/08/2021	44 Days

Urgent Withdrawn August 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
18/07/2021	06/08/2021	05/08/2021			11 Days	x		
21/04/2021	09/08/2021	06/08/2021			68 Days	x		
27/04/2021	09/08/2021			13/07/2021	40 Days	x		
04/05/2021	09/08/2021		08/07/2021		5 Days	x		
01/07/2021	09/08/2021	26/07/2021			18 Days	x		
10/05/2021	09/08/2021			17/07/2021	61 Days	x		
01/06/2021	09/08/2021			03/08/2021	56 Days	x		
24/05/2021	09/08/2021	07/07/2021			37 Days	x		
28/05/2021	09/08/2021	21/07/2021			47 Days	x		
10/06/2021	09/08/2021	07/07/2021			53 Days	x		
13/06/2021	09/08/2021				11 Days	x		
07/06/2021	09/08/2021	06/08/2021			53 Days	x		
30/06/2021	09/08/2021	29/07/2021			22 Days	x		
08/06/2021	10/08/2021	21/07/2021			36 Days	x		
30/06/2021	10/08/2021			25/07/2021	17 Days	x		
15/06/2021	10/08/2021	04/08/2021			39 Days	x		
08/06/2021	10/08/2021	30/07/2021			48 Days	x		
25/06/2021	10/08/2021		07/07/2021		5 Days	x		
25/06/2021	10/08/2021	09/07/2021			7 Days	x		
15/07/2021	10/08/2021	01/08/2021			10 Days	x		
14/07/2021	10/08/2021	01/08/2021			11 Days	x		
22/06/2021	11/08/2021	03/08/2021			35 Days	x		
22/04/2021	16/08/2021	16/08/2021			109 Days	x		
19/07/2021	25/08/2021	25/08/2021			30 Days	x		
09/08/2021	25/08/2021	25/08/2021			9 Days	x		
13/04/2021	27/08/2021	27/08/2021			137 Days	x		
12/08/2021	31/08/2021	26/08/2021			16 days	x		
29/07/2021	31/08/2021	27/08/2021			22 Days	x		
09/07/2021	31/08/2021	21/07/2021			5 days	x		
04/08/2021	31/08/2021	17/08/2021			6 Days	x		
17/06/2021	31/08/2021	28/08/2021			61 Days	x		
18/07/2021	31/08/2021			27/08/2021	33 Days	x		
26/07/2021	31/08/2021			28/08/2021	26 Days	x		
15/08/2021	31/08/2021	28/08/2021			6 Days	x		
13/06/2021	31/08/2021	24/08/2021			69 Days	x		
21/07/2021	31/08/2021	15/08/2021			18 Days	x		
24/05/2021	31/08/2021			24/08/2021	85 Days	x		
23/07/2021	31/08/2021	23/08/2021			24 Days	x		
26/07/2021	31/08/2021	20/08/2021			17 Days	x		

Standard/Further Withdrawn August 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**

Urgent September 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
02/08/2020	02/08/2020	03/09/2021	06/09/2021	25 Days
31/07/2021	31/07/2021	10/09/2021	20/09/2021	44 Days
03/08/2021	03/08/2021	09/09/2021	09/09/2021	30 Days
31/08/2021	31/08/2021	10/09/2021	14/09/2021	7 Days

Standard/Further September 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
28/06/2021	28/06/2021	27/09/2021	27/09/2021	70 Days

Urgent Withdrawn September 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
10/04/2021	07/09/2021	07/09/2021			112 Days	x		
27/07/2021	09/09/2021	09/09/2021			37 Days	x		
21/05/2021	15/09/2021	07/07/2021			39 Days	x		
15/07/2021	15/09/2021		07/08/2021		15 Days	x		
06/07/2021	15/09/2021	03/09/2021			54 Days	x		
25/06/2021	16/09/2021	15/09/2021			75 Days	x		
27/08/2021	16/09/2021	05/09/2021			2 Days	x		
04/07/2021	17/09/2021	06/09/2021			57 Days	x		
20/07/2021	17/09/2021	08/09/2021			43 Days	x		
28/08/2021	17/09/2021	13/09/2021			9 Days	x		
22/07/2021	17/09/2021	08/09/2021			41 Days	x		
07/08/2021	17/09/2021	11/09/2021			59 Days	x		
17/08/2021	17/09/2021		08/09/2021		15 Days	x		
25/08/2021	17/09/2021	11/09/2021			10 Days	x		
08/06/2021	24/09/2021	15/09/2021			92 Days	x		
29/07/2021	30/09/2021	13/09/2021			39 Days	x		
08/09/2021	30/09/2021			24/09/2021	9 Days	x		
10/08/2021	30/09/2021	24/08/2021			7 Days	x		
30/07/2021	30/09/2021	10/09/2021			35 Days	x		
24/07/2021	30/09/2021	20/09/2021			51 Days	x		

Standard/Further Withdrawn September 21						Information rec'd for w/d by		
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
26/05/2021	15/09/2021			03/08/2021	48 Days	x		
20/08/2021	17/09/2021			14/09/2021	4 Days	x		
17/06/2021	24/09/2021	23/09/2021			77 Days	x		
15/08/2021	24/09/2021	20/09/2021			15 Days	x		
25/06/2021	30/09/2021	17/09/2021			63 Days	x		
13/07/2021	30/09/2021		17/08/2021		14 Days	x		

Urgent October 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
23/07/2021	23/07/2021	05/10/2021	05/10/2021	67 Days
09/09/2021	09/09/2021	05/10/2021	05/10/2021	19 Days
07/10/2021	07/10/2021	25/10/2021	25/10/2021	18 Days

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

Urgent Withdrawn October 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
23/08/2021	01/10/2021	09/09/2021			11 Days	x		
10/09/2021	01/10/2021	30/09/2021			13 Days	x		
20/08/2021	03/10/2021	10/09/2021			14 Days	x		
14/09/2021	03/10/2021	01/10/2021			10 Days	x		
22/07/2021	04/10/2021	15/09/2021			17 Days	x		
23/07/2021	04/10/2021	16/09/2021			48 Days	x		
09/09/2021	05/10/2021			19/09/2021	3 Days	x		
25/08/2021	05/10/2021	26/09/2021			26 Days	x		
20/09/2021	06/10/2021			05/10/2021	8 Days	x		
24/09/2021	06/10/2021	04/10/2021			3 Days	x		
18/09/2021	06/10/2021		06/10/2021		11 Days	x		
01/07/2021	14/10/2021		13/10/2021		97 Days	x		
01/09/2021	14/10/2021	12/10/2021			34 Days	x		

Standard/Further Withdrawn October 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
06/09/2021	05/10/2021	01/10/2021			8 Days	x		

Urgent November 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
30/06/2021	30/06/2021	17/11/2021	07/12/2021	153 Days
10/09/2021	10/09/2021	04/11/2021	04/11/2021	48 Days
18/10/2021	18/10/2021	23/11/2021	09/12/2021	50 Days
20/09/2021	20/09/2021	08/11/2021	15/11/2021	49 Days
22/10/2021	22/10/2021	12/11/2021	12/11/2021	14 Days
13/07/2021	13/07/2021	08/11/2021	19/11/2021	122 Days

Standard/Further November 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
03/08/2021	03/08/2021	25/11/2021	13/12/2021	111 Days
09/10/2021	09/10/2021	10/11/2021	10/11/2021	11 Days
12/10/2021	12/10/2021	30/11/2021	30/11/2021	28 Days
15/07/2021	15/07/2021	08/11/2021	10/11/2021	95 Days
08/09/2021	08/09/2021	25/11/2021	26/11/2021	58 Days
09/09/2021	09/09/2021	25/11/2021	26/11/2021	57 Days

Urgent Withdrawn November 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
05/09/2021	11/11/2021	25/10/2021			43 Days	x		
20/09/2021	11/11/2021	29/10/2021			22 Days	x		
27/09/2021	11/11/2021	02/11/2021			29 Days	x		
01/10/2021	11/11/2021		25/10/2021		17 Days	x		
03/10/2021	11/11/2021	29/10/2021			19 Days	x		
05/10/2021	11/11/2021	02/11/2021			21 Days	x		
03/09/2021	11/11/2021	18/10/2021			38 Days	x		
28/09/2021	11/11/2021	18/12/2021			13 Days	x		
27/09/2021	11/11/2021			21/10/2021	17 Days	x		
12/10/2021	11/11/2021	22/10/2021			3 Days	x		
24/09/2021	15/11/2021	10/11/2021			40 days	x		
21/06/2021	16/11/2021	24/10/2021			119 Days	x		
28/09/2021	16/11/2021	02/11/2021			28 Days	x		
30/06/2021	20/11/2021	15/11/2021	15/11/2021		131 Days	x		
28/08/2021	20/11/2021	25/10/2021			51 Days	x		
22/09/2021	20/11/2021	16/11/2021			48 Days	x		
02/10/2021	21/11/2021	21/10/2021			12 Days	x		
10/10/2021	21/11/2021	19/11/2021			33 Days	x		
07/09/2021	21/11/2021	16/11/2021			63 Days	x		
04/11/2021	21/11/2021	19/11/2021			8 Days	x		
05/10/2021	21/11/2021	01/11/2021			20 Days	x		
05/10/2021	21/11/2021	17/10/2021			5 Days	x		
11/09/2021	21/11/2021			25/10/2021	32 Days	x		
27/09/2021	21/11/2021	13/10/2021			9 Days	x		
06/10/2021	25/11/2021			24/11/2021	42 Days	x		
11/06/2021	30/11/2021			04/07/2021	16 Days	x		

Standard/Further Withdrawn November 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
14/09/2021	16/11/2021	09/11/2021			42 Day	x		
25/09/2021	16/11/2021		25/10/2021		9 Days	x		
06/08/2021	20/11/2021		11/11/2021		46 Days	x		
16/09/2021	20/11/2021		13/10/2021		6 Days	x		
19/07/2021	21/11/2021	18/10/2021			39 Days	x		

Urgent December 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
22/11/2021	22/11/2021	13/12/2021	15/12/2021	16 Days
26/11/2021	26/11/2021	06/12/2021	12/12/2021	3 Days
30/11/2021	30/11/2021	13/12/2021	15/12/2021	8 Days

Standard/Further December 21				
Date Signed	**Date Rec'd**	**Assessment**	**Authorised**	**Breach**
13/10/2021	13/10/2021	08/12/2021	09/12/2021	36 Days
21/10/2021	21/10/2021	09/12/2021	09/12/2021	28 Days
25/10/2021	25/10/2021	07/12/2021	09/12/2021	24 Days

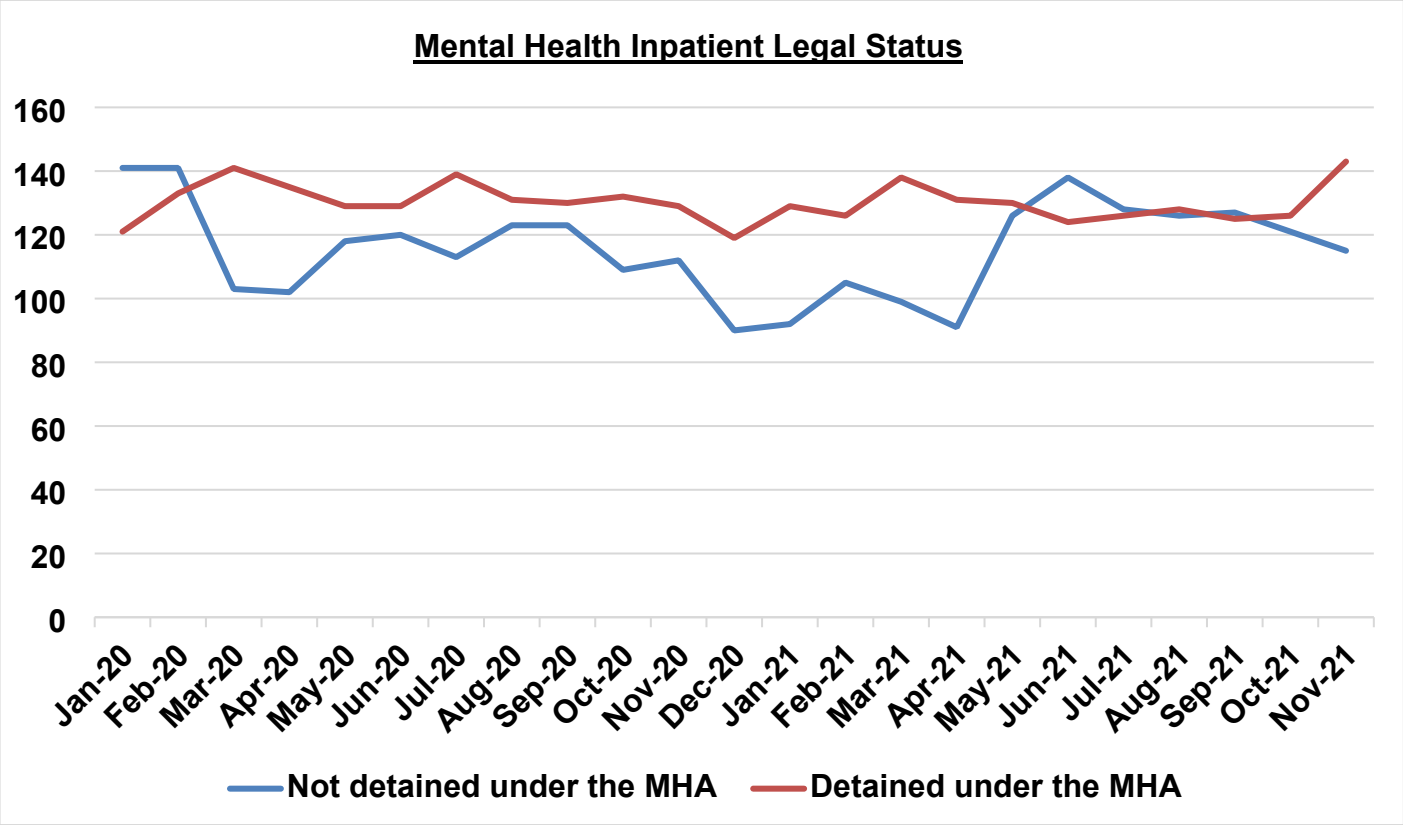
Urgent Withdrawn December 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
12/10/2021	02/12/2021		29/11/2021		41 Days	x		
27/09/2021	02/12/2021	26/11/2021			53 Days	x		
19/10/2021	02/12/2021			26/11/2021	31 Days	x		
10/10/2021	02/12/2021			25/11/2021	39 Days	x		
23/11/2021	07/12/2021	07/12/2021			7 Days	x		
07/10/2021	07/12/2021			02/12/2021	39 Days	x		
07/09/2021	08/12/2021			05/12/2021	77 Days	x		
01/11/2021	10/12/2021	08/12/2021			30 Days	x		
12/09/2021	10/12/2021	06/12/2021			78 Days	x		
06/10/2021	10/12/2021	24/11/2021			41 Days	x		
02/12/2021	10/12/2021	13/12/2021			4 Days	x		
04/11/2021	12/12/2021	04/12/2021			23 Days	x		
15/11/2021	12/12/2021		08/12/2021		16 Days	x		
13/10/2021	12/12/2021	01/12/2021			52 Days	x		
19/11/2021	19/12/2021		17/12/2021		21 Days	x		
12/10/2021	20/12/2021	14/12/2021			56 Days	x		
02/09/2021	20/12/2021	16/12/2021			98 Days	x		
01/11/2021	20/12/2021	06/12/2021			28 Days	x		
21/10/2021	20/12/2021		30/11/2021		23 Days	x		
08/12/2021	20/12/2021	17/12/2021			2 Days	x		
28/11/2021	20/12/2021			15/12/2021	10 Days	x		
05/11/2021	21/12/2021		03/12/2021		25 Days	x		
09/11/2021	21/12/2021	30/11/2021			14 Days	x		
01/11/2021	21/12/2021	16/12/2021			38 Days	x		
16/12/2021	29/12/2021	27/12/2021			4 Days	x		

Standard/Further Withdrawn December 21				Information rec'd for w/d by				
Date Rec'd	**Date W/D**	**Discharged**	**Transfer**	**RIP**	**Breach**	**Cleansed**	**MA**	**New App**
20/09/2021	07/12/2021	01/12/2021			50 Days	x		
20/10/2021	07/12/2021	02/12/2021			22 Days	x		
14/09/2021	08/12/2021	06/12/2021			34 Days	x		
05/09/2021	10/12/2021	01/12/2021			75 Days	x		

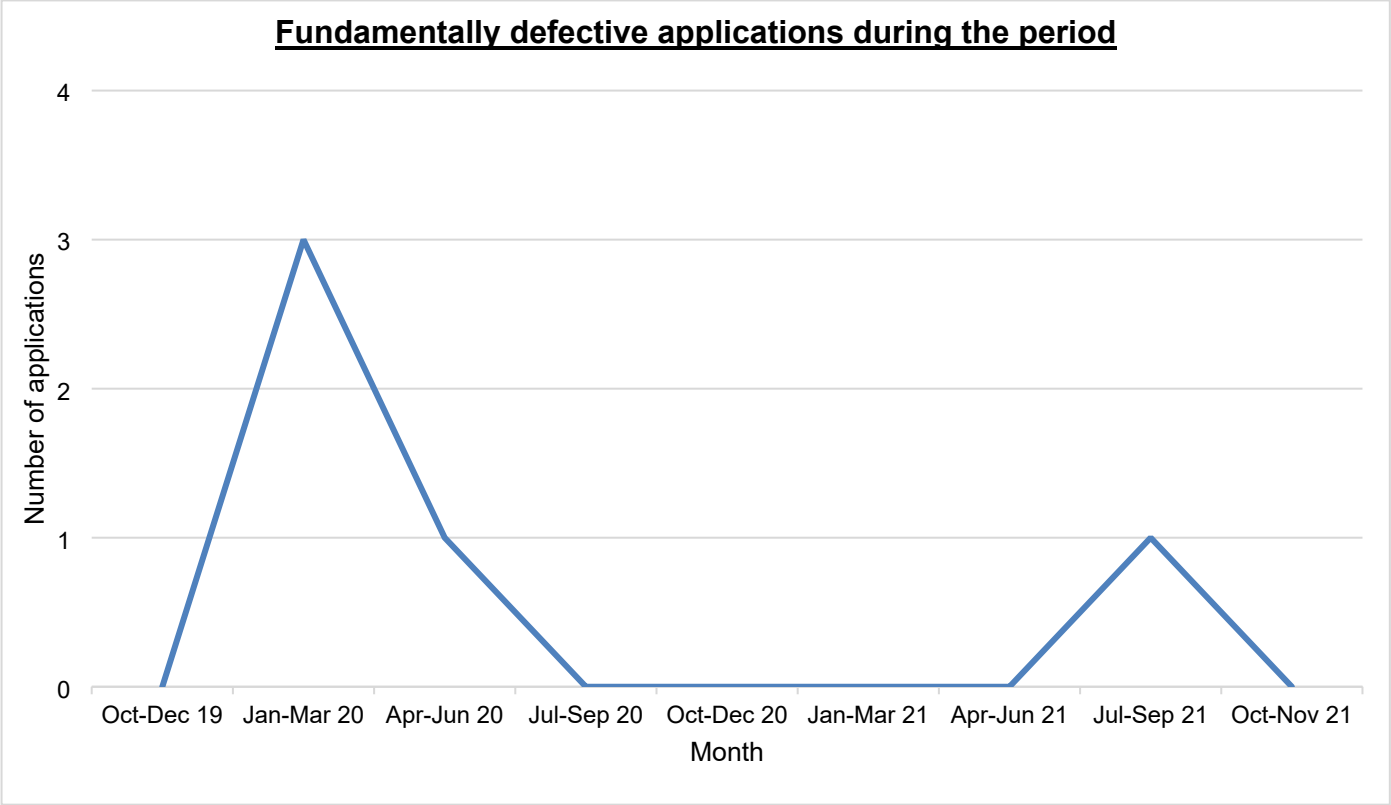
Report Title:	**MENTAL HEALTH ACT MONITORING**									
Meeting:	**Mental Health & Capacity Legislation Committee**							**Meeting Date:**	**9 February 2022**	
Status:	**For Discussion**	**x**	**For Assurance**	**x**	**For Approval**	**x**	**For Information**		**x**	
Lead Executive:	**Chief Operating 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 increased slightly this period with 53% of inpatients being detained under the Act at the end of Qtr.3 compared to 49% at the end of Qtr.2.



Fundamentally defective applications



During the previous period there was 1 fundamentally defective application for detention. This wasn't reported in the last quarter as we weren't made aware of this until October.

P was detained on a Section 2 in UHL general. The AMHP gave the detention papers to a ward nurse but there is no evidence that the AMHP left instruction for nursing staff which resulted in the detention papers not being given to a person authorised to receive them on behalf of the Hospital Managers, nor were the Mental Health Act office informed of the detention by the ward or the AMHP.
After a period of time, the patient moved to an MHSOP ward with the detention papers but the Mental Health Act office were not informed of this either. We were informed of the detention on the last (28th) day when another AMHP queried why the detention papers were not uploaded to PARIS.

After seeking legal advice from Richard Jones, he confirmed that although P was 'liable to be detained' on the basis of an AMHP application being completed, it does not alter the fact that the detention papers were not formally received by someone authorised on behalf of the Hospital Managers, therefore, the application was fundamentally defective and the patient was detained without authority.

This incident has been discussed with the Local Authority and all AMHP's have been advised that a receipt must be completed every time they detain someone and they must e-mail or call the Mental Health Act office to inform us of the detention so we can chase the paperwork if necessary.

Lapsed Detention

During this period 1 detention lapsed. P was detained on a Section 4 in the community due to lack of availability of another S12 doctor and risk of harm to self. P wouldn't travel to Hafan Y Coed with

the social worker or CPN and instead left his flat. The AMHP applied to the courts that same day for a Section 135(2) warrant which was granted. Police were contacted to attend the flat the next day with the social worker and CPN in order to execute the warrant and convey P to Hafan Y Coed. Upon execution of the warrant the police found P was not located in his flat and as the Section 4 was nearing expiry the Responsible Clinician made a recommendation for Section 2. The AMHP went before the courts again to secure a Section 135(1) warrant in order to bring P to Hafan Y Coed for a Mental Health Act assessment.

Section 136 A&E

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.*

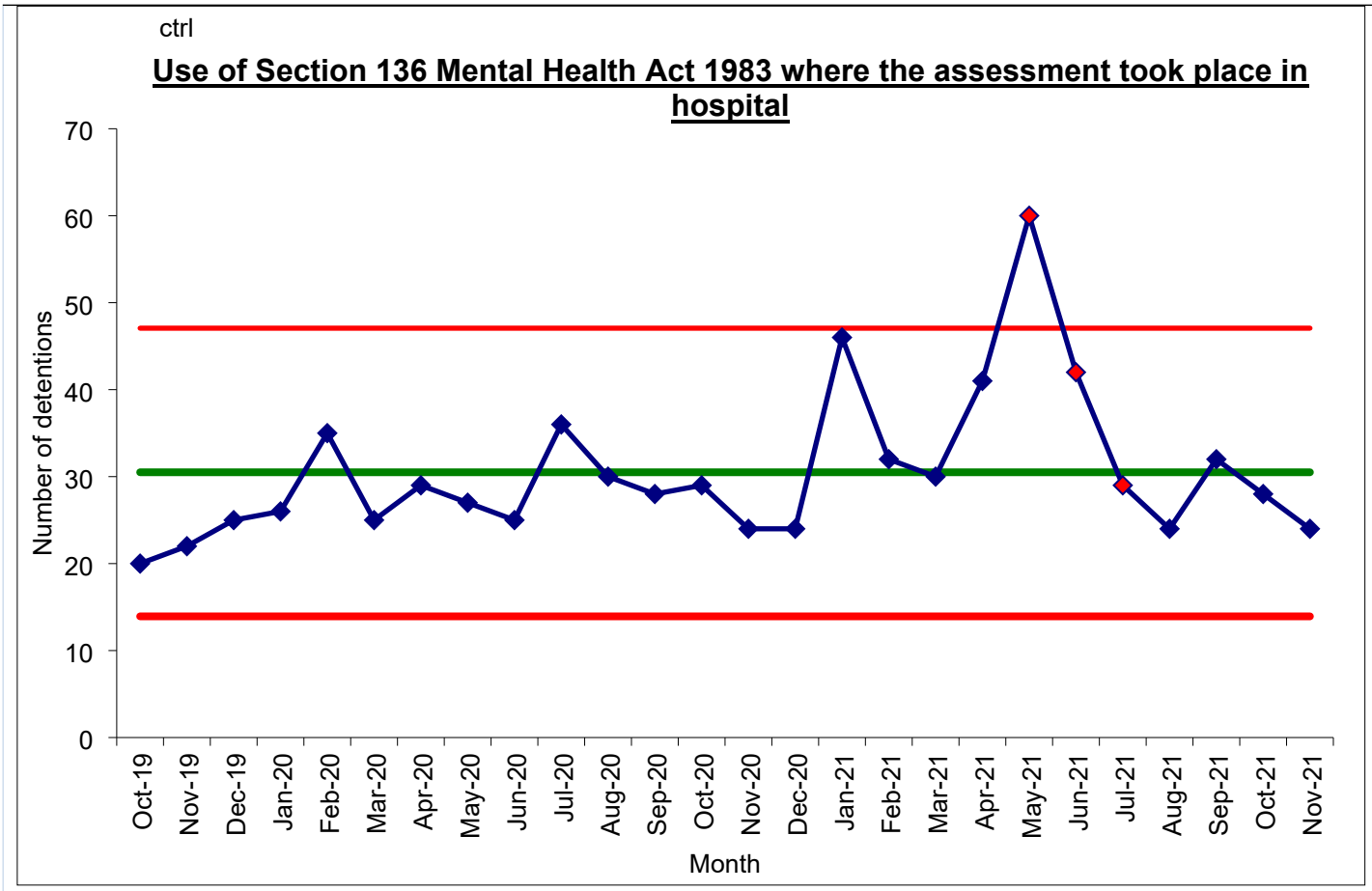
In all instances where the 136 has lapsed due to the patient not being fit for a mental health act assessment, a DATIX will be completed.

Section 136

During October and November, the use of section 136 has decreased. This suggests that the section 136 powers are still only being used when absolutely necessary by the police.

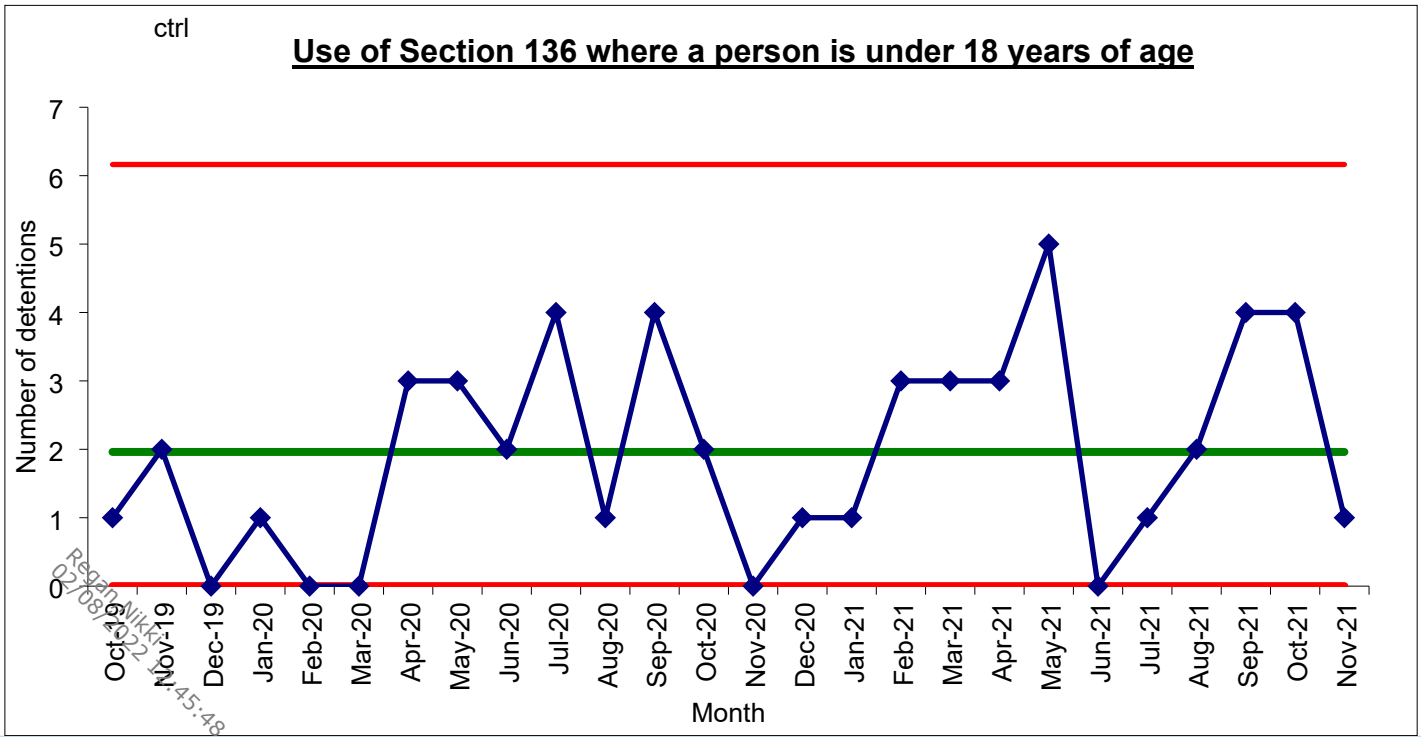
It was noted that 69.3% of individuals assessed were not admitted to hospital, with 46.2% being discharged with community support and 23.1% were discharged with no follow up. Overall during the period 30.7% of patients were admitted to hospital following a 136 assessment which is higher than the previous quarter at 25.9%.

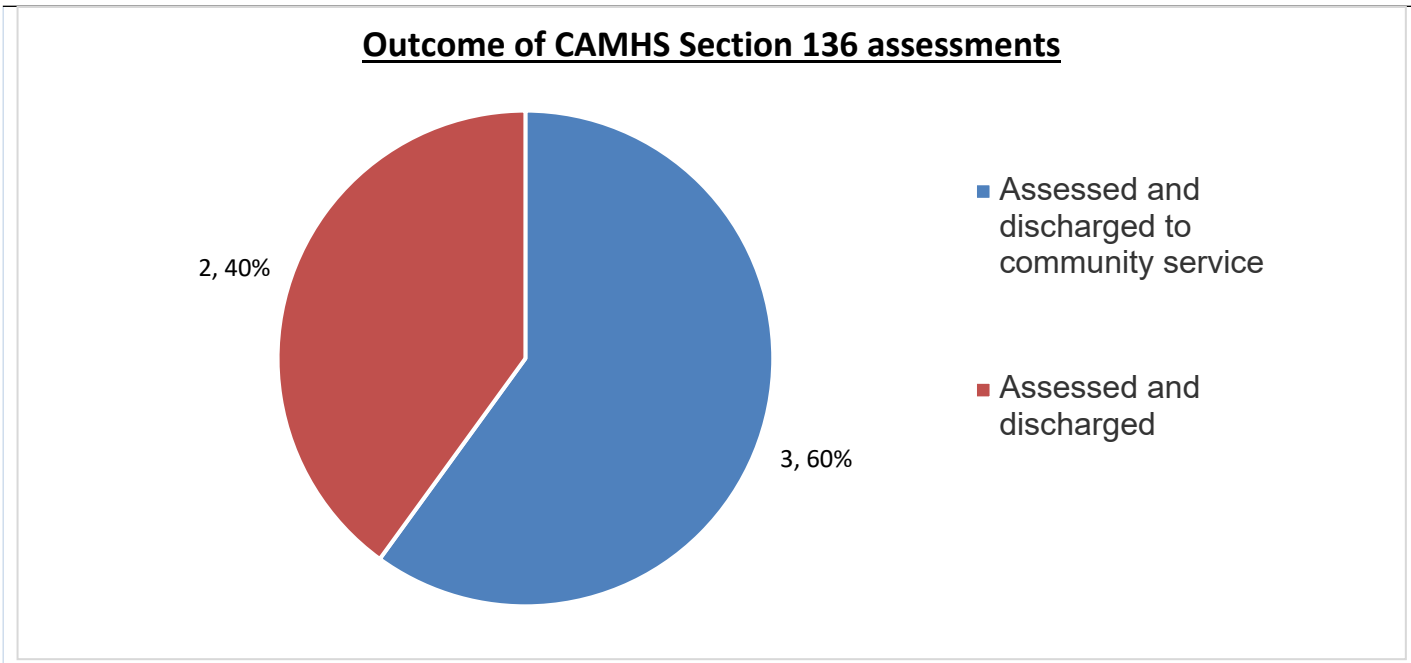
Period	% not admitted to hospital
October - November 2021	69.3%
July – September 2021	74.1%
April – June 2021	73.5%
January – March 2021	81.5%
October – December 2020	67.5%
July – September 2020	73.7%
April – June 2020	70.4%
January – March 2020	62.8%



Section 136 - CAMHS

The number of those under 18 assessed under section 136 has decreased from 7 in the previous quarter to 5 in October and November. There were 2 repeat presentations recorded.





Mental Health Review Tribunal for Wales (MHRT)
Due to security firewalls being changed in Welsh Government, the MHRT have been trialing hearings being conducted via Teams. This has largely been successful in most Health Board's and the independent sector. Trials were still happening throughout December with different Health Board's and the MHRT team are due to review the outcomes in January to work out the best way to offer Teams hearing's as standard for all patients.
Cardiff & Vale have been apart of 1 trial hearing via Teams and the feedback was very good with the patient commenting *"it is a better way of doing them"* and *"I prefer video rather than phone".*

There were 2 more Teams hearings scheduled but these were cancelled due to the patients being discharged.

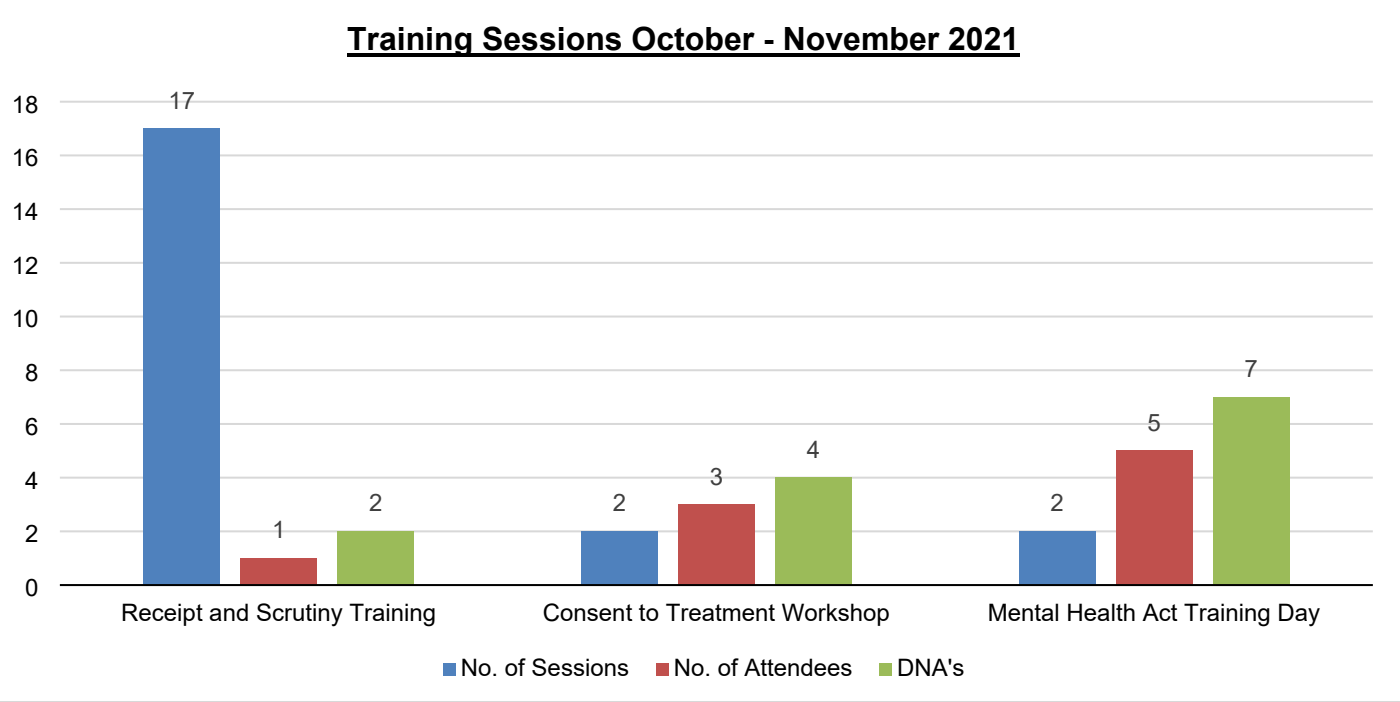
Mental Health Review Tribunal for Wales (MHRT) - Observers
Since the start of the pandemic observers have been refused to attend hearings which formulates part of their training and professional development. I have raised the query with the MHRT and received a reply from a Deputy President stating:

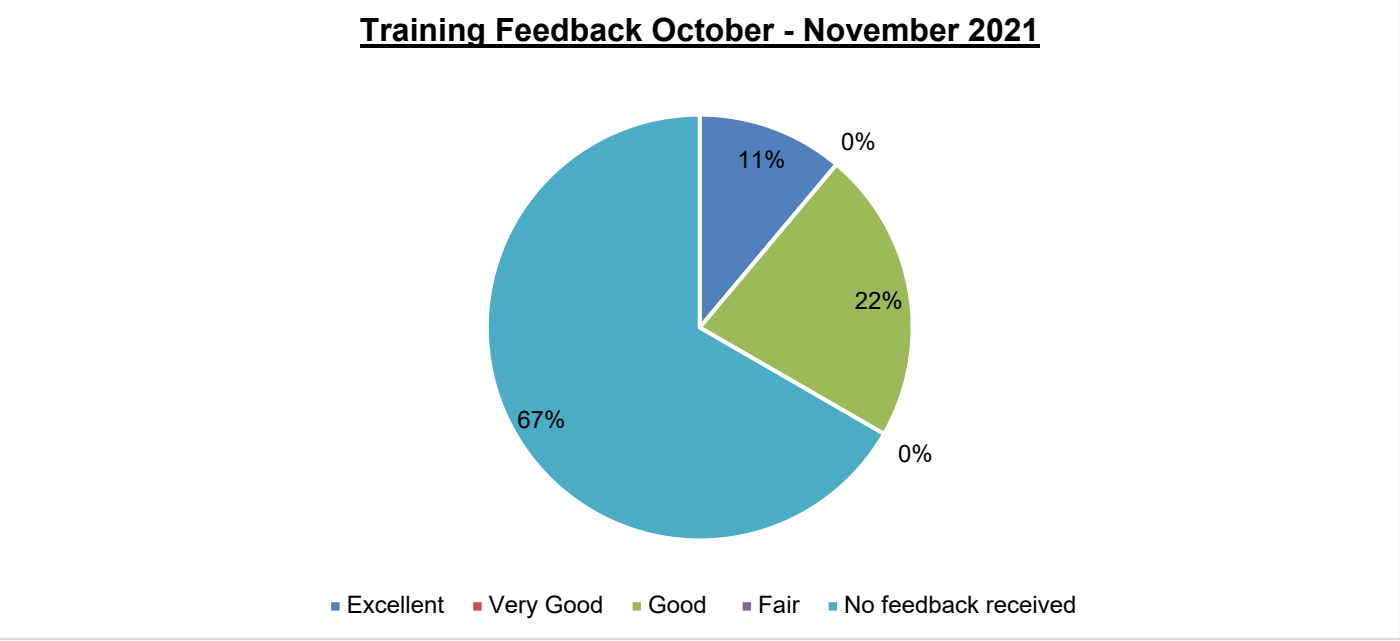
"The only people in training who qualify under our guidelines are our own new members and anyone in a professional role who is learning the process specifically to prepare to give evidence themselves at a future hearing.
You will be aware from the Observer Guidance document with which you have now been provided that the categories of observer are, however, limited and students do not come within the high priority category of those obliged to undertake observations in order to ensure that the Tribunal can continue to operate."

Professionals will request to attend MHRT hearings because at some point in the future they will be required to attend and present evidence based on their clinical knowledge and involvement with their patients but are not currently allowed to observe these practices, which could put them and their patients at a disadvantage in the future.

Development Sessions

The Mental Health Act office continues to run Mental Health Act awareness sessions including a monthly Mental Health Act training day, which is available to all staff within the Health Board, Receipt and Scrutiny and Consent to Treatment workshops. In the new year we will be running Section 17 Leave and a Rights workshop.





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 requires further monitoring to ensure AMHP's are advising the Mental Health Act Office when they have detained a patient. This should mitigate any future risk of detaining someone without authority.

Lapsed Detention
There is a potenial concertn if P isn't converyed to hospital as soon as possible, they could harm themselves or others.

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.

Mental Health Review Tribunal for Wales (MHRT) - Observers
Student doctors and nurses are concerned that they are not allowed to observe MHRT hearings which forms part of their professional training and development. This could impact the fairness of the patients hearing as professionals won't be familiar with the hearing process.

Development sessions
There has been very little attendance at Receipt & Scrutiny workshops during October and November which increases the likelyhood of errors being made when formally accepting detention papers.

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:-

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

Lapsed Detention
Continue to work with South Wales Police to ensure Section 135(1)/135(2) warrants are executed promptly.

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.

Section 136 – CAMHS
Continue to monitor and report accordingly ensuring that at least one of the people involved in the child's formal assessment (i.e. one of the two registered medical practitioners or the approved mental health professional) is an experienced specialist CAMHS practitioner wherever possible.

Mental Health Review Tribunal
Continue to work with the MHRT 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. This should be resolved in the new year with the MHRT potentially offering Teams hearings as standard to all patients.

Mental Health Review Tribunal for Wales (MHRT) - Observers
Continue to work with the MHRT for Wales to find a suitable resolution and to protect the patients' right to a fair hearing.

Development sessions
Continue to develop a robust training rota to ensure that development sessions in relation to all areas of the Mental Health Act are available and easily accessible. This will be provided by creating a Mental Health Act e-learning module. Refresher Receipt & Scrutiny training should be completed yearly and new shift coordinators should attend the relevant training before undertaking that role.

ASSURANCE is provided by:

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

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

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

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

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

Report to the

Mental Health and Capacity Legislation Committee

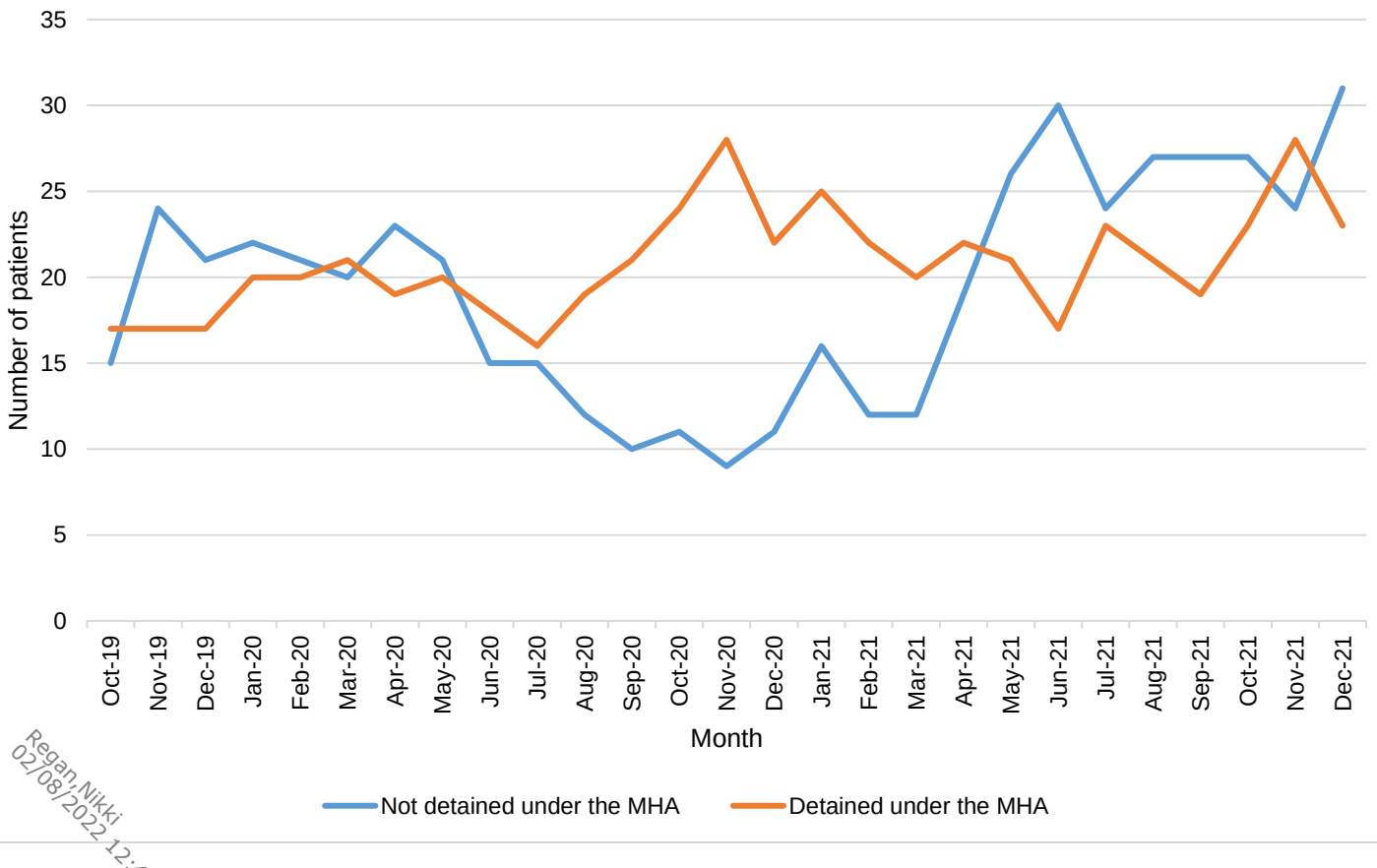
on the use of The Mental Health Act, 1983

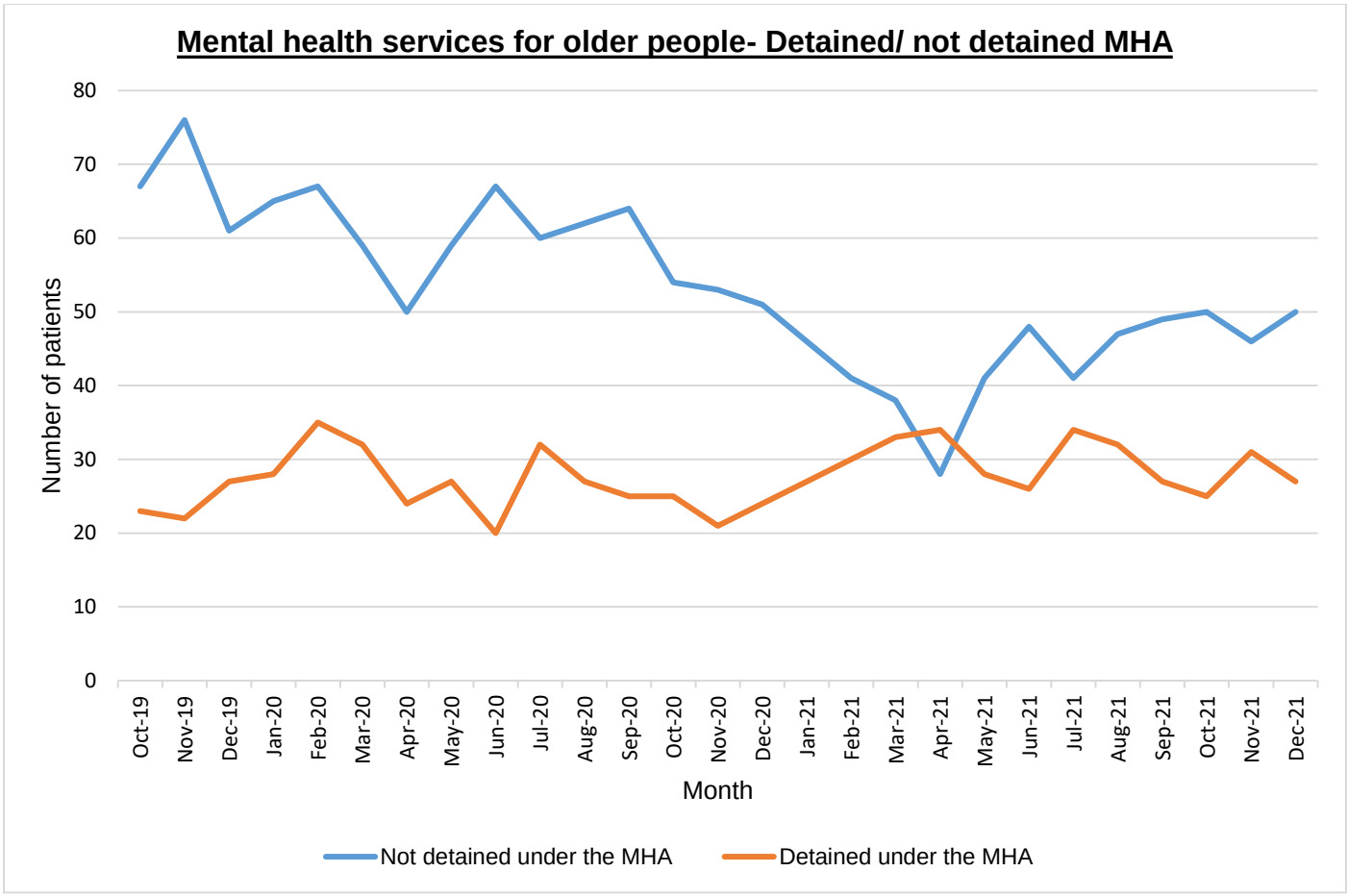
October- December 2021

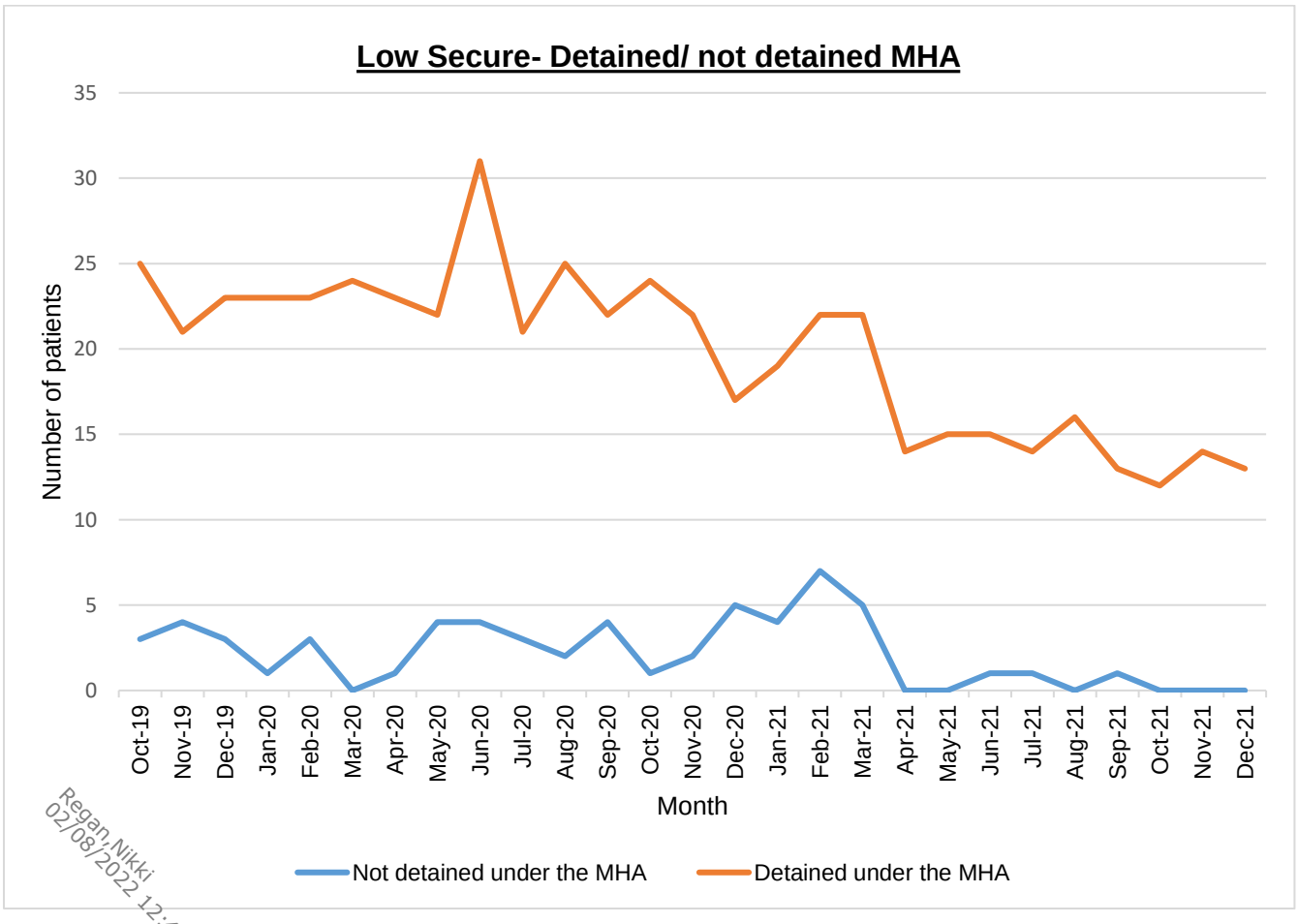
Contents **Page**

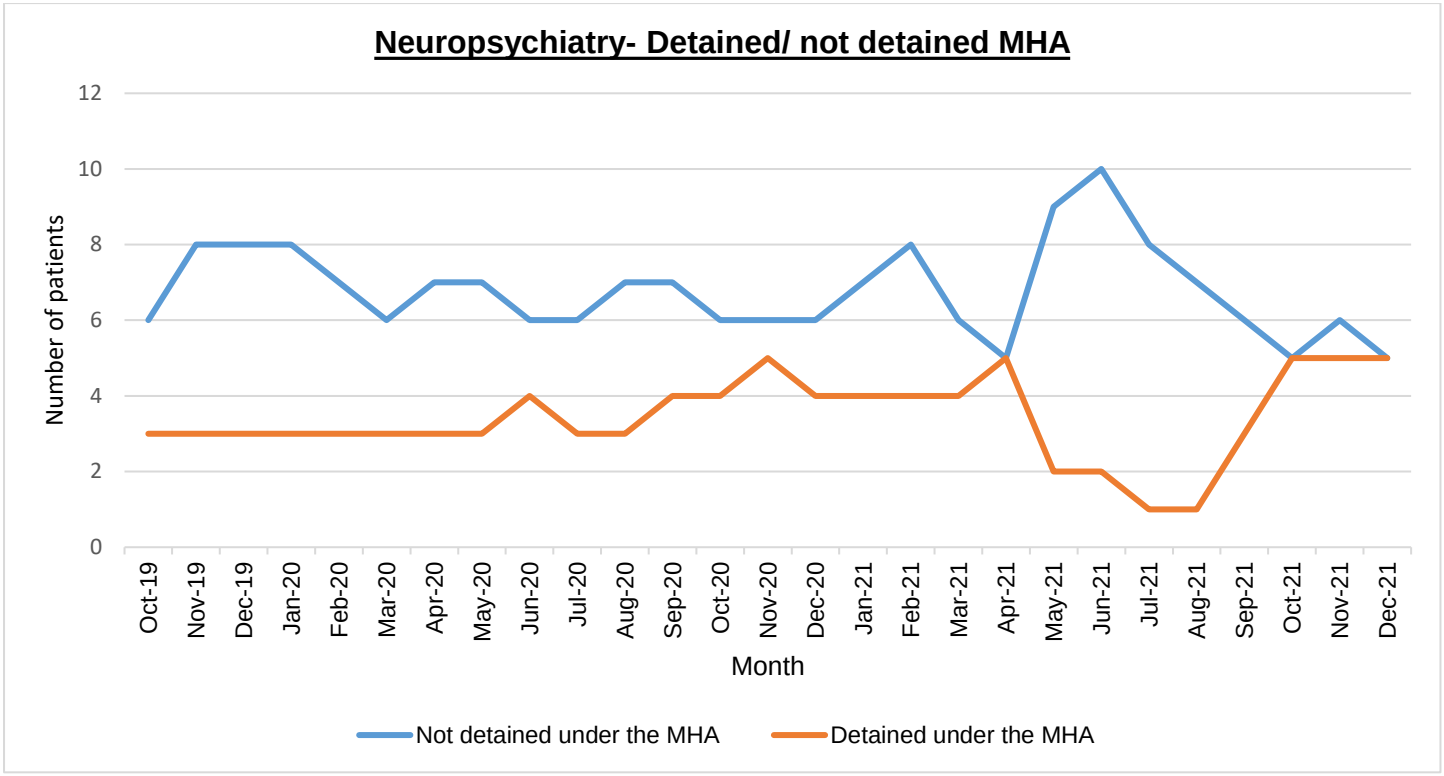
Adult Acute-Detained/Not detained MHA

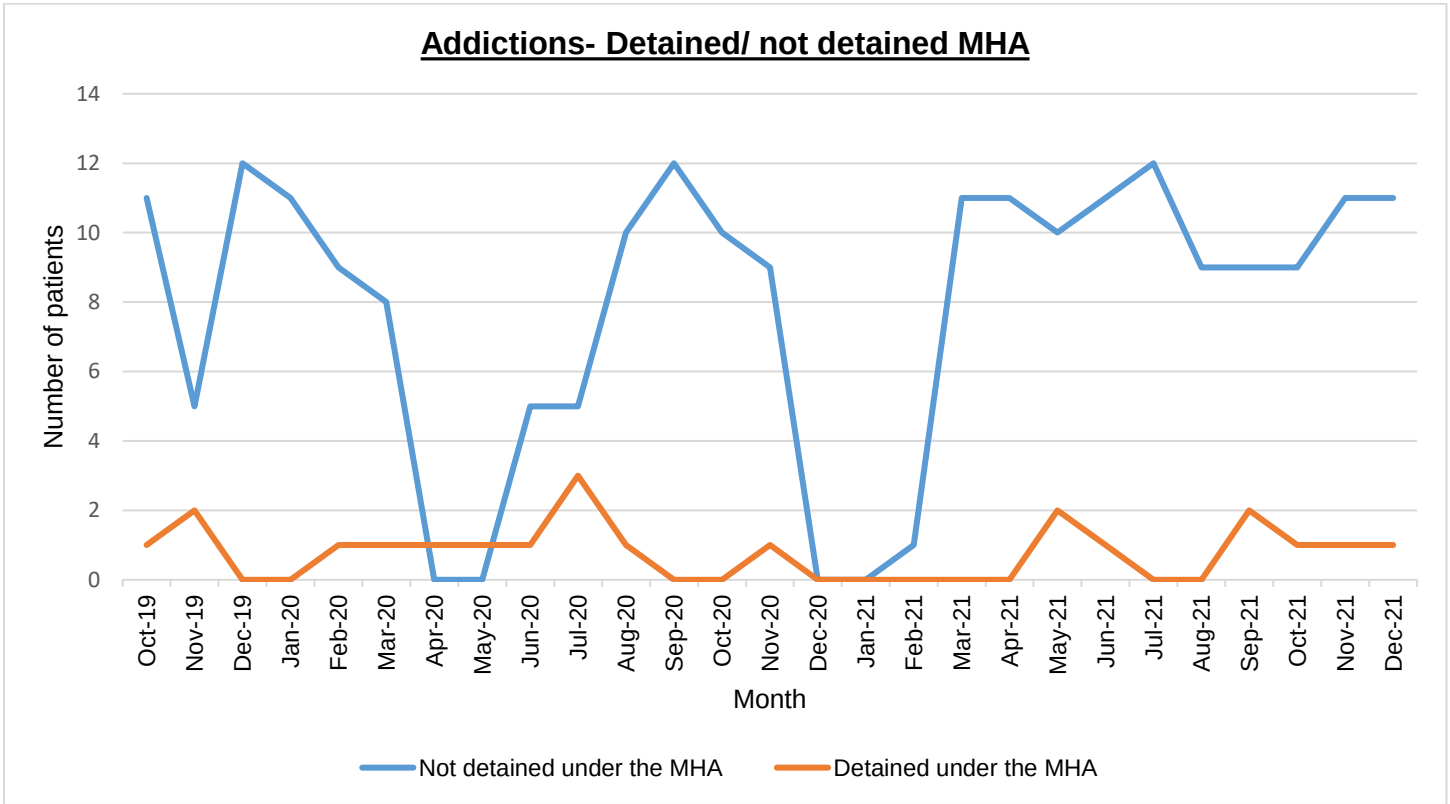
Rehabilitation Detained/ Not detained MHA







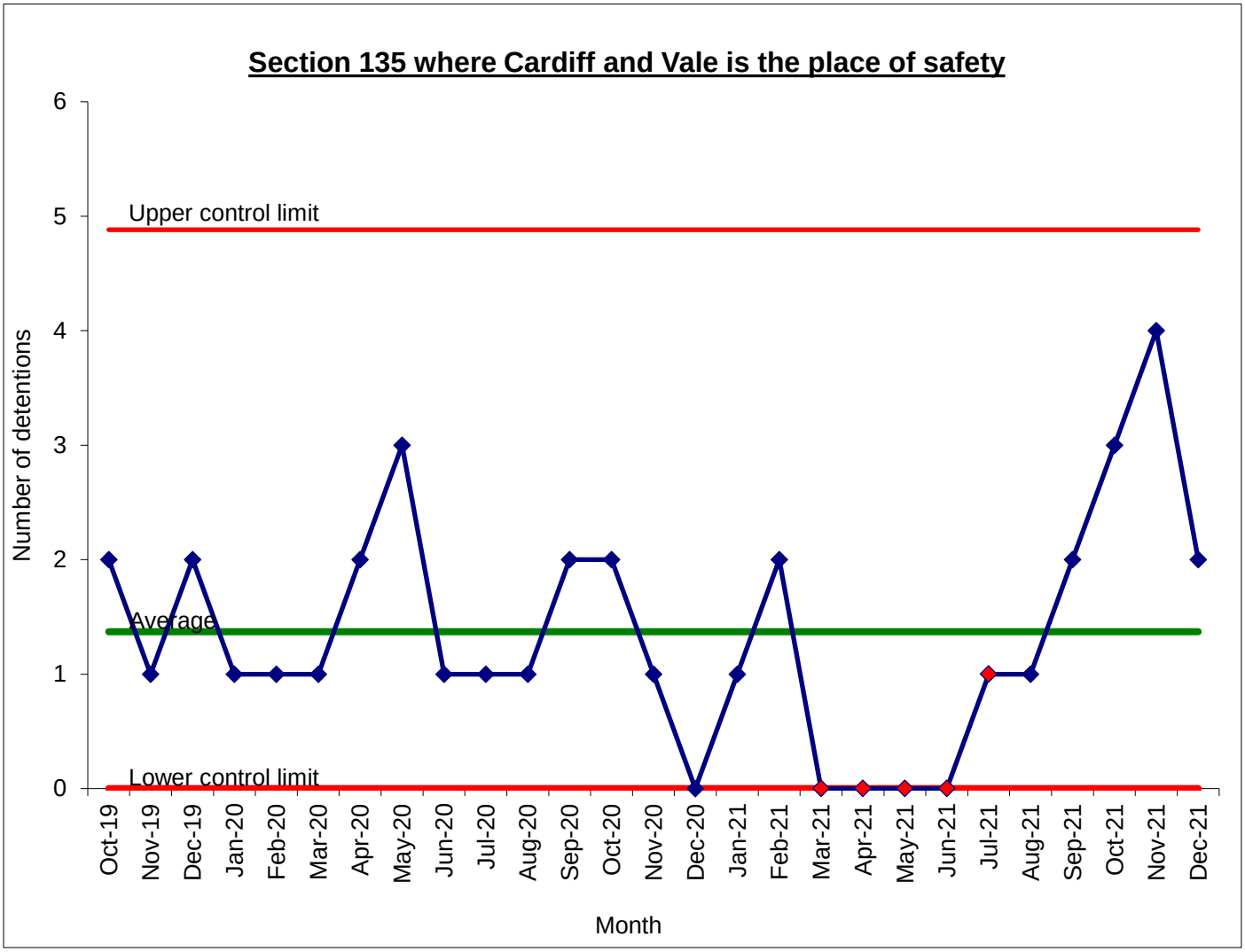




Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety

During the period Section 135 (1) powers were used nine times. All the patients were placed on Section 2.

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



Voluntary Assessment

During Summer 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;-

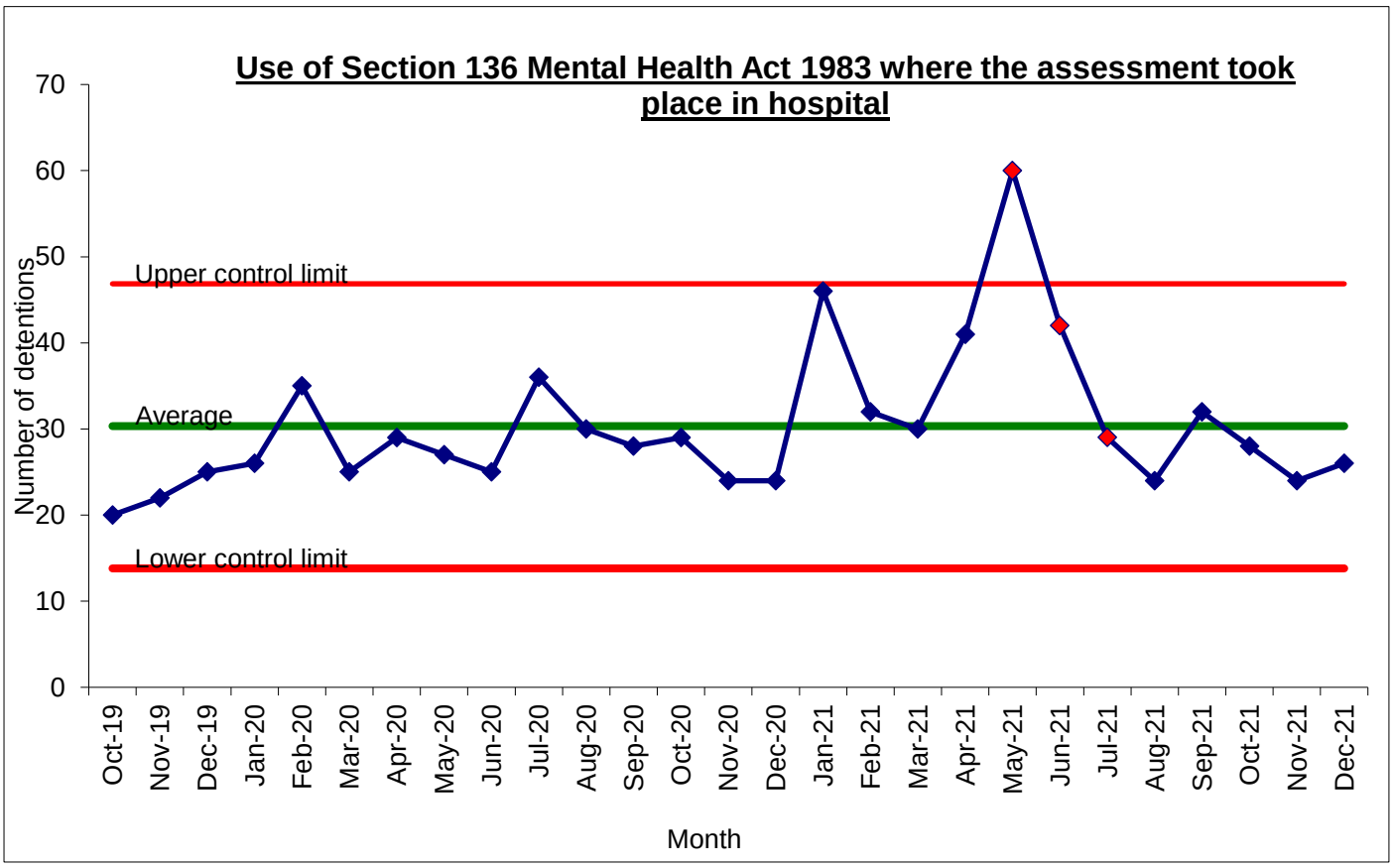
- Use of s135
- Use of s136
- Voluntary Assessment
- Mental Capacity Act

We continue to work with South Wales police to ensure the AWMF is completed each time a person is brought to hospital for an assessment and hope to see an improvement in the use of the electronic form going forward.

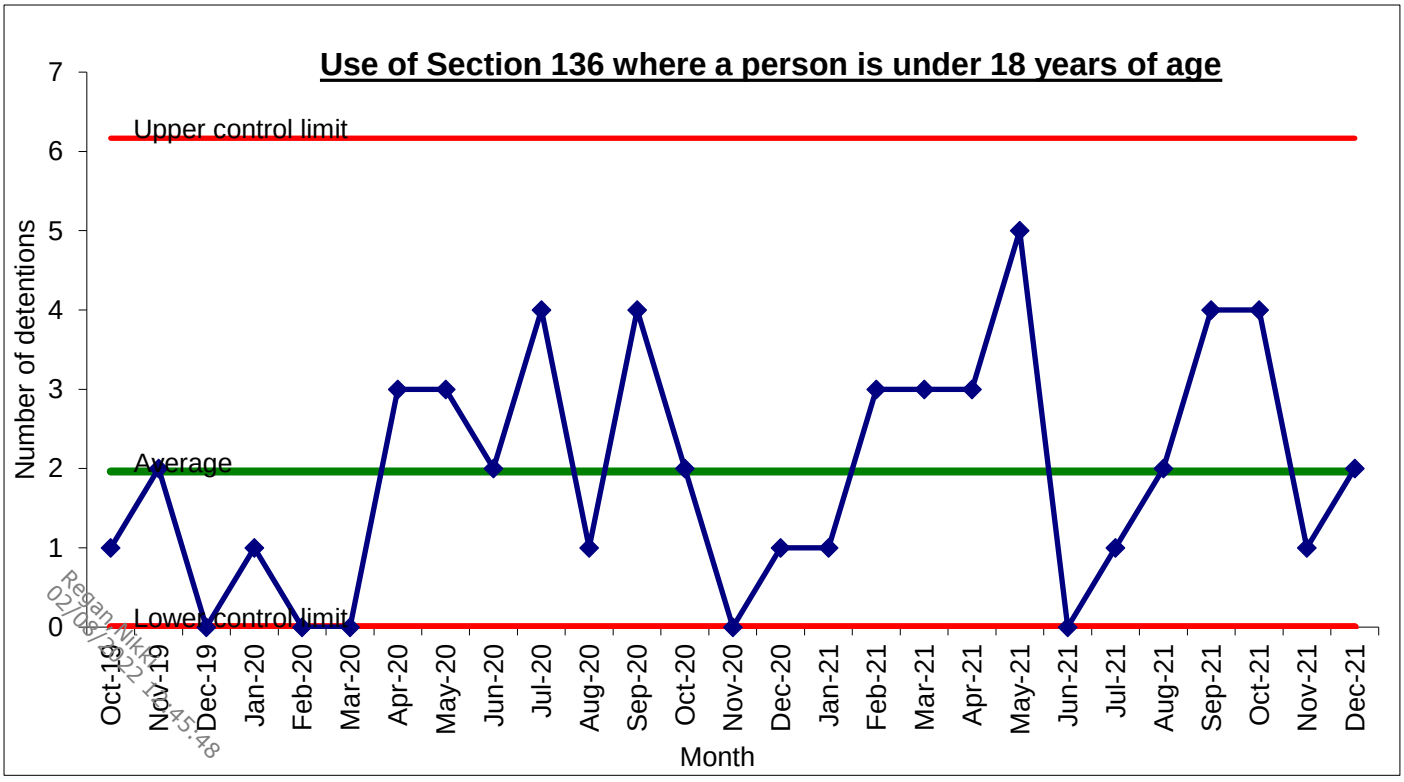
For this period we have seen eleven people for a Voluntary Assessment and one was brought into hospital under the Mental Capacity Act.

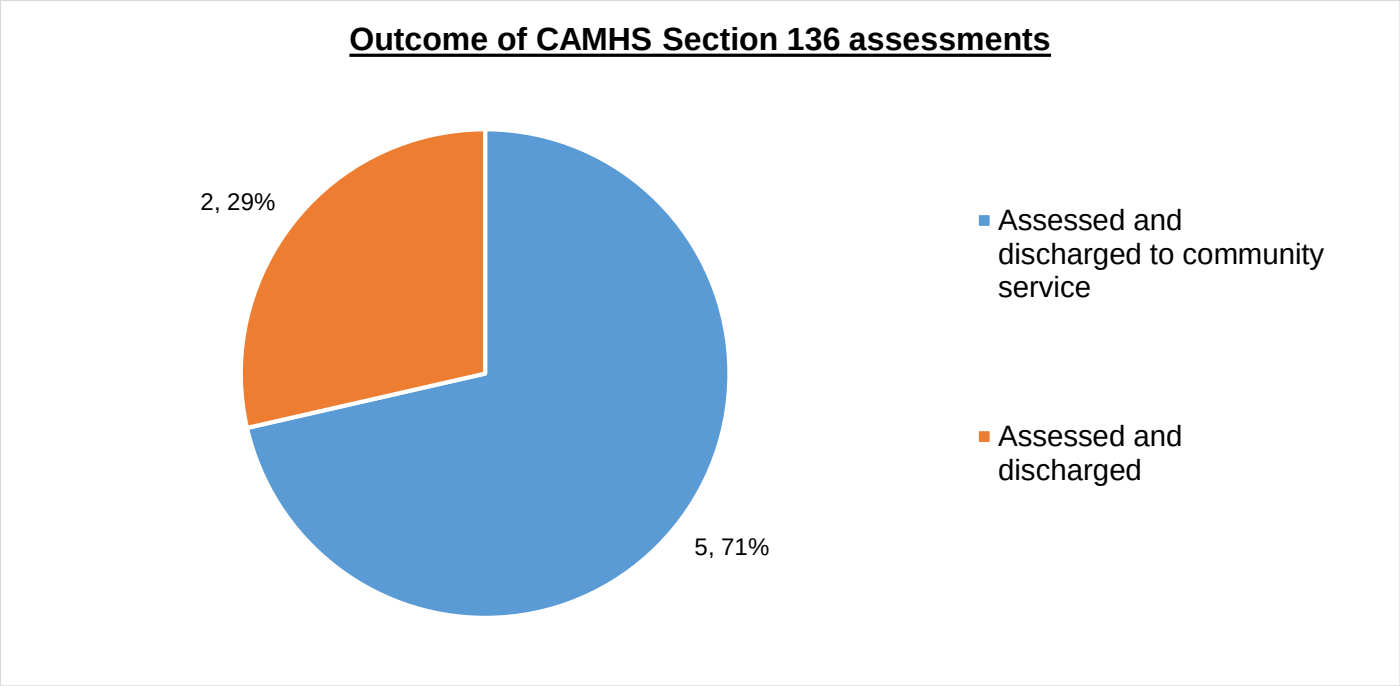
Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB

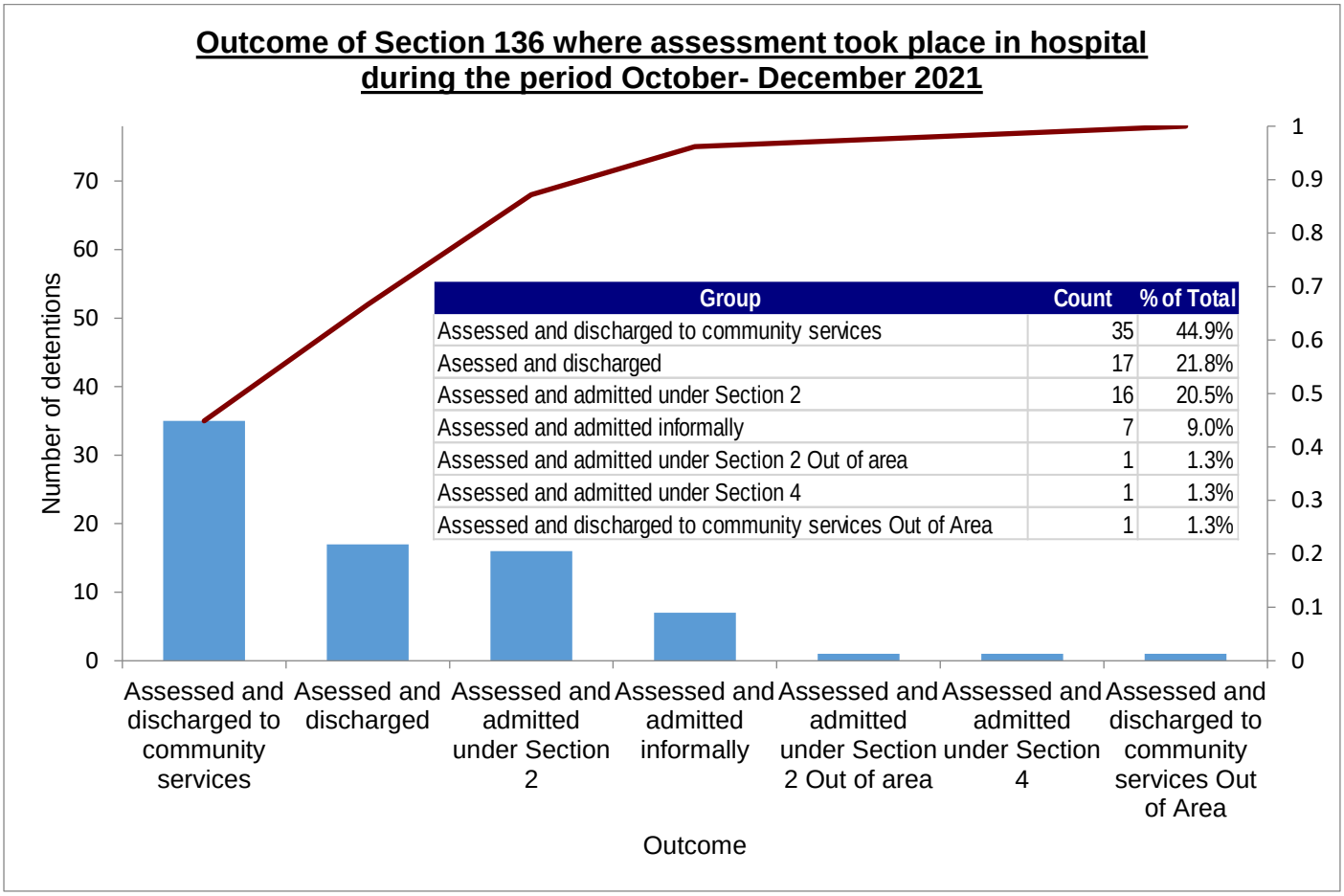
During the period a total of 78 assessments were initiated by Section 136 where the MHA assessment took place in a hospital as the place of safety.



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;-



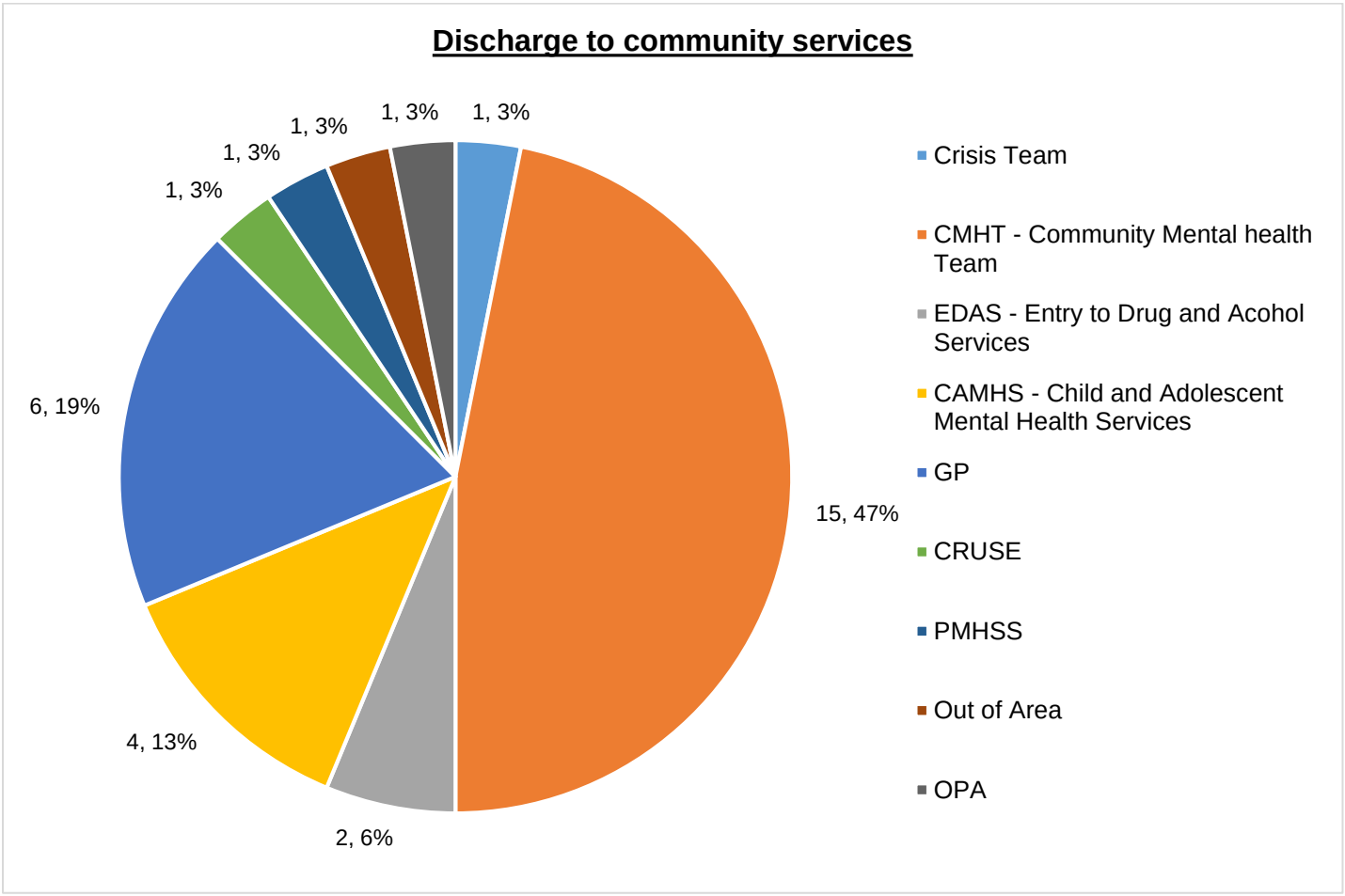




The pareto chart highlights that 68% of individuals assessed in hospital under Section 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self-referral.

Included in the above data are the outcomes for those under 18 years of age.

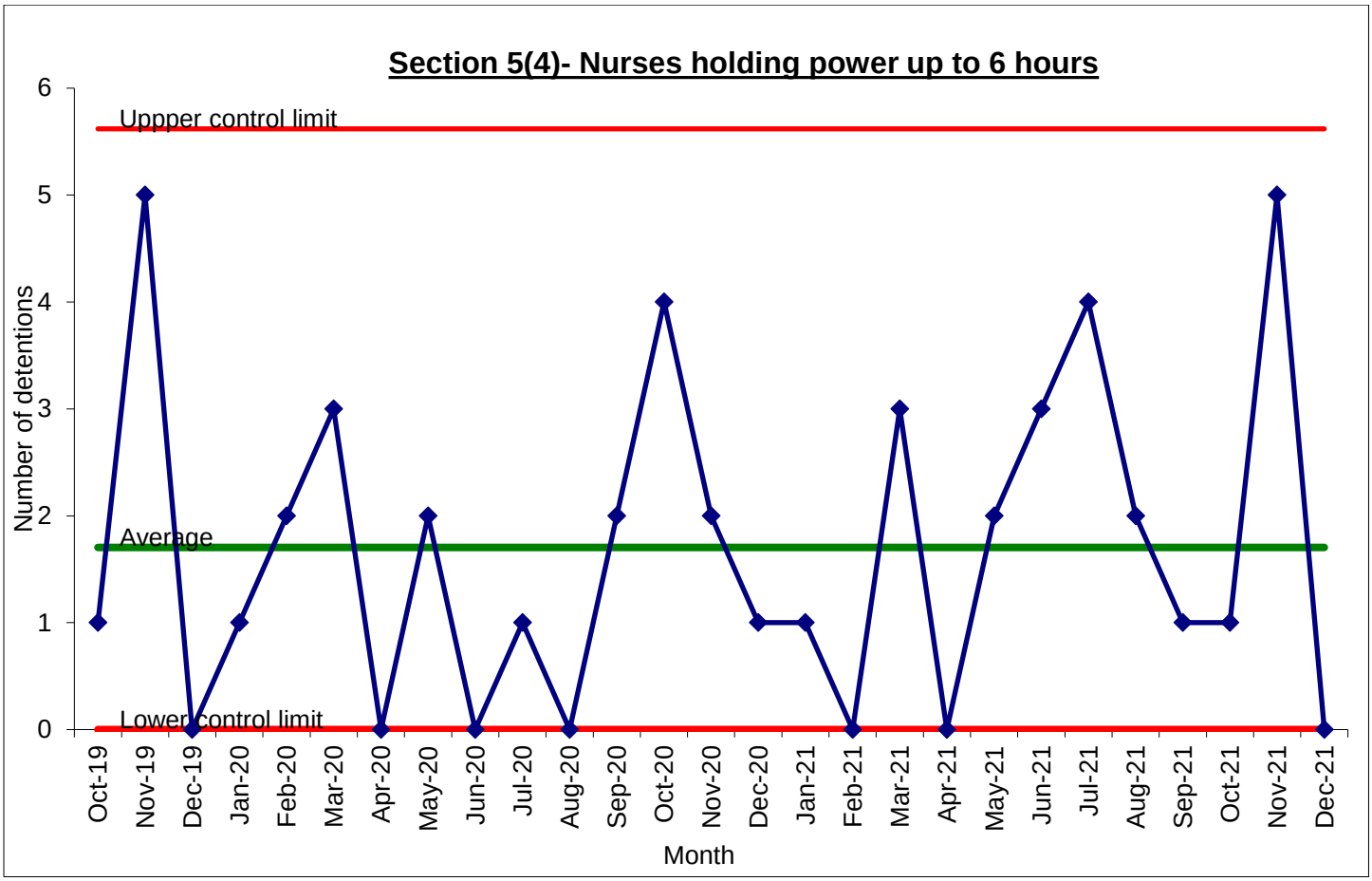
The below chart is a breakdown of the referrals to Community Services as a result of a s136 assessment. Please note that patients can be referred to multiple Community Services, so it is possible that the numbers below are higher than the total number of s136 used.

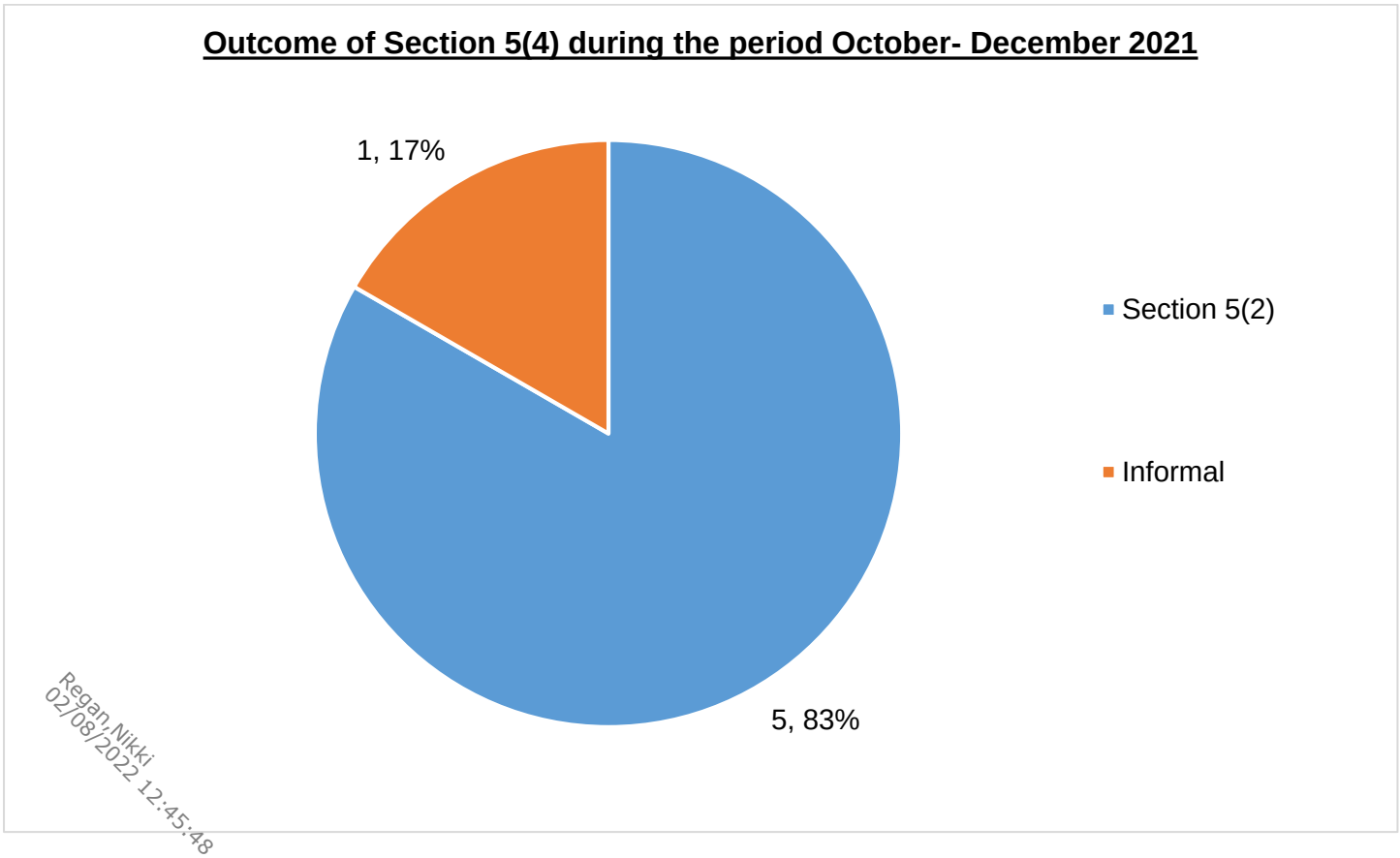


Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within a Police Station

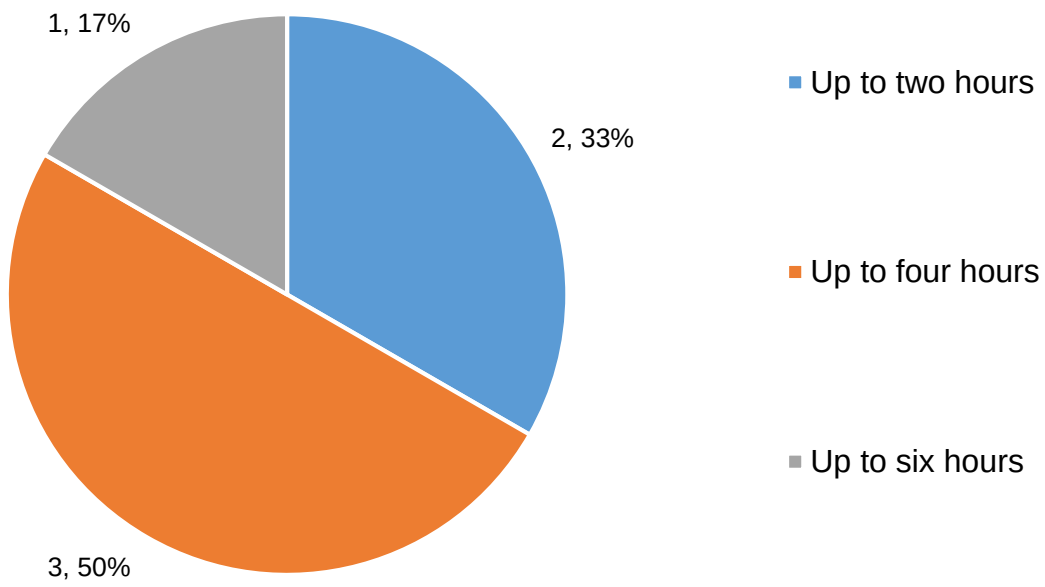
During the period there were no assessments initiated by Section 136 powers where the MHA Assessment took place in Cardiff Bay Custody Suite.

Section 5(4) - Nurses Holding Power

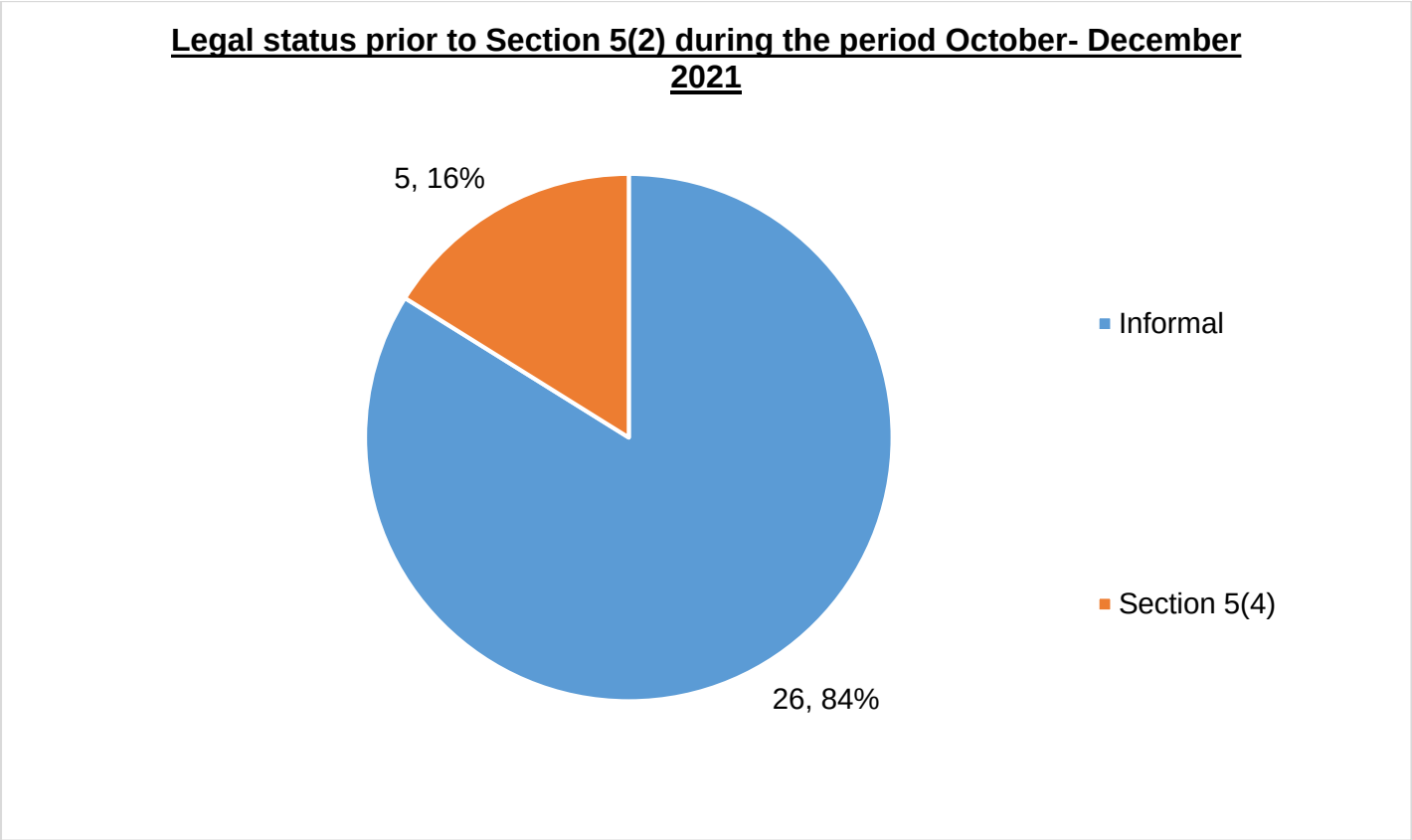


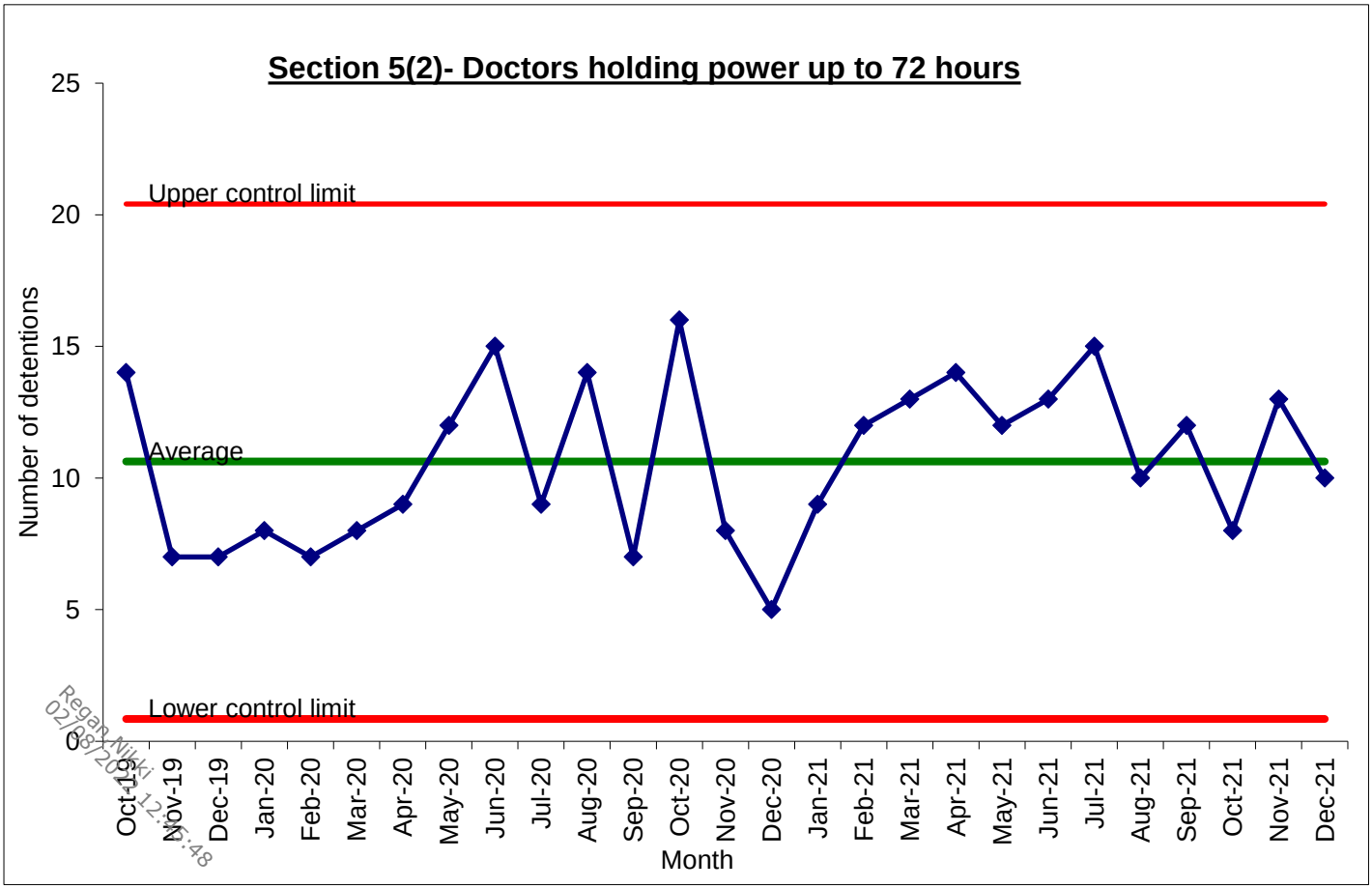


Number of hours patients were detained under Section 5(4) during the period October- December 2021

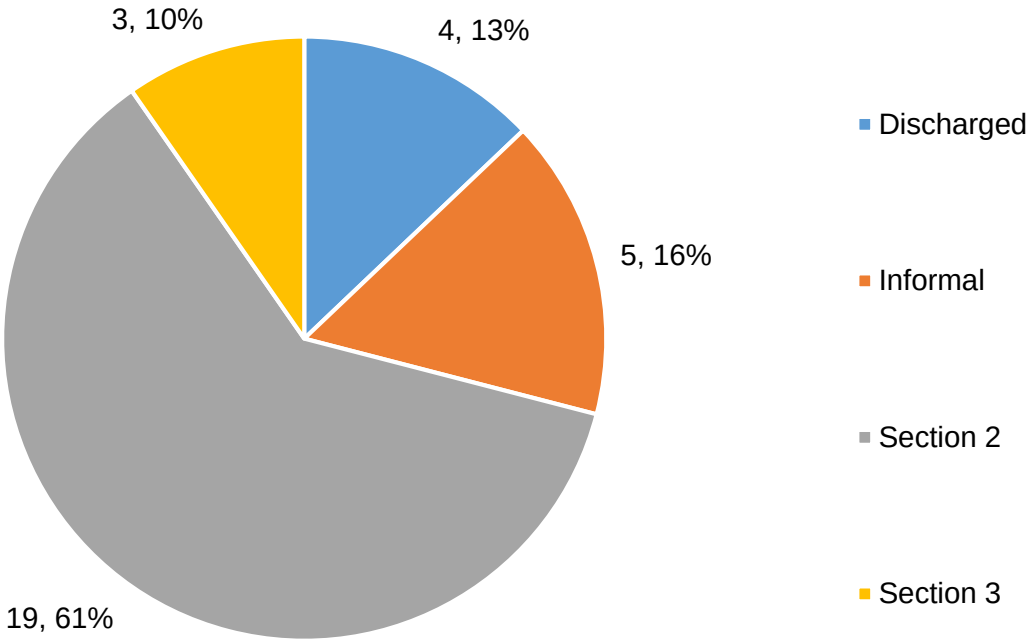


Section 5(2) - Doctors holding power

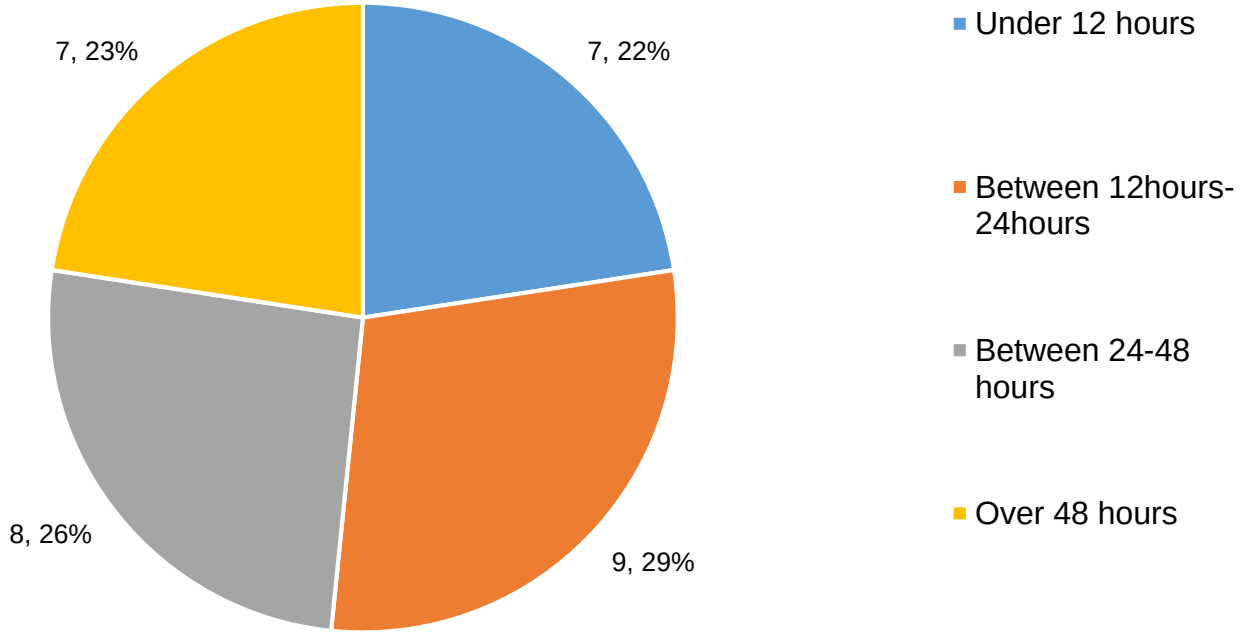




Outcome of Section 5(2) during the period October- December 2021



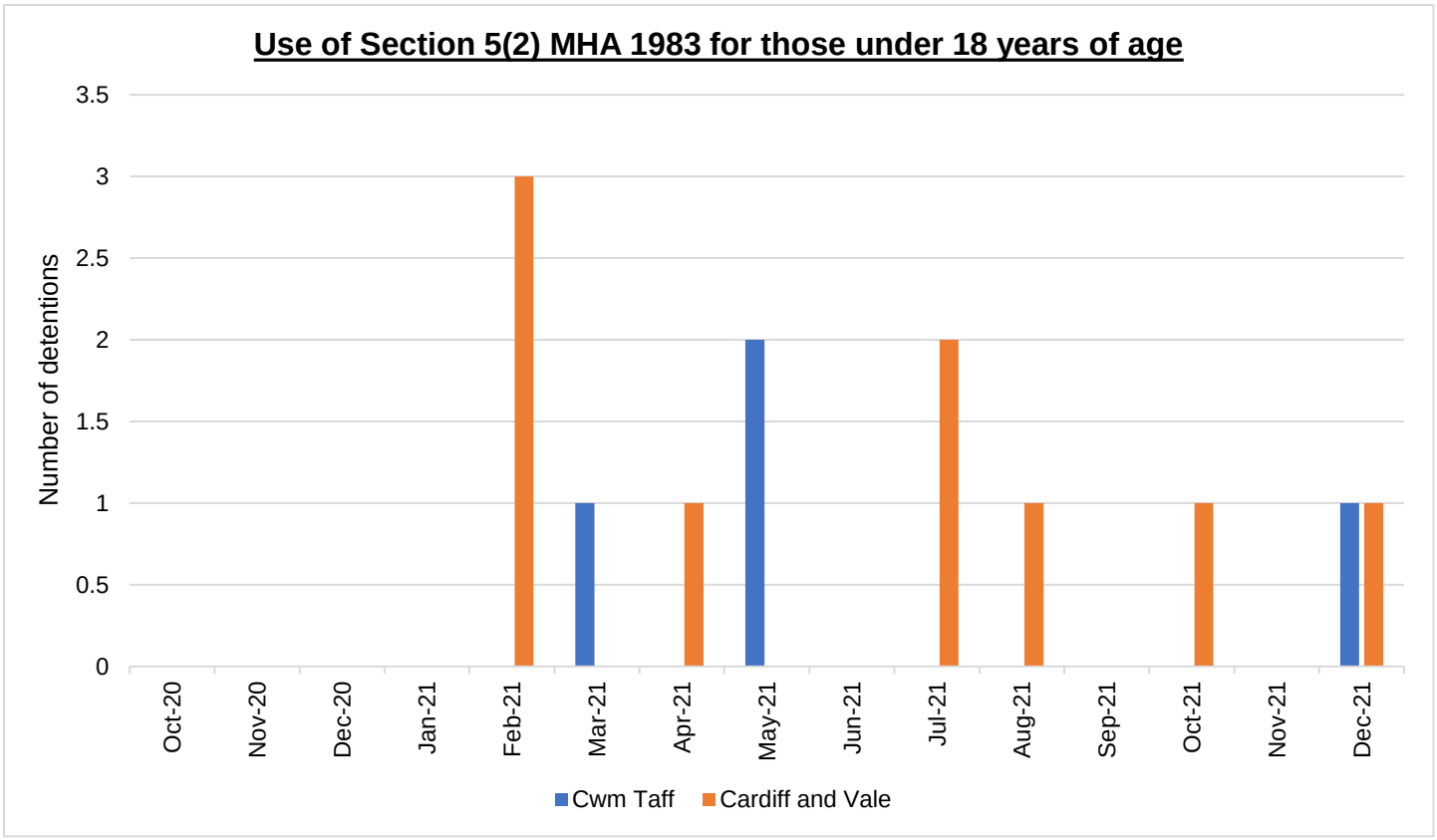
Number of hours patients were detained under Section 5(2) during the period October- December 2021

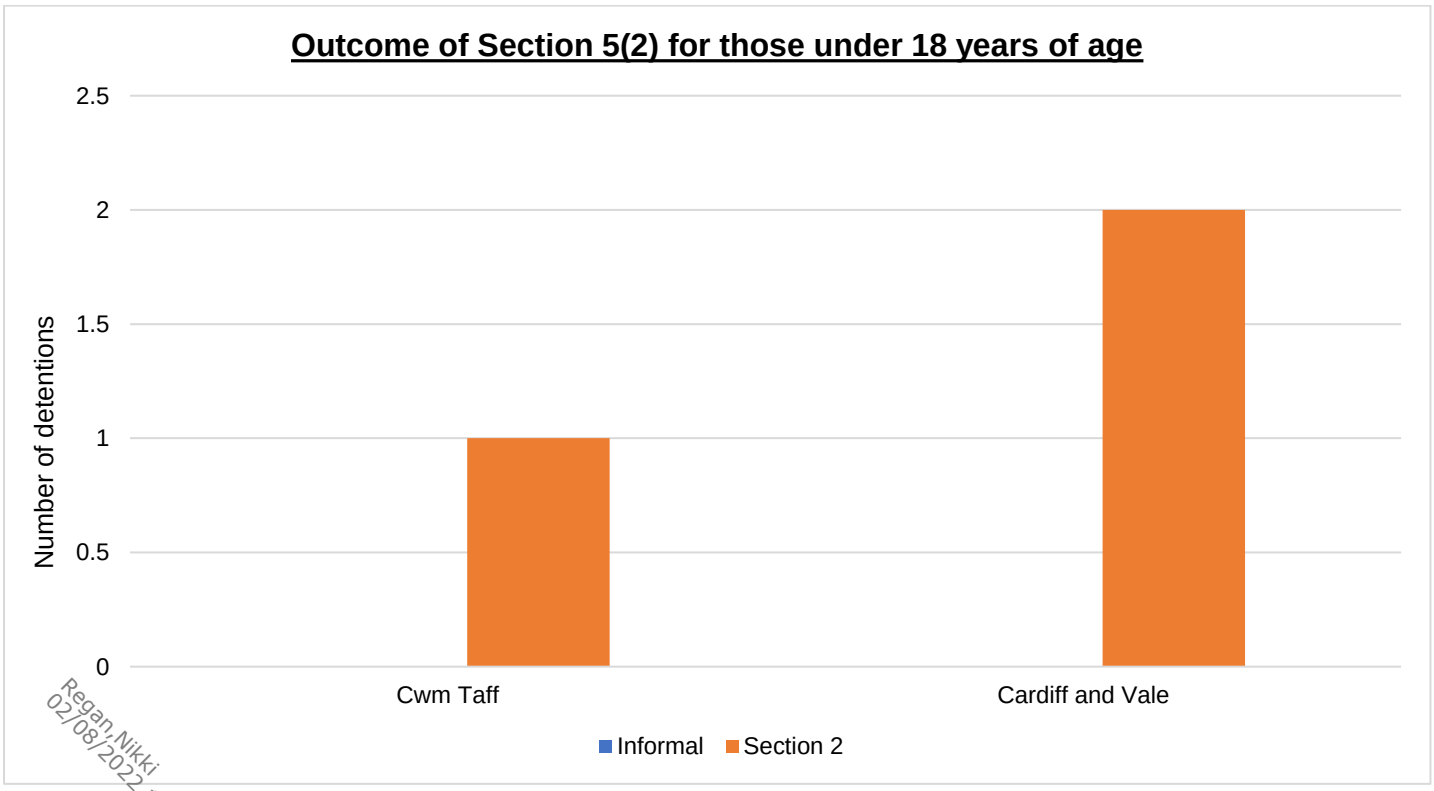


CAMHS Commissioned Inpatient Data

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

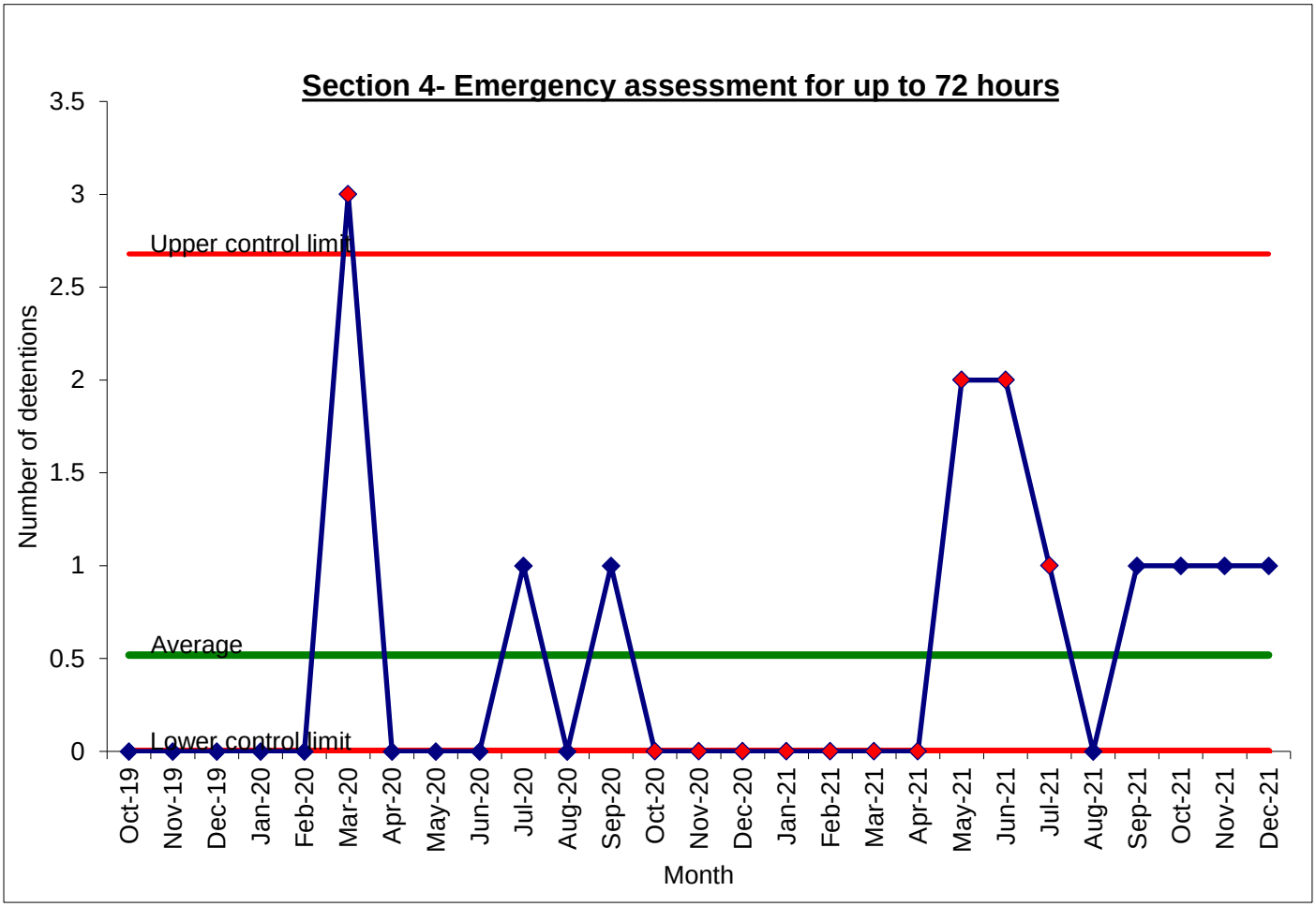
Included in the above data are those under 18 years of age. This is extracted below;-





Section 4 - Admission for Assessment in Cases of Emergency

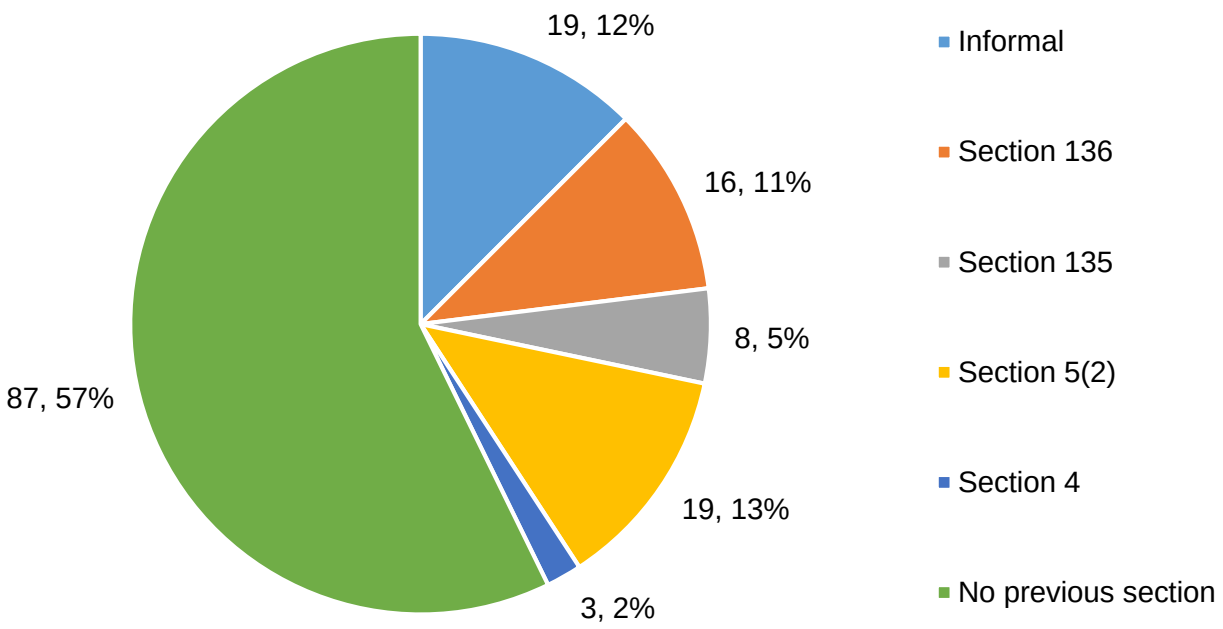
Section 4 was used on three occasions during the period due to an immediate and significant risk of mental or physical harm to the patient or others. All three patients were detained under Section 2.



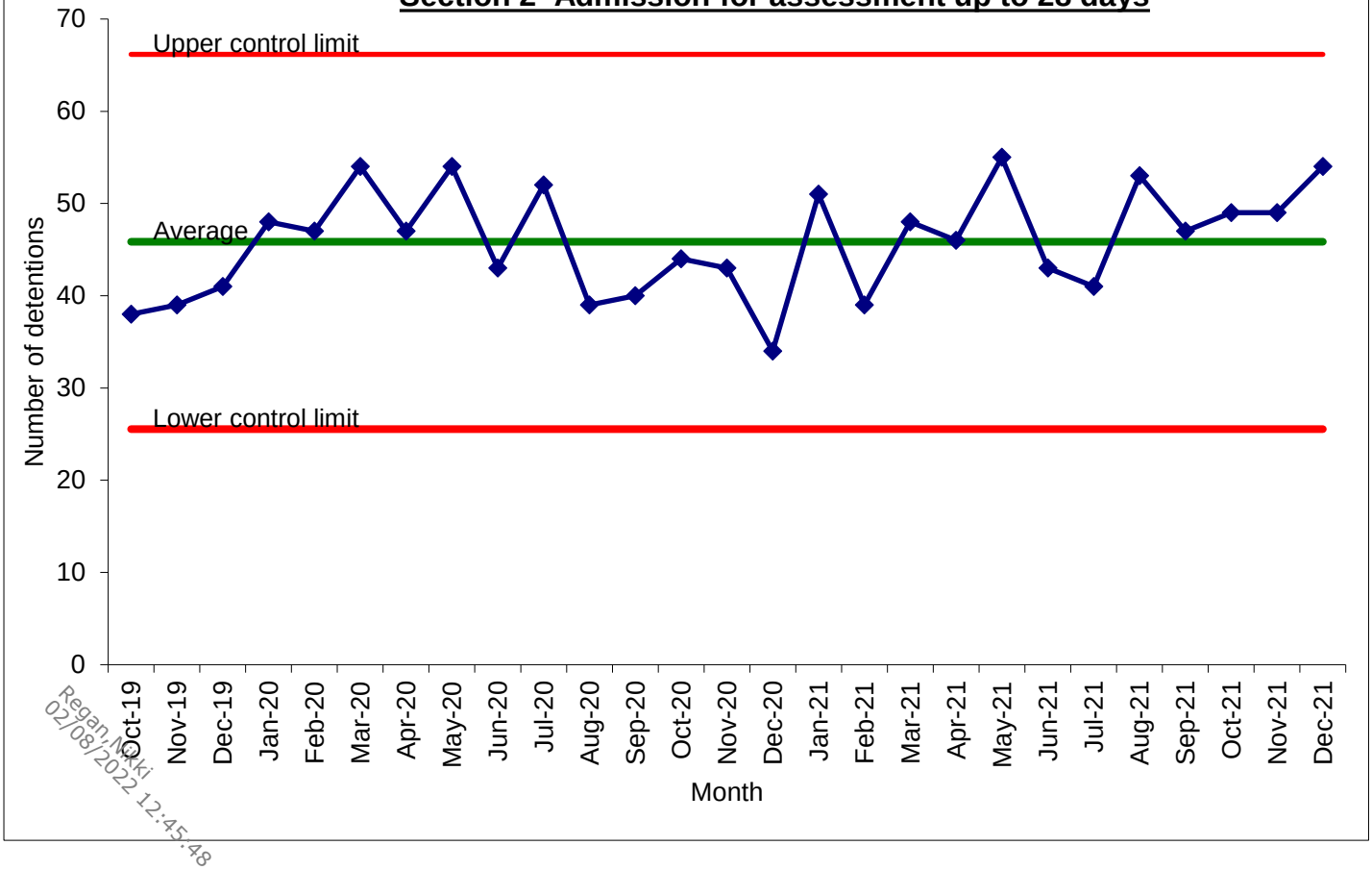
Section 4 was used on one further occasion during the period but the detention lapsed due to the patient not being admitted to hospital within 24 hours of assessment.

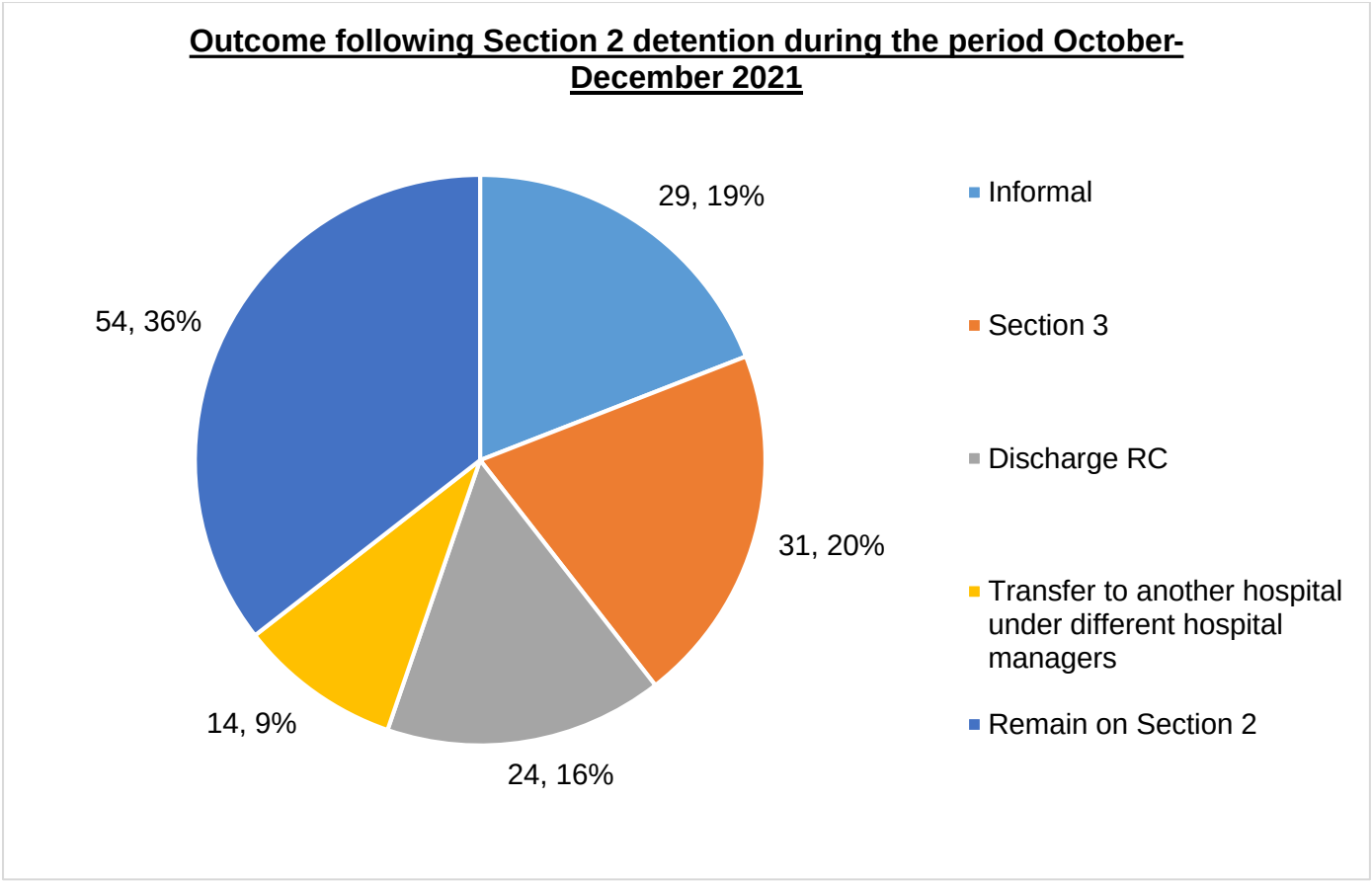
Section 2 – Admission for Assessment

Legal status prior to Section 2 during the period October- December 2021



Section 2- Admission for assessment up to 28 days

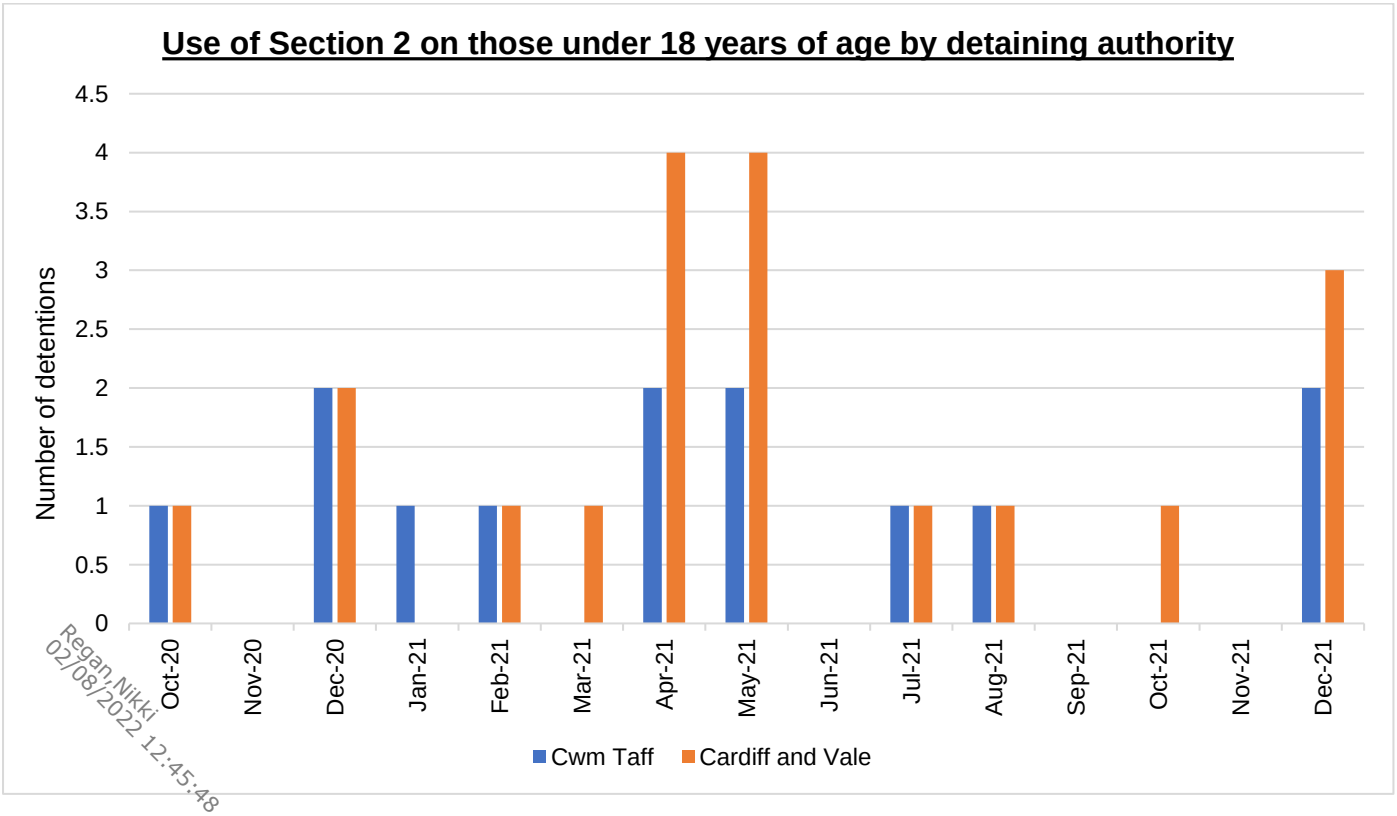


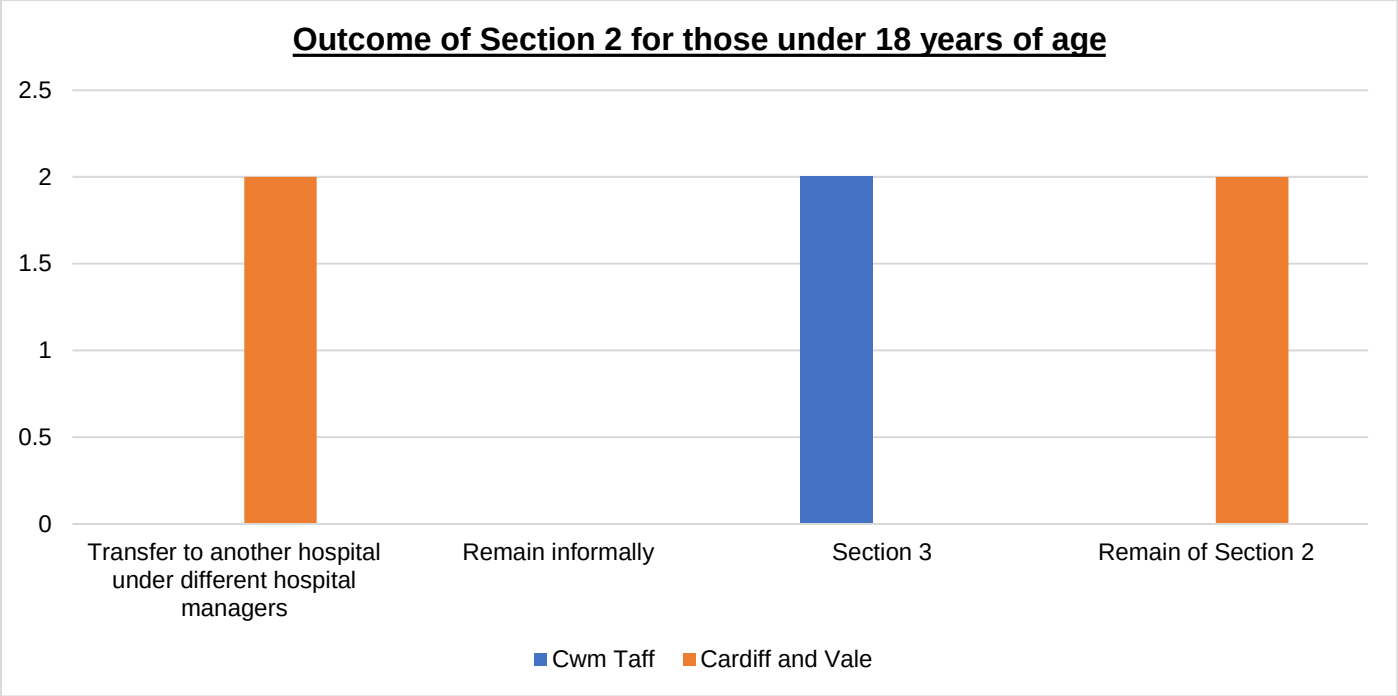


CAMHS Commissioned Inpatient Data

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

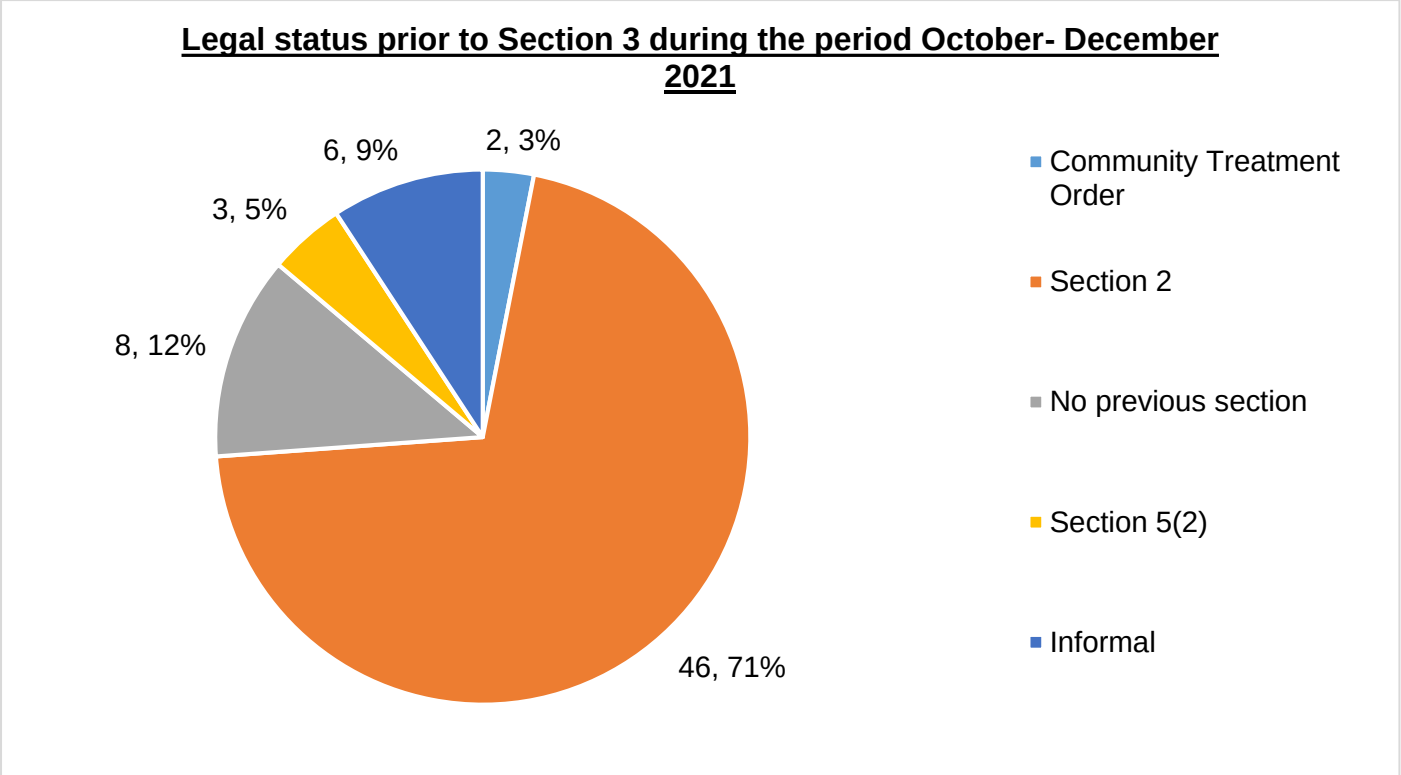
Included in the above data are those under 18 years of age. This is extracted below;-

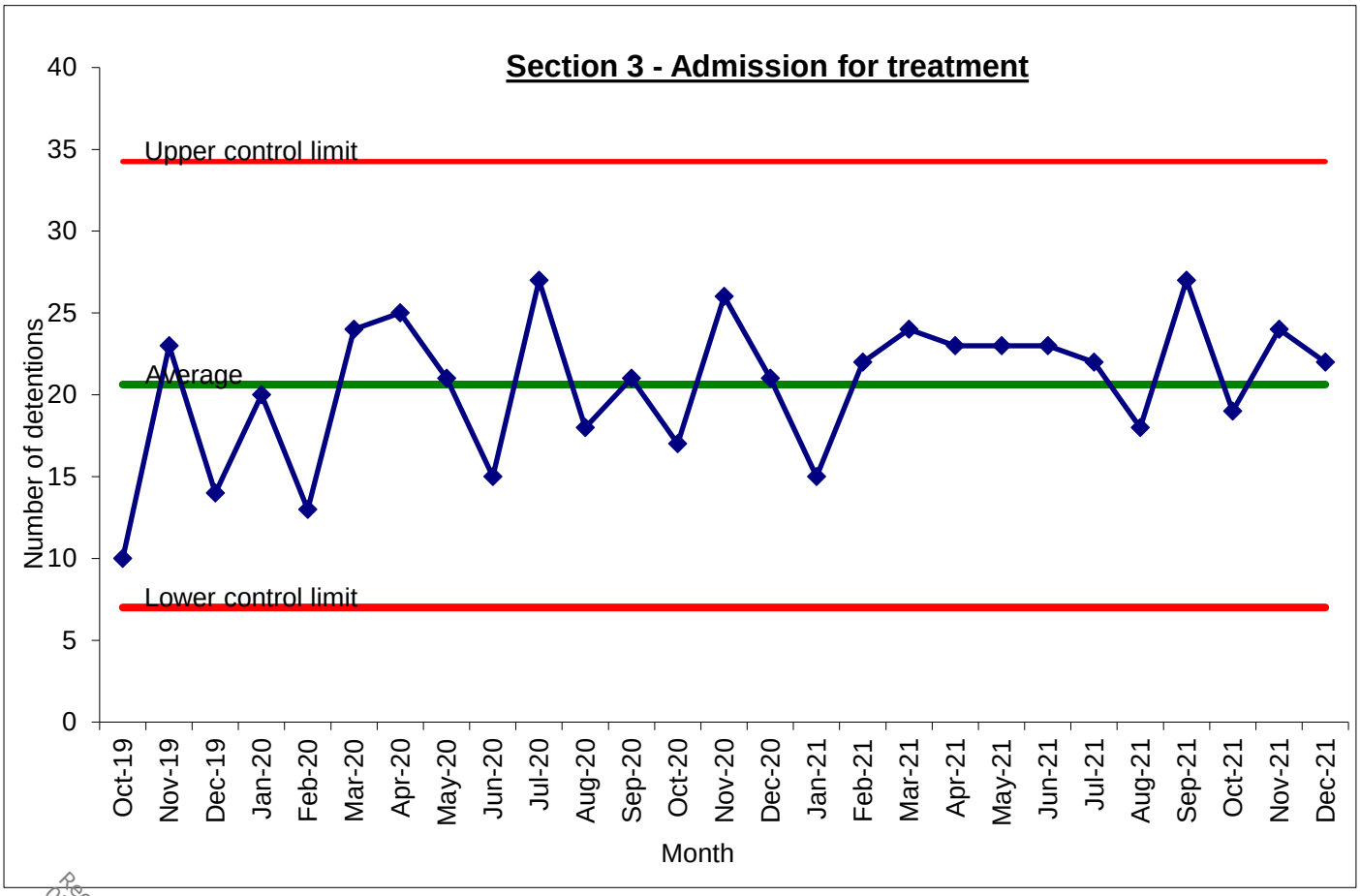


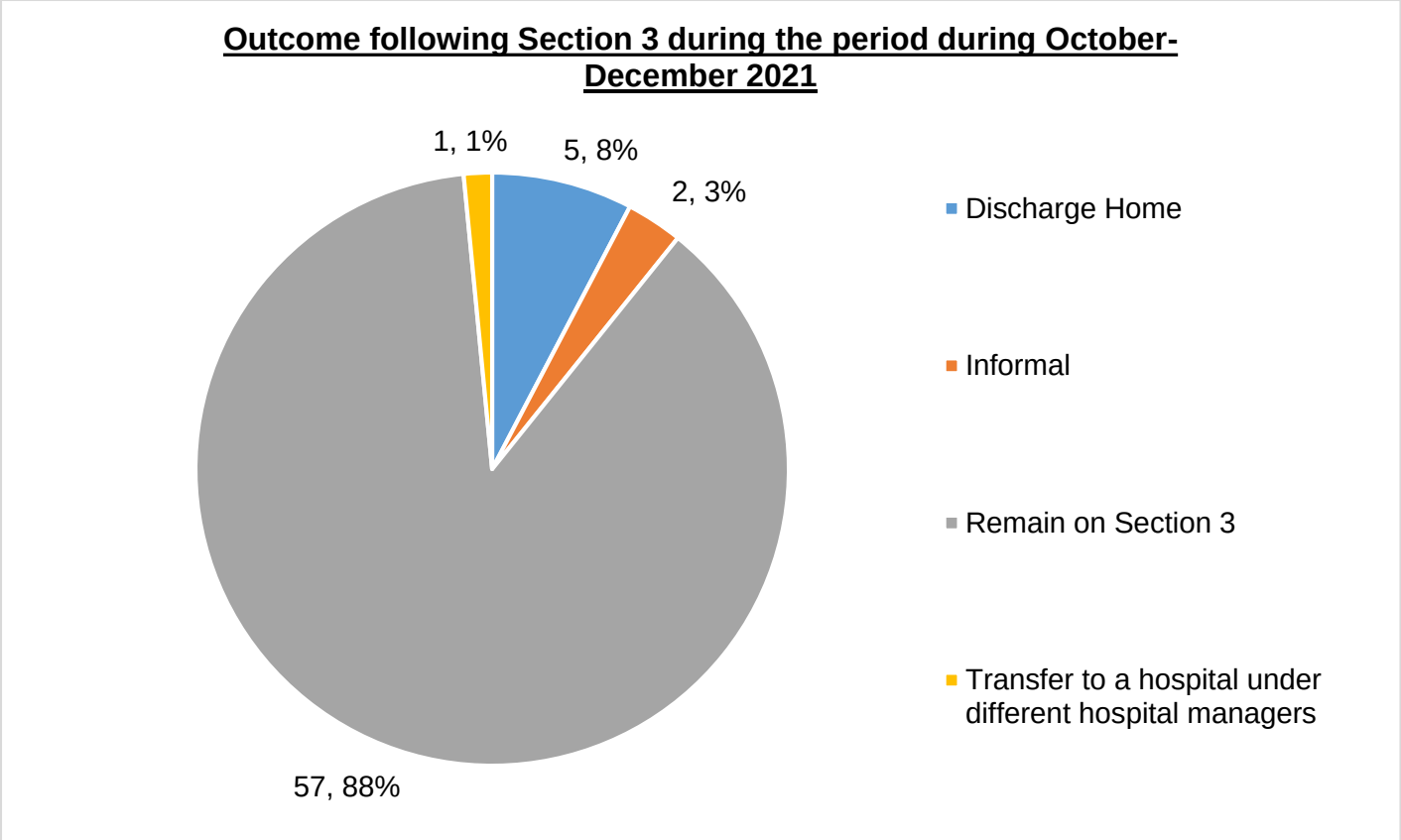


Two of the detentions listed are in relation to the same patient as they appear on both Health Boards figures.

Section 3 – Admission for Treatment

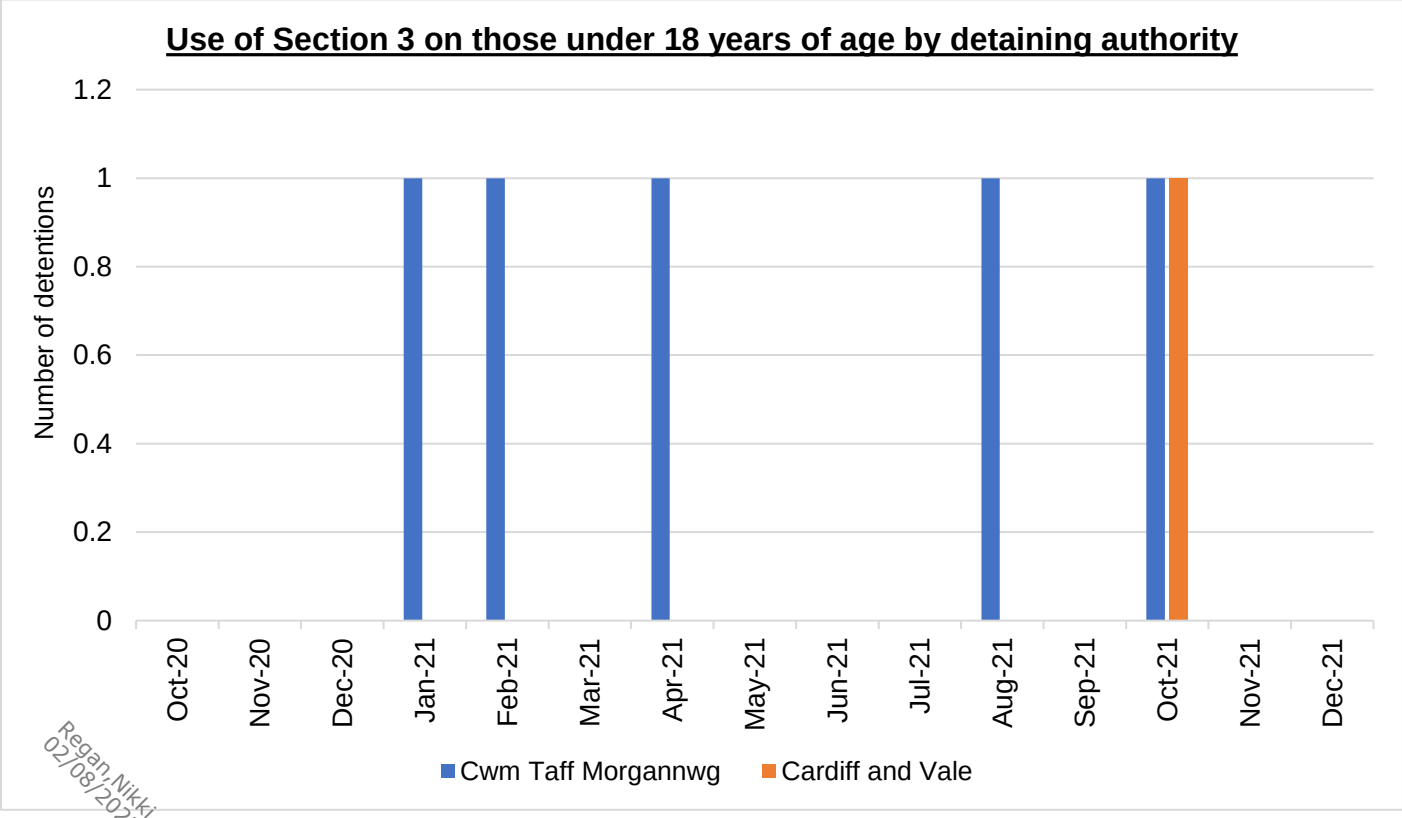




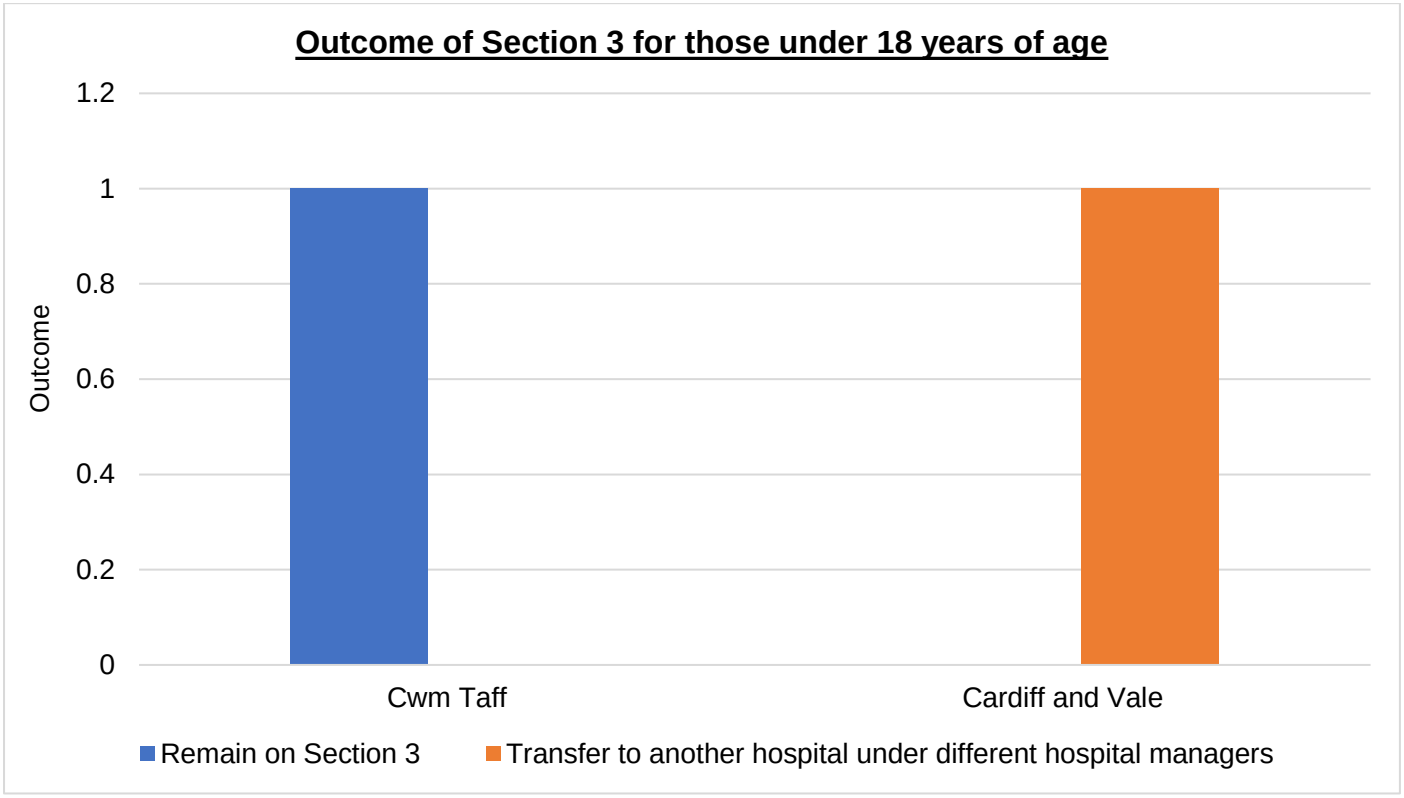


CAMHS Commissioned Inpatient Data

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



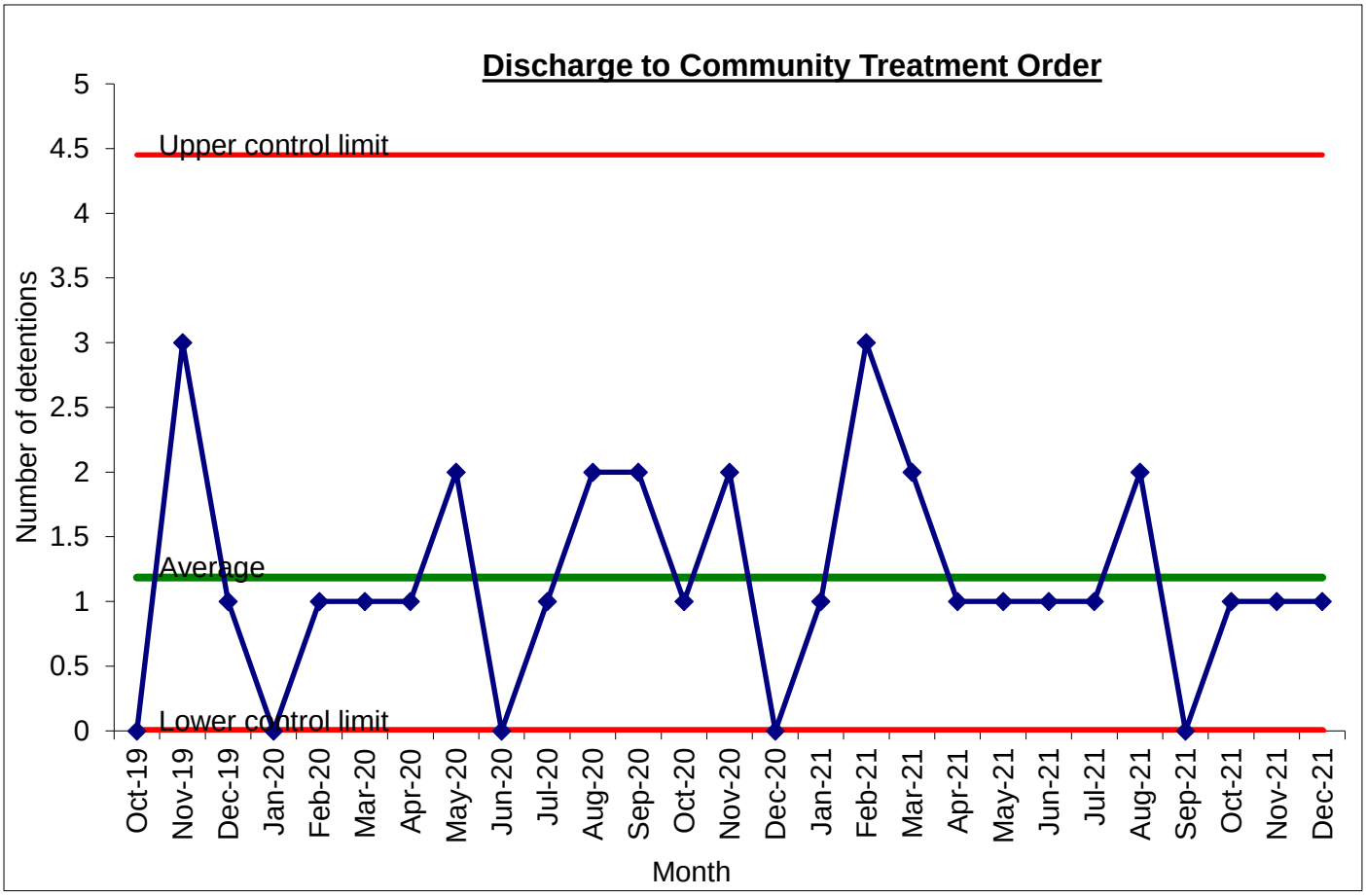
The above data would include those under 18 years of age. Both detentions are in relation to the same patient due to being transferred to a hospital under a different set of hospital managers.

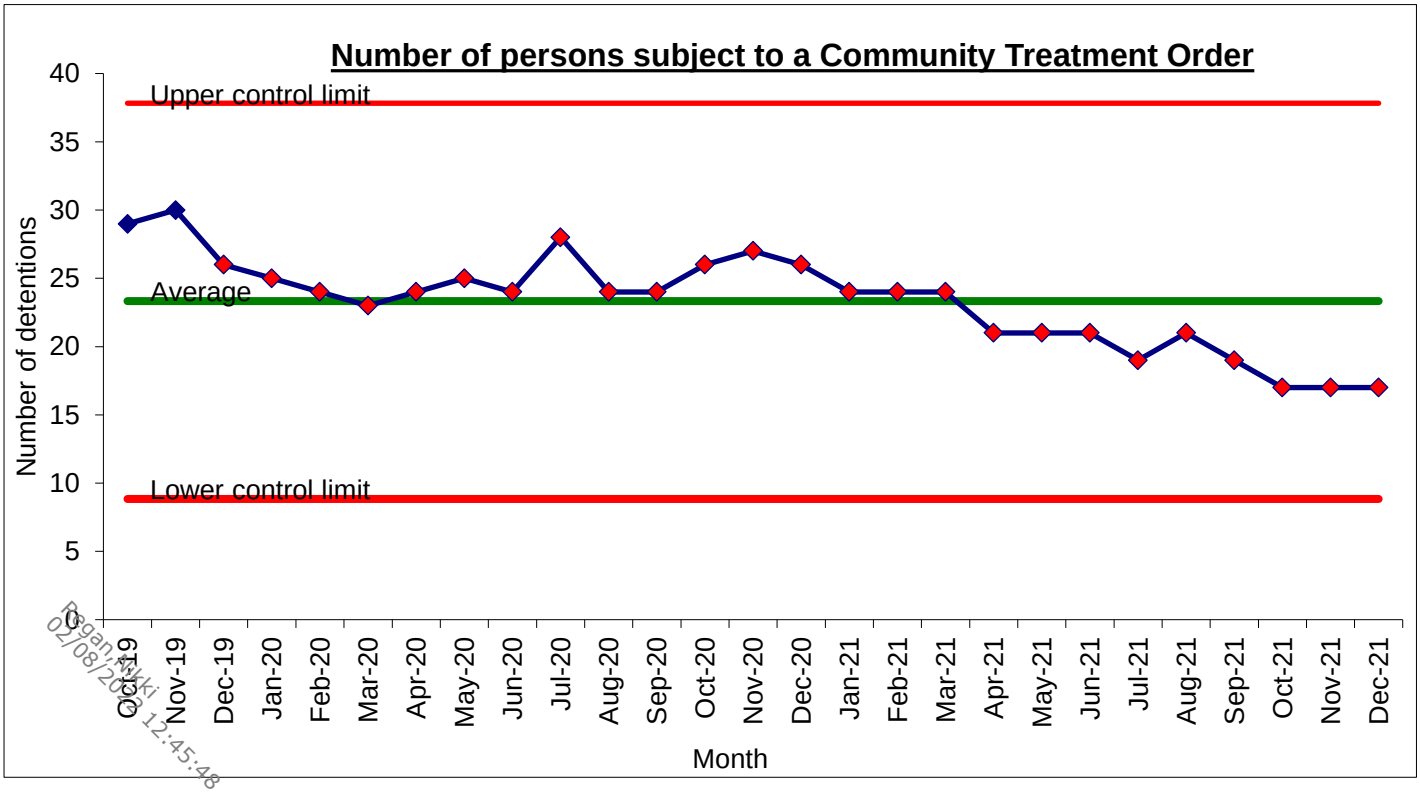


Community Treatment Order

During the period October- December 2021 three patients were discharged to Community Treatment Order.

As at 31st December, 17 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 three occasion occasions. The patient's CTO's were subsequently revoked.

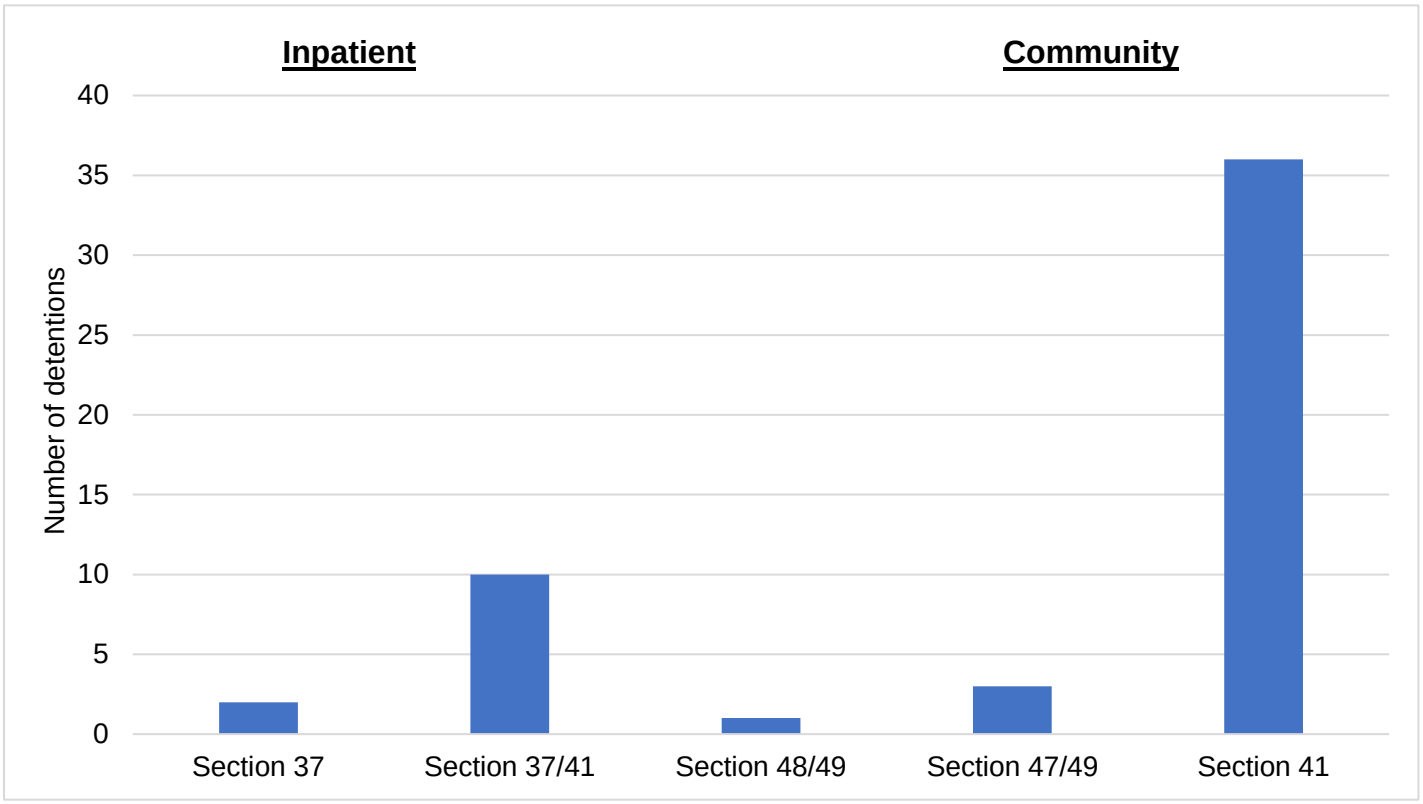
CAMHS Commissioned Inpatient Data

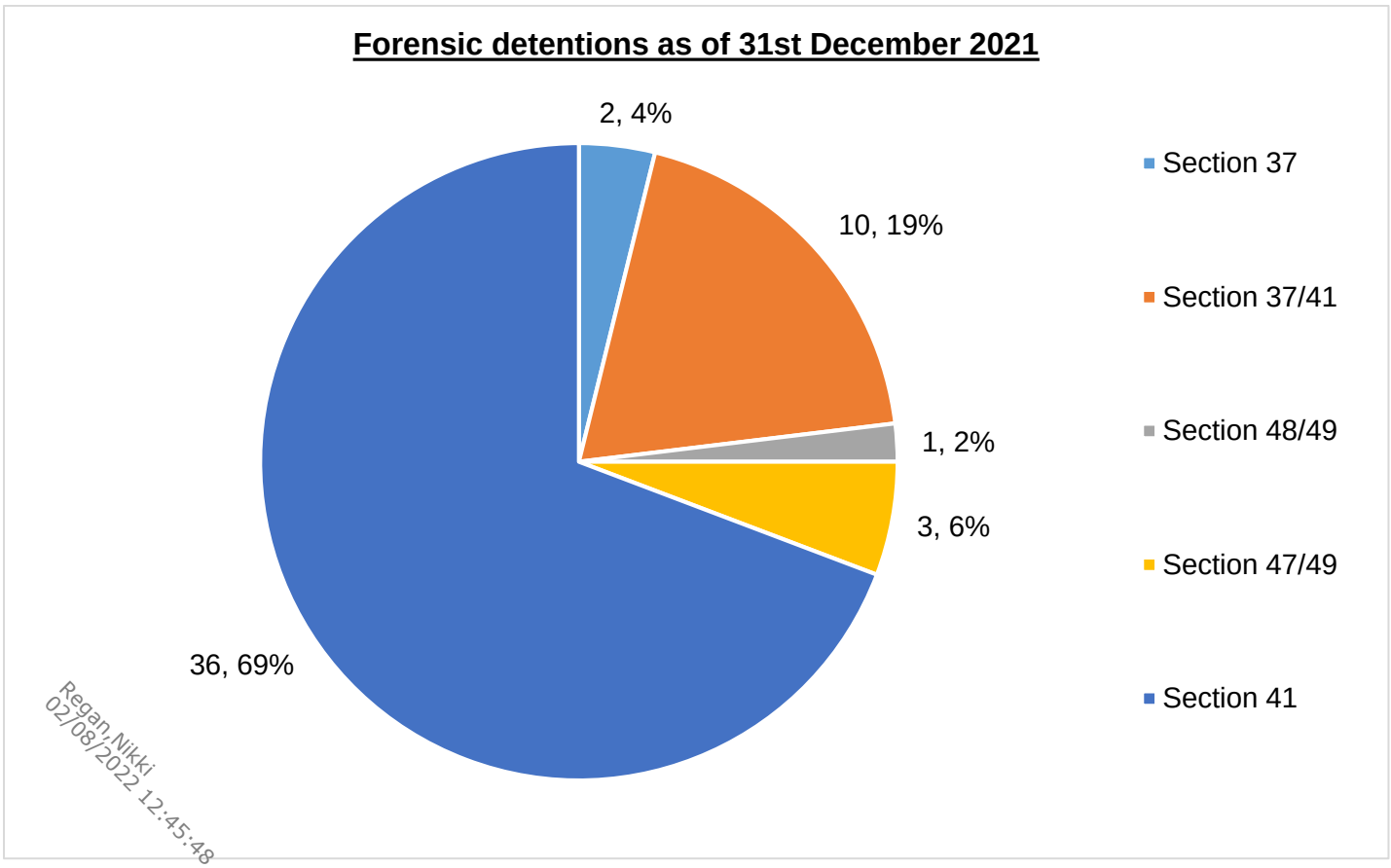
Cwm Taf Morgannwg UHB are commissioned to perform the role of Inpatient CAMHS for Cardiff and Vale UHB area patients.

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

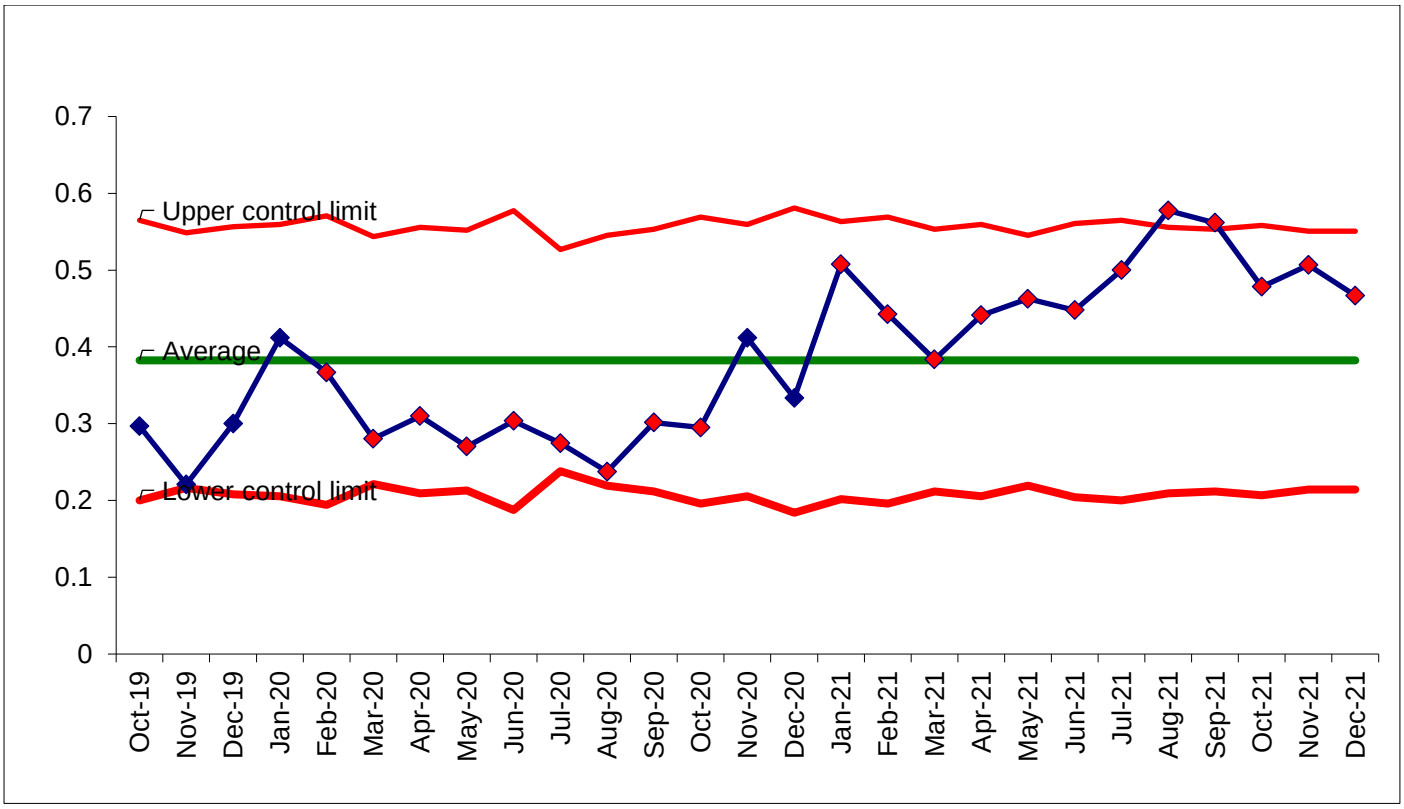
Part 3 of the Mental Health Act 1983

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 31st December 2021.



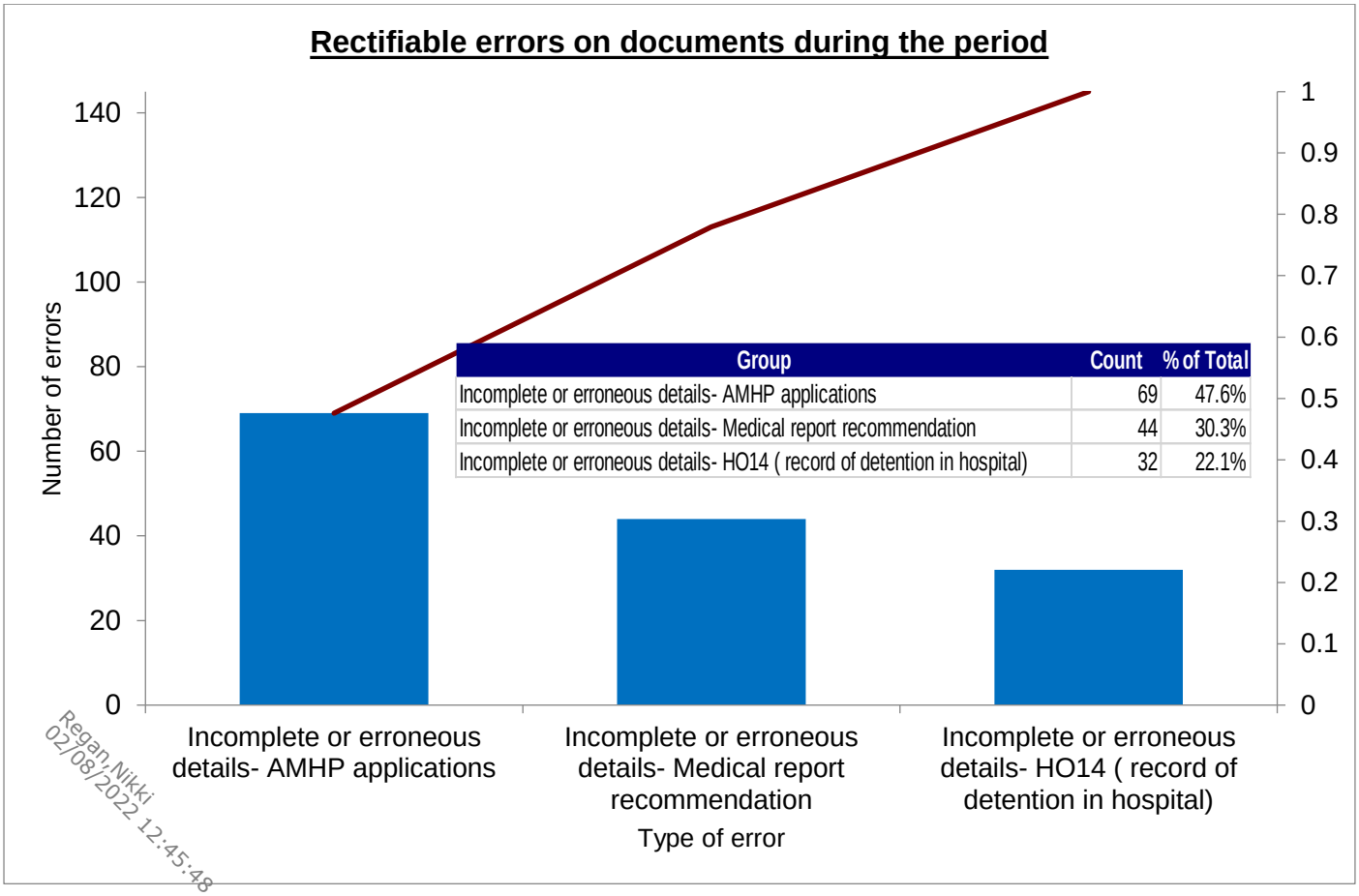


Scrutiny of documents during the period

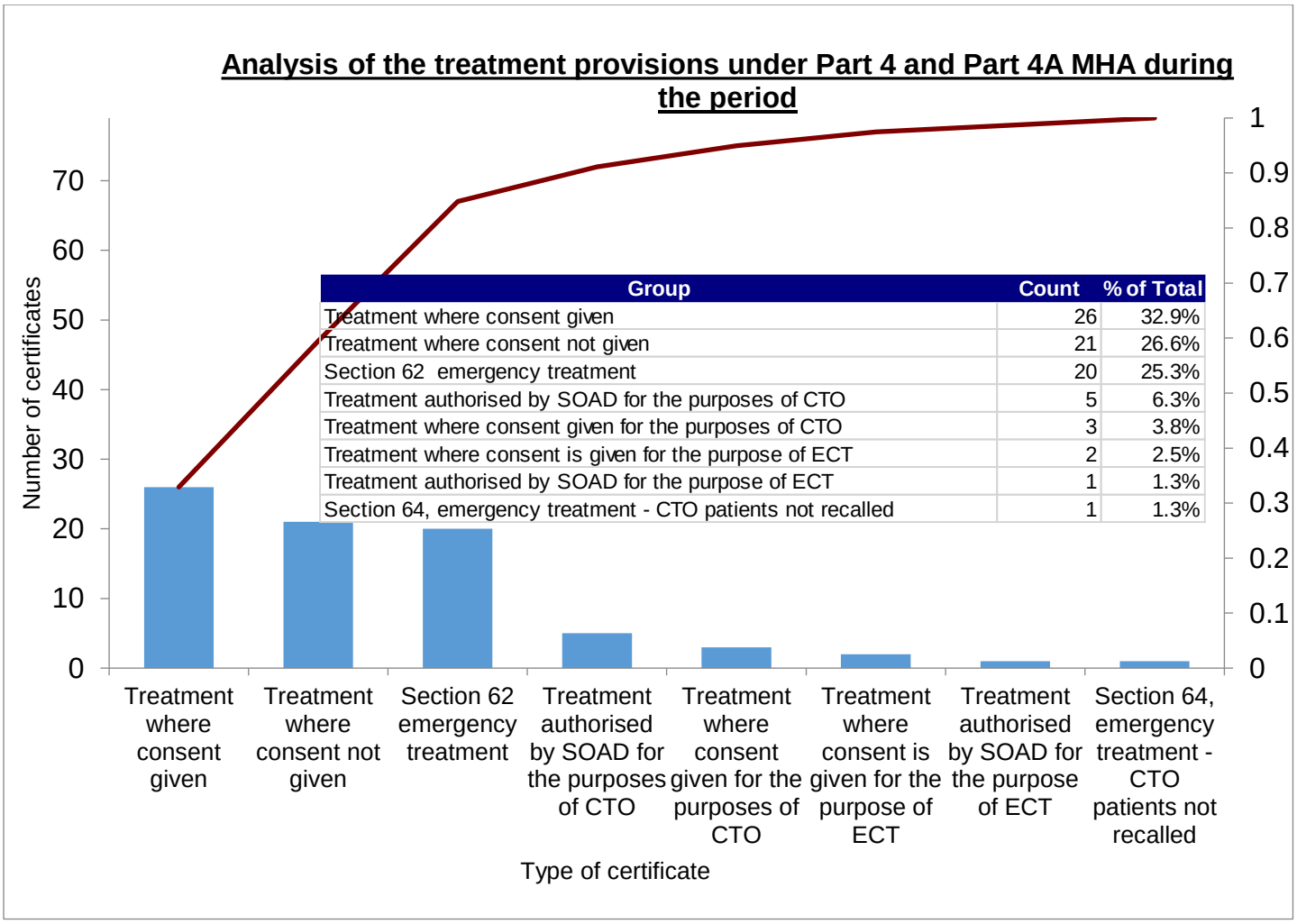


The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have a narrower limit.

Rectifiable errors on documents during the period



Consent to Treatment



Group	Count	% of Total
Treatment where consent given	26	32.9%
Treatment where consent not given	21	26.6%
Section 62 emergency treatment	20	25.3%
Treatment authorised by SOAD for the purposes of CTO	5	6.3%
Treatment where consent given for the purposes of CTO	3	3.8%
Treatment where consent is given for the purpose of ECT	2	2.5%
Treatment authorised by SOAD for the purpose of ECT	1	1.3%
Section 64, emergency treatment - CTO patients not recalled	1	1.3%

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.

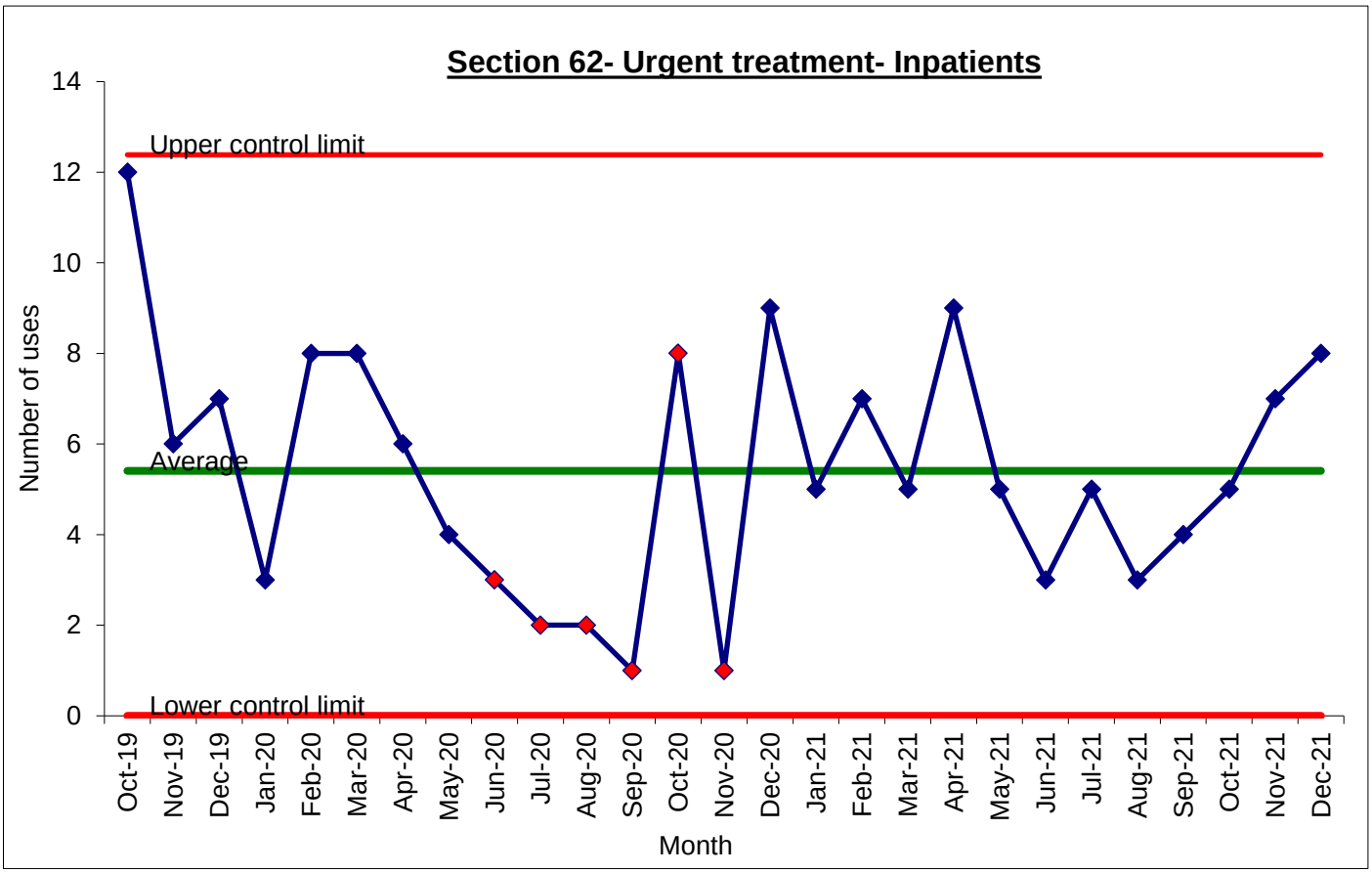
Urgent treatment is defined as treatment that is:

- 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.

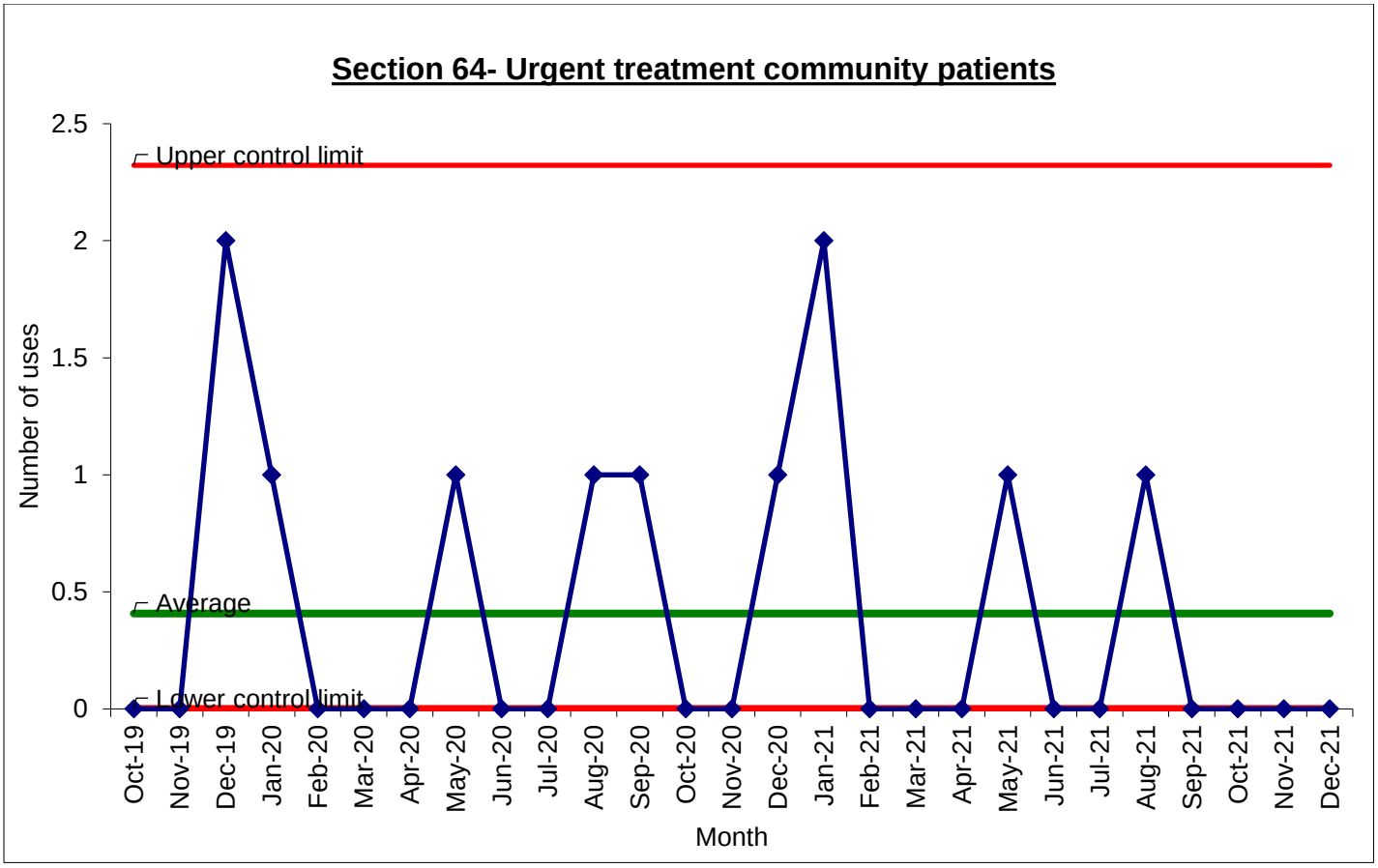
Urgent treatment can be used in any of the following instances:

- 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.



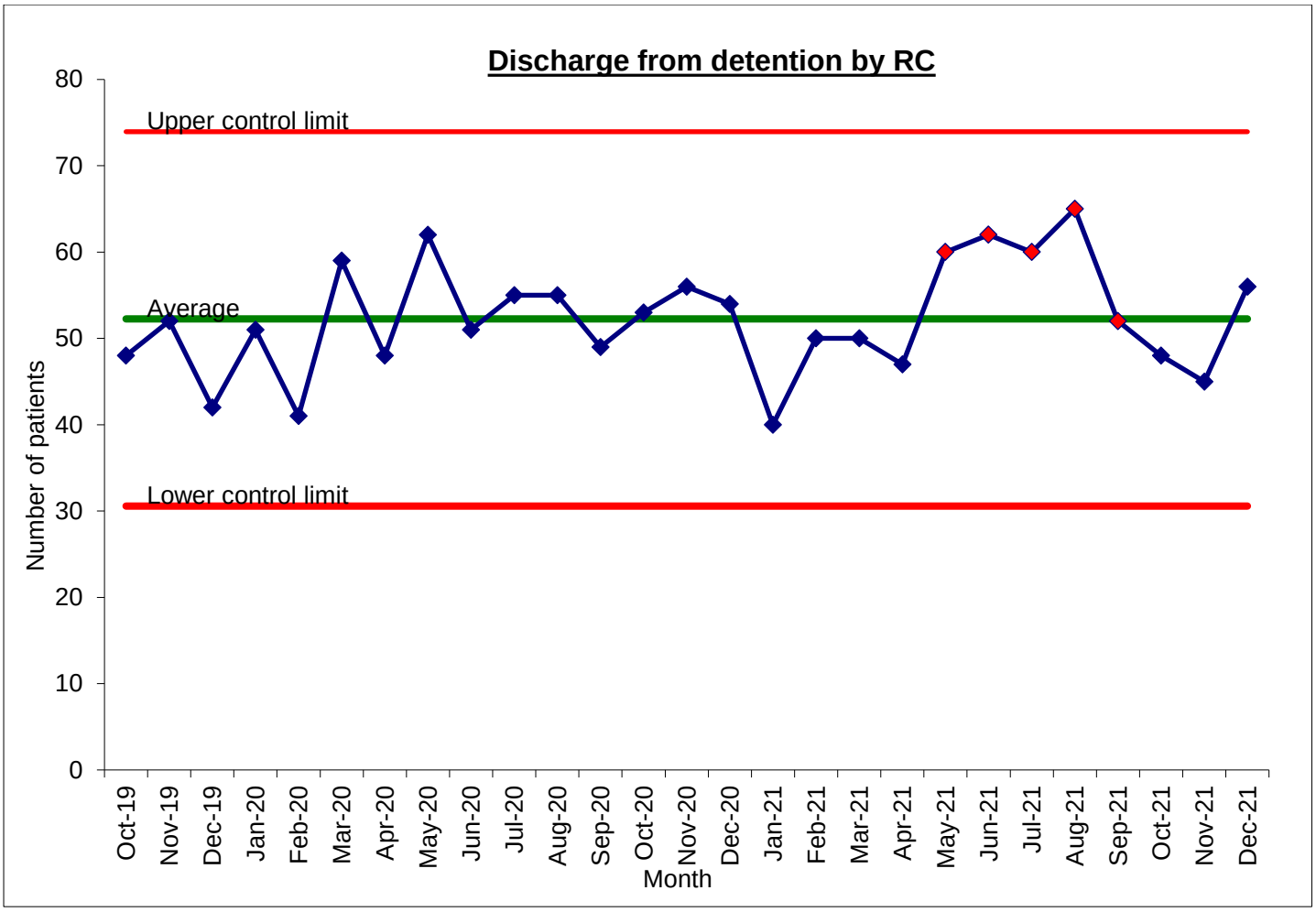
The above chart highlights that Section 62 was used on twenty occasions for the following reasons:

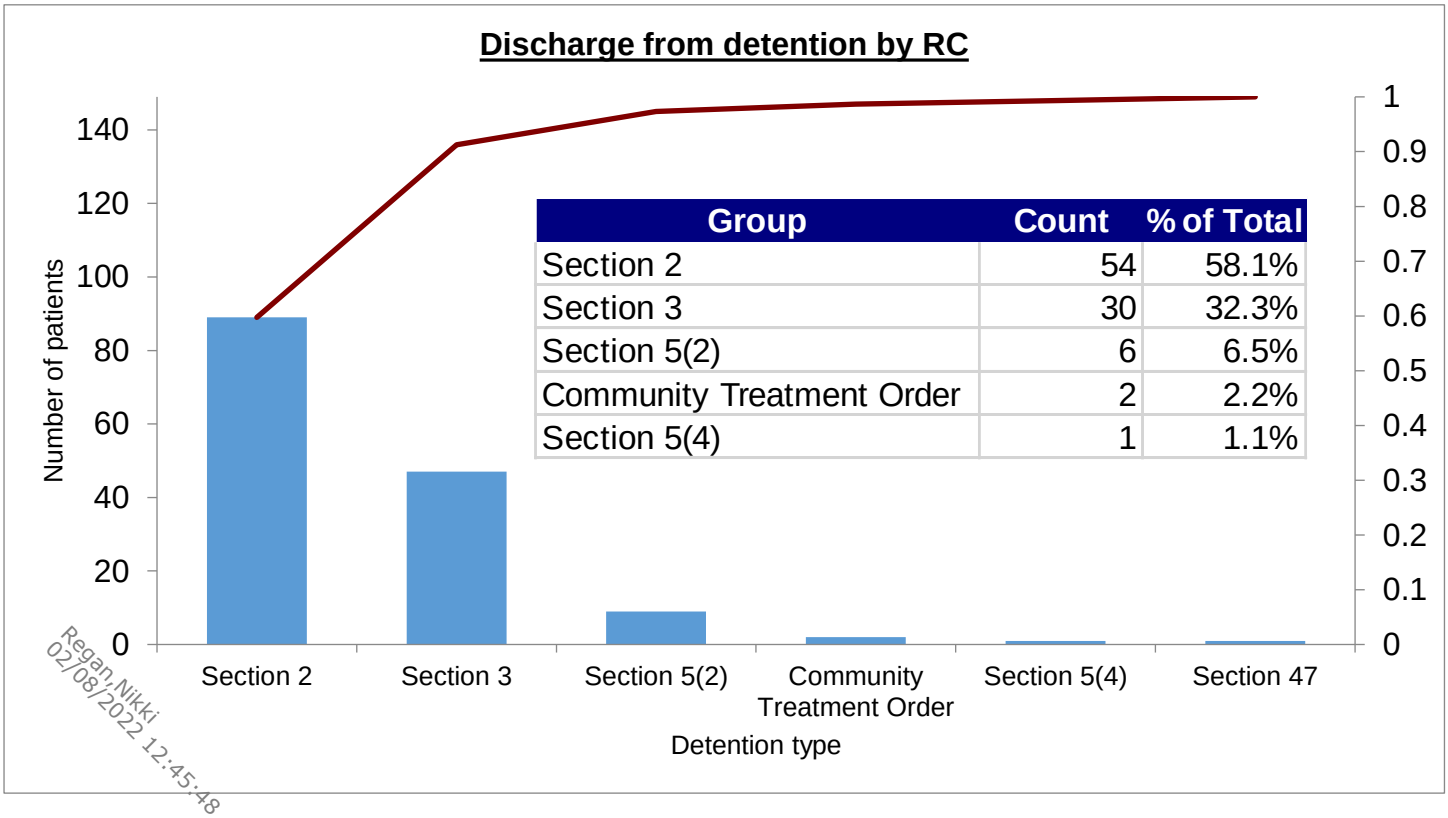
- Pending SOAD – 3 month rule x 9
- Change of capacity to consent x 1
- Change of medication x 5
- Until permanent certificate in place x 2
- CTO revoke- patient refusing treatment x 3



The above chart highlights that Section 64 was not used during the period.

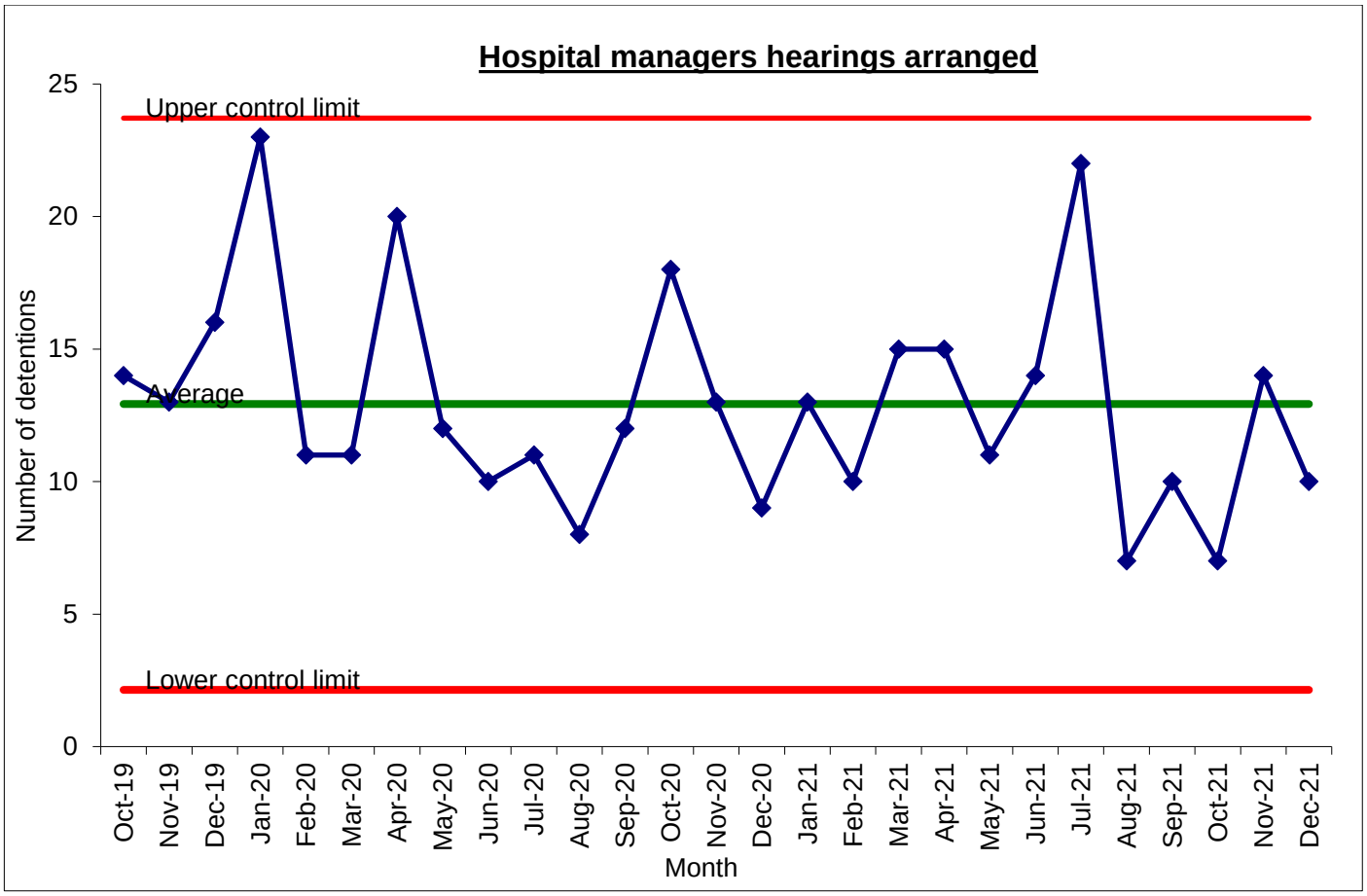
Discharge

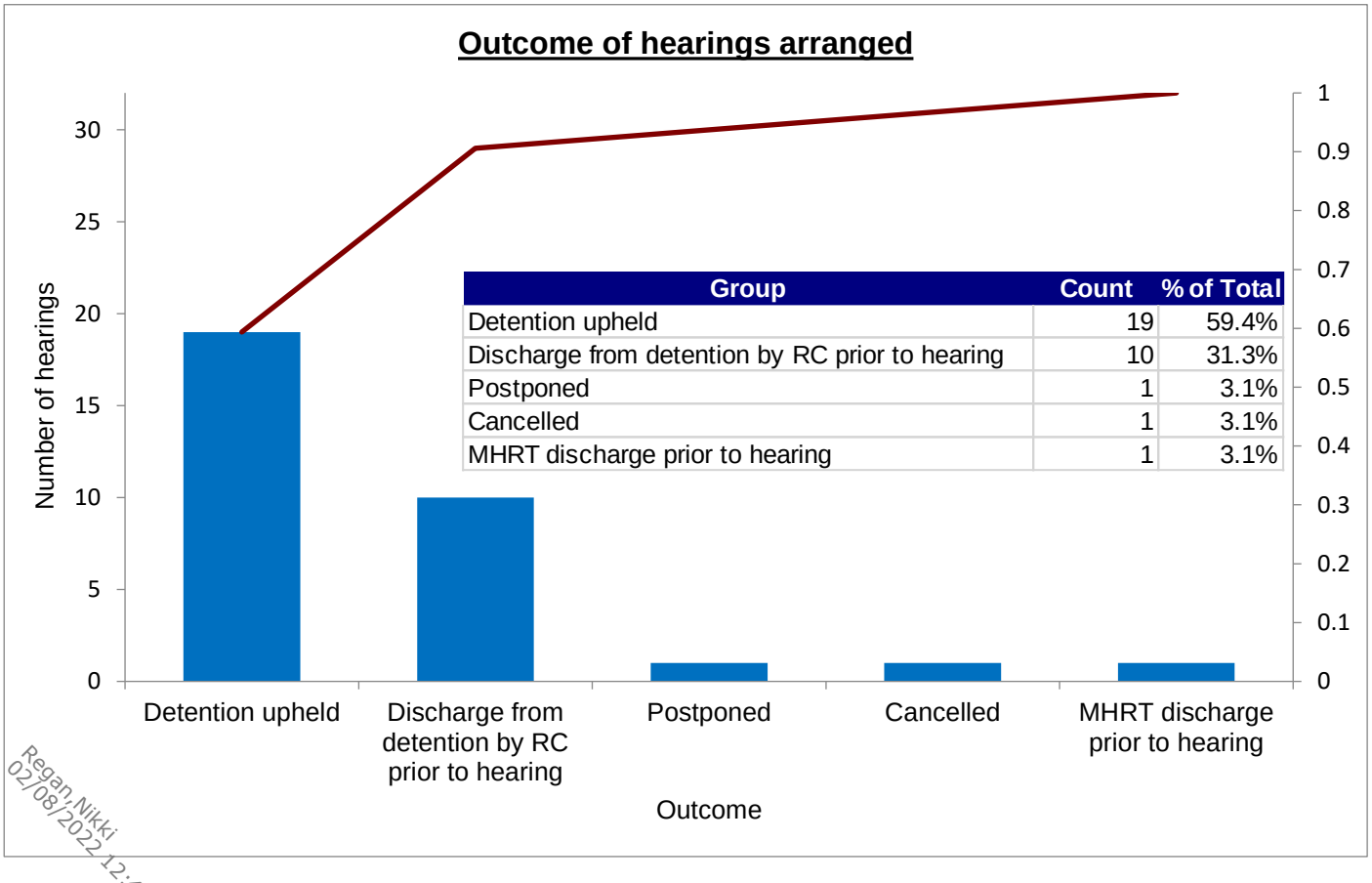




Group	Count	% of Total
Section 2	54	58.1%
Section 3	30	32.3%
Section 5(2)	6	6.5%
Community Treatment Order	2	2.2%
Section 5(4)	1	1.1%

Hospital Managers – Power of Discharge



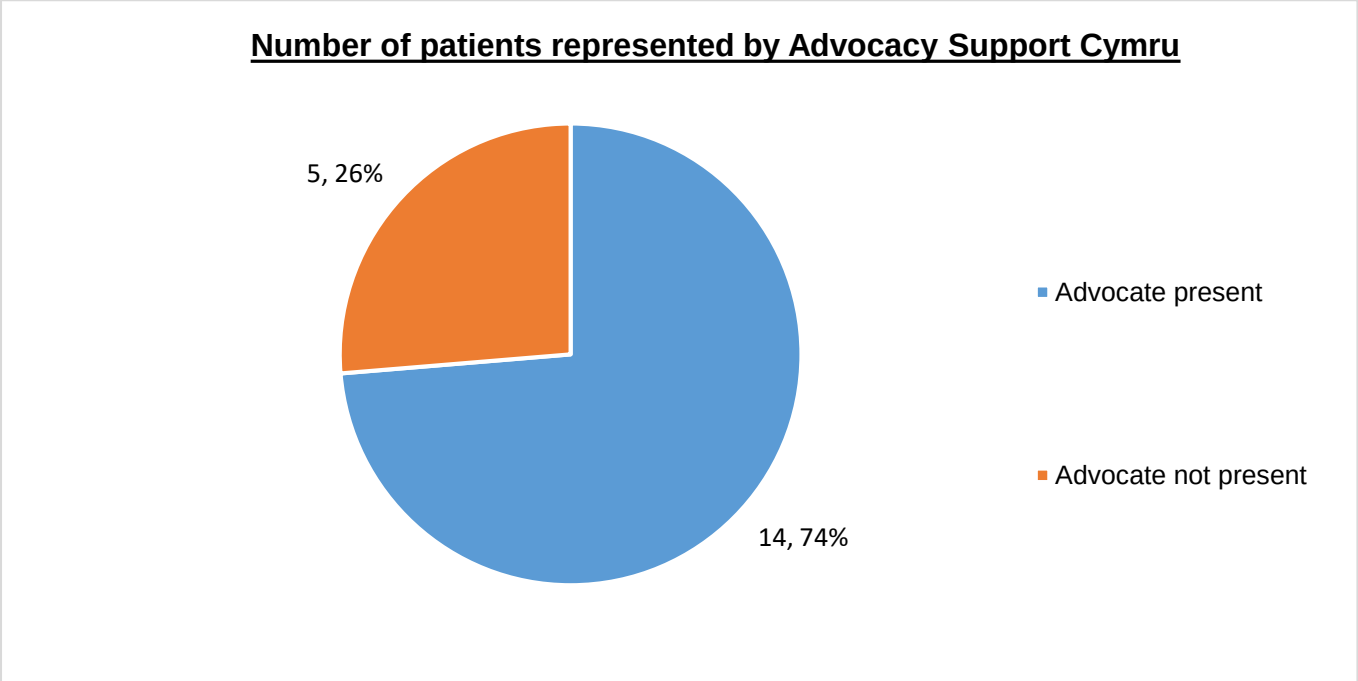


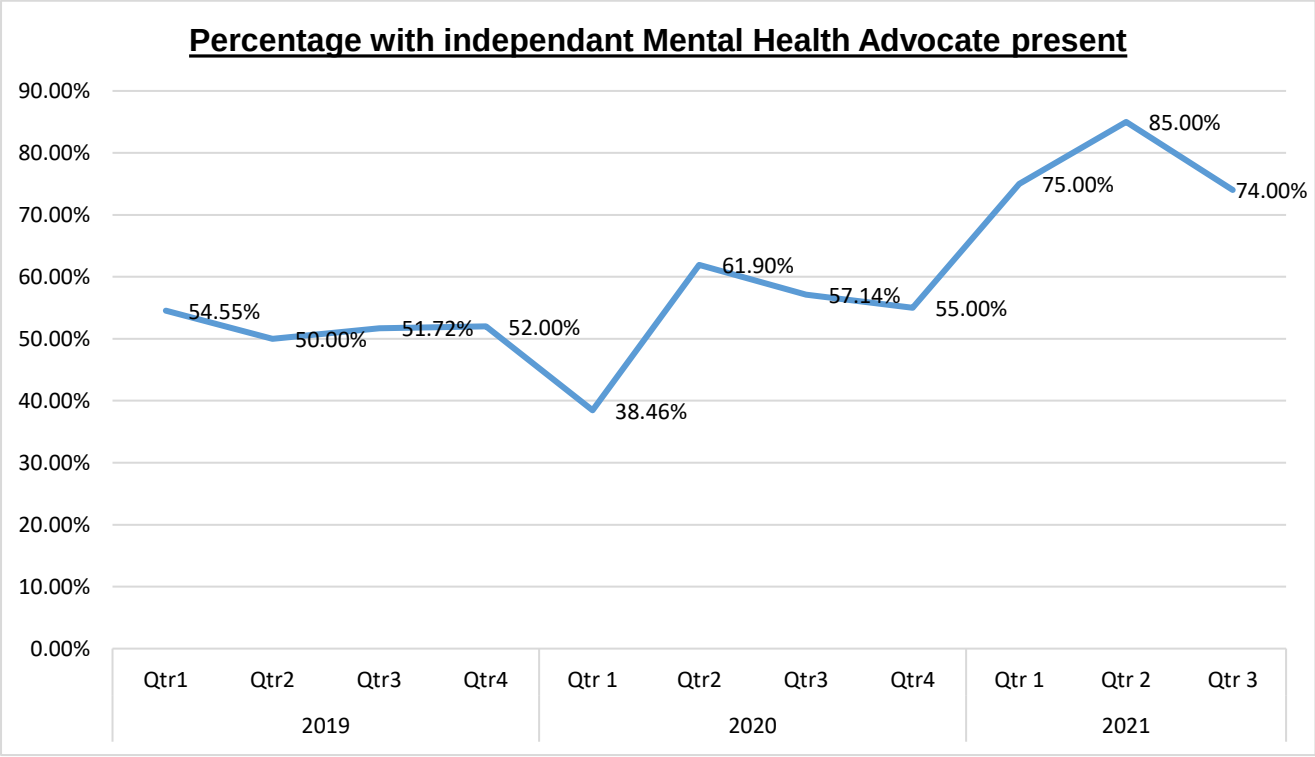
Group	Count	% of Total
Detention upheld	19	59.4%
Discharge from detention by RC prior to hearing	10	31.3%
Postponed	1	3.1%
Cancelled	1	3.1%
MHRT discharge prior to hearing	1	3.1%

One hearing was postponed for the following reason:

- Late submission of RC report.

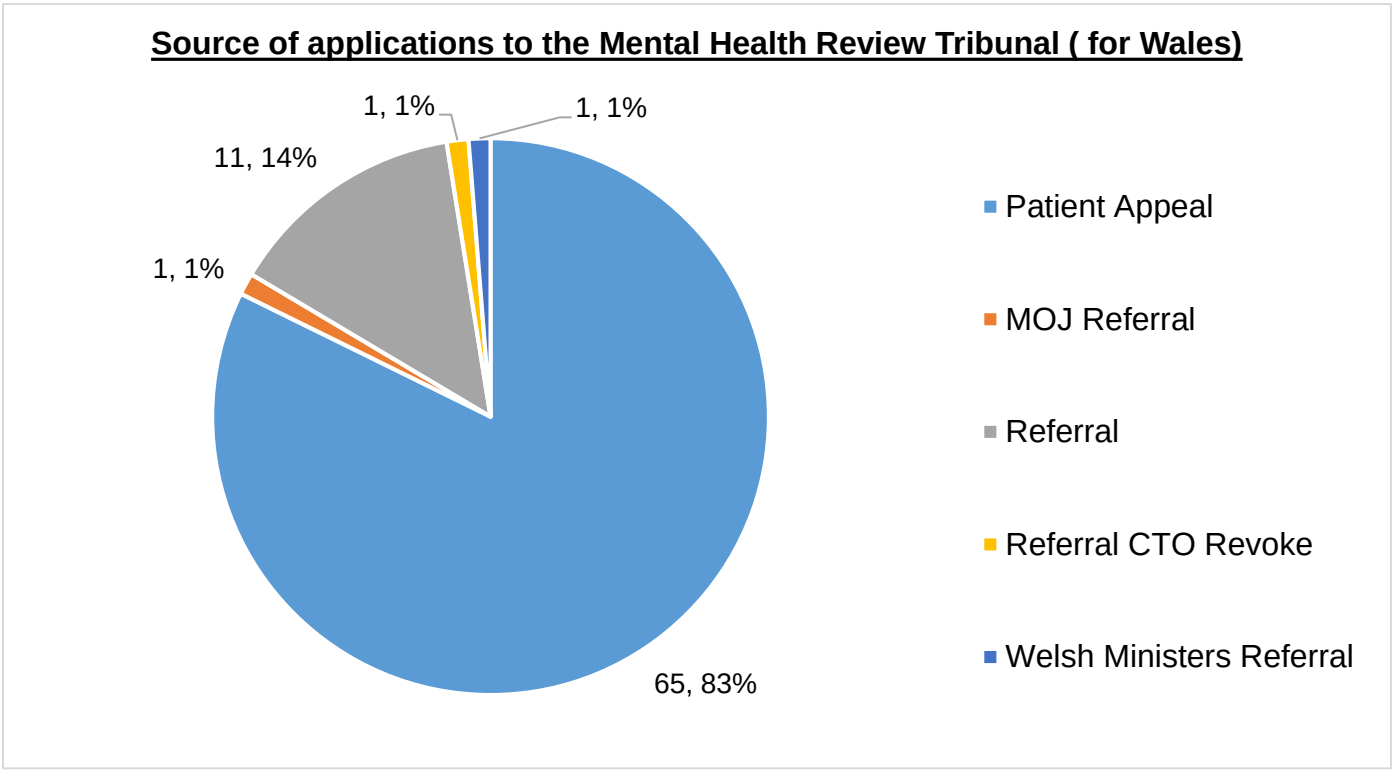
One hearing was cancelled due to the nearest relative withdrawing the request for discharge.

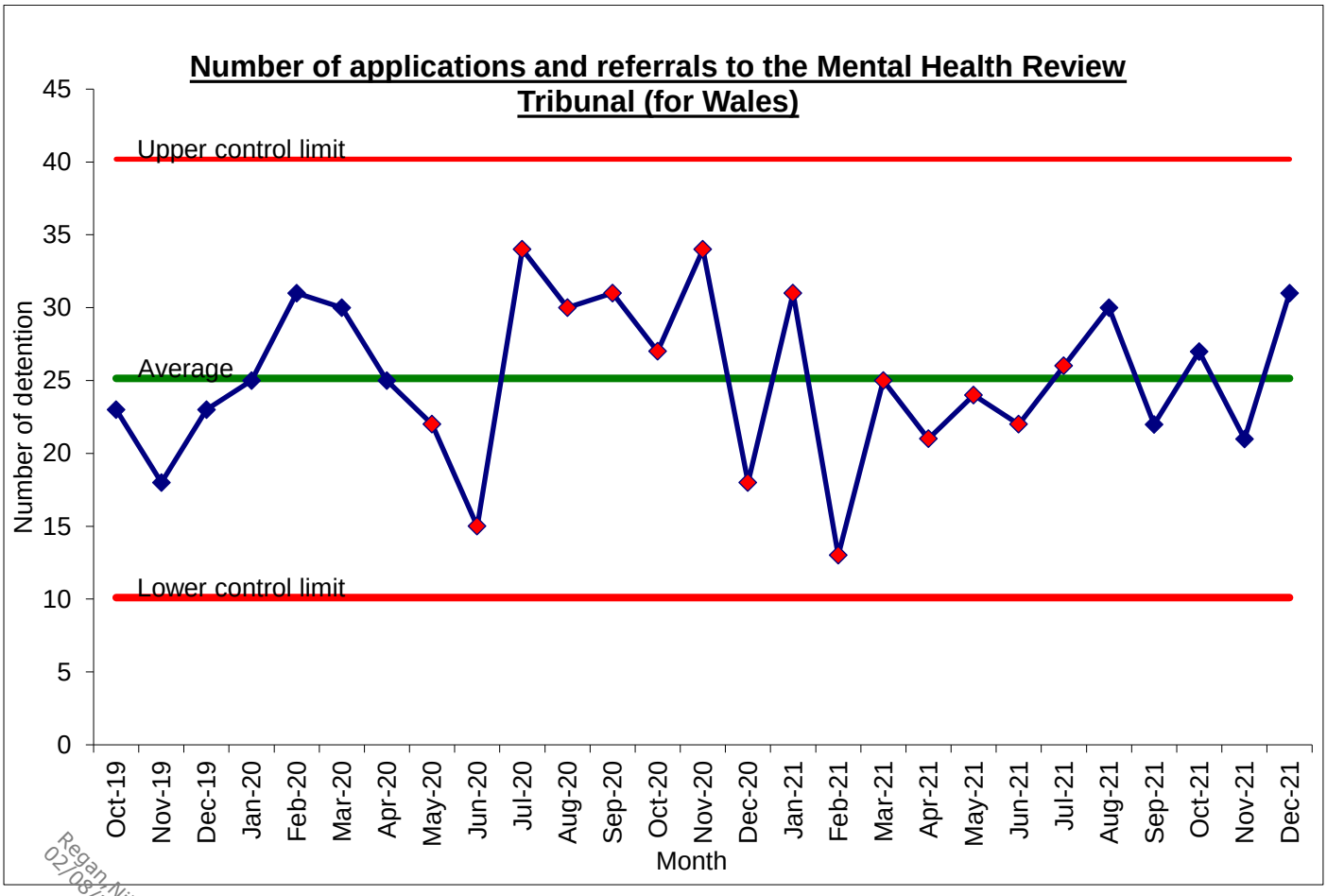


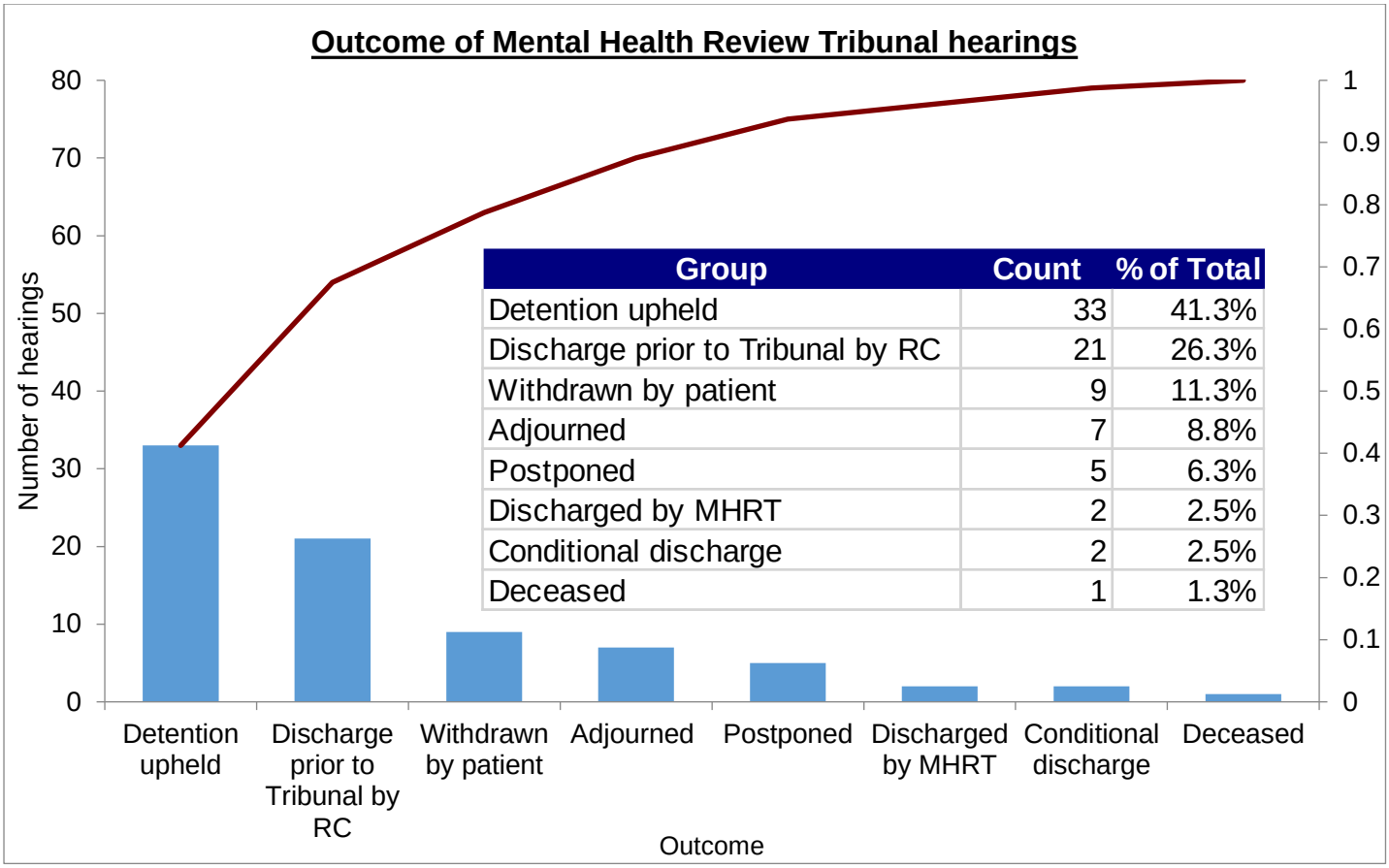


During the period the Mental Health Act Office made sixteen referrals to Advocacy Support Cymru where the patient was deemed not to have capacity make this decision. Two of the hearings were either postponed/ cancelled and therefore weren't attended by an advocate.

Mental Health Review Tribunal (MHRT) for Wales







Group	Count	% of Total
Detention upheld	33	41.3%
Discharge prior to Tribunal by RC	21	26.3%
Withdrawn by patient	9	11.3%
Adjourned	7	8.8%
Postponed	5	6.3%
Discharged by MHRT	2	2.5%
Conditional discharge	2	2.5%
Deceased	1	1.3%

Seven hearings were adjourned for the following reasons:

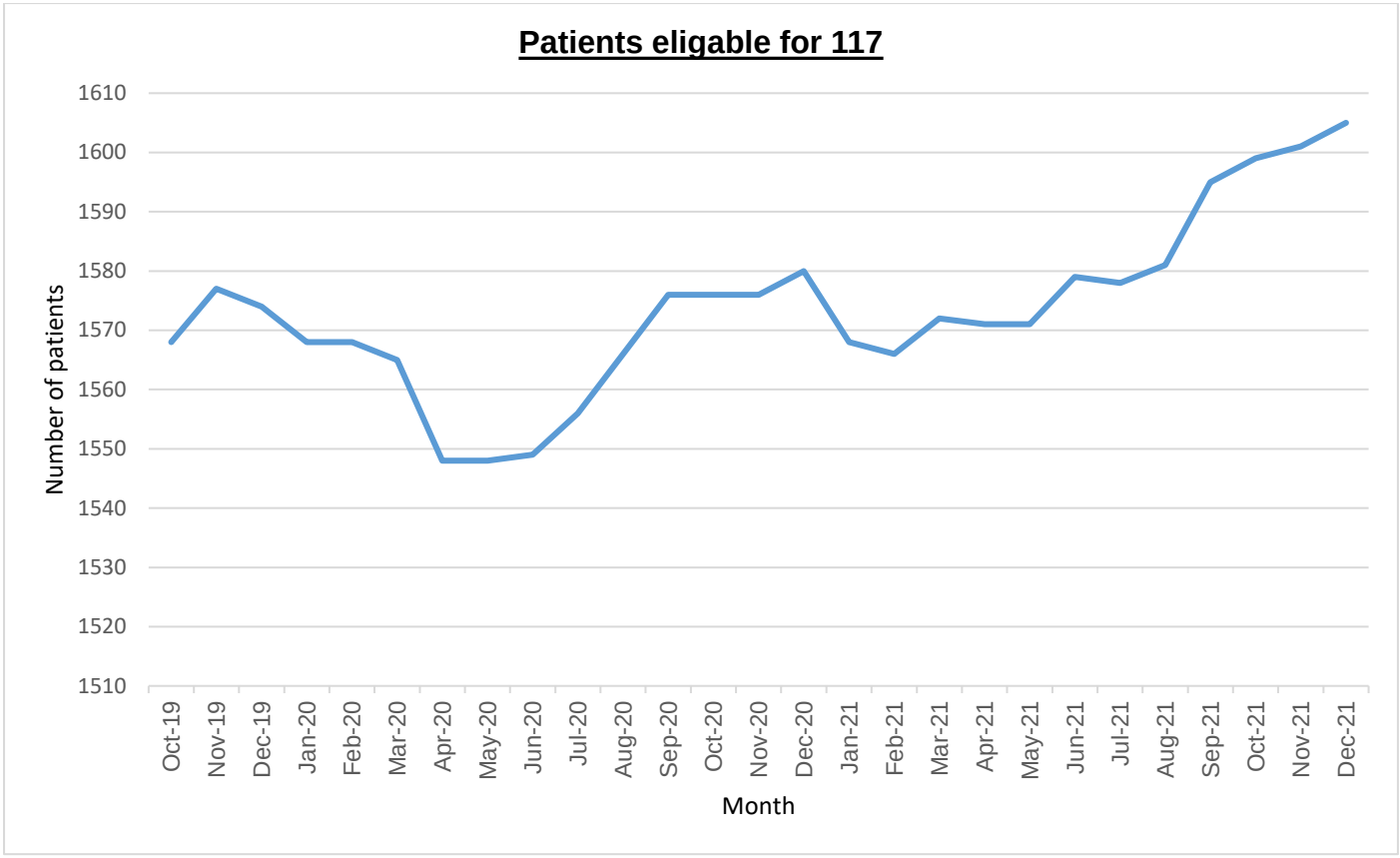
- Legal representative unwell x 1
- RC absent due to illness x1
- More information needed x4
- Patient instructed legal representation at the hearing x 1

Five hearings were postponed for the following reasons:

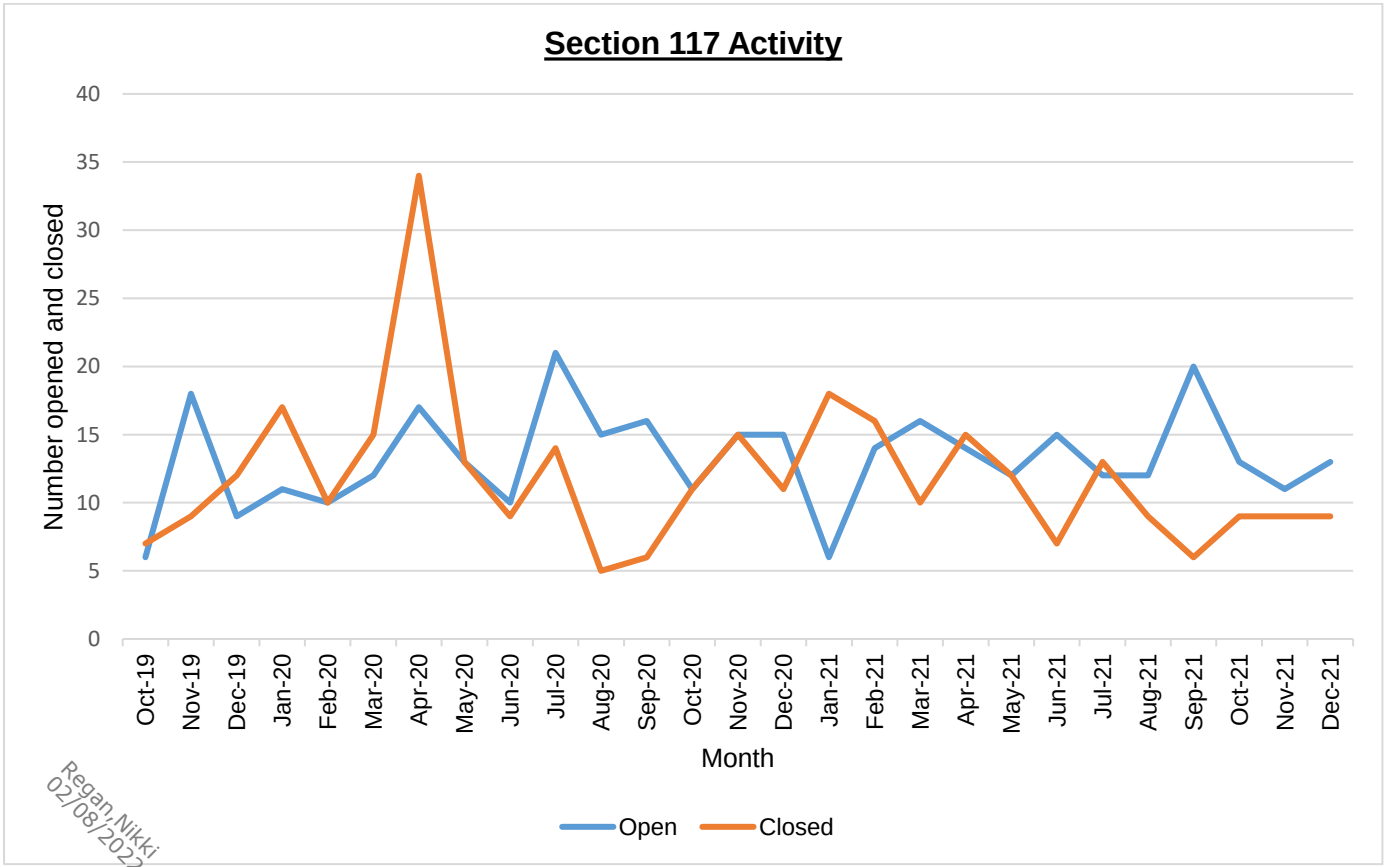
- At RC's request
- Due to RC sickness
- Due to legal representative sickness
- Due to legal representative availability x2

Section 117 Aftercare

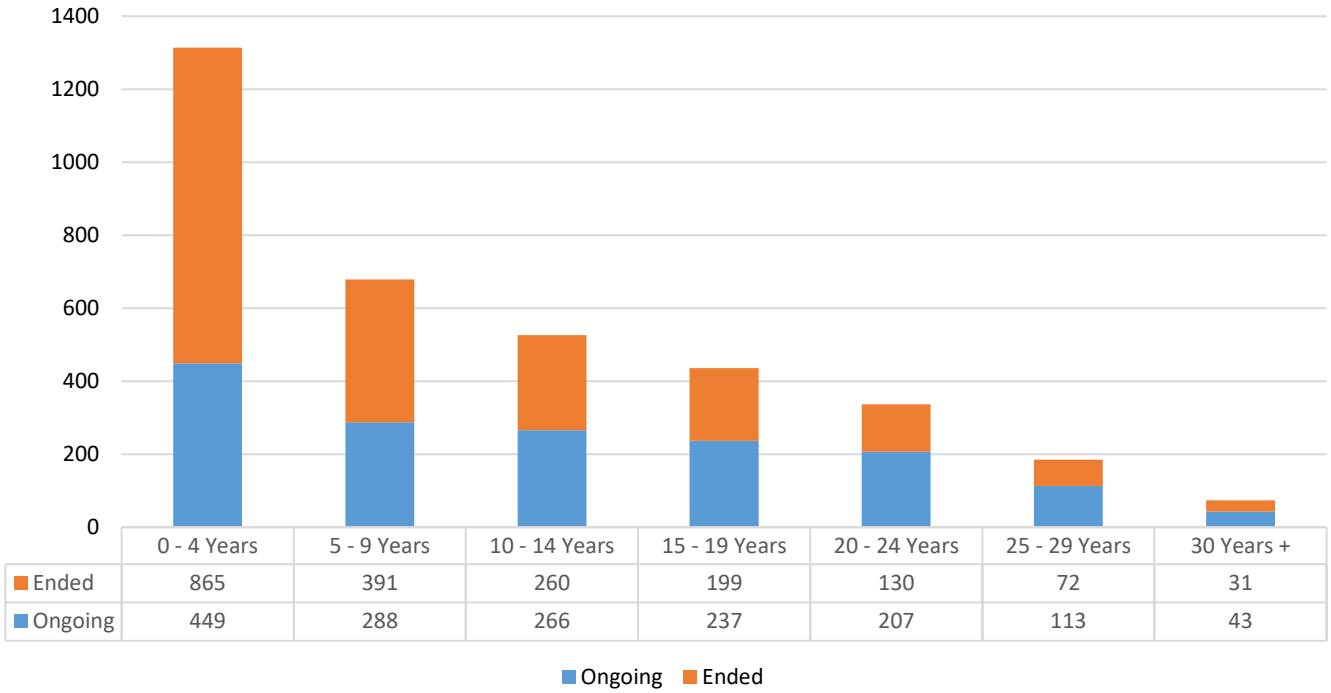
Patients eligable for 117



Section 117 Activity



Periods of time that patients remain eligable for Section 117 aftercare



	0 - 4 Years	5 - 9 Years	10 - 14 Years	15 - 19 Years	20 - 24 Years	25 - 29 Years	30 Years +
Ended	865	391	260	199	130	72	31
Ongoing	449	288	266	237	207	113	43

Section 19 transfers to and from Cardiff and Vale UHB

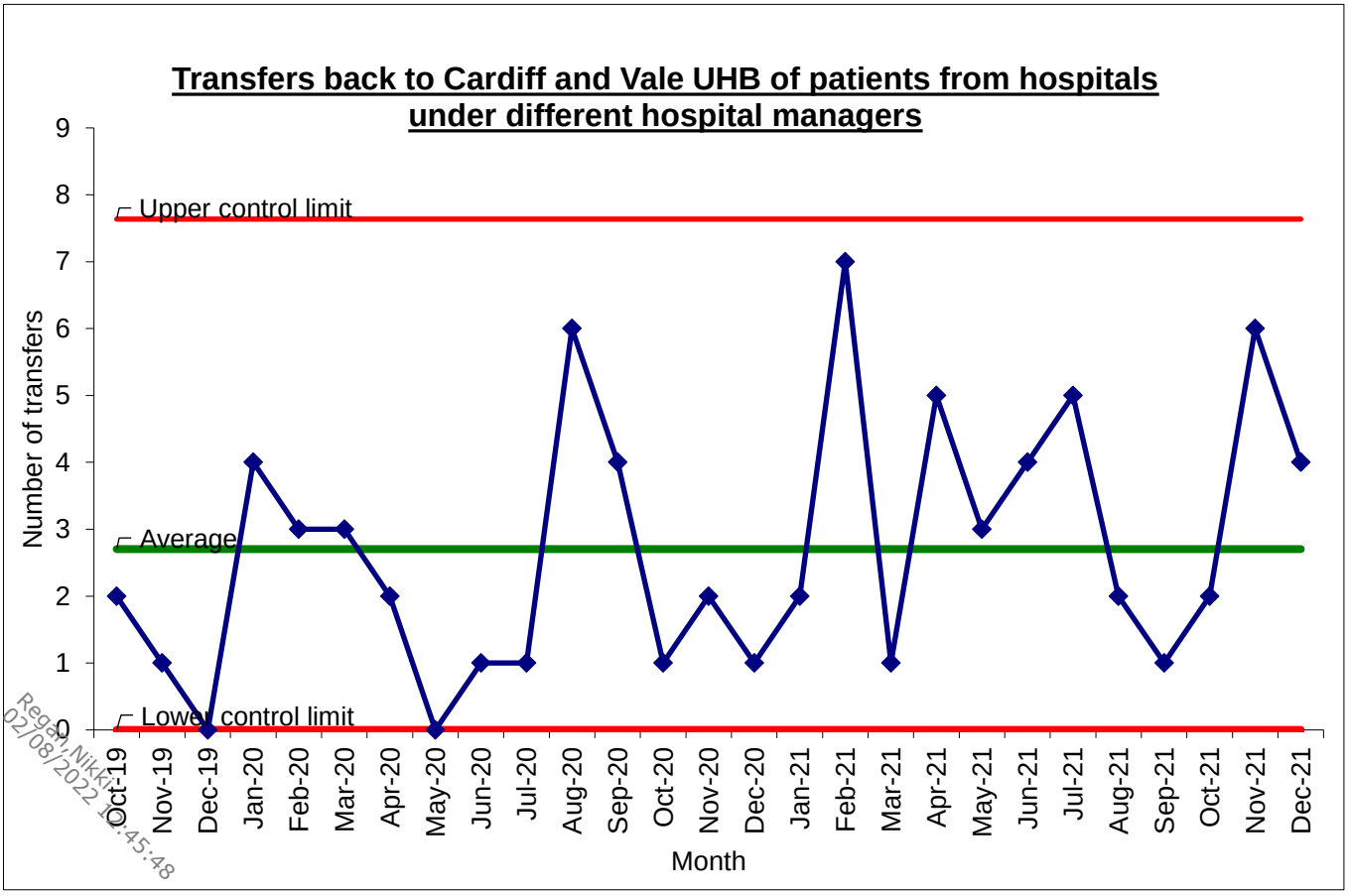
During the period:

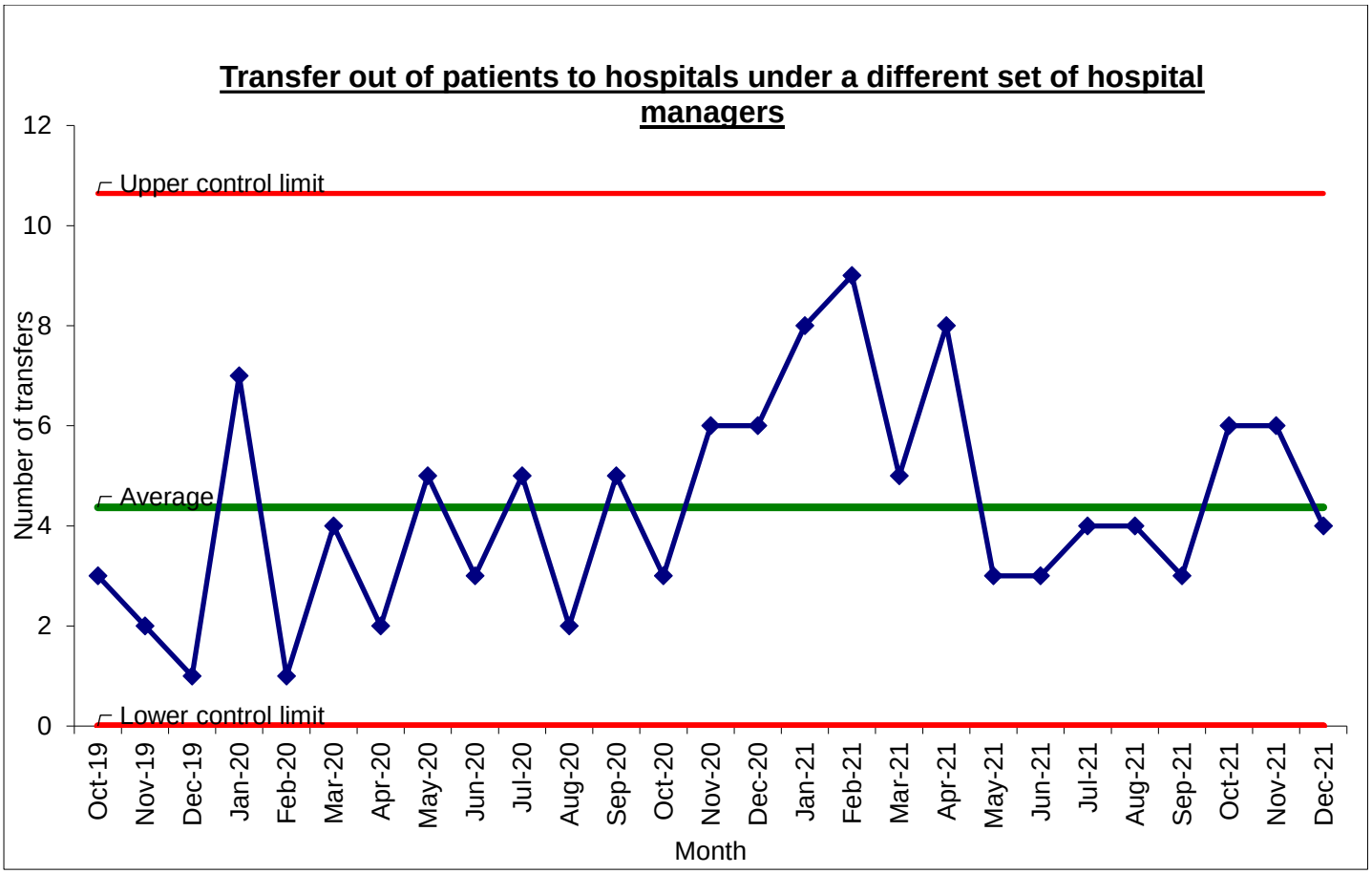
- Sixteen patients detained under Part 2 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Managers for the following reasons:
    - five to return to their home area
    - Two to CAMHS
    - eight to a private PICU bed
    - One to a specialist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

- Two patients detained under Part 3 of the Mental Health Act were transferred from Cardiff and Vale UHB to a hospital under a different set of Mangers for the following reasons:
    - Medium Secure placement
    - Specialist placement

Twelve 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
- Two from a medium secure bed
- Four from an out of area bed





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

October- December 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.

Death of detained patients

During the period there was one death of a detained patient.

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

Report Title:	Mental Health Measure (Wales) 2010 incl. Part 2	**Agenda Item no.**	**10.1**
Meeting:	Mental Health Legislation Committee	**Meeting Date:**	9th February 2022
Status:	**For Discussion** X **For Assurance** X **For Approval**	**For Information**	
Lead Executive:	Chief Operating Officer		
Report Author (Title):	Director of Operations, Mental Health		

Background and current 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.

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

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

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

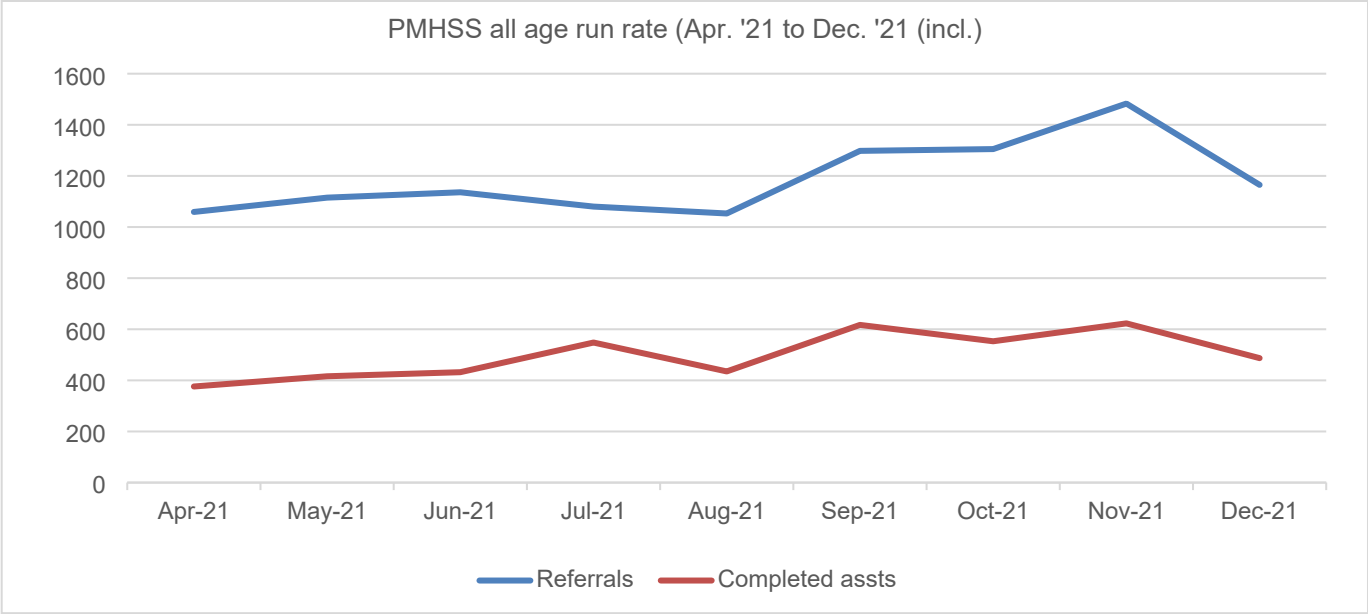
For Parts 1, 2, 3 & 4 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

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

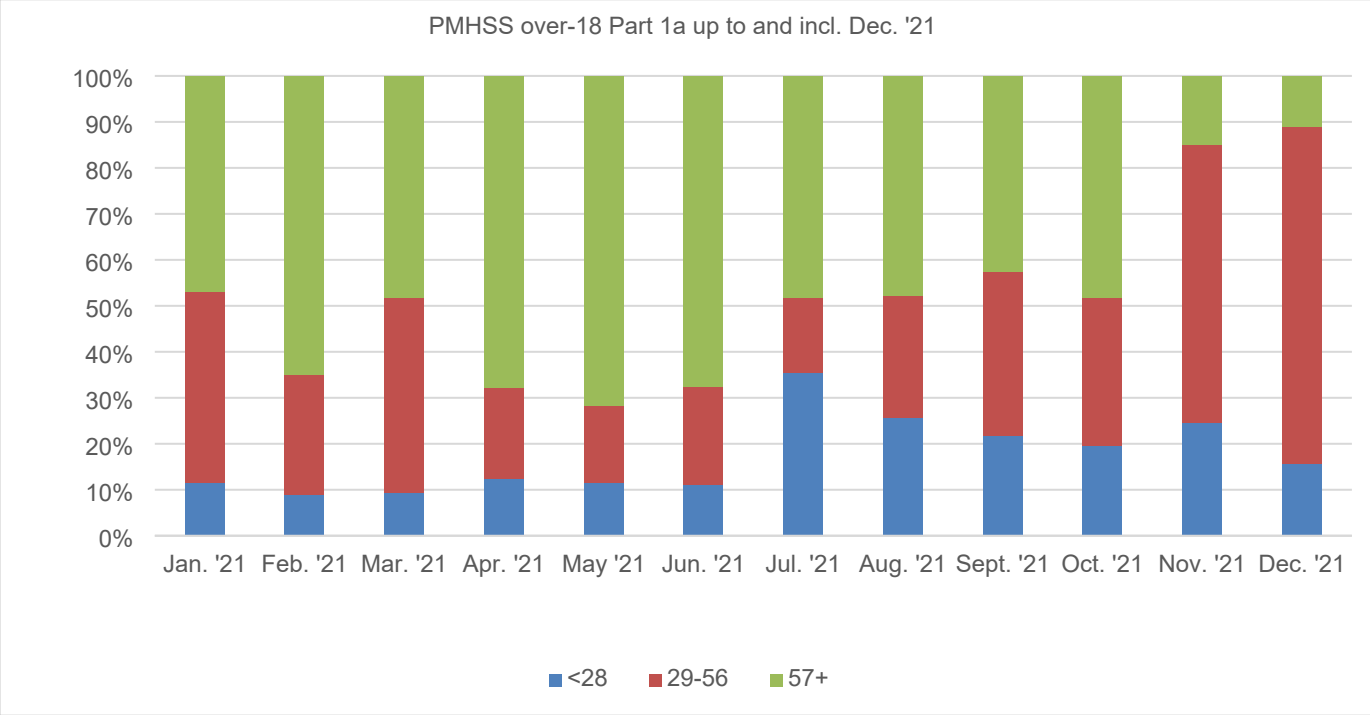
Both referral and completed assessment activity for Q2 & Q3 2021 has seen a gradual increase with the customary dip in activity in December. (See Graph 1).

Graph 1



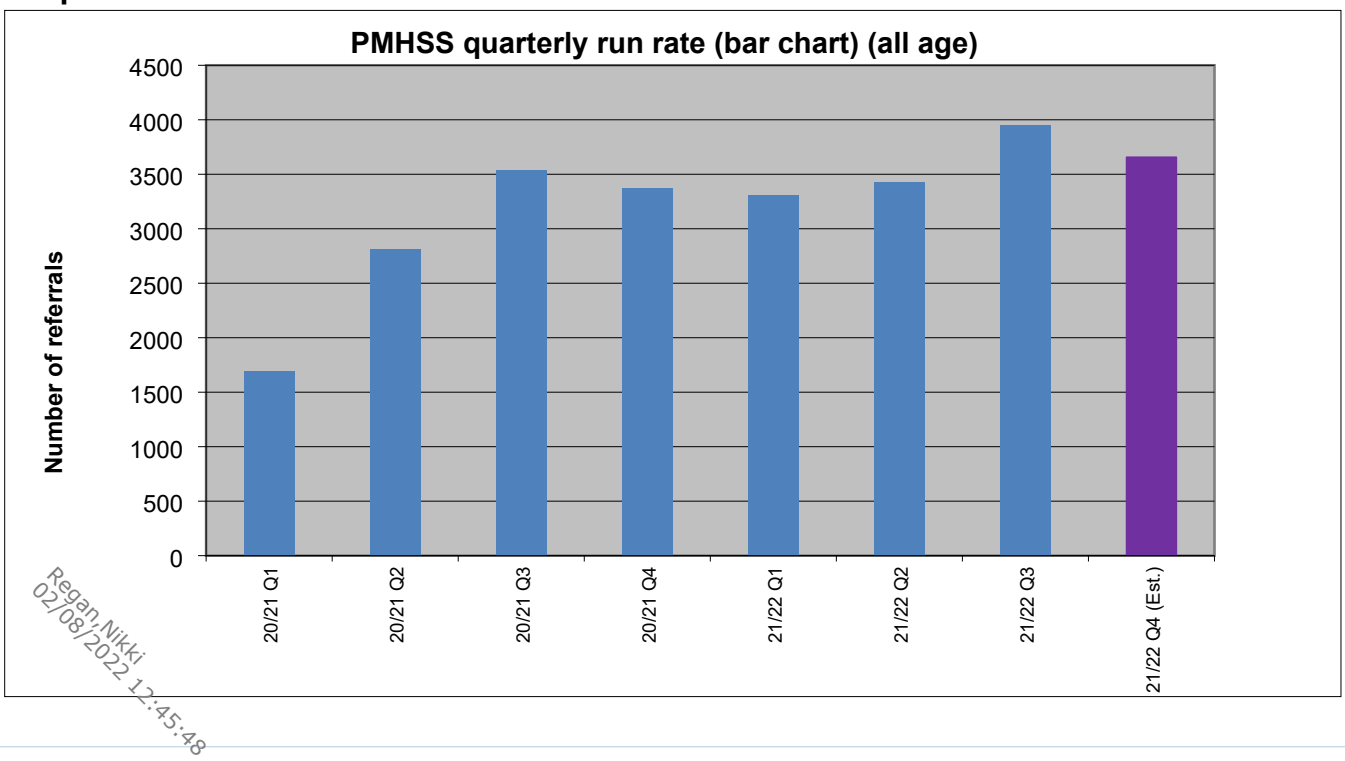
Regarding the over-18 Part 1a performance (see Graph 2), a recent successful recruitment drive, has shown a gradual reduction in over 56 day waiting. The actual waiting list for assessment has dropped from 699 on 19/10/21 to 596 on 31/12/21. Average waiting times for assessment have similarly improved from 51 on 19/10/21 to 42 on 31/12/21. The trajectories for both of these indicate continued improvement. The compliance with the Tier 1 target of 28 days has improved only slightly in this time (from 6% to 9%) but given the above waiting list and average waiting times this will continue to gradually improve before rapidly reaching compliance. Much is dependent on referral numbers referred in Q4 (often being the busiest quarter of the financial year). Early indications are for a Q4 less busy than Q3 but still in the region of 3,500+.

Graph 2



Following the dramatic dip in referrals during lockdown, PMHSS all-age referrals then rapidly peaked to over 3,500 in Q3 2020/21 with a further peak of just under 4,000 in Q3 2021/22. (See Graph 3).

Graph 3



Since referrals 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 2-6 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.
- Investment into Tier 0 providers to deliver Tier 0 interventions (Stress Control and ACTion for Living) at scale to reduce referrals into PMHSS- 2 out of 4 completed.

Currently referrals are being booked in at 28 days, with the expectation that increasing numbers of assessment will be booked in under target this quarter.

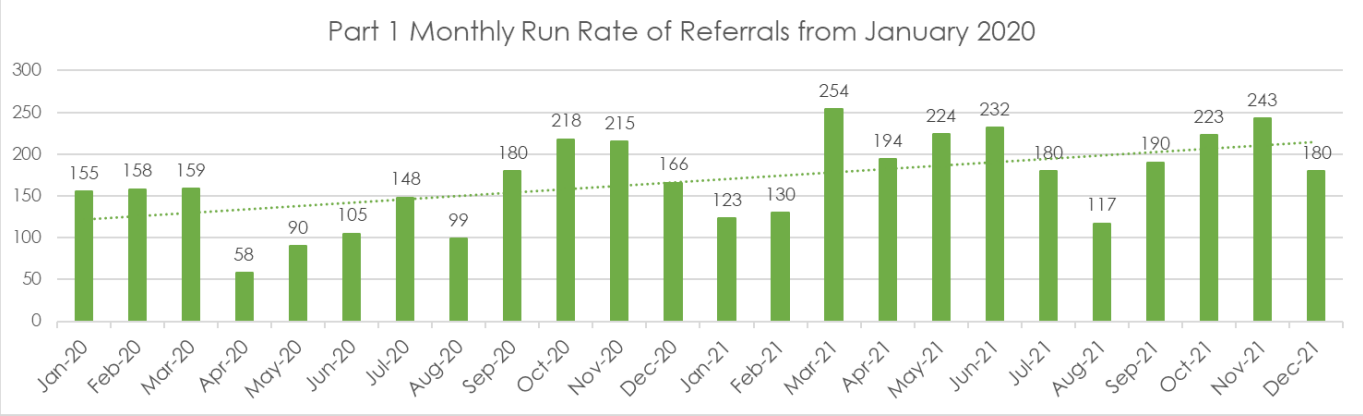
Part 1a – target: 28-day referral to assessment compliance target of 80% (Children & Young People)

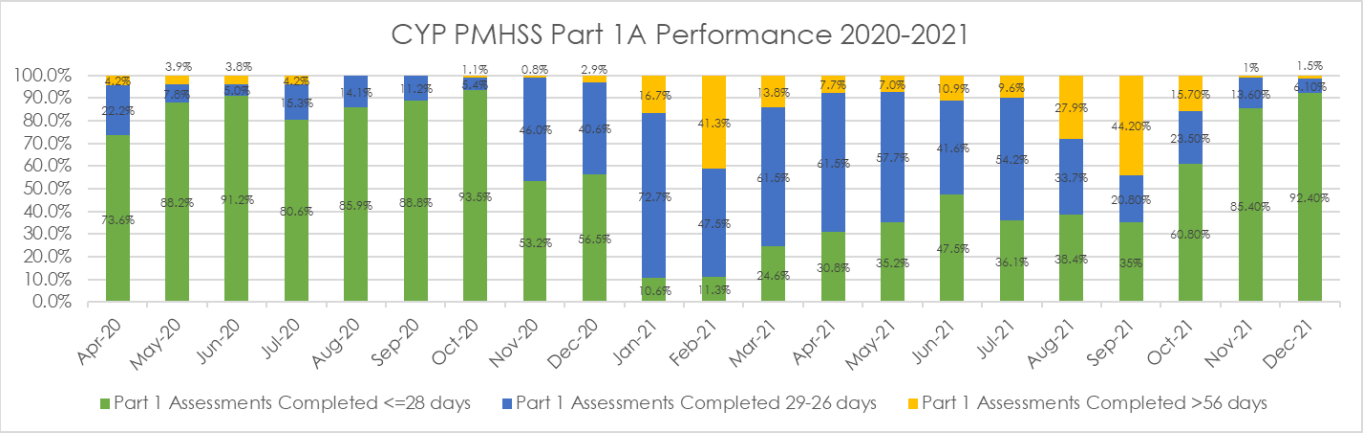
Compliance against the part 1 target has been achieved since the middle of November 2021 as a result of a waiting list initiative in conjunction with Healios. Following a decline in referrals during the height of Covid, referral levels significantly increased during October 2020 and November 2020 following the re-opening of schools. Whilst there was a decrease between December and February 2021, referrals have sharply increased from March 2021 and have remained significantly higher than pre-Covid levels. As expected, there was a decrease in referrals during July and August 2021 which is as a result of the school summer holidays but

since the return to school in September 2021, referrals have been steadily increasing (see Graphs 4&5).

The average wait for assessment is currently *21 days.*

Graph 4 & 5



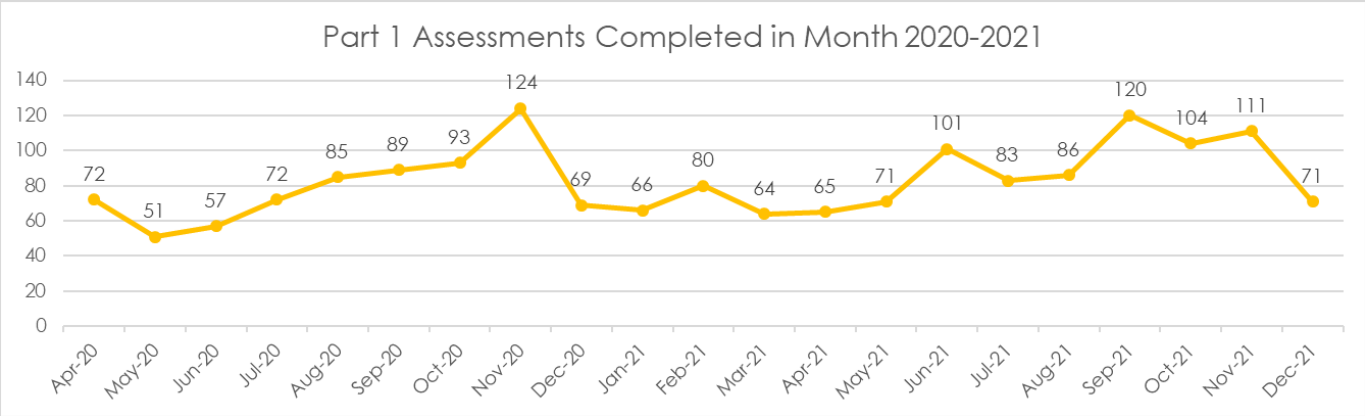


Capacity has been a challenge for the team, with a mixture of short and long-term sickness, the team has been operating on approximately 66% capacity since the beginning of December 2020.

The service is continuing to deliver its full offer via virtual (telephone and video) and face-to-face means and expects to continue to utilise these mediums as part of 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. Assessment shown in Graph 6.

The Single Point of Access team was launched at the end of November 2021 and will help to manage referrals through improved processes and use of consultation with referrers.

Graph 6



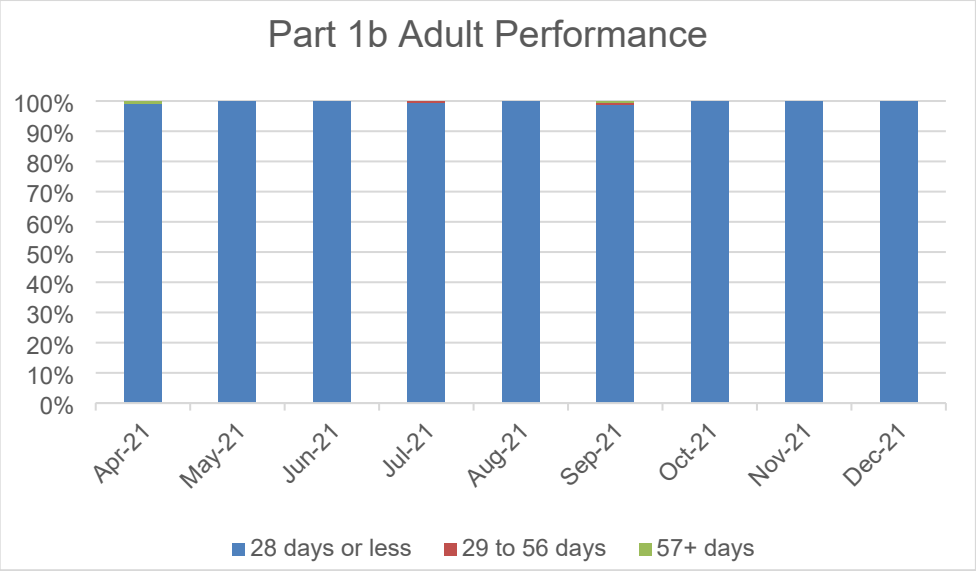
Actions to maintain compliance against the target include:

- Active sickness monitoring and wellbeing support to the team
- Additional capacity through the use of partnership working with Healios to deliver Part 1 assessments.
- 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 the new year but will be fully operationalised from April 2022.

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

PMHSS has been compliant with the Part 1b performance target since August (See Graph 7). This has continued during the Covid 19 period. Currently compliance is at 100% and has been for 3 consecutive months. The Compassion Focused Therapy group Understanding Me had a successful pilot and is running again this quarter. Overall a range of interventions for over 120 participants are running this reporting period.

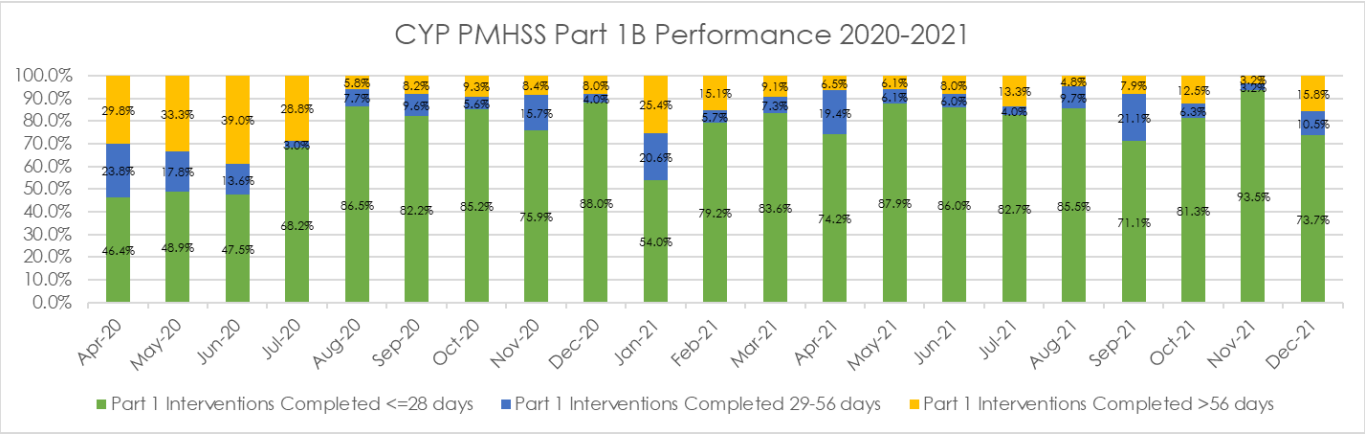
Graph 7



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 with two months of non-compliance in September & December 2021 as a result of focus on the external waiting list for assessment and reduced capacity over Christmas. 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).

Graph 8



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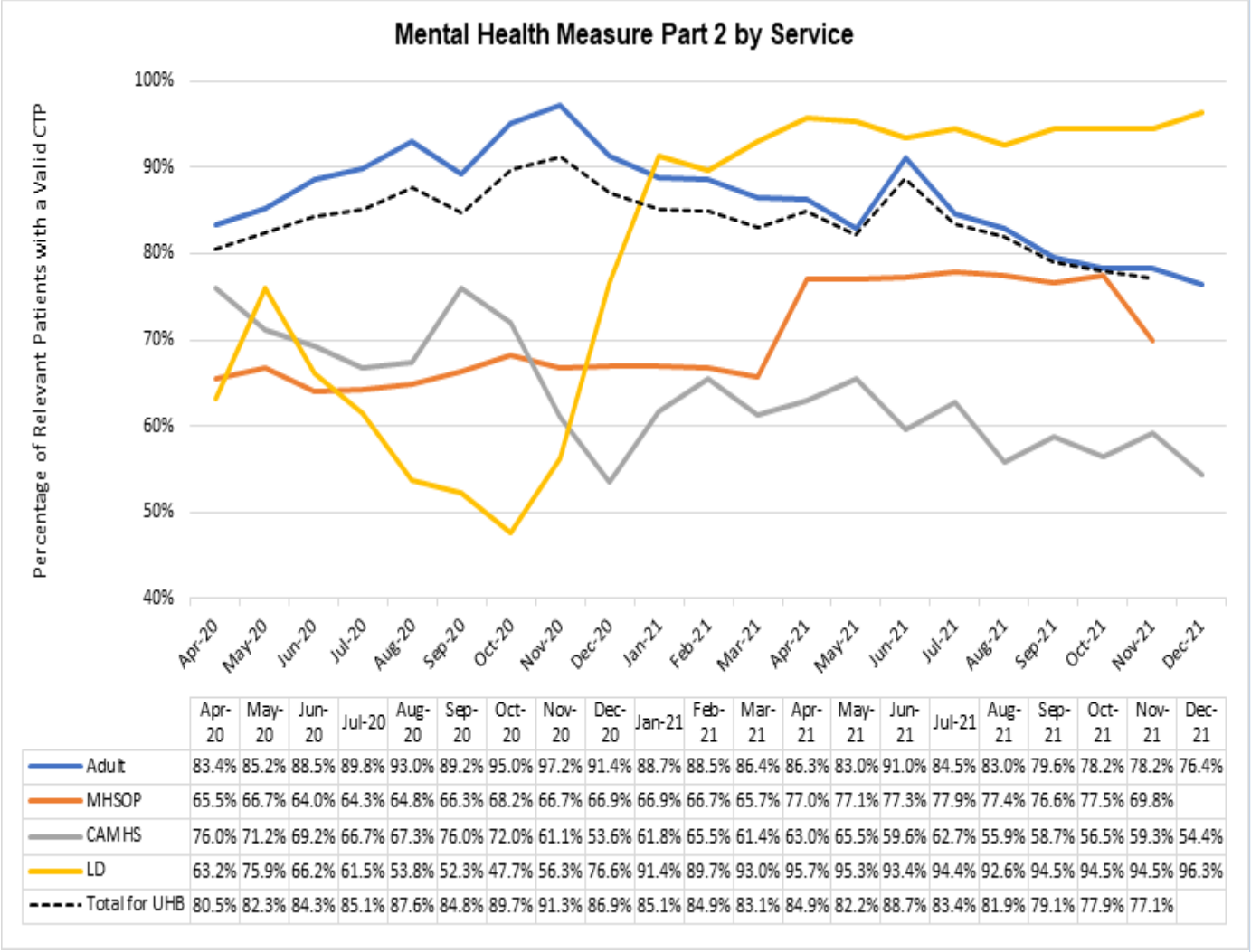
Part 2 – Care and Treatment Planning (Adult)

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

Graph 9 shows average compliance has dropped below 80% with a pattern of reduced discharges and higher allocations. MHSOP data for December is currently outstanding, Adult performance (where the majority of Part 2 patients are allocated) shows a slight decrease in compliance, down 1.8% on the previous month. Staff absences and sickness have been up to 8% in Mental Health services during the pandemic, these absences have resulted in consolidation of services around continuity of care for high risk patients, along with some recent redeployments of CMHT staff into other services.

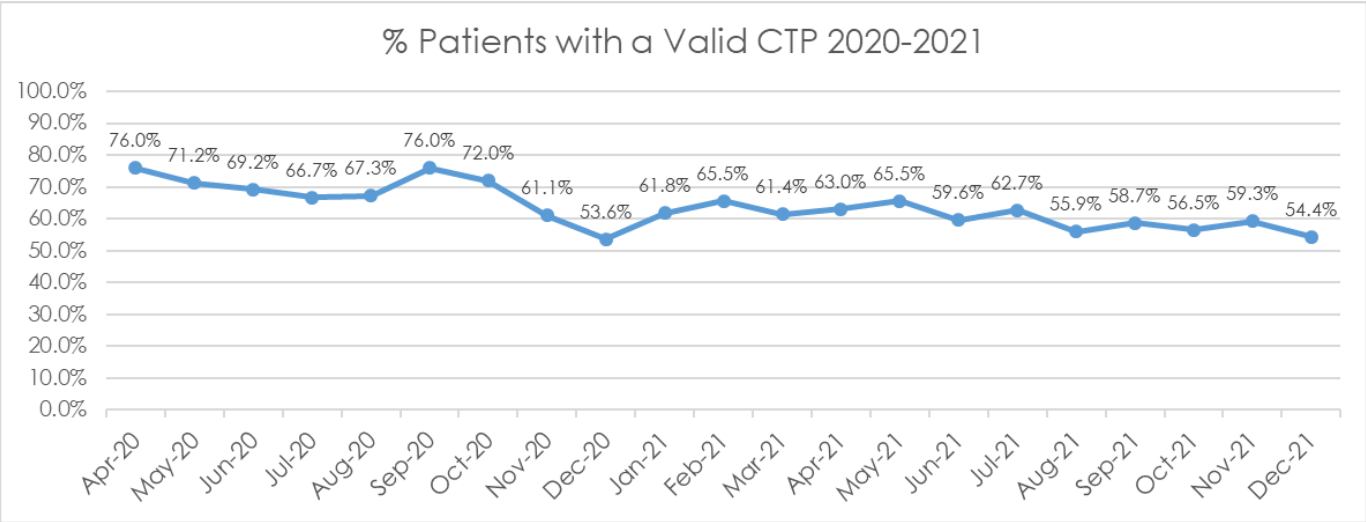
Graph 9



	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	Sep-21	Oct-21	Nov-21	Dec-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%	79.6%	78.2%	78.2%	76.4%
MHSOP	65.5%	66.7%	64.0%	64.3%	64.8%	66.3%	68.2%	66.7%	66.9%	66.9%	66.7%	65.7%	77.0%	77.1%	77.3%	77.9%	77.4%	76.6%	77.5%	69.8%	
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%	58.7%	56.5%	59.3%	54.4%
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%	94.5%	94.5%	94.5%	96.3%
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%	79.1%	77.9%	77.1%	

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

Graph 10

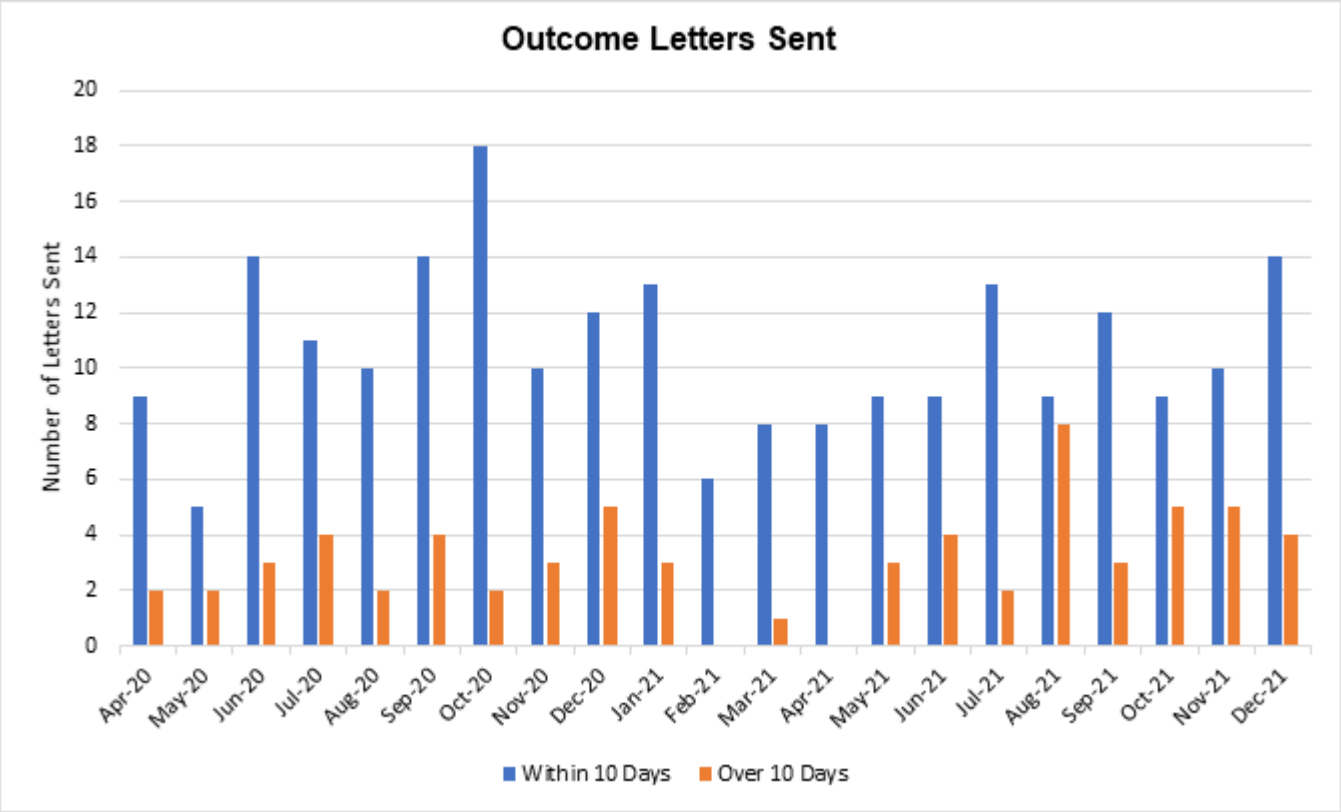


Graph 10 shows the service continues to underperform against the target, challenges to achievement have included poor engagement from patients in the CTP process and a high number of new patients requiring one. There are number of particularly complex cases that require a CTP where these have been unable 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). Graph 11 details our compliance of the target time of within 10 working days for an assessment outcome letter to be sent to the patient.

Graph 11



Since the changes in data capture in August 21 indicated some inaccuracies in reporting performance is improving while Part 3 referrals are rising (see Graph 11). Data now includes any breaches post discharge where Part 3 letters were not sent. New automated reports to teams have been set up to reduce breaches and to flag any consistent process concerns.

<u>Part 4 – Advocacy – standard to have access to an IMHA within 5 working days</u>

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:
The Committee is asked to support the proposed approach taken by the Mental Health Clinical Board to ensure compliance with the Mental Health (Wales) Measure 2010 as set out in the body of the report and as follows

Part 1:
Ongoing monitoring and recruitment in support of Part 1a. Longer term funding through transformational programmes will be required to support compliance with Tier 1a and 1b targets in Adult. Longer term demand analysis post covid and anticipated impact of 111 'Press 2' will need to be explored.
Part 2:
Increase co-production in the development of Care and Treatment Plans. Auditing care plans using Delivery Unit tool.
Part 3:
Continue to flag any performance issues to teams locally for improvement.
Part 4:
100% compliance, no further actions.

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	
2. Deliver outcomes that matter to people	X	7. Be a great place to work and learn	
3. All take responsibility for improving our health and wellbeing	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	

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:	HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021. **Covering report**	**Agenda Item no.**	**11.1**
Meeting:	**Mental Health & Capacity Legislation Committee**	**Meeting Date:**	9th February 2022
Status:	**For Discussion** | **For Assurance** | **For Approval** | **For Information**		
Lead Executive:	**Chief Operating Officer**		
Report Author (Title):	**Dan Crossland Interim Director of Operations Mental Health Clinical Board**		

Background and current situation:
HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021, HIW regulates and inspects NHS and independent Mental Health Services. This report is a summary of the 41 visits to healthcare providers during the 2020-21 period including a visit to Hazel Ward in Hafan Y Coed and independent providers used by Cardiff and Vale to support service users during this period.
The summary report also includes patient concerns and Regulation 30 and 31 notifications.
Of note during this period the majority of quality checks were conducted digitally due to the Covid 19 pandemic. Finally there is a review of the SOAD (Second Opinion Appointed Doctor) assessments completed during the period.

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

Nationally:

- PPE and restrictions have radically changed the way care is provided.
- Concerns and complaints raised by patients have risen in 2021, mainly in the category 'other' which included complaints in relation to infection prevention and control.
- Concerns and complaints raised by staff were mainly in relation to infrastructure, facilities, the care environment and staffing.
- Regulation 30/31s have fallen except in relation to deprivation of liberty.
- Digital exclusion affects quality of experience.
- Improvement in SOAD documentation.
- Video and telephone consultations have led to improvements in timescales and it is recommended these are maintained post-covid.

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

Quality impact: Leave restrictions and limited visiting arrangements can be compensated for by the use of technology. However, some patients are likely to be more disadvantaged due to digital exclusion and poor access by families to digital equipment.

Reputational: Mental Health Clinical Board are exploring the possibilty of developing seclusion facilities. There is a clear message in the report that 1 in 8 facilities with seclusion did not have satisfactory care planning, safeguarding and dignity considerations in place. Any service

developments around seclusion will need to provide firm assurance and involve external inspectors in the development of these facilities and their policies.

Safety and reputation: There has been an increased use of independent providers by the Mental Health Clinical Board during the pandemic. Providers mentioned within the report have since closed due to governance and safety concerns from the National Collaborative Commissioning Unit (NCCU), though no Cardiff and Vale service users have been in these placements, close contact and relationships with the NCCU are required to ensure that the Clinical Board are aware of any governance issues relating to service users in placements provided by independent units.

Recommendation:

The Committee are requested to:

NOTE the content of the HIW Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring Annual report 2020-2021.

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

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

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

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Mental Health Hospitals, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2020-2021

Contents

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose
To check that people in Wales receive good quality healthcare.

Our values
We place patients at the heart of what we do.

We are:
- Independent
- Objective
- Caring
- Collaborative
- Authoritative

Our priorities
Through our work we aim to:

Provide assurance:
Provide an independent view on the quality of care.

Promote improvement:
Encourage improvement through reporting and sharing of good practice.

Influence policy and standards:
Use what we find to influence policy, standards and practice.

Executive Summary

Our role is to ensure people in Wales receive good quality, safe and effective healthcare. We regulate and inspect independent mental health and learning disability healthcare services, we inspect NHS mental health and learning disability healthcare services. We monitor how services discharge their powers and duties under the Mental Health Act 1983 in Wales.

Through our inspection and monitoring processes we identify areas of good practice and areas of concern. We encourage providers to take steps to improve the services they provide, and we take action if we identify people using services are at risk of harm. This report sets out our activity and findings during the period April 2020 to March 2021, and explores the extent to which mental health and learning disability healthcare services across Wales provided safe, dignified and least restrictive care during the pandemic.

Our findings are drawn from a combination of digitally enabled quality checks, onsite focussed review and inspection visits, analysis of information received through our concerns and notifications processes, and the work of our Review Service for Mental Health (RSMH). During the reporting period we:

- Carried out 8 on-site inspection visits:
  - 1 NHS
  - 7 independent healthcare providers

- Undertook 33 digitally enabled quality checks:
  - 18 NHS
  - 15 independent healthcare providers

- Reviewed and where necessary sought further assurance about:
  - 151 patient concerns
  - 553 Regulation 30 and 31 Notifications

- Completed 756 Second Opinion Appointed Doctor (SOAD) assessments.

We found that the pandemic required rapid and unprecedented change in the way that healthcare was delivered across Wales, and whilst many of the services we considered had coped well, we also heard that in some areas the pandemic had significantly impacted on patients and staff.

The services we checked had introduced infection prevention and control measures and had adapted the care environment to minimise the transmission risk of COVID-19. Most services had developed COVID-19 risk assessments, management plans and policies specifically to support and sustain the operational changes required to stop the spread of infection. Sadly, and despite changes being implemented to help reduce the spread of COVID-19, we were notified on a number of occasions throughout the pandemic, of incidents of COVID-19 affecting patients and staff in independent mental health and learning disability healthcare settings, and we were

aware of outbreaks of COVID-19 in NHS mental health and learning disability healthcare settings.

We learnt that maintaining a positive patient experience during the pandemic had been challenging for some care providers. National and local restrictions meant that patients were at times unable to have leave of absence (section 17 leave), or receive visits from family and friends. We heard that the requirement for social distancing and wearing of personal protective equipment (PPE) had also radically changed the way in which care was provided.

We found a clear focus on the need for regular and effective communication with patients about the latest guidance and restrictions, including local lockdowns and changes to leave arrangements. We were told that increased activities had been provided, and video calling could be used, at times when visitors and leave of absence were not permitted, to enable patients to maintain contact with family and friends. We learnt that arrangements had been introduced to enable patients to use telephone and video conferencing facilities to participate in consultations with members of the multi-disciplinary team, to access statutory advocacy and support services, and to participate in Mental Health Review Tribunals. We identified the potential for some patients, for a range of reasons, to experience difficulties with this approach and recommended that providers take steps to support and enable patients to engage with others via digital means.

In previous years we have commented on the variability in quality and robustness of risk assessment and care and treatment planning documentation. Through our on-site inspection and focussed review work we saw some examples of good practice, but overall improvement is still needed. During some of our visits our concerns about care plans required urgent remedial action and resulted in the issue of non-compliance notices.

We checked whether environmental risk assessments had been undertaken and acted upon. As in previous years we identified the need for routine maintenance, redecoration and replacement of fixtures, fittings and furniture in some settings. We were particularly concerned to find inconsistent practice around ligature risk assessment and examples where action had not been taken to reduce or remove identified ligature point risks. These issues were particularly concerning, and as a result we wrote to the Chief Executive of NHS Wales to raise our concerns and to ask that action be taken in this area.

Many staff working in mental health and learning disability healthcare settings across Wales have worked under significant pressure throughout the pandemic. We heard through our conversations with managers and others that they were very proud and complimentary about their staff, and the work that had been accomplished during a difficult and challenging time. We found that the pandemic had prevented opportunities for face to face training, and we learnt that at times staffing levels were only achieved through frequent and considerable use of temporary agency staff. Some settings were carrying a number of registered nurse and support worker vacancies, and in these settings staffing had been further compromised at times when permanent staff were absent from work because they had symptoms of coronavirus or were required to self-isolate. We identified that a number of NHS and

independent mental healthcare providers needed to take action to recruit permanent staff to ensure safe and effective care, and this is an area that needs urgent attention and focus in the coming months.

Context

The COVID-19 pandemic has had a significant impact on the citizens of Wales. Healthcare services had to adjust in unprecedented ways to respond to the challenges presented by the pandemic and also to comply with the measures implemented nationally and locally to reduce the spread of the virus. These measures were set out in the Coronavirus Act (2020), and at times included restricting the free movement of the public.

Mental health and learning disability hospital services continued to operate within the NHS and independent sector throughout this time, and were required to continue to comply with mental health legislation and requirements of the Mental Health Act Code of Practice for Wales (Revised 2016). As a consequence of national and local restrictions, visiting and leave arrangements were paused a number of times during the pandemic. This meant that patient relatives, friends and visiting professionals did not attend care settings during much of the period covered by this report, and patients who would ordinarily have been able to have leave of absence (section 17 leave) were confined to the hospital and its grounds for extended periods of time.

In March 2020 we took the decision to temporarily pause our routine inspection and review activity. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of undertaking digitally enabled quality checks. Through this approach we were able to seek assurance from services at a time when the risk threshold for conducting inspection visits was high because COVID-19 was spreading in the community.

Throughout the pandemic we continued to operate the Second Opinion Appointed Doctors (SOAD) through our Review Service for Mental Health (RSMH) to ensure the rights of patients detained under the Mental Health Act 1983 were safeguarded. We also continued to operate the Regulation 30 and 31 notification process to ensure we were notified of events that could impact on patient safety in independent mental health and learning disability healthcare settings. Throughout the pandemic we continued to listen and respond to patients, relatives and staff members who contacted us about their concerns.

Our role in mental health care

As the regulator and inspector of independent mental health and learning disability healthcare services, and inspector of NHS mental health and learning disability services we have a responsibility to monitor how services discharge their powers and duties under the Mental Health Act 1983. Our role is to provide the public with assurance about the quality, safety and effectiveness of mental healthcare services in Wales. We do this by:

Listening to concerns

We use information about healthcare services to gain assurance about the quality and safety of services provided to citizens in Wales. This includes:

- Listening to the concerns of patients, relatives and advocates
- Listening to staff concerns
- Monitoring and reviewing incidents, notifications and safeguarding concerns

By triangulating evidence from a number of sources we obtain a fuller picture about the quality of care and support provided by mental health and learning disability healthcare services in the NHS and independent sector. When issues are identified we may visit a hospital outside of our routine work programme to assess the level of compliance with legislation and the delivery of effective care. These inspections seek evidence and assurance on a range of matters that effect outcomes for patients.

Throughout the pandemic we continued to operate our concerns and notifications processes, and we also continued to respond to people in mental health and learning disability healthcare settings who contacted us. Information we received through concerns and notifications is summarised in section 4 of this report.

Inspection and regulation

We are the regulator for all independent healthcare providers in Wales and we monitor and regulate the sector in accordance with the Care Standards Act 2000 and Independent Health Care (Wales) Regulations 2011.

We inspect NHS healthcare settings in Wales to check that people receive good quality healthcare. We use the Health and Care Standards (2015) and other standards to inform our inspection approach.

We took the decision to temporarily pause our routine inspection and review visits during the pandemic to support healthcare providers to focus their resources on keeping patients and staff safe. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of digitally enabled quality checks during the pandemic. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the risk of COVID-19 spreading.

Our quality check process commenced in August 2020 and focused on the key areas of COVID-19 arrangements, environment, infection prevention and control, and governance.

Our findings from the quality checks, inspections and focussed reviews we undertook during the period April 2020 to March 2021 are summarised in section 5 of this report. A list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring use of the Mental Health Act 1983

We monitor how services discharge their powers and duties in relation to the Mental Health Act 1983. This is undertaken on behalf of Welsh Ministers and is to protect the interests of people whose rights are restricted under the Act. Our Review Service Mental Health (RSMH) can investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment. Information is reviewed to seek assurance that:

- Individuals are lawfully detained, well cared for, and informed of their rights under the Act
- The Mental Health Act Code of Practice for Wales (Revised 2016) is being followed
- Appropriate plans are made for patients before they are discharged from hospital.

When considering information about the use of the Mental Health Act we are attentive to potential patterns and themes emerging in mental health and learning disability healthcare services, and we use this information to formulate judgements about the effectiveness and quality of the care provided. Our findings for the period April 2020 to March 2021 are summarised in section 6 of this report.

Review Service Mental Health (RSMH)

Through the Review Service Mental Health (RSMH) we operate the Second Opinion Appointed Doctor (SOAD) service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the Mental Health Act, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.

When requested by the Responsible Clinician (RC) with overall responsibility for the patient's care, the RSMH appoints a Second Opinion Appointed Doctor. The role of the SOAD is to provide an independent opinion about the prescribed treatment, and to ensure that it is appropriate and in the patient's best interests.

A summary of work undertaken by SOADs between April 2020 and March 2021 is provided in section 7 of this report.

Monitoring use of the Deprivation of Liberty Safeguards (DOLS)

We monitor use of the Deprivation of Liberty Safeguards (DOLS). The DOLS were introduced in April 2009 as part of the implementation of the Mental Capacity Act 2005. The DOLS ensure legal and administrative protection for people who lack capacity to consent to how they are cared for on a day to day basis, and are used when detention under the Mental Health Act 1983 is not appropriate. The safeguards protect human rights by providing a framework to ensure that care is provided to people in the least restrictive way. We monitor use of the Deprivation of Liberty Safeguards in NHS settings through analysis of statistical information and examination of policy and procedure implementation. Our Deprivation of Liberty (DOLS) annual monitoring reports are available via the Healthcare Inspectorate Wales web site.

Working as part of the UK National Preventive Mechanism

HIW is one of 21 member bodies of the UK's National Preventative Mechanism (NPM).

The UK ratified the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. The National Preventative Mechanism (NPM) was established in 2009 to comply with the OPCAT.

We monitor and inspect healthcare settings where people may be detained in Wales as part of this arrangement. Our reviewers meet with patients, managers and others to talk about their experiences, and we make recommendations to improve the treatment of individuals and conditions of detention when necessary. During our inspection visits we check that patients are:

- Lawfully detained and well cared for
- Informed about their rights
- Treated with dignity and respect
- Enabled to lead as fulfilling a life as possible.

The UK's NPM liaises directly with the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, which is an international body established by OPCAT.

We attend NPM business meetings, and we are a member of the NPM steering committee, the mental health sub group, and children and young people's sub group.

Listening to concerns

We receive information in the form of concerns, complaints and notifications from people who use mental health and learning disability services, their relatives, visitors, service providers, staff, and visiting professionals. This information forms a key component of our approach to checking that people in Wales receive safe and good quality care and treatment.

Each concern, complaint or notification we receive is assessed by a case manager who engages with the care setting, and when appropriate, coordinates with relevant agencies to ensure that concerns are investigated and action is taken when required. We are particularly attentive to potential patterns and themes that may be apparent in mental health and learning disability healthcare services, and we use the information received to consider the safety and quality of care provided.

Some concerns and notifications may trigger us to have formal discussions with a care provider or to carry out inspection or other assurance activity. If necessary, concerns about NHS settings can be escalated, and action can be taken on regulatory breaches in independent settings in line with our enforcement and non-compliance processes.

Concerns and complaints

During the reporting period we received:

- 434 complaints and concerns about healthcare providers in Wales
- 151 of these were about mental health and learning disability healthcare services:
  - 65 NHS mental health and learning disability services
  - 86 independent mental health and learning disability services.

Nature of concerns

We record information about the concerns and complaints we receive in the following categories:

- Allegations of abuse and/or neglect
- Infrastructure, including concerns about staffing, facilities and the care environment
- Consent, confidentiality and communication
- Treatment and/or procedures
- Clinical Assessment
- Mental Health Act 1983
- Other, to capture all concerns that fall outside of our existing themes

Table 1: Subject of concerns and complaints

Subject of concerns and complaints	NHS Settings			Independent healthcare Settings		
	2018-19	2019-20	2020-21	2018-19	2019-20	2020-21
Alleged abuse and/or neglect	3	8	3	1	15	17
Infrastructure, including staffing, facilities and the care environment	16	12	7	54	28	20
Consent, /communication/confidentiality	0	1	2	0	1	2
Treatment/Procedure	7	7	15	17	12	9
Clinical Assessment	9	2	4	3	1	2
Mental Health Act	5	5	1	1	6	1
Other	2	6	33	1	21	35
Total	**42**	**44**	**65**	**77**	**84**	**86**

Notably in 2020-21 we received a greater number of concerns that did not fall into one of our existing categories. This included an increased number of concerns and complaints about infection prevention and control, specifically related to the Covid-19 pandemic. These concerns and complaints have been included in the 'other' category.

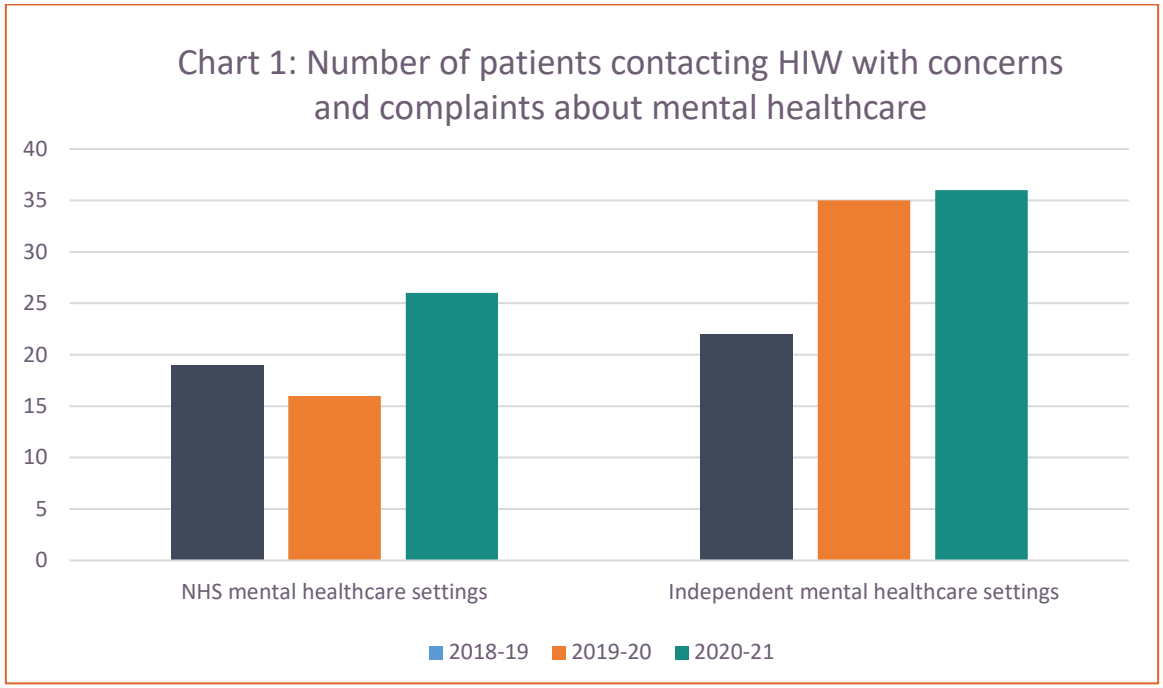
Concerns of patients, family members and advocates

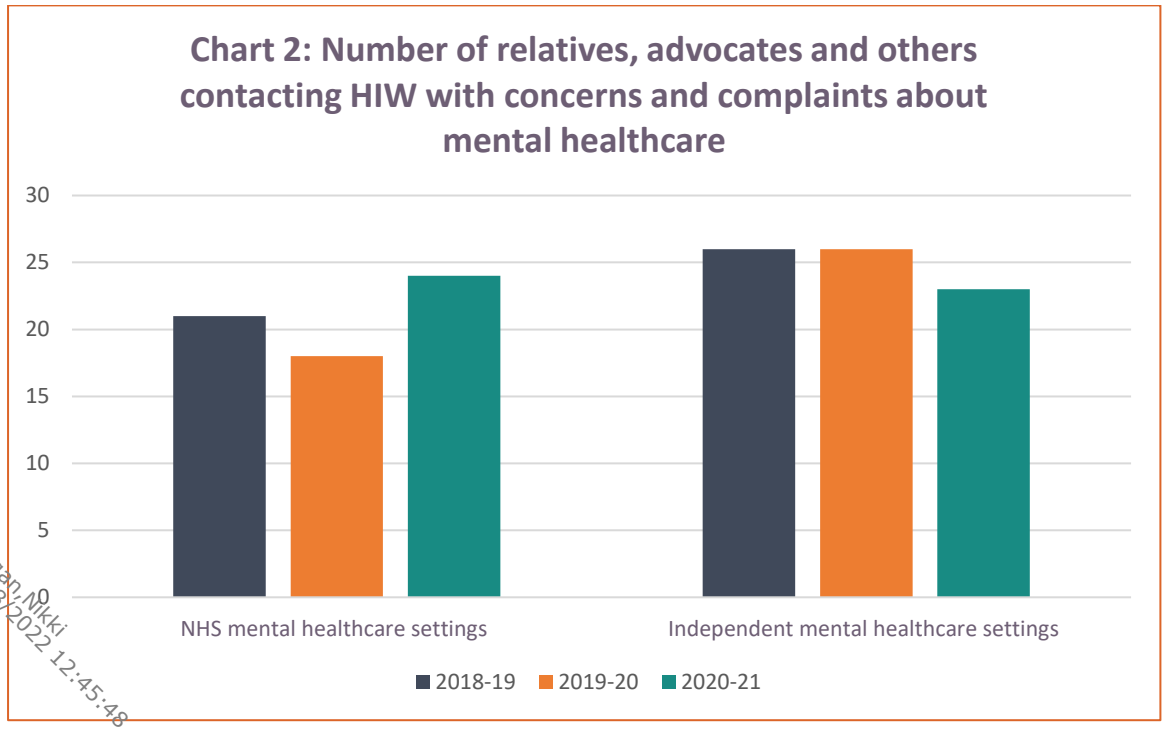
Over the last three years we have seen an increase in the total number of concerns and complaints that we have received from patients, relatives and advocates about mental health and learning disability services:

- 88 in 2018-19
- 95 in 2019-20
- 109 in 2020-21

A further breakdown is provided in charts 1 and 2, and further information about the theme of concerns is provided in Table 1.

Many of the complaints we received from patients were included in our 'other' category. We received concerns about section 17 leave, and detention under the Mental Health Act. Most of the concerns we received from patient relatives, advocates and others were in relation to their relative's treatment and/or procedures undertaken.





Staff concerns

As a Prescribed Body defined in the Public Interest Disclosure Act, we have a responsibility to consider 'whistleblowing' concerns reported in the public interest by workers or former workers in the mental health and learning disability healthcare services we regulate and inspect. Concerns may be about incidents occurring in the past, present, or could happen in the near future.

Over the last three years we have seen an increase in the total number of concerns and complaints that we have received from staff or former staff about mental health or learning disability healthcare services:

- 31 in 2018-19
    - 2 in relation to NHS services
    - 29 in relation to independent services

- 33 in 2019-20
    - 10 in relation to NHS services
    - 23 in relation to independent services

- 42 in 2020-21
    - 15 in relation to NHS services
    - 27 in relation to independent services

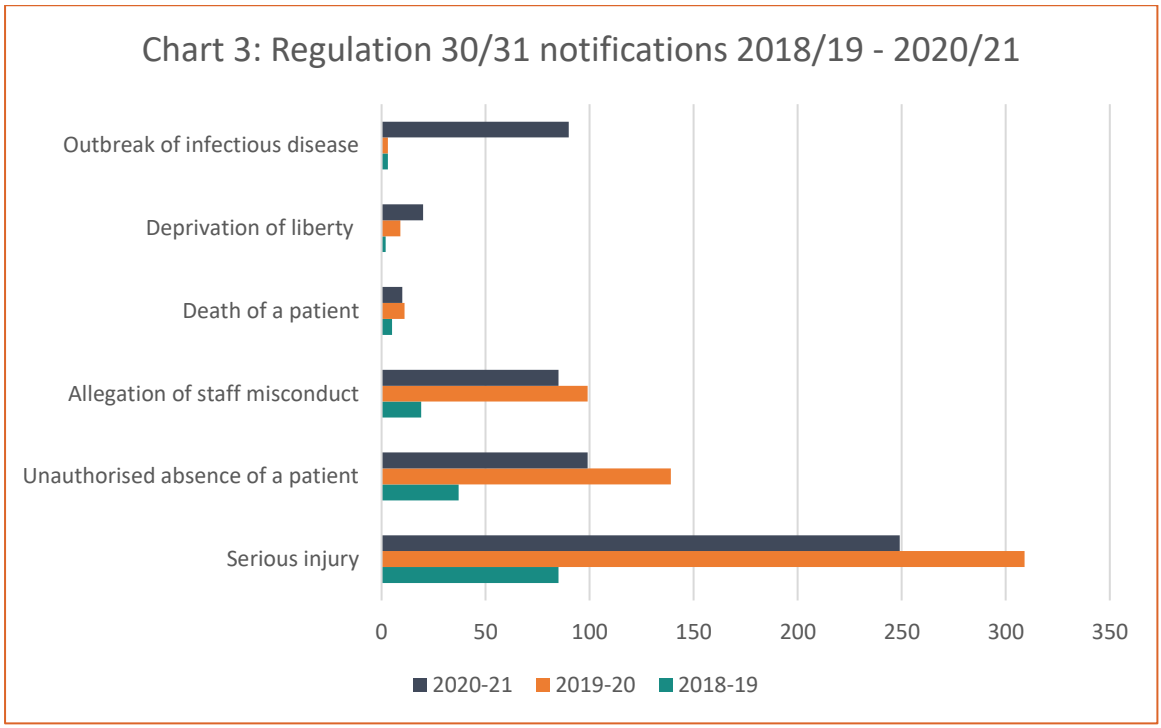
This year the majority of concerns received from existing or former staff were themed as being about infrastructure, facilities, the care environment, and staffing.

Reviewing Regulation 30 and 31 Notifications

Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 require the registered person of an independent hospital, independent clinic, or independent medical agency to notify us about particular events that occur relating to patient safety. This is a legal requirement, and includes notification of:

- Death of a patient
- Unauthorised absence
- Serious injury
- Outbreak of infectious disease
- Alleged staff misconduct
- Deprivation of liberty

During the reporting period, we received 553 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was slightly less than the number of notifications we received in 2019-20. Notifications were themed as shown in Chart 3.



During 2020-21 we noted an increase in notifications about depravation of liberty, and a significant increase in notifications of an outbreak of an infectious disease. This was indicative of the Covid-19 pandemic impact within independent mental health and learning disability healthcare settings in Wales. We received fewer notifications about allegations of staff misconduct, unauthorised absence of a patient, and serious injury than in 2019-20.

In our report for last year we indicated that during that year we had worked with independent providers of mental health and learning disability care to ensure that we were correctly notified of all incidents in accordance with the Independent Health Care (Wales) Regulations 2011. As a result, significantly more reports of serious injury were received in 2019-20 than in the previous year and we commented that we had provided clarification on the definition of serious injury to ensure more accurate reporting. In 2020-21 we noted a slight reduction in the number of serious injury notifications when compared to 2019-20, and we will continue to monitor all such notifications throughout the course of the coming year.

In our 2019-20 report we also commented that increased allegations of staff misconduct were notable. We set out that this had coincided with a change in ways of working that resulted in local safeguarding teams providing us with information about safeguarding concerns and referrals. In 2020-21 we noted a slight decrease in the number of notifications we had received alleging staff misconduct. We continue to scrutinise all notifications and safeguarding referrals we receive and will continue to use this information to inform our actions in the coming year.

Inspecting mental health and learning disability healthcare services

We took the decision to temporarily pause our routine inspection and review activity during the pandemic. This meant that whilst we maintained our ability to undertake inspection visits when we had concerns about risks to patient safety, we adopted a new approach of undertaking digitally enabled quality checks for most of our work in mental health and learning disability healthcare care settings. This approach enabled us to seek assurance from services at a time when the risk threshold for conducting inspection visits was particularly high because of the spread of COVID-19.

We undertook:

- 8 on-site inspection and focussed reviews:
  - 1 NHS setting
  - 7 independent healthcare settings

- 33 Quality Checks:
  - 18 NHS settings
  - 15 independent healthcare providers

Our on-site inspection and focussed review visits were all unannounced, often starting in the evening so that the inspection team could observe care and treatment provided at different times of the day. Two independent healthcare providers were visited more than once because of the nature of the concerns identified in those settings.

During our on-site inspections and focussed reviews we:

- Observed how staff interacted with patients, and asked patients about all aspects of their experience
- Looked at assessment, care and treatment plans, including records of restraints undertaken
- Reviewed policies, procedures and audit findings, including those related to infection prevention and control
- Considered the environment of care, and checked that it was appropriate to meet the needs of patients
- Reviewed administration of the Mental Health Act, and compliance with the Mental Health Code of Practice for Wales.

Our quality checks were announced in advance. We wrote to providers to request documents and written evidence for our inspector and, when required, a clinical peer reviewer, to assess before interviewing staff as part of the quality check process.

Through our quality checks we:

- Considered how services designed and managed the environment of care to maintain safety for patients, staff and visitors during the pandemic
- Checked how services responded to the challenges presented by the pandemic, including how well they managed and controlled the risk of infection
- Explored whether management arrangements ensured sufficient numbers of appropriately trained and supported staff to provide safe and effective care.

Throughout the pandemic we also worked with the National Collaborative Commissioning Unit, the body that commissions specialist services on behalf of health boards in Wales, to ensure that enhanced arrangements were in place to monitor patient and staff safety within independent mental health and learning disability healthcare settings. This included seeking assurance about business continuity arrangements and obtaining regular updates on key issues, including staffing levels, potential infections, and instances where patients needed to isolate from others to prevent transmission of COVID-19.

A list of the health boards and independent registered providers we visited or were subject to a quality check is included as Appendix A, along with links to the reports of findings.

Our findings

Our findings are drawn from a combination of the quality checks and the on-site focussed review and inspection visits we carried out during the year.

We know that the Covid-19 pandemic required rapid and unprecedented change in the way that healthcare services were delivered across Wales, and whilst many of the services we considered had coped well, we also heard that in some settings the pandemic had significantly impacted on the health and wellbeing of patients and staff.

Preventing and controlling the spread of COVID-19

We found that mental health and learning disability healthcare services had introduced infection prevention and control measures and had adapted the care environment to minimise the transmission risk of COVID-19. It was positive to learn that arrangements had been put in place in many settings to ensure that patients were regularly provided with information about the pandemic, and the need for enhanced infection prevention and control arrangements and other restrictions.

We learnt that individual wards were considered as household bubbles in line with national guidance, and changes had been implemented to increase social distancing between patients within the ward bubble. These included decluttering patient areas

and the introduction of clear signage reminding patients and staff about the need for social distance. Some settings had introduced changes including staggered meal times so that less people were present at the same time in dining rooms and other communal areas. However, through our inspection activity we also saw areas such as offices where social distancing was not always complied with, and where we saw this we brought this to the immediate attention of the service providers.

We found that there were good arrangements in place across all mental health and learning disability healthcare settings we checked to ensure staff had appropriate access to the required levels of personal protective equipment (PPE). During most of our inspection visits we observed the correct use of PPE, and that audits were being undertaken to monitor staff compliance with guidance and requirements. We highlighted to some providers the need to ensure that staff correctly wore face masks in accordance with the current guidance and requirements, and to ensure information to support the correct donning and doffing of PPE and good hand hygiene practice was displayed.

We found that most services had developed COVID-19 risk assessments, management plans and policies specifically to support and sustain the operational changes required to stop the spread of infection. However, we observed through our quality checks and inspection visits that some services had not updated their plans and policies to reflect the latest government and public health guidelines, and we made recommendations for individual services when we found this.

Sadly, and despite changes being implemented to help reduce the spread of COVID-19 we were notified throughout the pandemic of incidents of COVID-19 affecting patients and staff in independent mental health and learning disability healthcare settings, and we were aware of outbreaks of COVID-19 in NHS mental health and learning disability healthcare settings. We found, through our quality checks, that independent mental health and learning disability healthcare services had been able to access advice and guidance from experts in Public Health Wales when needed, and NHS mental health and learning disability healthcare services had been supported though health board infection, prevention and control teams.

Dignified and least restrictive care

Maintaining a positive patient experience during the pandemic has been challenging for some mental health and learning disability healthcare services. National and local restrictions have meant that patients were at times unable to have leave of absence (section 17 leave), or receive visits from family and friends.

We learnt that throughout the pandemic, patients in some settings were considered to be one household for the purposes of the coronavirus regulations. This approach was adopted to ensure that care was provided in the least restrictive way. Expecting people who are detained under the Mental Health Act 1983 to be confined to their own bedroom would have be overly restrictive and could have negatively impacted on the mental wellbeing and recovery of some patients.

We heard that the requirement for social distancing and wearing of personal protective equipment (PPE) had radically changed the way in which care was

provided during the pandemic. We found that there was a clear focus on the need for regular and effective communication with patients about guidance and restrictions, including local lockdowns and changes to leave arrangements. We learnt that hospital managers and clinical staff approached this in a variety of ways, which included the introduction of daily patient briefings in some settings, along with one to one meetings when required. We heard positive comments from patients during our inspection visits about their relationship and interactions with staff. During our visits we also observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

We were told that video calling could be used to enable patients to maintain contact with family and friends at times when visitors and leave of absence were not permitted because of the pandemic. However, during some of our inspection visits we noted poor Wi-Fi access in some facilities, and poor access to ward mobile phones. In addition, as patient access to personal phones and other electronic devices might be dependent on risk assessment or level of independence, we were concerned that some patients may have experienced digital exclusion, and contact with family and friends might have been inhibited as a result. We encouraged care providers to take steps to maximise Wi-Fi coverage in patient areas, and to ensure arrangements were in place to provide assistance when necessary to support and enable patients to maintain contact with family and friends.

It was positive to learn that when restrictions eased, and visiting was permitted, significant efforts had been made to enable this in a safe and supportive way. Some settings had invested in additional garden furniture or had identified dedicated space for visiting. Enhanced cleaning regimes and 'track and trace' arrangements had been introduced. We found that this was generally well managed, and the necessary risk assessments were in place to ensure that the safety of patients, visitors and staff was maintained.

We found that arrangements had also been introduced to enable patients to use telephone and video conferencing facilities to enable participation in consultations with members of the multi-disciplinary team, and to enable continued access to statutory advocacy and support services. We found that all of the settings we checked could demonstrate that patients' rights to have their detention reviewed by the Mental Health Review Tribunal for Wales were maintained during the pandemic.

Use of restraint

Mental health and learning disability healthcare settings are required to have systems in place to ensure all incidents of restraint are recorded in sufficient detail, reviewed and monitored to ensure safe and lawful practice.

During our inspection and review visits we were told about strategies for managing challenging behaviour to promote the safety and well-being of patients. We heard about preventative and de-escalation techniques, and were advised that physical restraint of patients was used as a last resort to prevent harm to the patient or others. We saw good evidence in some settings that showed each patient had an

individualised restraint reduction plan in place which identified the least restrictive options for risk management.

We reviewed restraint data and identified a setting with a high number of restraints and instances of prolonged restraint taking place. The data included the use of 'soft' restraint of patients being fed through use of a nasogastric (NG) tube so we required the provider to review the data and to provide us with more information about whether restraint was only used as a last resort, and was proportionate to the circumstances. We revisited the setting and spoke with patients, staff, and looked at documentation, policies and procedures regarding the practice of restraint which resulted in a non-compliance notice in regards to the Independent Health Care (Wales) Regulations 2011 being issued.

We also identified, through our onsite work, a setting where patients detained under the Mental Health Act had been placed in handcuffs to go to a general hospital. Use of handcuffs must always be proportionate and necessary in the circumstances, and use must at all times be compliant with the Mental Health Act Code of Practice for Wales. On further scrutiny of this practice we required the provider to review and update their policy documentation to support safe and least restrictive practices.

Use of seclusion

The use of seclusion should always be the final option in response to a patient's risk behaviours, and should only be utilised when other behaviour management strategies have been unsuccessful. The rights of patients must at all times be safeguarded, and the potential for use of seclusion must be identified through robust assessment and care planning processes, and decision making informed by evidence based policies and procedures.

In 1 of the 8 inspection visits we undertook we identified significant deficiencies in the seclusion care plans provided to our inspection team. We identified that a patient was being cared for in a seclusion suite on an empty ward. Staffing requirements were unclear and the patient's care plan did not contain sufficient detail to assure us that staff were able to care for the patient safely and effectively. We were concerned about the use of CCTV cameras to monitor the patient when undertaking personal care, and the absence of a documented rationale to support this practice. We considered these to be serious matters resulting in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Meaningful and therapeutic activities

Through our Quality Check work we were told by some mental health and learning disability healthcare providers that the pandemic had significantly impacted on the wellbeing of patients, and had sometimes resulted in increased incidents of behaviours that challenge.

Providing opportunity and encouraging people to engage in meaningful and therapeutic activities can help provide a structured day and can positively impact on wellbeing and recovery by reducing stress, frustration and boredom. It was positive therefore to find through our quality check work that significant efforts had been made to develop additional activities and new initiatives to enable patients to be engaged with activities during the pandemic.

We learnt that patients were able to access a range of activities, and had opportunity to engage in therapies, educational and recreational activities. These included gardening and use of the hospital grounds for walking, yoga and outside gym activities, access to indoor exercise equipment, and indoor golf. We learnt that some mental healthcare settings had established a shop within the hospital to enable patients to buy items at times when they were unable to access local shops because leave of absence was not possible.

We have in previous reports stressed the importance of meaningful social and recreational activities for patients in mental health and learning disability healthcare settings and would strongly encourage service providers to maintain this additional provision when services return to usual ways of operating after the pandemic.

Risk assessment and care planning

Comprehensive risk assessments and care plans are necessary to ensure safe, effective and person centred care. In previous years we have commented on the variability in quality and robustness of risk assessment and care and treatment planning documentation.

It was pleasing to see during our inspection visits examples of good practice, including evidence of multidisciplinary team (MDT) input into care planning processes. We saw examples where individualised risk assessments and care plans relating to COVID-19 arrangements had been put in place to support patients, and to promote understanding about the importance of social distancing, good hand hygiene, and the use of face masks.

However, we also saw examples of inadequate risk assessment and care plan documentation. These were in relation to a variety of matters including, wound care, self-harming behaviours, observation levels, seclusion, the use of CCTVs, restraint, and a failure in some cases to evidence and document unmet needs. We again saw that documentation in relation to medicines management needed to be improved.

During some of our visits concerns about care plans resulted in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Whilst we saw evidence during some of our inspection visits that care documentation and risk assessments had improved following a previous inspection of the setting, overall improvement is still needed. Service providers must ensure appropriate systems and oversight arrangements, including clinical audit, are in place to ensure that care documentation is always completed to the required standard.

Environment of care

We heard that significant efforts had been made in response to the pandemic to redesign some clinical areas. This included the creation of facilities for isolation of new patients on admission, and for existing patients when displaying symptoms of COVID-19 or returning from periods of leave. This was easier to achieve in settings with single bedroom and en-suite facilities, and was more challenging to achieve in other settings, particularly those services provided from old estate.

We found that arrangements had been put in place in many settings to enhance cleaning arrangements to reduce the spread of COVID-19. We reviewed evidence, such as cleaning schedules and audits that highlighted frequent cleaning of higher traffic areas, including door handles, handrails and chairs. However, this was not the case in all settings and we highlighted the need for improved cleaning, decluttering and routine maintenance in patient and staff areas during some of our inspection visits, including the need for adequate numbers of cleaning staff during weekends to ensure this.

Through our quality checks and inspection visits we checked whether environmental risk assessments had been undertaken and acted upon. As in previous years we identified the need for routine maintenance, redecoration and replacement of fixtures, fittings and furniture in some settings. During some of our inspection visits we saw damaged or unsuitable furniture in patient areas and inadequate storage arrangements for patient belongings and ward equipment. In some cases we saw that this was having a detrimental effect on safety, privacy and dignity.

We checked the arrangements for ligature point risk assessments, and we were concerned to find inconsistent practice in six of the 12 quality checks we completed in NHS mental health settings. We found examples where action had not been taken to reduce or remove identified ligature point risks, and risk assessments that were over 12 months old. We were told by some staff that remedial work had been delayed due to cost and a backlog of work for estates and maintenance teams to address. These issues were particularly concerning, and as a result we wrote to the Chief Executive of NHS Wales in March 2021 to raise our concerns and to ask that action be taken in this area.

Workforce

Many staff working in mental health and learning disability healthcare settings across Wales have worked under significant pressure throughout the pandemic. We heard through our conversations with managers and others that they were very proud and complimentary about their staff, and the work that had been accomplished during a difficult and challenging time. We were told about a range of positive interventions to help support the well-being and mental health of staff, including access to

occupational health and psychological support. We also heard about the value of peer support in helping staff to feel supported.

We found that the pandemic has prevented opportunities for face to face training. In addition, increased work pressures had led to reduced compliance with mandatory training in some settings, particularly during the early stages of the pandemic. Across Wales, we were told about an increased emphasis on e-learning, however, some essential training, such as safe de-escalation techniques, cannot be delivered as effectively remotely, and lack of training can pose significant risks to patients and staff. This will need urgent attention to address.

We learnt that, at times, staffing levels were only achieved through frequent and considerable use of temporary agency staff. We found that some settings were carrying a number of registered nurse and support worker vacancies, and in these settings staffing had been further compromised at times when permanent staff were absent from work because they had symptoms of coronavirus or were required to self-isolate. We identified that a number of NHS and independent service providers needed to take action to recruit permanent staff in order to maintain required staffing levels and skill mix to ensure safe and effective care. This is an area that needs urgent attention and focus in the coming months.

Monitoring the Mental Health Act, 1983 (the Act)

People who access mental health and learning disability services do so either as an informal patient or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the Mental Health Act 1983.

The Mental Health Act (hereafter referred to as 'the Act') is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The Act provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

As part of our statutory responsibilities we monitor how services discharge their powers and duties under the Act, and we provide the public with assurance about the quality, safety and effectiveness of mental healthcare services in Wales.

How the Act is monitored

HIW is one of a number of individuals and organisations with powers and responsibilities under the Act. These include officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained.

On behalf of Welsh Ministers, we:

- Publish an annual report detailing how the Act is being implemented in Wales
- Review how powers granted by the Act are exercised
- Operate the Second Opinion Appointed Doctor (SOAD) service
- Investigate complaints about application of the Act.

During 2020-21, and as part of the work we undertook to fulfil our role and responsibilities to monitor how mental healthcare services discharged their powers and duties under the Act, we:

- Talked to detained patients during our visits to mental healthcare settings
- Listened to the concerns of patients and family members who contacted us, and engaged with mental healthcare services to ensure concerns were investigated and action taken when required
- Spoke to hospital managers and other staff about matters that effected care and treatment provided to people detained under the Act
- Reviewed information and documentation to seek assurance that people were lawfully detained, well cared for, and were informed of their rights.

Mental Health Act Reviewers

During our visits to mental healthcare services we used Mental Health Act Reviewers to consider how the Act was being implemented and administered. They looked at relevant documents and checked if:

- The Mental Health Code of Practice 2016 was being implemented
- Legal papers for detention were appropriately completed and accessible
- All reasonable steps were taken to ensure that detained patients were given information about their rights in accordance with section 132 of the Act
- Policies and procedures reflected the requirements set out in the Mental Health Act Code of Practice 2016
- Effective care and treatment plans were in place, that reflected the patients detained status, and the requirements of the Mental Health (Wales) Measure 2010
- Patients had access to members of the multi-disciplinary team.

In each of our visits to mental healthcare settings we reviewed a sample of patient records and documentation relevant to a patient's detention.

Our Findings

Ensuring patient rights

Through our review of statutory detention documents we verified that the patients whose records we reviewed were legally detained. We saw evidence that detentions

had been renewed within the requirements of the Act, and that copies of legal detention papers were available.

We saw electronic documents on wards, and that paper records were stored securely in the Mental Health Act Administrator's office. The records we viewed were, in the main, well organised, easy to navigate and contained detailed and relevant information.

We saw entries in the patient records we reviewed which documented that the individual had been informed of their rights. We saw evidence of multidisciplinary team involvement in care plans, which reflected the domains of the Mental Health (Wales) Measure.

In most cases we saw evidence that appeals against detention were held within the required timescales. However, during one of our visits we were told that Hospital Manager Hearings had fallen behind during the COVID-19 pandemic, as the focus had been on ensuring that Mental Health Tribunals went ahead to review the patients appeal. We required the provider to address this.

During our inspection visits we checked that medication was provided to patients in accordance with section 58 of the Act, and that consent to treatment certificates were kept with the corresponding Medication Administration Record. We found that staff administering medication could refer to the certificate to ensure that the medication was prescribed in compliance with the consent to treatment provisions of the Act.

Generally we saw that section 17 leave forms were completed appropriately, risk assessed, and that there was evidence of patient involvement in this process. On the occasions when we identified that corrective action was necessary Mental Health Act Administrators agreed to do this. This included when we identified that a statutory consultee form was missing from the records being reviewed, a setting where we identified an error on the record of a patient no longer at the hospital, and the storage of section 17 and section 132 documentation.

Care and treatment planning

Generally we found that the patient records we reviewed were maintained to a good standard, were comprehensive and easy to navigate. We saw that recognised assessment tools were used to assess risk, and to monitor the mental and physical healthcare needs of the patient. We also saw evidence of multidisciplinary involvement in care plans which reflected the domains of the Mental Health (Wales) Measure 2010.

It was positive to see care documentation that was patient focussed and clearly demonstrated patient involvement in care discussions. However, we also saw care plans that lacked detail, did not adequately address identified risks, and did not include clear objectives and outcomes to support recovery. We noted in some instances that unmet needs were not always documented.

During some of our visits our concerns about care plans resulted in the issue of a non-compliance notice as urgent remedial action was required. This meant that we alerted the service to our concerns during our visit, and wrote to the Registered Provider immediately following the inspection requiring action to be taken. Full inspection reports can been accessed on our website, or by following the relevant hyperlink in Appendix A.

Audit and governance arrangements

During our visits we reviewed the systems and processes that mental healthcare providers had in place to ensure oversight, monitoring and audit of their application of the Act.

In many settings we found there to be robust systems of audit in place for checking and managing statutory documentation. We found that some providers maintained oversight of the Act through clinical governance meetings. In some settings we noted that improvements had been made following our previous inspections. However, we were also advised that completion of improvement actions following audit process had been disrupted in some settings by the pandemic and the need for some staff to work from home. We recognised that the pandemic had presented new and varied challenges to mental healthcare services, however, service providers must take action to ensure improvements are completed in a timely manner.

Review Service Mental Health (RSMH)

We monitored how services discharged their powers and duties under the Mental Health Act 1983. We did this on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our Review Service Mental Health (RSMH) can investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The role of the Second Opinion Appointed Doctor (SOAD) is to safeguard the rights of patients who are detained under the Act and either do not consent, or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

The SOAD is an independent doctor, and assessment by a SOAD is always required to safeguard the rights of:

- Liable to be detained patients subject to Community Treatment Orders (CTOs) (section 17A) who either do not consent, or do not have capacity to consent to the proposed treatment

- Patients for whom serious and invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive (section 57) are proposed
- Detained patients of any age who do not consent or do not have capacity to consent to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder
- All patients under 18 years of age, including those who are not detained, for whom ECT is proposed

SOADs come to their own opinion about the degree and nature of an individual's mental disorder, and whether or not the patient has capacity to consent to the proposed treatment. The SOAD has responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

During the pandemic the SOAD service has continued to operate using an adapted 'COVID-19 safe' methodology. This meant that hospital visits were suspended, and a digitally enabled approach was put in place to ensure that SOADS were able to fulfil their statutory responsibilities, including having discussions with patients and staff. Full details of the temporary methodology can be viewed on the Review Service for Mental Health (RSMH) pages of the healthcare Inspectorate Wales website.

SOAD activity

During the period April 2020 to March 2021, our Review Service Mental Health (RSMH) received:

- 756 requests for an assessment by a SOAD:
  - 693 were related to the certification of medication
  - 43 were related to the certification of ECT
  - 20 were related to both medication and ECT

Fewer requests were received in 2020-21 than in the previous 6 years. The reasons for this are unclear. Information about the number of requests per year since establishment of the SOAD service within HIW in 2006 is provided in Table 2.

Table 2: Requests for visits by a SOAD, 2006-07 to 2020-21

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756

Source: SOAD requests to HIW

Timely SOAD assessment

It is important that the SOAD assessment is completed in a timely way, and once a request has been received the RSMH aim to ensure that the SOAD undertakes the assessment as soon as possible, and within:

- 2 working days for a referral in relation to ECT
- 5 working days for referrals about prescribed medication when the patient is in hospital
- 10 working days when the referral is in relation to someone subject to a Community Treatment Order.

In our report last year we indicated that when SOAD assessments took longer to complete this was most often linked to the need to request further information or for consultations or interviews to be arranged, and included:

- The availability of the Responsible Clinician or Statutory Consultees to be consulted by the SOAD
- Absence of documentation detailing interview with the patient
- The availability of the patient, or it was not clear whether the patient wished to be interviewed by the SOAD

We have found that implementation of the COVID-19 safe methodology has enabled the SOAD easier access to consult with the Responsible Clinician and Statutory Consultees. This, in combination with the requirement for all relevant

documentation to be provided to the SOAD in advance of the consultations, has resulted in an improvement in the time taken to complete the assessment process.

Throughout the pandemic we have continued to work with the Mental Health Act Administrators in local health boards and independent mental healthcare settings to ensure that the SOAD referral and assessment process was completed in a timely way. We intend to keep elements of the COVID-19 safe methodology to maintain the improvements in the referral and assessment timescales seen during the reporting period. This will include:

- Offering the option of telephone or video conference consultations with the Responsible Clinician and Statutory Consultees, and Maintaining the requirement for health boards and independent mental health hospitals to provide information for the SOAD in advance.

Review of treatment (Section 61)

When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.

Our lead SOAD audited the reports on a monthly basis to ensure that appropriate safeguards were in place to protect the patient's rights. Although we have continued to identify areas for improvement, overall we have noted continued improvement in the quality of the documentation. We will continue with our audit programme in the coming year and will continue to work with mental healthcare service providers to make improvements.

Our Data

To prepare this report we analysed data from our work between April 2020 and March 2021, including our Mental Health Act monitoring activities, quality checks, and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Feedback on this report

If you have any comments or queries regarding this publication please contact us

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Appendix A: Relevant work 2020-2021

	Hospital	Link	Date	Type
1	Ty Grosvenor, Wrexham	English	29/06/2020	Focussed review
2	Heddfan Unit, Wrexham Maelor Hospital	English	07/07/2020	Focussed review
3	Delfryn House and Lodge, Mold	English	10/08/2020	Quality check
4	Gellinudd Recovery Centre, Pontadawe	English	11/08/2020	Quality check
5	Ty Gwyn Hall, Abergavenny	English	12/08/2020	Quality check
6	Cefn Carnau Uchaf, Caerphilly	English	12/08/2020	Quality check
7	Coed Du Hall, Mold	English	12/08/2020	Quality check
8	St Teilo house, Rhymney	English	13/08/2020	Quality check
9	St David's Independent Hospital, Corwen	English	13/08/2020	Quality check
10	Newton Ward, Caswell Clinic, Glanrhyd hospital	English	25/08/2020	Quality check
	Angelton Clinic, Glanrhyd Hospital	English	03/09/2020	Quality check

12	Heatherwood Court, Pontypridd	English	08/09/2020	Quality check
13	Ty Llidiard, Bridgend	English	09/09/2020	Quality check
14	Careg fawr Unit, Bryn Y Neuadd Hospital	English	29/09/2020	Quality check
15	Tawe Ward, Ystradgynlais hospital	English	30/09/2020	Quality check
16	Ty Grosvenor, Wrexham	English	04/10/2020	Focussed review
17	Bryngolau Ward, Prince Phillip Hospital	English	06/10/2020	Quality check
18	Adferiad Ward, St Cadoc's hospital	English	07/10/2020	Quality check
19	New Hall hospital, Wrexham	English	21/10/2020	Quality check
20	Priory Church Village, Pontypridd	English	10/11/2020	Quality check
21	Aderyn, Pontypool	English	16/11/2020	Quality check
22	Cefn Yr Afon, Bridgend	English	18/11/2020	Quality check
23	Ablett Unit, Ysbyty Glan Clwyd	English	20/11/2020	Quality check

24	Aberbeeg Hospital, Abertillery,	English	25/11/2020	Quality check
25	Ty Skirrid Ward, Maindiff Court Hospital	English	25/11/2020	Quality check
26	Rushcliffe Independent Hospital, Port Talbot	English	27/11/2020	Quality check
27	Ty Catrin Cardiff	English	30/11/2020	Inspection
28	Ty Lafant Assessment and Treatment Unit, Llanfrechfa Grange Hospital	English	01/12/2020	Quality check
29	Hillview Regis Ebbw Vale	English	17/01/2021	Focussed review
30	Pinetree Court, Cardiff	English	18/01/2021	Quality check
31	Llanarth Court, Abergavenny,	English	25/01/2021	Inspection
32	Ty Cwm Rhondda, Ystrad, Pentre	English	27/01/2021	Quality check
33	Hillview Regis, Ebbw Vale	English	23/02/2021	Focussed review
34	Enlli Ward, Bronglais Hospital	English	02/03/2021	Quality check
35	Morlais Ward, Glangwili Hospital	English	04/03/2021	Quality check

36	East 12, University Hospital Llandough,	English	10/03/2021	Quality check
37	Coed Celyn Hospital, Wrexham	English	17/03/2021	Quality check
38	Hazel Ward, Hafan y Coed	English	18/03/2021	Quality check
39	Delfryn Lodge, Mold	English	22/03/2021	Inspection
40	Clywedog ward, Llandrindod Wells Hospital	English	23/03/2021	Quality check
41	Hergest Unit, Ysbyty Gwynedd	English	30/03/2021	Quality check

Appendix B: Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also *independent mental health advocate*.
Appropriate Medical Treatment	Medical treatment for mental disorder which is appropriate taking into account the nature and degree of the person's mental disorder and all the other circumstances of their case.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers
CO1 form	Certificate of consent to treatment and second opinion (Section 57)
CO2 form	Certificate of consent to treatment (Section 58(3) (a))

CO3 form	Certificate of second opinion (Section 58(3) (b))
CO7 form	Certificate of appropriateness of treatment to be given to a community patient
CO8 form	Certificate of consent to treatment for a community patient
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory Treatment	Medical treatment for mental disorder given under the Act
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.

Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as “sectioning” or “sectioned”
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.
Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g. an NHS Trust or Health Board)

	Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence (section 17 leave)	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interests of their health or safety or for the protection of others. Sometimes referred to as *'Section 17 leave'*.
Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety

Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
National Collaborative Commissioning Unit	The National Collaborative Commissioning Unit (NCCU), hosted by Cwm Taf Morgannwg University Local Health Board is the collaborative commissioning service of NHS Wales.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term *'patient'* should be used in practice in preference to other

	terms such as *'service user', 'client'* or similar. It is simply a reflection of the terminology used in the Act itself.
Prescribed body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the *Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.*
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49

	The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.
Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually
Section 12 doctor	See doctor approved under Section 12.
Section 17A	This is a Community Treatment Order
Section 37	This is a hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function,
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.

Section 61	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary remove them to a place of safety
Section 136	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts; Part 1 – Primary mental health support services Part 2 – Coordination of and care planning for secondary mental health service users Part 3 – Assessment of former users of secondary mental health services Part 4 – Mental health advocacy
Voluntary patient	See informal patient.

Welsh Ministers	Ministers in the Welsh Government.

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

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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 4th January 2022 VIA Teams

Present:
Jeff Champney-Smith Chair, PoD Group
Elizabeth Singer Vice Chair, Pod Group
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
Mary Williams – PoD member
Wendy Hewitt-Sayer PoD member
Dr John Copley PoD member
John Owen PoD member
Teresa Goss PoD member

In attendance:
David Seward - Interim Mental Health Act Manager
Morgan Bellamy – Acting Deputy Mental Health Act Manager
Georgia Walsh – Assistant Mental Health Act Administrator

Apologies:
Huw Roberts PoD member
Alan Parker PoD member
Rashpal Singh
Amanda Morgan

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. On behalf of the members and MHA office staff the Chair offered condolences to Alan Parker and Huw Roberts for their recent losses.

4. Members points for open discussion

Discussing panels professional background at Hearings - This issue had arisen at a Hearing where panel members were asked about their professional backgrounds by the nearest relative. There was a general discussion and it was agreed that members are performing a lay function. The Health Board consider them an appropriate person to

discharge this function on their behalf because of the life skills they bring to the role. Panel members professional background is irrelevant in this context.

5. Minutes of Meeting held on 6th July 2021

These were agreed as an accurate record of the meeting. The only amendment was Item 6 “unconscious bias training” to amend the second sentence to include the word “generally” between the words “was” and “a” to read: *There was generally a positive response from those who had taken part.*

6. Matters Arising

CTP/RA to be raised at MHLGG – the Chair advised that he has repeatedly raised the issue and would do so again at the next meeting on the 6th January. It was an issue that was a priority for MHLGG. **Action - Chair and MHA Manager**

Late Minutes – the Chair reminded the members of the requirement to complete minutes within 2 working days of a Hearing. This allowed time for discussion between panel members when a case wasn’t straightforward. There had been some issues of late. The Chair expects minutes to be completed by the next working day in the majority of cases. **Action - All**

7. Operational Issues

Feedback on the Annual Review Process –the Chair is currently reviewing the documentation in preparation for the 2022 Annual Review process. Professor Ceri Phillips has indicated that he wished to be involved in the process. **Action - Chair**

Protocol for virtual Hearings – The Chair informed the meeting as to the background to this and advised that the protocol had been amended. To be circulated to members following the meeting. **Action - MHA Manager**

Feedback After Hearings – The Chair reminded the Panel that the feedback after the Hearing served to enable discussion on what was to be included in the minutes. It was also part of the 360-degree feedback that members had asked for as part of the continuing improvement agenda. **Action - All**

8. Lessons Learnt

There were no particular issues for the meeting.

9. MHA Activity Monitoring Reports

Due to the timing of the meeting only October and November reports were available. The reports were noted. The MHA Manager advised that no Hearings had been arranged over the Christmas period due to the difficulty of staff attending. One member raised the issue of cancelled Hearings. The MHA Manager agreed to look at when Hearings were being cancelled to see whether any changes in process would help. **Action - MHA Manager**

10. Concerns/compliments from Power of Discharge group Hearings

These were noted. Again, the issue of CTPs dominated the comments. It is a legal requirement to have an outcome focussed CTP completed within the last year or when there has been a change in circumstances. One concern noted that the CTP was out of date. The feedback received from these concerns is almost always that the CTP has been updated. There is no assurance for the managers that the CTP is in fact outcome focused. The Chair agreed to raise at MHLGG. **Action – Chair**

The PoD commended the compilation of the report and thanked the MHA office staff.

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 shortly. Minutes of the previous meetings were included in the papers for this meeting.

12. Training

The All Wales AHM Event – this has been scheduled for May 2022 but further information will be provided. Topics for inclusion in the conference to be sent to MHA Manager. **Action - MHA Manager and PoD members**

Working with interpreters –unfortunately little progress has been made on this area of training. Both the MHA Manager and Carol Thomas had looked into this. Chair to contact Diverse Cymru and speak to Professor Phillips. **Action – Chair**

ECT – Dates for the training have been sent to PoD members. Please respond to the MHA Manager if wishing to attend. **Action – PoD members**

Other less common disorders – Dr Cantrell is to provide this training on the 12th January at 10am via TEAMS.

13.A.O.B

Mental Health Act Office Update – The Mental Health Act Manager advised of the changes within the MHA office. Bianca and Morgan are seconded into the Deputy MHA Manager post as a job share. Beth is acting up into the Band 5 MHA Team Lead post. MHA Manager agreed to send out contact information. All those present agreed to their personal data being shared with colleagues. MHA Manager to obtain the consent of those not present. **Action - MHA Manager**

The Chair conveyed Elaine's thanks for her gifts. He was pleased to report that Elaine's sister in law was much improved as was Elaine's health. Likewise, Sunni had expressed her gratitude for the gifts from the PoD.

Expenses – members were advised of the different expense rates for the different roles/meetings attended. The Chair advised that if members clicked the right tab it would automatically pay the right amount. **Action – All**

Reorganisation – one of the members asked for clarity on the Mental Health reorganisation. There are 3 locality groups and each has responsibility for both community

and some aspect of inpatient services. The MHA manager agreed to source a paper to share with the PoD. **Action – MHA Manager**

As there was no other business the Chair closed the meeting. He thanked members for the continuing support in what are challenging times.

Date and time of next meetings

5th April 2022
5th July 2022
4th October 2022

Minutes of the Mental Health Legislation and Governance Group held at 10:00 on 06 January 2022 via Microsoft Teams

Present

Robert Kidd	(Chair) Consultant Psychologist
David Seward	Interim Mental Health Act Manager
Morgan Bellamy	Interim Deputy Mental Health Act Manager
Bianca Simpson Lepore	Interim Deputy Mental Health Act Manager
Ceri Phillips	Vice Chair, Cardiff and Vale UHB
Mary Lawrence	Consultant representative, Adult
Michael Ivenso	Consultant representative, MHSOP
Simon McDonald	Digital Lead for Mental Health
Peter Thomas	South Wales Police representative
Jeff Champney-Smith	Chair, Power of Discharge Group
Katherine Lewis	Consultant social worker DOLS/ AMHP
Lynda Woodley	Operational Manager, Vale of Glamorgan
Carys Buss	Emergency Unit representative
Susan Broad	DoL's Lead- Cardiff and Vale UHB
Jayne Jenning	Senior Nurse- Vale Locality
Chloe Evans	Mental Capacity Act Manager
Andrea Sullivan	Senior Nurse for education, quality & safety. and patient experience

Apologies

Catherine Morris	Emergency Unit representative
Tayeeb Tahir	Consultant representative, Liaison Psychiatry
Alex Allegretto	Independent Mental Health Advocacy Manager
Darren Shore	Senior Nurse, south east locality
Daniel Crossland	Interim Director of Operations, Mental Health Clinical Board
Paul Williams	Locality Service Manager, north west locality
Simon Amphlett	Senior Nurse, substance misuse service
Rakesh Pankajakshan	Consultant representative, Adult
Natalie Williams	Locality Service manager, south east locality

Jane Jones Consultant representative, CAMHs

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 7 October 2021

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

4 MHA Activity

The monitoring reports for October - November 2021 were discussed at length and some pertinent points from each were raised.

There has been an increase in the use of Section 135 of the Act over the last couple of months. It was confirmed by the police representative that this has been seen across the South Wales Police force. The operational manager for the Vale feels that the process for acquiring a warrant is now simpler and more user friendly for AMHPs, however there are still issues with coordinating assessments in so far as getting people to converge at the same time poses as challenge. This is a time consuming job for AMHPs. At present the lead AMHPs in attendance weren't aware of any adverse incidents occurring due to these pressures.

It was noted that the majority of hospital managers hearings were attended by Advocacy Support Cymru which will no doubt have a positive impact on patients.

It was noted that new graphs have been inserted into the MHA monitoring report to show how many hours someone was detained on a Section 5(2) and 5(4).

The Section 117 graphs were discussed and what each one is aiming to show was explained. The discharging of people from Section 117 was briefly raised. This has historically been a fairly contentious issue but it is being worked through by CMHTs. Legal advice is sought when necessary. Some concern was raised about whether professionals working outside of CMHTs knew the correct procedure for discharging someone from Section 117. Issues do remain that people are discharged without local authority presence. It was confirmed that discharge paperwork is scrutinised by the MHA Office before being signed off and that if any advice is needed the MHA office do assist.

Action – Chair to consider how to improve knowledge of 117 discharges across LA and Health Board staff

The chair of the PoD group queried whether the use of the upper and lower control limits should be looked into. It was queried whether they are still fit for purpose.

Action – Chair to discuss

The exception report was discussed and the one exception that occurred around a fundamentally defective application was looked into. Measures to mitigate against this kind of instance happening again have been put in place. The use of receipts by AMHPs is now mandatory and AMHPs should also ring and/or e-mail the MHA Office as confirmation of a detention. The senior nurse for education may hopefully be able to take this learning opportunity forward to help ensure it doesn't happen again.

The large gap in knowledge of general nurses was also highlighted by one of the consultant representatives and this is definitely an area where training could be improved. The senior nurse for education will also bring this agenda item forward.

A discussion was held surrounding the time that the 24-hour clock starts ticking for someone detained under Section 136 and taken to the emergency unit prior to Hafan Y Coed. It was agreed that the Health Board has now agreed that the general rule is that the clock does start from the time that the person arrived at A&E other than in exceptional circumstances whereby the patient was taken to A&E for a reason not connected to their mental health. There is still some dispute between the health board and South Wales Police in these instances but further legal advice will be sought in time for the next meeting. The police representative stated that if the Health Board don't agree to extending the Section 136 this can put pressure on the police and that it may result in the officer leaving the patient. The emergency unit representative confirmed that there are ongoing issues with officers still leaving detained patients at A&E. This may be the British Transport Police rather than South Wales Police officers but work is being done to try and ensure this information is captured accurately in future.

Action – Chair to discuss further and bring a response to next meeting

The MHA Manager is concerned that attendance of shift coordinators at both initial and annual refresher training is very low at present. Improvement in this is needed.

Action – Senior Nurse for Education to liaise with shift coordinator lead to address the issue

5 Matters Arising

Unfortunately, there is no update with regard to the use of attend anywhere software for SOAD consultations.

The digital lead did confirm that he is working on gaining access to the BIS system again. This will allow staff at A&E to easily see admissions to them within the last eight weeks. It is hoped that eventually everyone has access to this system. This agenda item will be kept high up on the digital leads radar.

There has been positive progress in regard to the use of telephone conferences for Mental Health Review Tribunals. The MHRT have recently been piloting the use of

Microsoft Teams and so far, this has gone smoothly. The MHRT are hoping to review Teams' usage in the next couple of weeks and then potentially roll this out for all hearings. As a Health Board we need to consider how best to support patients to be able to meaningfully participate in their hearings once they are held over video conference. It's envisaged that previous and current experience of hospital managers hearing being held over Teams should help.

Action – Chair to discuss how best to support patients to access hearings

The use of St Johns Ambulance continues to be rolled out to positive effect. At the previous meeting the lack of access to secure transport was raised as a potential for concern. The chair of the meeting confirmed a company called Prometheus has been signed off for use if necessary. One of the lead AHMPs commented that although this is useful information the viability of using this company will depend on where they are based. Some previously suggested companies have been based many hours' drive away which makes them inviable in emergency situations.

Action – Chair to find out where Prometheus are based and report back

Scrutinising of consent to treatment documents is still to be discussed by the senior nurses at nurse advisory board meeting. There has been no response since the Director of Nursing has retired.

Action – MHA Manager to chase the new DoN for update

The chair of the group has confirmed that the shortage of Section 12 doctors has been raised with the Mental Health Clinical Board Director and that this issue will be put forward in workforce planning. The issue will be kept high on the agenda of the chair of the meeting. It was confirmed that this shortage is across Health Board's in Wales and is not particular to Cardiff and Vale.

Action- Chair to raise shortage of Section 12 doctors again

One of the consultant representatives has asked for further clarification on when they can carry out section 12 work as at present it seems to be unclear when doctors can claim for this kind of work. This will be discussed further at the next big MAC meeting.

The matter of who should submit DATIX forms for conveyancing issues has yet to be formalised but it was agreed that any agreement made needs to be universal across the new localities.

No further progress has been made with regard to designing a Section 136 flow chart for the various people involved with this part of the Act.

Action – MHA Manager to complete flow chart with SWP

At the previous meeting the responsibility to Section 140 of the Mental Health Act was discussed. The MHA Manager, AMHP lead and Clinical Director have all agreed that there is ambiguity as to what constitutes a "special urgency". We need to define what this is before progress can be made. A protocol is being written by the Clinical Director and once that is completed it will be sent out for scrutiny by the LA's.

6 Feedback on operational issues and incidents:

The lead AMHP confirmed that she was asked to look into the possible use of the temporarily MHA provisions and has fed back to the All Wales AMHP forum.

An agreement has been made that CAMHs consultants will take on RC responsibilities for young persons detained in adult settings. The MHA department weren't aware of this agreement so clarification will be sought.

Action- MHA Manager to seek clarification as to agreement with CAMHs consultants

The senior nurse for education read out an SBAR that has been written in regard to the MHRT refusing to allow student nurses to attend MHRTs as part of their training. One of the consultant representatives was in strong agreement that this issue has also been affecting student medics who also feel they should be able to observe hearings as part of their training. The chair of the meeting confirmed that he would respond to this SBAR outside of the hearing.

Action- Chair to respond to SBAR

The chair also confirmed that consideration should be given to the new sentinel's processes and the new national reportable incidence system. These instances could well include people detained under the Act and therefore improvements to allow the system to run more smoothly should be sought.

The new Mental Capacity Act Manager was introduced to those in attendance and she explained her role within the Health Board. The role is an advisory one and she is there to support staff who have queries regarding capacity/best interest and other MCA issues.

The chair briefly explained the scenario relating to assessments of two people who had engaged in relatively serious acts of self-harm and capacity issues surrounding these assessments. It is hoped that the involvement of the new MCA manager may help raise this issue again as the pandemic has caused problems with getting it discussed further.

The MCA manager informed the group that she is looking to commence a training programme again shortly and is in the process of ironing out any logistical problems with getting training started remotely.

7 Feedback

MHA Manager received an e-mail updated from Advocacy Support Cymru Manager to read out. ASC have acknowledged how well ward staff are informing them of whether it is safe to visit in relation to Covid issues. The advocacy service also acknowledged the hard work of the MHA Office. It was also noted that the advocacy service is receiving a lot of invites to discharge planning meetings at short notice. This is mainly affecting the older people wards and may be due to Covid issues.

The AMHP forum's feedback was discussed. The use of the duty consultant for MHA assessments has on occasion caused friction between the duty AMHP and the

medic. At present there is no resolve for this but one of the medics did feel that the default often falls to the duty consultant and this puts a lot of pressure on these individuals. The chair of the group confirmed that this matter should be discussed externally to this meeting so that a better understanding is gained on both the Health Board and Local Authorities' positions.

The police representative confirmed that South Wales Police have got the lead for mental health across the whole of the United Kingdom. This commenced in June 2021. From the police service's perspective, they are expecting the new Mental Health Act to come into force August 2023. The police service's main consideration is any changes made to the ability to detain patient in police custody if they are unable to be managed by the Health Board.

Shane Mills has delayed the introduction of the 111 option 2 plans. The chair of the group confirmed the Health Board had not yet had discussion about this initiative.

8 Power of Discharge Group comments, compliments and feedback

CTP's are a long-standing issue for the Power of Discharge Group and remain a large part of the comments made each quarter. The PoD may wish to receive further clarification of how CTPs have been updated. This is being discussed.

The chair of the PoD was invited to a quality and safety forum however at short notice neither himself or the vice chair could attend. It is hoped that the chair or vice chair will be able to attend the forums held by each locality going forward.

The chair of the PoD group also welcomes any feedback from professionals regarding the effectiveness of hearings. This benefits the 360-degree appraisal process.

9 External reviews

The MHA Manager has circulated the HIW Annual Mental Health Report 2020-2021 for those present to go through. No comment was made about this.

10 Interface MHA/MCA/DOLS

There is no time scale for the CoP, however we are aware that the commencing of the LPS' will be delayed. Once the CoP and regulations are issued everyone will be questioned regarding timescale's and when is realistic for the changes to come into place. It is only at this point that a starting time will be issued and training started in conjunction with this. The Vice Chair confirmed that the consultation has not yet taken place but is hoped to during the first part of 2022. The Health Board needs to be mindful of the workforce implications of these changes. At present it is felt that the pressure on section 12 doctors may reduce. However, the DoL's lead feels that this lull in workload may only be short lived whilst professionals are becoming more experienced in the process.

11 Quality indicators and audit activities

No further update.

Any other business

Tara Robinson is the Interim Director of Mental Health Nursing.

The MHA manager discussed the issue of patients not being discharged from the bed state when they are transferred out of area. This causes the MHA department PARIS difficulties when that person is transferred back. At present there is a difference of opinion between senior nurses and the MHA Manager. Solutions to this do need to be investigated with the senior team.

Action – MHA Manager to arrange meeting with DoN, SNL, DoO and ADM to discuss

One of the consultant representatives raised his concern that at present PARIS isn't able to record someone who is subject to DoL's. Patients currently show up as informal which has the potential to cause confusion and doesn't not reflect a person's correct legal status.

Date of future meetings

07 April 2022

07 July 2022

06 October 2022

Report Title:	**Corporate Risk Register**						
Meeting:	Mental Health Capacity and Legislation Committee				**Meeting Date:**	09/02/2022	
Status:	**For Discussion**	✓	**For Assurance**	✓	**For Approval**		**For Information** ✓
Lead Executive:	**Director of Corporate Governance**						
Report Author (Title):	**Head of Risk and Regulation**						

Background and current situation:

The Corporate Risk Register ('the Register') has been developed to enable the Board to have an overview of the key operational risks from the Health Board's Clinical Boards and Corporate Directorates. Whilst the Register and the overarching Board Assurance Framework and Risk Management Policy ("the Policy") were embedded in practice and consistency in application developed, the Register included those risks which were rated 15 and above to provide the Board and it's committees with an overview of the Health Board's extreme Operational Risks.

Since the July 2021 Board meeting, where an updated version of the Policy was agreed, the Register has recorded those risks scoring 20 and above and those scoring 15 or above where they demonstrate a wider trend that may impinge on the delivery of Health Board strategy and objectives.

Each of these risks are linked to a Committee of the Board and the Board Assurance Framework. Those risks which are linked to Mental Health Capacity and Legislation Committee are attached at Appendix A for further scrutiny and to provide assurance to the committee that relevant risks are being appropriately recorded, managed and escalated.

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

The Risk and Regulation Team continue to work with clinical and corporate colleagues to refine risk descriptors, controls and actions within Risk Registers. Since the September 2021 Board meeting the Risk and Regulation Team have undertaken a 'Check and Challenge Process' with all Clinical Board and Corporate Directorate risk leads to ensure that those risks recorded within the Register are correctly recorded in line with the Risk Scoring Matrix detailed within the Policy.

This ensures that the Board and its Committees can take assurance that the risks detailed in the Register are consistent with agreed procedures and are a true reflection of the operational risks that the Health Board continues to manage.

Alongside this process the Risk and Regulation Team continue to provide ongoing support and training to risk leads across the Health Board.

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

At January's Board meeting 1 Extreme Risks reported to the Board was linked to the Mental Health Capacity and Legislation Committee for assurance purposes. The risks reported is summarised as follows:

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

This risk has remained on the Clinical Board risk register and following a review in February 2022 it is anticipated that the entry will be de-escalated at Prior to March's Board meeting.

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

ASSURANCE is provided by:

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

RECOMMENDATION

The Committee is asked to:

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

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

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

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

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

CORPORATE RISK REGISTER - BOARD MEETING JANUARY 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Capital Estates and Facilities	1	Mar-21	Risk/Issue: UHW Cardiac Theatre GF AGSS Pump is faulty Impact: Failure of scavenging system in Theatre GF would lead to increased medical gas saturation with an impact on staff and patient safety and failure to comply with HTM and H&S regulations/legislation.	5	4	20	Regular inspection and maintenance.	5	4	20	Renew AGSSS Pump and Enclosure	5	1	5	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	2	Mar-21	**Obsolete Medical Gas Delivery Equipment** **Risk/Issue**: Medical Gas (Oxygen) Manifold is obsolete in Barry. Medical Gas (Nitrous Oxide) manifolds are obsolete in UHW Maternity (manifolds 1&7), UHW A&E, UHW Dental (manifolds 4&10). In addition the UHW Medical Gas Pressure reducing set is obsolete. **Impact:** Equipment failure leading to Loss of Service and interruption of supply. This would adversely impact on patient safety. quality of service and HTM regulatory compliance.	5	4	20	Regular inspection and maintenance	5	4	20	New manifolds and pressure reducing sets required	5	1	5	Feb-22	Quality, Safety & Experience Committee	Patient Safety
	3	Mar-21	Risk/Issue: UHW Tunnels corroded Main O2 Pipeline due to building leakage Impact: Equipment Failure leading to Loss of Service and Interruption of oxygen supply to whole of UHL - impacting on patient safety and failure to meet HTM regulations.	5	4	**20**	Regular inspection and maintenance.	5	4	**20**	Repair building leak and renew section's of corroded pipework.	5	1	**5**	Feb-22	Quality, Safety & Experience Committee	Patient Safety Capital Estates
	4	Mar-21	The Clinical Board has experienced a significant number of healthcare acquired Covid-19 outbreaks during both pandemics. It is currently unknown to what extent the level of harm that has been sustained for both patients and staff. The Clinical Board currently do not have an accurate oversight for the total number of patients who have acquired Covid-19, and those patients that have died. The Clinical Board are therefore unable to provide meaningful evidence that would support the UHB in the investigations required, and to understand any learning or themes.	5	5	**25**	The Quality and Governance Lead is currrently supporting all areas with the completion of the required Covid-19 Rapid Assessments and the accurate completion of Datix. These have been commenced in some areas, but not all. The Clinical Board is working with the UHB Covid-19 Investigating Lead to support information required for those patients that have died as a result of healthcare acquired Covid-19. Support from IP&C and Covid-19 outbreak meetings to ensure that accurate and timely information is obtained. Update December 2021: Investigations are being undertaken by the Covid team (Corporate) whihc is supporting the CB identify common themes and trends.	5	3	**16**	Appointment of a Senior Nurse for Covid-19 for a six month secondment to lead on the investigations for healthcare acquired Covid-19. To identify learning and themes. To review IP&C processess within clinical areas. To support the UHB in completing the required level of investigations to establish level of harm for both patients and staff.	5	3	**15**	Feb-22	Quality, Safety & Experience Committee	Planned Care Capacity

Medicine CB	8	01/03/2019	Patients are remaining on WAST ambulances for above the agreed 15 minute Welsh Government turn around time secondary to lack of capacity within the Directorate and UHB. This results in delays for patient assessment and treatment with the potential to cause patient harm.	5	5	**20**	When patient arrives by WAST, patient is booked in and major assessment nurse (MAN) is alerted to immediately triage patient and handover taken. If there is any change in the patient's condition, the WAST crew will immediately inform the MAN. All non paramedic crews are assesseed by the Triage Nurse/Majors Assessment Nurse to ensure a patient clinical assessment is conducted.Concern by either party about the length of any delay or the volume of crews being held will be escalated by the Senior Controller/EU NIC to the Patient Access for usual UHB escalation procedures, or by WAST to their Silver Command. WAST have introduced a number of hospital avoidance initiatives with some evidence this has reduced ambulance transfers. Protection of Resus capacity when possible including one buffer. For patients arriving in UHW and UHL assessments units, the NIC will assess these patients and escalate in line with policy. Standard Operating Procedure in place within the Emergency Department to support any 'Immediate Releases' requested by WAST. Update December 21: Joint CB/ WAST partnership meetings in place to focus on improvements. The Clinical Board is engaged with the NRI process for reporting incidents where WAST delays have resulted in major patient harm. Update Transformational work being undertaken across Acute and Emergency Medicine to support flow, including RATZ, virtual ward.	5	4	**20**	Daily review and risks noted within Safety Huddles and EU Controller reports. Escalated to MCB Hub and Patient Access Services. Evaluation of Standard Operating Procedure to reflect any changes required. WAST Immediate Release Standard Operating Procedure in use to support 'Red' calls in the community. Update December 2021: OPAT accross both UHW and UHL to support WAST and patient flow.	5	2	**10**	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patient Safety
	9	01/01/2021	The ability to safely provide medical cover across all Specialities and disciplines across the Clinical Board secondary to ongoing Covid pressures and overall recruitment is resulting in the delay of assessment for patients which could result in clinical risk and poor patient experience.	5	5	**25**	Ongoing recruitment of medical staff including Consultant body. Review of Consultant Job Plans. Engagement with the Workforce Hub. Electronic rota database.	5	4	**20**	Medical staffing reviewed as part of the daily LCC meetings with ongoing planning to ensure safe staffing.	5	2	**10**	Feb-22	Quality, Safety & Experience Committee Strategy and Delivery Committee	Patienty Safety and Workforce
	10	01/12/2021	There is a risk of overcrowding with the Emergency and Acute Medicine footprint secondary to no flow or lack of UHB capacity. This results in the inability to provide and maintain key quality standards as patients are being nursed in inappropriate areas affecting timely access to treatment and discharge.	5	5	**25**	UHB and local escalation policy and implementation led by MCB HUB and Patient Access Services working in partnership with the EU Controller and Senior Floor Cover to improve flow. Escalation of all constraints to all Directorates. Internal escalation to key clinicians/staff to assist with flow across the department. All vulnerable patients escalated to ensure timely bed allocation. Standard Operating Procedure in place for all ambulatory areas. Implementation of Internal Professional Standards to deliver prompt specialist review within agreed timeframe	5	4	**20**	Appropriate escalation and discussion with MCB HUB, Patient Access Services and OPAT regarding safe and timely patient flow.	5	3	**15**	Feb-22	Quality, Safety & Experience Committee	Patient Safety
Children & Womens CB	11		Delay and interuption to induction of labour due to staffing levels. This has the potential risk of poor outcomes for mothers and babies. This also effects the women's experience. Approx 30 DATIX submitted 27.10.21 - 8.12.21 (6 week period as on August risk register	4	5	**20**	1.Undertaking an in depth review of our that there is continued assurance that sickness is being managed according to the policy. 2. Introduced a weekend planning meeting each Friday at 12pm so that we have assurance that weekends are covered 3. Introduced a postnatal / newborn spot screening clinic at UHW on the weekends. This means that women will attend ANC at UHW or UHL for their care rather than a midwife visiting. This will release a community midwife to come in to support the hospital setting but keep the home birth service going. 4. Operational Ward Managers – while they have a clinical component to their role, we have requested that they roster one clinical shift per week so that they're included in the overall numbers 5. Midwives offered bank / additional hours and overtime 6. Elan midwives to provide on call support to wider community teams with home birth service 7. Digital Midwife, Practice Education Facilitator, Fetal Surveillance Midwife & Women's Experience Midwife – to provide at least one clinical shift per week. 8. Research and Development Midwives to be temporarily redeployed back to providing frontline clinical care until the staffing situation improves 9. Clinical Supervisors for Midwives to be redeployed 50% back into clinical practice. 50% CSfM to continue to provide ongoing support to clinical practice / capability / action learning	4	4	**16**	1.Band 6 vacancies to be filled - interviews scheduled 2. 24 midwives have been offered 27 hrs each upon qualification in September.3. continues to be escalated to clincal board and executative leve	4	2	**8**	Feb-22	Quality, Safety & Experience Committee	Patient Safety

Specialist Services CB	15	Sep - 21	**Critical Care - Nursing Workforce** There is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner due to insufficient Critical Care Nursing Capacity resulting in patient safety risks including serious harm and death, staff burnout and a failure to adhere to national standards and guidelines. This risk is currently exacerbated by the consequences of the Covid19 pandemic due to staff absences due Covid19 infection, sheilding & self-isolation requirements, and the significant associated impacts upon staff wellbeing.	5	5	**25**	Block booking of temporary staffing is ongoing; Recruitment strategies in place (ongoing recruitment events); Increased our educational team from 2.64 WTE to 5.04 WTE to support the junior workforce; Relying on the availability of an additional clinical area to admit patients; Working collaboratively with patient access to identify beds in a timely manner for Level 1 patients (not currently effective) Robust implementation of the CC escalation plan; Implement the smaller pod-focused initiative.	5	4	**20**	Develop a strategy to attract prospective employees to work in C&V CC; Develop further cross- Health Board working; Develop a staff feedback opportunity to generate ideas to support Point 1. Gain support from HR and Recruitment to have an open CC recruitment advert; Implement the Leadership Programme developed for senior staff Identify a more robust process for discharging patients within the 4 hour target; Robust implementation of the CC escalation plan; Develop a staff feedback opportunity to generate ideas to support Point 2. Initiate Workforce Task & Finish Group	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety and Planned Care Capacity
	16	Jan-16	**Critical Care - Bed Capacity** Due to an inadequate bed capacity there is a risk that patients will not be admitted to the Critical Care Department in a timely and safe manner. Where demand exceeds capacity patients are cared for in inappropriate settings such as Recovery Area, Emergency Department and ward areas and patients may be discharged at risk to generate capacity. This risk of dealyed admission to Critical Care Dept or care in inappropriate settings could lead to increased morbidity and mortality, increased re-admisison rates, longer hospital length of stay and a failure to adhere to national standards and guidelines. A resumption of pre-pandemic service levels and a restoration of previous clinical area configurations will lead the risk level to increase to its previously elevated level.	5	5	**25**	Highlight patients to Patient Access for discharge to ward areas Additional footprint identified for more Critical Care capacity Funding has been granted by the Executive Team for 6 additional Level 3 equivalent beds in CC and these have been commissioned recently. The unprecedented demand during the current Covid19 Pandemic has resulted in a temporary increase in the unit footprint and capacity which has ameliorated this issue whilst at the same time exacerbating the Crtitical Care workforce risks detailed elsewhere.	5	4	**20**	Continue to work with Patient Access and Health Board to have more effective discharge processes in place. Not all of the recommended staff are being supported at this time. Increase Patient Flow role to 7 days per week	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Planned Care Capacity
	17	Jul-20	**Critical Care - Clinical Environment** There is a risk that patients admitted to the Critical Care Department will not receive care in an environment that is suitable for purpose due to a number of facility shortcomings resulting in patient safety risks including serious harm and death. The normal capacity is 35 beds with a single isolation cubicle. Analysis shows that the stated normal capacity is inadequate for the population served and needs to increase to 50 beds. The number of isolation cubicles is significantly below national guidelines and presents serious Infection Control & Prevention risks. The Covid19 crisis has led to a temporary increase in capacity to 44 beds however the isolation cubicle capacity remains at 1. There is no air handling available on the unit which results in there being no means to manage airborne infection risk or manage ambient temperatures. This exacerbates the IP&C risks and also compromises the care of patients where temperatiure is a critical concern. The well being of staff working in the environment is also compromised leading to issues of heat exhaustion and collapse secondary to dedydration. The inadequate size of the facility footprint leads to there being inadequate space for all non-clinical areas including office space, consumable storage, clean utility area, dirty utility areas, equipment storage, phamaceutical storage, device storage and management hubs areas.	5	5	**25**	**The clinical area is divided into zones to where patients are grouped according to IP&C risk to reduce the risk of cross-infection.** **Staff entering the clinical area are required to wear full PPE to reduce the risk of cross-infection.**	5	4	**20**	**There is an urgent need for a capital investment program and business case developed to address this need.**	5	2	**10**	Feb-22	Strategy and Delivery Committee Quality, Safety and Experience Committee	Patient Safety Capital Assets
	19	Aug-21	**CARDIOTHORACIC** Deaths on Cardiac Surgery waiting list Provision of Cardiac Surgery - including ability to meet 36 week RTT, ability to treat urgent patients, impact of staff shortages (theatre and CITU staff), impact of lack of access to inpatient beds leading to increased mortality and morbidity of patients on the WL	5	4	**20**	Daily validation of cardiac surgery waiting lists by the directorate management team. Weekly monitoring of booking and scheduling, utilisation and productivity. Weekly cardiac surgery operational meeting to discuss cancellations, late starts, overruns and staffing constraints. Standardised communication processes for patients on the waiting list for cardiac surgery. Forward planning for Cardiac surgery. Recruitment and retention of theatre personnel. Obtain anaesthetics	5	3	**15**	Theatre staff shortages, limited flexibility on CITU beds. Inability to undertake weekend working Limited assurance due to significant establishment gaps in both theatre scrub staff and anaesthetics Commisioning review of potential outsoucing contract. Recruitment of anaestheic and theatre personnel. Daily flow monitoring to ensure timely transfer between CITU and Ward C5	5	1	**5**	Feb-22	Quality, Safety & Experience Committee	Patient Safety Planned Care Capacity

	21	Jan - 2010	**Haematology and Immunology - Clinical Environment** There is an inadequate clinical environment for the care of Haematology Patients (including Bone Marrow Transplant). This creates a risk of cross infection for patients particularly vulnerable to infection. There is a potential impact on patient morbidity and mortality, quality of service and reputation. Despite the controls and assurances currently applied, it is extremely likely that the clinical environment will not meet the minimum required standard at the next JACIE accreditation assessment and the ensuing consequences of this cannot currently be prevented.	5	5	**25**	**Risk specific policies, protocols, and guidelines.** **Cleaning schedules.** **Installation of air pressure gauges outside BMT cubicles to measure positive air pressures.** **Patients admitted to ward C4 North (amber) for triage prior to admission to B4 (green).** **HCAI monitored monthly. Positive air pressure gauges outside the BMT cubicles are monitored daily to ensure appropriate air pressures are maintained. Air pressure system validated by Estates Dept. High C4C scores consistently achieved.**	5	4	**20**	**New dedicated Haematology facility required.** **Escalated to Clinical Board, estates and WHSSC.** **Bid for Lakeside Wing is to be submitted for consideration.**	5	1	**5**	Feb-22	Strategy and Delivery Committee and Quality, Safety and Experience Committee	Planned Care Capacity Patient Safety

CORPORATE RISK REGISTER JANUARY 2022

Clinical Board/Corporate Directorate	Risk Reference	Date risk added	Risk	Initial Risk Rating			Controls	Current Risk rating			Actions	Target Risk rating			Date of next review	Assurance Committee	Link to BAF
				Consequence	Likelihood	Total		Consequence	Likelihood	Total		Consequence	Likelihood	Total			
Mental Health CB	14	Aug-20	**Young Person in Adult Mental Health Placement** Young person with complex needs required admission to adult mental health services as no suitable alternative available. There is a risk that the patient will be in a sub-optimal clinical environment which will adversely impact on the patient's safety and wellbeing. There is a further risk of staff having to act outside their competencies which may adversely impact on statutory duty and reputation.	5	5	**25**	Additional staff allocated to the care of the patient.	5	4	**20**	Safeguarding discussions ongoing with private care providers with no realistic placement available for the forseeable future. Away day to plan alternatives to admission with C&W CB. Earmarked area in HYC post covid to allow impact of Sanctuary to be evaluated while reducing impact on Cedar ward and CAMHS patients.	5	2	**10**	Feb-22	Mental Health &Capacity Legislation Committee	Patient Safety

Report Title:	**Mental Health Legislation and Mental Capacity Act Committee – Terms of Reference**						
Meeting:	**Mental Health Legislation and Mental Capacity Act Committee**				**Meeting Date:**	9th February 2022	
Status:	**For Discussion**	**x**	**For Assurance**		**For Approval**	**x**	**For Information**
Lead Executive:	**Director of Corporate Services**						
Report Author (Title):	**Director of Corporate Services**						

Background and current situation:

In line with the UHB's Standing Orders, Terms of Reference for Committees of the Board, should be reviewed on an annual basis.

This report provides Members of the Mental Health Legislation and Mental Capacity Act Committee (MHLMCAC) with the opportunity to review the Terms of Reference prior to submission to the Board for approval.

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

The Terms of Reference for the MHLMCAC were last reviewed in February 202. Prior to that a thorough review of the Committee and its purpose was undertaken alongside training for Committee Members.

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

The Terms of Reference for the MHLMCAC have been reviewed by the Director of Corporate Governance and changes, although limited, are highlighted in red.

Recommendation:

The Committee is asked to:

(a) Review the changes to the Terms of Reference for the MHLMCAC;
(b) Ratify the changes to the Terms of Reference for the MHLMCAC and
(c) Recommend the changes to the Board for approval on 31st March 2022.

Shaping our Future Wellbeing Strategic Objectives

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

1. Reduce health inequalities		6. Have a planned care system where demand and capacity are in balance	

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

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

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

Mental Health Legislation and Mental Capacity Act Committee

Terms of Reference

Reviewed by Committee: 9th February 2022
Approved by the Board:

1. INTRODUCTION

1.1 The University Health Board's (UHB) Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the UHB Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In line with Standing Orders (and the UHB Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Mental Health Legislation and Mental Capacity Act Committee.** The detailed terms of reference and operating arrangements agreed by the Board in respect of this Committee are set out below.

1.3 The principal remit of this Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS)) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and any subsequent amendments to the legislation.

Mental Health Act

1.4 The Mental Health Act 1983 covers the detention of people deemed a risk to themselves or others. It sets out the legal framework to allow the care and treatment of mentally disordered persons. It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

1.5 The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

1.6 Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to a Community Treatment Order (CTO), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to CTO - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

1.7 Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation.

1.8 With the exception of the power of discharge, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the UHB Scheme of Delegation.

Mental Health Measure

1.9 The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

1.10 The MCA came into force mainly in October 2007. It was amended by the Mental Health Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in April 2009.

1.11 The MCA covers three main areas –

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

Thus the scope of MCA extends beyond those patients who have a mental disorder.

2. PURPOSE

2.1 The purpose of the Mental Health Legislation and Mental Capacity Act Committee (the Committee) is to seek and provide assurance to the Board or to escalate areas of concerns and advise on actions to be taken in relation to :

- Hospital Managers' duties under the Mental Health Act 1983;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

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3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will:

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health Act and Capacity legislation, have the relevant skills, competencies and knowledge to discharge the Board's responsibilities;.
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- consider and approve relevant policies and control documents in support of the operation of Mental Health and Capacity legislation;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge sub-committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review Service relating to legislation issues and get assurance that actions identified have been responded to appropriately in particular, issues relating to Mental Health Act 1983;
- The Quality, Safety and Experience Committee will advise the Mental Health Act and Capacity Legislation Committee of any complaints in relation to the Mental Health Act and Capacity legislation received from within reports from Public Services Ombudsman for Wales;
- consider any other information, reports related to the legislation that the Committee deems appropriate.

Authority

3.2 The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference, concentrating on the governance systems in place and indicators of their effectiveness, particularly in the management of risk. In doing so, the Committee shall have the right to inspect any books, records or documents of the UHB relevant to the Committee's remit, ensuring patient/client and staff confidentiality, as appropriate. It may seek any relevant information from any:

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- other Committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

3.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the UHB's procurement, budgetary and other requirements.

Sub Committees

3.4 In accordance with Regulation 12 of the Local Health Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee, to be known as the Power of Discharge Sub-Committee. Three or more members drawn from the Sub-Committee will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to CTO.

The Mental Health Legislation and Governance Group is also a sub Committee. The purpose of this group is to monitor use of the MHA and deal with operational issues. Therefore allowing the MHACLC to focus on policy.

3.5 The Committee has authority to establish short life working groups which are time limited to focus on a specific matter of advice or assurance as determined by the Board or Committee.

Retention of Board Responsibility

3.6 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Cardiff and Vale University Health Board, as well as the Power of Discharge Group.

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members, comprising:

Chair	Vice Chair of the Board
Vice Chair	Chosen from amongst the Independent Members on the Committee
Members	A minimum of one other Independent Member of the Board The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

Attendees

4.2. The following officers and partners are expected to be in attendance so that the Committee can obtain appropriate assurances on compliance with mental health and mental capacity legislation across its breadth of statutory responsibilities:

- Chief Operating Officer (Lead Executive)
- Director of Corporate Governance
- Executive Nurse Director
- Clinical Board Director - Mental Health Clinical Board
- Director of Nursing - Mental Health Clinical Board
- Director of Operations- Mental Health Clinical Board
- Service users

The Director of Operations – Womens and Children's Clinical Board and the Mental Capacity Act Manager will attend the Committee in relation to specific items on the agenda as and when required.

4.3. By invitation:

The Committee Chair may extend invitations to attend Committee meetings to others from within or outside the organisation who the Committee considers should attend, taking account of the matters under consideration.

Secretariat

4.4 The Director of Corporate Governance shall attend every meeting and the meeting will be serviced by a member of the Corporate Governance team.

Member Appointments

4.5 The membership of the Committee shall be determined by the Board, based on the recommendation of the UHB Chair, taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

4.6 Terms and conditions of appointment, (including any remuneration and reimbursement) in respect of co-opted independent external members are determined by the Board, based upon the recommendation of the UHB Chair (and, where appropriate, on the basis of advice from the UHB Remuneration and Terms of Service sub-committee).

Support to Committee Members

4.8 The Director of Corporate Governance, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- ensure the provision of a programme of organisational development for Committee members as part of the UHB overall OD programme developed by the Director of People and Culture.

5. COMMITTEE MEETINGS

Quorum

5.1 Two Independent Members, one of whom should be the Committee Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held no less than three times a year or as the Chair of the Committee deems necessary – consistent with the UHB Annual Plan of Board Business.

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw, to facilitate open and frank discussion of particular matters.

Format of agenda

5.4 The agenda for the meeting will be split into three parts comprising:

- Mental Health Act 1983;
- Mental Health Measure (Wales) 2010;
- and Mental Capacity Act 2005.

The proportion of time to be spent at each meeting on the respective parts will be set out in the Committee meeting planner, alternating the focus during the cycle of meetings and according to need.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its patients through the effective governance of the organisation.

6.2 The Committee is directly accountable to the UHB for its performance in exercising the functions set out in these Terms of Reference.

6.3 The Committee, through its Chair and Members, shall work closely with the Board's other Committees and groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information.

In doing so, it will contribute to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee shall embed the UHB values, corporate standards, priorities and

requirements, for example equality and human rights, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity, the submission of Committee minutes and written reports, as well as the presentation of an annual report;
- bring to the Board's specific attention any significant matters under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the UHB Chair, Chief Executive or Chairs of other relevant Committees/groups of any urgent/critical matters that may affect the operation and/or reputation of the UHB.

7.2 The Board may also require the Committee Chair to report upon the Committee's activities at public meetings, for example the Board's Annual General Meeting, or to community partners and other stakeholders, where this is considered appropriate, for example where the Committee's assurance role relates to a joint or shared responsibility.

7.3 The Director of Corporate Governance, on behalf of the Board shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation, including that of any Sub-Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the UHB Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum
- Notifying and equipping Committee members – Committee members shall be sent an Agenda and a complete set of supporting papers at least seven (7) clear days before a formal Committee meeting (unless specified otherwise in law).
- Notifying the public and others – at least seven (7) clear days before each Committee meeting a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Health Board's website together with the papers supporting the public part of the agenda (unless specified otherwise in law).

9. REVIEW

9.1 These Terms of Reference shall be reviewed annually by the Committee with reference to the Board or sooner if required e.g. change in legislation.

Report Title:	**Mental Health Legislation and Mental Capacity Act Committee – Annual Workplan 2022-23**								
Meeting:	Mental Health Legislation and Mental Capacity Act Committee						**Meeting Date:**	9th February 2022	
Status:	**For Discussion**		**For Assurance**		**For Approval**	**x**	**For Information**		
Lead Executive:	Director of Corporate Governance								
Report Author (Title):	**Director of Corporate Governance**								

Background and current situation:

The purpose of the report is to provide Members of the Mental Health Legislation and Mental Capacity Act Committee (MHLMCAC) with the opportunity to review the MHLMCAC Work Plan 2022/23 prior to presentation to the Board for approval.

The work plan for the Committee should be reviewed on an annual basis to ensure that all areas within its Terms of Reference are being delivered.

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

The work plan for the Mental Health Capacity and Legislation Committee has been developed based upon the requirements set out in its Terms of Reference .

Recommendation:

The Mental Health Capacity and Legislation Committee is asked to:

(a) Review the Work Plan 2022/23;
(b) Ratify the Work Plan 2022/23;
(c) Recommend approval to the Board of Directors at the Board Meeting on 31st March 2022.

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	x

			sectors, making best use of our people and technology		
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.*

Mental Health Legislation and Mental Capacity Act Committee Work Plan 2022- 23					
App. -Approval Ass.- Assurance Inf.- Information	**Exec Lead**	**26-Apr**	**26-Jul**	**25-Oct**	**31-Jan**
Agenda Item					
Mental Health Act					
MHA Monitoring Exception Report	CB	Ass.	Ass.	Ass.	Ass.
Section 17 Compliance	CB	Ass.	Ass.	Ass.	Ass.
Section 138 Partnership Arrangements	CB	Ass.	Ass.	Ass.	Ass.
Policies in support of operation of MHCL	CB	Ass.	Ass.	Ass.	Ass.
Hospital Managers Power of Discharge Sub Committee Minutes	CB	Ass.	Ass.	Ass.	Ass.
Mental Health Measure Act Monitoring					
Mental Health Measure Monitoring Report	CB	Ass.	Ass.	Ass.	Ass.
Care and Treatment Plans Update Report	CB	Ass.	Ass.	Ass.	Ass.
Mental Capacity Act					
MCA Monitoring Report	CB	Ass.	Ass.	Ass.	Ass.
DOLs Monitoring Report	CB	Ass.	Ass.	Ass.	Ass.
DOLs Audit	CB			Ass.	
Inspection Reports					
HIW MHA Inspection Reports (where they relate to legislative compliance)	CB	Ass.	Ass.	Ass.	Ass.
Public Service Ombudsman Wales Reports (where they relate to legislative compliance)	CB	Ass.	Ass.	Ass.	Ass.
Annual Reports					
Hospital Managers Power of Discharge Sub Committee Annual Report	CB		Ass.		
HIW MHA Annual Report	CB		Ass.		
MHCL Committee Governance					
Annual Work Plan	NF	App.			
Self assessment of effectiveness	NF		Ass.		
Review Terms of Reference	NF	App.			
Produce Committee Annual Report	NF	App.			
Minutes of MHL&MCA Committee Meeting	NF	App.	App.	App.	App.
Action log of MHL&MCA Committee Meeting	NF	Ass.	Ass.	Ass.	Ass.

Report Title:	**Draft Annual Report 2021/22 – Mental Health Capacity Legislation Committee**	**Agenda Item no.**	**12.3**
Meeting:	**Digital & Health Intelligence Committee Meeting**	**Meeting Date:**	**09.02.22**
Status:	**For Discussion**	**For Assurance**	**For Approval**	**x**	**For Information**
Lead Executive:	**Director of Corporate Governance**		
Report Author (Title):	**Corporate Governance Officer**		

Background and current situation:

An Annual Report from the Committee is produced to demonstrate that it has undertaken duties set out in its Terms of Reference and to provide assurance to the Board that this is the case.

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

At the time of writing this report, the Committee has achieved an overall attendance rate of 75% based upon the number of Committees held to date. The draft Annual Report will be updated following the Committee's meeting in February 2022 to reflect attendance for the period 1 April 2021 to 31 March 2022.

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

The attached Annual Report 2021/22 of the Mental Health Capacity Legislation Committee demonstrates that the Committee has undertaken the duties that have been set out in the Terms of Reference.

Recommendation:

The Mental Health Capacity Legislation Committee is asked to:

- **REVIEW** the draft Annual Report 2021/22 for the Mental Health Capacity Legislation Committee
- **RECOMMEND** the draft Annual Report to the Board for formal approval.

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		Long term		Integration		Collaboration		Involvement	

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board

Annual Report of Mental Health, Capacity and Legislation Committee 2021/22

1.0 INTRODUCTION

In accordance with best practice and good governance, the Mental Health, Capacity and Legislation Committee ("the Committee") produces an Annual Report to the Board setting out how the Committee has met its Terms of Reference during the financial year.

2.0 MEMBERSHIP

The Committee membership is a minimum of four Independent Members. During the financial year 2021/22 the Committee comprised four Independent Members. In addition to the Membership, the meetings are also attended by the Chief Operating Officer (Executive Lead for the Committee) and the Director of Corporate Governance. The Chair of the Board is not a Member of the Committee but attends at least annually after agreement with the Committee Chair. Other Executive Directors are required to attend on an ad hoc basis.

3.0 MEETINGS AND ATTENDANCE

The Committee met four times during the period 1 April 2021 to 31 March 2022. This is in line with its Terms of Reference. The Mental Health, Capacity and Legislation Committee achieved an attendance rate of ___% (80% is considered to be an acceptable attendance rate) during the period 1st April 2021 to 31st March 2022 as set out below:

	20.04.21	20.07.21	19.10.21	09.02.22	Attendance
Ceri Phillips (Chair from July 2021)	✓	✓	✓		%
Akmal Hanuk	X	X	X		%
Michael Imperato	✓	✓	X		%
Sara Moseley (Interim Chair to July 2021 and Vice Chair from July 2021)	✓	X	✓		%
Total	**75%**	**50%**	**50%**		%

To be completed upon conclusion of the February 9th 2022 meeting.

4.0 TERMS OF REFERENCE

The Terms of Reference will be reviewed and are to be ratified by the Committee on 9th February 2022 prior to formal approval being sought from the Board on 31st March 2022.

5.0 WORK UNDERTAKEN

The principal remit of the Committee is to consider and monitor the use of the Mental Health Act 1983 ("MHA"), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards ("DoLS") and the Mental Health (Wales) Measure 2010 ("the Measure"). In particular, the Committee should seek and provide assurance to the Board or to escalate areas of concerns and advise on actions to be taken in relation to:

- Hospital Managers' duties under the Mental Health Act 1983;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the associated Regulations

During the financial year 2021/22 the Mental Health, Capacity and Legislation Committee reviewed the following key items at its meetings:

PRIVATE MENTAL HEALTH, CAPACITY AND LEGISLATION COMMITTEE

There were no private meetings held during the reporting year of 2021/22.

PUBLIC MENTAL HEALTH, CAPACITY AND LEGISLATION COMMITTEE – SET AGENDA ITEMS

April 2021 - March 2022

PATIENT/ STAFF STORY

The Patient Stories presented were as below:

1. 20 April 2021 - Sectioned under the Mental Health Act (Patient)
2. 20 July 2021 - Shielding & My Mental Well-being (Staff Story)
3. 19 October 2021 - My Battle with Food (Patient Story)
4. **9 February 2022 – To be confirmed following the meeting**

MENTAL CAPACITY ACT

At three of the meetings the Committee was provided with updates and a monitoring report regarding the Mental Capacity Act 2005 ("MCA") which has been in force for over 13 years and covers people aged 16 years and over. The Committee had noted that the MCA was amended to include the Deprivation of Liberty Safeguards ("DoLS"), which came into force in April 2009.

Members of the Committee were also informed of the work undertaken by the Independent Mental Capacity Advocate ("IMCA") highlighting the number of referrals made and areas of concern / service issues. The IMCA Procedure had been slightly revised which was approved by the Vulnerable Adult risk management working group.

Liberty Protection Safeguards (LPS) was featured prominently within the Health Board and it was noted to Committee members that relevant Health Board procedures, policies and strategies would need to be amended in line with LPS.

Policies and procedures are reviewed on a rolling programme and LPS elements will be included as and when required.

- **Deprivation of Liberty Safeguards (DoLs)**

The Committee received updates at each meeting with regards to the Deprivation of Liberty Safeguards (DoLs) and compliance in relation to the same. The Committee noted that the Cardiff and the Vale DOLS / MCA team operated the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff & Vale UHB, Cardiff City Council and the Vale of Glamorgan Council, through a Partnership Management Board which consisted of senior representatives of each Supervisory Body.

To insert information around DoLs from the meeting on 9 February 2022

MENTAL HEALTH ACT

- **Mental Health Act Monitoring Exception Report**

The report, which was shared at each meeting, provided the Committee with further information relating to wider issues of the Mental Health Act. Any exceptions highlighted in the Mental Health Act Monitoring report were 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 are only as the Act allows.

At the April 2021 meeting, the Committee were informed of an ongoing issue regarding when "the clock started ticking" for custody of mental health patients in A&E. That issue had remained unresolved albeit further legal opinion had been sought and the Mental Health Clinical Board were awaiting a response.

The response was received by members of the Committee at the July 2021 meeting where Committee Members had noted that the "clock had started ticking" for section 136 in Accident & Emergency (A&E) and that relevant data was being collected in relation to those patients who were too unwell in A&E to receive an assessment.

In July 2021 the Committee was provided with an update on the number of people detained. The Committee noted that the figures had risen significantly by May 2021 due to the ongoing COVID-19 pandemic, although by October 2021 the use of section 136 had decreased significantly. That had suggested that the section 136 powers were only used when absolutely necessary by the police.

- **Child and Adolescent Mental Health Service**

At each meeting, Members of the Committee were advised of the number of those children under 18 who had been assessed under section 136.

Members of the Committee were advised of the care and treatment plan trends which had incorporated the pressures of the COVID-19 pandemic and the Committee was provided with assurance on the parts of the Mental Health Measure applicable to children and young people (those aged under 18). A report provided further assurance that compliance against 28 days referral to assessment had been achieved and sustained. The service had continued to monitor its capacity for the delivery of interventions.

REFORM OF THE MENTAL HEALT ACT

At each meeting, Members of the Committee were provided with an update in relation to the proposed reform of the Mental Health Act.

The Committee had noted that the biggest response from Health Board staff was in relation to the increase in work demand and how that would be managed.

Members of the Committee were advised that the consultation with staff had lasted over a month and was also shared with Local Authority (LA) staff via the integrated teams but noted that the responses were from the Health Board and not the LA.

It was noted that all the responses from Wales would be sent to the Welsh Government and a decision would then be made.

At the October 2021 meeting, members of the Committee were advised that the UK Government (and not the Welsh Government) had prepared a response following the consultation undertaken in relation to its White Paper relating to the review of the Mental Health legislation.

MENTAL HEALTH MEASURE

- **Mental Health Monitoring Report**

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

The Committee noted that the Measure introduced 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. At each meeting the Committee receives a report which details the Health Board's compliance rates in relation to Parts 1 to 4 of the measures relate as follows:

- Part 1a – 28-day referral to assessment compliance target of 80%
- Part 1b – 28-day assessment to intervention compliance target of 80%
- Part 2 – Care and Treatment Planning Within Secondary Mental Health Services
- Part 3 - Right to request an assessment by self –referral
- Part 4 – Advocacy – standard to have access to an IMHA within 5 working days

The Committee was also presented with a report on the parts of the mental health measure application to children and young people under the age of 18. The Committee noted and discussed how the COVID -19 pandemic had impacted upon these services. In particular, the notable increase of referrals to the services, which had also seen an unprecended demand to the Children and Young People in Crisis services and how the same was being managed.

- **Care and Treatment Plans**

Part 2 of the Mental Health (Wales) Measure 2010 (the Measure) places a statutory duty on Local Mental Health Partners to ensure that all patients who are accepted into secondary mental health services have a written care and treatment plan (CTP) that is developed and overseen by an appointed care coordinator.

At all meetings, Members of the Committee were presented with an update report for the Mental Health Measure Monitoring Reporting including Care and Treatment Plans.

An update was provided at each meeting outlining issues, concerns and solutions.

POLICIES / PROCEDURES

2 policies and 2 procedures are to be approved by the Committee in February 2022 as follows:

- Section 5(2) Doctor's Holding Power Policy/Procedure
- Section 5(2) Doctor's Holding Power Procedure
- Section 5(4) Nurse's Holding Power Policy
- Section 5(4) Nurse's Holding Power Procedure

- **COMMITTEE GOVERNANCE**

Reports submitted to the Committee for review and approval in February 2022.

1. Committee Annual Report 2021/22
2. Committee Terms of Reference
3. Committee work plan

Also presented to the Committee were the minutes from the:

1. Hospital Managers Power of Discharge Minutes
2. Mental Health Legislation and Governance Group Minutes
3. Annual Review of Comments Raised by Members of Power of Discharge

6.0 REPORTING RESPONSIBILITIES

The Committee has reported to the Board after each of the Mental Health, Capacity and Legislation Committee meetings by presenting a summary report of the key discussion items at the Mental Health, Capacity and Legislation Committee. The report is presented by the Chair of the Mental Health, Capacity and Legislation Committee.

7.0 OPINION

The Committee is of the opinion that the draft Mental Health, Capacity and Legislation Committee Report 2021/22 is consistent with its role as set out within the Terms of Reference and that there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

CERI PHILLIPS

Committee Chair

SARA MOSELEY

Interim Committee Chair

Report Title:	**APPROVAL OF SECTION 5(2) DOCTORS HOLDING POWER POLICY & PROCEDURE**						**Agenda Item no.**	**12.4.1**	
Meeting:	**Mental Health and Capacity Legislation Committee**						**Meeting Date:**	**9th February 2022**	
Status:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**	**X**	**For Information**		**X**
Lead Executive:	**Mental Health Clinical Board Director of Operations**								
Report Author (Title):	**Interim Mental Health Act Manager – David Seward**								

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

The Section 5(2) Doctors Holding Power Policy sets out the requirements for provision of the doctors holding power under section 5(2) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients' subject to a doctors holding power**.**

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

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:
The current policy and procedure have been updated to ensure statutory requirements under the Mental Health Act 1983 are met.

Removal of glossary of terms.

Inserted clarity on the legal position relating to the use of section 5(2) and inpatient status in the Emergency Department, General Hospital and in relation to a conditionally discharged patient subject to restrictions by the Ministry of Justice.

Enhanced section to clearly explain the procedure in relation to receiving the HO12 on behalf of the Hospital Managers.

Inserted section in relation to support from the independent Mental Health Advocacy Service.

Inserted:

- Appendix 1 – Summary of complete s.5(2) procedure
- Appendix 2 – HO12, Example
- Appendix 3 – Ending of section 5(2) form
-

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):
Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 29th September 2021 and 26th October 2021;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager and the Principal Health Promotion Specialist.

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

The primary source for dissemination of this document the Section 5(2) Doctors Holding Power Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

There are no financial implications associated with this policy/procedure.

Recommendation:
The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Section 5(2) Doctors Holding Power Policy and Procedure

and

- **APPROVE** the full publication of the Section 5(2) Doctors Holding Power Policy and procedure in accordance with the UHB Publication Scheme

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

1. Reduce health inequalities	X	6. Have a planned care system where demand and capacity are in balance	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.*								

Reference Number: *UHB 411* **Version Number:** 2	**Date of Next Review:** *19/08/2024* **Previous Trust/LHB Reference Number:**

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

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering use of the doctors' holding power under section 5(2).

Section 5(2) allows a doctor to detain an inpatient for a maximum period of up to 72 hours in order for assessment under the Mental Health Act.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use Section 5(2). This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

The Responsible Clinician must be fully aware of the diverse needs of the patient when considering use of section 5(2) and must take them in to account at all times. They must ensure the patient fully understands what is happening to them in a language and format which they are able to understand, this will include sensory and cognitive abilities and physical impairment. Where necessary, an interpreter should be obtained.

Policy Commitment

To set out the requirements for provision of the doctors' holding power under section 5(2) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients subject to a doctors' holding power**.**

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

Supporting Procedures and Written Control Documents

This Policy and the Section 5(2) Doctors' Holding Power Procedure describe the following with regard to the use of a doctors' holding power:

- The purpose of a doctors' holding power
- The process for assessing the suitability for the use of a doctors' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a doctors' holding power

Other supporting documents are:

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

Scope

This policy applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

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

Policy Approved by	Mental Health and Capacity Legislation Committee
Group with authority to approve procedures written to explain how	Health Systems Management Board

this policy will be implemented	
Accountable Executive or Clinical Board Director	Chief Operating Officer

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	26/06/2018	02/07/2018	*New document*
2	09/02/2022	10/02/2022	Approved by Mental Health and Capacity Legislation Committee

Equality & Health Impact Assessment for

SECTION 5(2) DOCTORS' HOLDING POWER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	SECTION 5(2) DOCTORS' HOLDING POWER POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	The aim of this policy is to ensure doctors' are aware of their individual and collective responsibilities when considering implementing holding powers. Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007. Ensure that statutory requirements under the Mental Health Act 1983 are met. Practitioners should have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of Doctors' holding powers. This would ensure that considerations are given as to whether the objectives can be met in

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

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

		populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression, and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health)

		Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase

		of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report

		highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016 Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report

		from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system. Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with

		severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, "Our Communities, Our Mental Health") The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors' misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice.

		A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health"). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in

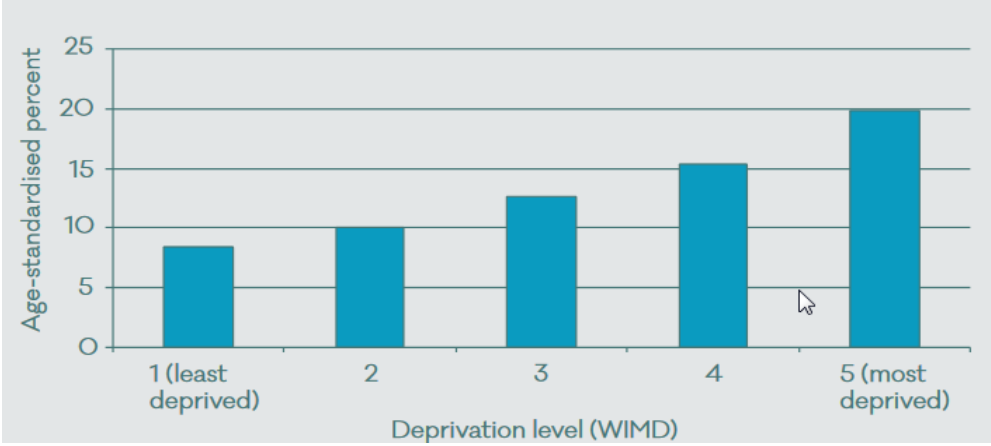
		shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind "Our Communities, Our Mental Health"). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men

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

		be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood

et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004).

People according to where they live



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

There is a wealth of evidence that mental health influences a very wide

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

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

		http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf **Homeless** Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain

		relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that

		25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder. 49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:-

		Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.** The policy addresses administrative issues and responsibilities rather than the direct care and treatment of patients, although decisions made have an impact on the clinical pathways of patients. The section 5(2) policy applies to any inpatient receiving treatment in hospital and who is not already liable to be detained or subject to a community treatment order (CTO). Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- https://www.google.co.uk/search?site=&source=hp&q=doctors'+holding+power+policy+equality+impact+assessment+&oq=doctors'+holding+power+policy+equality+impact+assessment+&gs_l=psyab.12...2021.16849.0.19472.76.52.5.0.0.0.606.9184.0j3j12j5j5j3.28.0....0...1.1.64.psyab..45.28.7940...0j0i10k1j0i131k1j0i22i30k1j0i13k1j0i13i30k1j33i22i29i30k1j33i160k1j33i21k1.0el4ViGQVWM

Action Plan for Mitigation / Improvement and Implementation

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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Health Systems Management Board for consideration and the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine t an earlier review is required.	N/A	N/A	N/A Hospital managers should monitor the use of section 5(2), including: • How quickly patients are assessed for detention and discharged from the holding power. • The proportion of cases in which applications for detention are, in fact, made following use of section 5(2).

Reference Number: **Version Number:** 2	**Date of Next Review:** *19/08/2024* **Previous Trust/LHB Reference Number:** *UHB 412*

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

Introduction and Aim

This document supports the Section 5(2) Doctors' Holding Power Policy, Mental Health Act, 1983.

To ensure staff are aware of their individual and collective responsibilities when considering use of the doctors' holding power under section 5(2).

To Provide clear direction and guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

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

Objectives

This Procedure describes the following with regard to a doctors' holding power:

- The purpose of a doctors' holding power
- The process for assessing the suitability for the use of a doctors' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a doctors' holding power

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of a doctors' holding power. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007)

	• The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Section 5(2) Doctors' Holding Power Policy Section 5(4) Nurses' Holding Power Policy Section 5(4) Nurses' Holding Power Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Mental Health and Capacity Legislation Committee

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

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*MHLCC*	*02/07/2018*	*New document*
2			*Removal of glossary of terms.* *Inserted clarity on the legal position relating to the use of section 5(2) and inpatient status in the Emergency Department, General Hospital and in relation to a conditionally discharged patient subject to restrictions by the Ministry of Justice.* *Enhanced section to clearly explain the procedure in relation to receiving the HO12 on behalf of the Hospital Managers.* *Inserted section in relation to support from the independent Mental Health Advocacy Service.* *Inserted:* • *Appendix 1 – Summary of complete s.5(2) procedure* • *Appendix 2 – HO12, Example* • *Appendix 3 – Ending of section 5(2) form*

CONTENTS

1. INTRODUCTION

Section 5(2) is the power under the Mental Health Act, 1983 (MHA) that allows a responsible doctor or approved clinician to detain a patient for a maximum period of up to 72 hours in order to make arrangements for their assessment for detention under section 2 or section 3 of the MHA. This power can only be used to detain patients who have already been informally admitted to a hospital. It can be used whether or not the patient has capacity to consent to their admission but cannot be used with out-patients, or with those attending the hospital in other capacities, e.g. as visitors.

Section 5(2) should only be used if; at the time it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. It should not be used as an alternative to making an application, even if it is thought that the patient will only need to be detained for 72 hours or less.

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of section 5(2) doctors' holding powers in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

Holding powers when implemented authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Act being made.

3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

This procedure is applicable to all qualified doctors' within all Mental Health inpatient settings and general hospital settings.

4. DUTIES AND RESPONSIBILITIES OF DOCTORS' AND APPROVED CLINICIANS

Section 5(2) authorises the detention of the patient in the hospital for a maximum of 72 hours so the patient can be assessed with a view to an application for detention under the Act being made. It should only be used if, at the time, it is not practicable or safe to initiate an application for detention without also detaining the patient in the interim. That is, the patient must be unwilling to remain in hospital in order for the assessment for detention to be made and it must be necessary for the person to remain in hospital until the assessment can be undertaken.

Section 5(2) should not be used as an alternative to making an application, even if it is thought the patient will only need to be detained for 72 hours or less.

The identity of the person in charge of a patient's medical treatment at any time will depend on the particular circumstances. However, a professional who is treating the patient under the direction of another professional should not be considered to be in charge.

There may be more than one person who could reasonably be said to be in charge of a patient's treatment e.g. where a patient is receiving treatment for both a physical and a mental disorder. In such a case, the psychiatrist or approved clinician in charge of the patient's treatment for the mental disorder is the preferred person to use the power in section 5(2).

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

They must complete a written record of the assessment (Statutory Form HO12). As well as the completion of the statutory documentation, doctors' must make a record of the assessment including the start time of the section in the patients' clinical notes.

5. NOMINATION OF DEPUTIES

Section 5(3) allows the doctor or approved clinician in charge of an inpatient's treatment to nominate a deputy to independently exercise section 5(2) powers in their absence.

Only a doctor or approved clinician on the staff of the same hospital may be a nominated deputy. The deputy does not have to be a member of the same profession as the person nominating them. Only one deputy may be authorised at any time for any patient, and it is unlawful for a nominated deputy to nominate another.

Doctors' and approved clinicians should only be nominated as a deputy if they are competent to perform the role. Nominated deputies should report the use of section 5(2) to the person for whom they are deputising as soon as practicable.

It is permissible for deputies to be nominated by title, rather than by name e.g. the junior doctor on call for particular wards, provided there is only one nominated deputy for any patient at any time and it can be determined with certainty who that nominated deputy is.

Doctors' and approved clinicians may leave instructions with ward staff to contact them (or their nominated deputy) if a particular patient wants or tries to leave. However, they may not leave instructions for their nominated deputy to use section 5(2), nor may they complete a section 5(2) report in advance to be used in their absence. The deputy must exercise their own professional judgment. Patients should not be admitted informally with the sole intention of then using the holding power.

6. DUTIES AND RESPONSIBILITIES OF QUALIFIED NURSES

The qualified nurse should check that the doctor has completed form HO12 correctly. The form must then be forwarded to the Mental Health Act Team for receipt on behalf of the Hospital Managers.

During office hours (09:00 – 17:00, Monday to Friday) detention papers must be submitted to the Mental Health Act Office in Hafan Y Coed, University Hospital

Llandough to enable the team to undertake receipt and scrutiny. Other sites must make contact with the Mental Health Act Office to inform them that they have detention papers to be received and make arrangements to fax or email a scanned copy the papers as a priority.

Outside of office hours between 17:00 and 20:30 the Shift Coordinator for the appropriate area i.e. Hafan Y Coed, MHSOP or Rehab must contacted via bleep or through the main switchboard in order to make arrangements to receive detention papers.

The Night Site Manager is the delegated officer between 20:30 and 08:30 for the purpose of receipt of detention papers and can be contacted by bleep or the main switchboard.

The ward must keep a copy of the section papers in the patients file until the final version which has been processed by the Mental Health Act Office is available.

Once the detention papers have been formally received on behalf of the Hospital Managers outside of office hours it is the responsibility of the receiving officer to ensure the detention papers are forwarded to the Mental Health Act Office, Hafan Y Coed, University Hospital Llandough immediately.

Detention papers received off site must be faxed/scanned or emailed to the Mental Health Act Office. Once confirmation has been received the original detention papers must be sent to the Mental Health Act Office in the internal mail system.

Detention papers received on the Hafan Y Coed site must be placed in an envelope and delivered to the Mental Health Act Office letterbox staff to collect on the next working day.

The nurse should ensure that the patient is made aware of their rights under the Act and this is documented in the patients' notes. Information and leaflets are available on the Mental Health Act page, Cardiff and Vale intranet.

7. PROCEDURE

Holding powers can only be used on a patient who has been admitted to hospital. Admission should be defined as completion of the admission process performed by nursing staff or medical staff.

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(2). It does not matter whether the patient was originally admitted for treatment primarily for either a mental disorder or a physical condition.

If the doctor invoking the section 5(2) power is not a psychiatrist, approved clinician or nominated deputy they should make immediate contact with a psychiatrist or an approved clinician to obtain confirmation of their opinion that the patient needs to be detained so that an application can be made.

If a patient is already detained under section 5(4) the request from a nurse to assess for detention under section 5(2) should be treated as an emergency and be responded to accordingly i.e. within 6 hours of the section 5(4) commencing.

Although section 5(2) can last up to a maximum of 72 hours, the assessment process must be put in place once the HO12 is completed.

The Approved Mental Health Practitioner (AMHP) should be contacted at this stage in order to co-ordinate a Mental Health Act assessment and for those attending to consider the need for section 2 or section 3 of the Mental Health Act.

Patients subject to section 5(2) are not subject to consent to treatment provisions contained in Part 4 of the MHA. If the patient is mentally capable of making a decision about treatment, the common law enables him to refuse to be treated for either a physical or mental disorder. However, if the patient is assessed as being mentally incapable of making a decision about treatment, the treatment can be provided under the Mental Capacity Act 2005 if it is deemed to be in his best interests.

A record of the assessment must be made in the patient's clinical notes.

8. USE OF SECTION 5(2) IN A GENERAL HOSPITAL

Any doctor in charge of a patient's care may detain an informal patient under section 5(2), using form HO12. This includes a doctor in a non-psychiatric hospital.

The non-psychiatric doctor should, wherever possible, consult with a senior psychiatrist prior to the use of section 5(2). If this is not practicable then the senior psychiatrist should see the patient as soon as possible to determine whether the patient should be detained further.

The full Mental Health Act assessment should be requested as soon as possible after the use of section 5(2).

Section 5(2) cannot be used in an Accident and Emergency Department. However if a patient has been allocated a hospital bed and is occupying that bed he or she is an "in-patient" for the purposes of section 5(2). The internal classification of the patient is not legally relevant because whether a patient is an in-patient is a question of fact. The Mental Health Act 1983, Code of Practice for Wales defines and inpatient in this context as:

"any person who is receiving inpatient treatment in a hospital and who is not already liable to be detained or who is subject to a Community Treatment Order (CTO)"

A patient does not lose their inpatient status until they have physically removed themselves from the hospital (which includes the hospital grounds).

9. CONDITIONALLY DISCHARGED PATIENTS

There is nothing to prevent the holding powers contained in section 5(2) from being used on a conditionally discharged patient who is being treated in a psychiatric hospital informally. If this does occur the Ministry of Justice should be notified on 020 33343335 and 0300 303 2079 (outside of office hours).

10. SECTION 17 LEAVE

A patient detained on Section 5(2) cannot receive section 17 leave. They are not detained by virtue of either an application under Section 2 or Section 3 and therefore do not have a Responsible Clinician to grant such leave.

11. COMMUNITY TREATMENT ORDER PATIENTS

Section 5(2) is not applicable to a patient subject to a Community Treatment Order (CTO). Patients can be recalled even during periods when they are in-patients. Therefore where it is considered necessary, the recall procedure must be used to detain the patient and within the 72 hours allowed a decision must be made whether to revoke the CTO.

Section 5(2) cannot be used to keep a patient in hospital after the end of the 72 hour recall period if the CTO has not been revoked.

12. SECTION 18 ABSENT WITHOUT LEAVE (AWOL)

A patient detained under section 5(2) who leaves the hospital is AWOL and can be retaken but only within the 72 hour period.

13. INAPPROPRIATE USE OF SECTION 5(2)

Section 5(2) cannot be used in the following circumstances:

- For an outpatient attending an accident and emergency department or any other out-patient facility.
- For a patient who is already liable to be detained in hospital or who is subject to a CTO.
- Is not to be used as a holding power simply for the purpose of persuading the patient to stay.
- To prolong the detention of a patient whose section is about to expire.
- To provide time for an application to be made to the county court pursuant to s29(4) to displace a nearest relative after the expiration of the 28-day period of detention provided for under section 2.

The doctor or approved clinician should assess the patient as soon as practicable and discharge if appropriate. They should not wait until the end of the 72 hours, nor, should they allow the section 5(2) to lapse.

Patients should not be informally admitted with the sole intention of then using the holding power.

14. ENDING OF SECTION 5(2)

Section 5(2) holding powers last for a maximum of 72 hours and cannot be renewed.

Detention under section 5(2) will end if:-

- The result of the assessment is a decision not to make an application under section 2 or section 3.
- The power has been invoked by a nominee under section 5(3) and the doctor or approved clinician in charge decides that no assessment for possible detention needs to be carried out.
- An application under section 2 or section 3 is made.
- The patient is discharged for clinical reasons before an assessment can be undertaken.

The maximum period a patient may be held under section 5(2) is 72 hours, which will include anytime the patient is held on section 5(4) of the Act.

The patient should be informed once they are no longer held under section 5(2) and advised of the reasons why. If this is because section 2 or section 3 was not applied, the patient should be informed they are free to leave hospital.

15. MEDICALTREATMENT OF PATIENTS

The rules in Part 4 of the Act do not apply to patients detained under section 5(2) and as such there is no power under the Act to treat them without their consent. In other words, they are in exactly the same position in respect of consent to treatment as patients who are not detained under the Act.

16. TRANSFER TO OTHER HOSPITALS

Patients detained under section 5(2) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(2) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA.

If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(2) to provide authority to detain the patient in that hospital.

In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made by the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

17. APPEALS

A patient detained under a section 5(2) cannot make an application to the Mental Health Review Tribunal for Wales or appeal to the hospital managers.

18. INDEPENDENT MENTAL HEALTH ADVOCACY

A patient detained under a section 5(2) is eligible to receive independent mental health advocacy services.

A qualifying patient may ask for the support of an Independent Mental Health Advocate (IMHA) at any time. It is the responsibility of the ward staff to ensure that the patient is informed that this service is available to them and how they may obtain it.

19. MONITORING

Hospital managers should monitor the use of section 5(2), including:

- How quickly patients are assessed for detention and discharged from the holding power.
- The proportion of cases in which applications for detention are, in fact, made following use of section 5(2).

20. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the mental health act administration team.

21. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

22. RESPONSIBILITIES

22.1 Chief Executive

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

22.2 Chief Operating officer

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

22.3 Designated Individuals

This procedure applies to all ~~doctors'~~ individuals who have defined responsibilities under the provisions of the Act.

23. REFERENCES

All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales - www.justice.gov.uk/tribunals/mental-health
Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents

Appendix 1

Summary of complete S5.2 procedure

- Ensure you are the nominated doctor before acting (Duty Dr, on call Dr or patient's consultant).
- Assess situation and patient.
- Discuss with colleagues and senior on call.
- Complete form HO 12 as follows:

1. The full and correct address of the hospital in which the patient is to be held under section 5(2).
2. Your full name.
3. Declare by deletion, your status for the purpose of section 5(2).
4. The patient's full name.
5. Full reasons why informal treatment is no longer available with evidence:
   - Suggesting the presence of mental disorder.
   - Suggesting that the patient was at risk.
   - That the patient would no longer remain on the ward informally.
   - That there is a need for a further assessment under the Act.
6. The exact time that the completed form was furnished to the hospital managers - this means the time that the report is consigned to the hospital's internal mail system operated by the hospital managers. **N.B. due to the geography of Cardiff and Vale UHB this would normally be by fax/email/scan to eliminate any delay.**
7. Sign and date the completed Form HO 12.
8. Make arrangements for an assessment to consider section 2 or section 3 as soon as the report is furnished to the Hospital Managers.
9. Accurately record in the patients' case notes the use of section 5(2), include the start and end dates and times.

- **It is <u>essential</u> to deliver the form HO 12 to "Hospital Managers". Monday-Friday between 9am & 5pm by hand, scanned email (mentalhealthact.team.cav@wales.nhs.uk), or fax (02921 8 24740) to the MHA Office. If scanned or faxed, the originals <u>must</u> be sent in the internal mail. After 5pm and before 9am you <u>must</u> give the forms to the Shift Co-ordinator. You can contact the Shift Co-ordinator via switchboard.**
- **Inform RC and AMHP or their on-call colleagues.**
- **For further information between the hours of 9am and 5pm the MHA Team can be contacted on 02921 8 24744. Out of hours the Shift Coordinator should be contacted via switchboard.**

Regulation 4(1)(g)

Mental Health Act 1983 section 5(2) - report on hospital in-patient

PART 1

(To be completed by the registered medical practitioner or approved clinician in charge of the treatment of the patient under section 5(2) or any person nominated under section 5(3))

To the managers of

(name and address of hospital)

Cardiff and Vale University Local Health Board

Full Correct Address of Hospital - Current address list can be found on the

Mental Health Act Intranet Page

(full name)

I am Full name of Doctor - No Initials

and I am

Delete (a) or (b) as appropriate

(delete the phrase which does not apply)

(a) the registered medical practitioner/the approved clinician (who is not a registered medical practitioner)

OR

(b) a registered medical practitioner/an approved clinician who is the nominee of the registered medical practitioner or the approved clinician

in charge of the treatment of

(full name of patient)

Full name of Patient - No Initials

who is an in-patient in this hospital and not at present liable to be detained under the Mental Health Act 1983.

It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons

(the full reasons why informal treatment is no longer appropriate must be given)

For Mental Disorder only.
Full reasons why Informal treatment is no longer appropriate. Support this with evidence;- Suggesting the presence of Mental Disorder; Suggesting that the patient was at risk; That the patient would not remain informally;
That there is a need for further assessment under the Mental Health Act

Please turn over

Delete the phrase which does not apply

I am furnishing this report by:

consigning it to the hospital managers' internal mail system today

(time) at Doctor to complete

delivering it (or having it delivered) by hand to a person authorised by the hospital managers to receive it.

Signed: Doctor to sign……

Date: Doctor to date……

PART 2

To be completed on behalf of the hospital managers

This report was:

(delete the phrase which does not apply)

furnished to the hospital managers through their internal mail system

delivered to me in person as someone authorised by the hospital managers

(time and date) to receive this report at Time on Date

Signed: Shift Coordinator/MHA Administrator on behalf of the hospital managers

Name: Full Na e……

Date: Shift Coordinator or MHA Administrator to date……..

Appendix 3

Ending of Detention under Section 5(2)

This form is to be completed in all cases by the Doctor, Approved Clinician or the Nominated Deputy and delivered to the Mental Health Act Office, Hafan Y Coed, University Hospital Llandough as soon as possible.

Patient's full name		
Patient's date of birth		
Commencement of s.5(2)/s.5(4)	(date)	(time)
Ending of s.5(2)	(date)	(time)

Detention under section 5(2) ended because:
(Section 5(2) will end with one of the explanations below, please identify applicable reason)

☐ Following assessment it has been decided not to make an application under section 2 or 3.

OR

☐ Power has been invoked by a nominee under section 5(3) and the Dr or AC has decided that no assessment for possible detention needs to be carried out.

OR

☐ An application under section 2 or 3 has been made.

OR

☐ Patient has been discharged due to clinical reasons before assessment could be undertaken e.g the patients violent conduct leads to arrest and removal to police custody.

The patient has been informed of the outcome further to assessment and I have advised of the reasons why. The patient will be:

☐ Remaining in hospital on an informal basis.

OR

☐ Detained in hospital under section _____ .

OR

☐ Discharged from hospital

Signed:..... **Dr in charge of patient care, AC or Nominated Deputy**

Name: .....

Date: .....

Report Title:	**APPROVAL OF SECTION 5(4) NURSES HOLDING POWER POLICY & PROCEDURE**							**Agenda Item no.**	**12.4.2**		
Meeting:	**Mental Health and Capacity Legislation Committee**							**Meeting Date:**	**9th February 2022**		
Status:	**For Discussion**	**X**	**For Assurance**	**X**	**For Approval**	**X**	**For Information**				**X**
Lead Executive:	**Mental Health Clinical Board Director of Operations**										
Report Author (Title):	**Interim Mental Health Act Manager – David Seward**										

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

The Section 5(4) Nurses' Holding Power Policy sets out the requirements for provision of the nurses' holding power under section 5(4) of the Mental Health Act 1983 (as amended by the MHA 2007) to the practitioners and agencies involved in the management of patients' subject to a nurses' holding power**.**

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

Executive Director Opinion/Key Issues to bring to the attention of the Board/Committee:
The current policy and procedure have been updated to ensure statutory requirements under the Mental Health Act 1983 are met.

Removal of glossary of terms.

Inserted section to clearly explain the duties and responsibilities of qualified nurses and the procedure in relation to receiving the HO13 on behalf of the Hospital Managers.

Inserted section in relation to support from the independent Mental Health Advocacy Service.

Inserted:

- Appendix 1 – Informal to 5(2)/5(4) flowchart
- Appendix 2 – HO13 example

Assessment and Risk Implications (Safety, Financial, Legal, Reputational etc.):
Wide consultation has taken place to ensure that the policy and procedure meets the needs of our stakeholder and the Health Board. The consultation undertaken specific to this document was as follows:-

- The document was added to the Policy Consultation pages on the intranet between 29th September 2021 and 26th October 2021;
- The document was shared with the Mental Health Policy Group, Adult Directorate Medics, Cardiff Local Authority, Vale of Glamorgan Local Authority, the Mental Health Clinical Board Quality and Safety Sub Committee and the All Wales Mental Health Act Administrators Policy Group;
- Comments were invited via individual e-mails from the Mental Health Policy Group, the Equality Manager and the Principal Health Promotion Specialist.

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

The primary source for dissemination of this document the Section 5(4) Nurses' Holding Power Policy within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

There are no financial implications associated with this policy/procedure.

Recommendation:
The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Section 5(4) Nurses' Holding Power Policy and Procedure

and

- **APPROVE** the full publication of the Section 5(4) Nurses' Holding Power Policy and procedure in accordance with the UHB Publication Scheme

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

1.	Reduce health inequalities	X	6.	Have a planned care system where demand and capacity are in balance	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.*

Reference Number: UHB 413 **Version Number:** 2	**Date of Next Review:** *19/08/2024* **Previous Trust/LHB Reference Number:**

Section 5(4) Nurses' Holding Power Policy
Mental Health Act, 1983

Policy Statement

To ensure the Health Board delivers its aims, objectives, responsibilities and legal requirements transparently and consistently, we will ensure staff are aware of their individual and collective responsibilities when considering use of the nurses' holding power under section 5(4) of the Mental Health Act.

Section 5(4) allows a registered mental health or learning disability nurse to detain an inpatient for a maximum period of up to 6 hours in order for their assessment under the Mental Health Act.

Practitioners will have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use Section 5(4). This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

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

Policy Commitment

We will set out the requirements for provision of the nurses' holding power under section 5(4) of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) to the practitioners and agencies involved in the management of patients subject to a nurses' holding power**.**

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

Supporting Procedures and Written Control Documents

This Policy and the Section 5(4) Nurses' Holding Power Procedure describe the following with regard to the use of a nurses' holding power:

- The purpose of a nurses' holding power
- The process for assessing the suitability for the use of a nurses' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a nurses' holding power

Other supporting documents are:

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

Scope

This policy applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(4).

This power can only be used in respect of patients who are receiving hospital treatment for mental disorder; it is not sufficient for the patient to be merely suffering from a mental disorder. Although the power can be invoked in any hospital where the patient is receiving treatment for mental disorder, it is unlikely that a non-psychiatric ward will be staffed with nurses' of the "prescribed class".[1]

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

[1] http://www.legislation.gov.uk/wsi/2008/2441/article/2/made

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

Disclaimer

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

Summary of reviews/amendments

Version Number	Date Review Approved	Date Published	Summary of Amendments
1	26/06/2018	02/06/2018	*New document*
2	09/02/2022	10/02/2022	Approved by Mental Health and Capacity Legislation Committee

Equality & Health Impact Assessment for

SECTION 5(4) NURSES' HOLDING POWER POLICY

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	SECTION 5(4) NURSES' HOLDING POWER POLICY
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Mental Health Clinical Board Sunni Webb, Mental Health Act Manager 029 21824745 Sunni.webb@wales.nhs.uk
3.	Objectives of strategy/ policy/ plan/ procedure/ service	Section 5(4) allows a registered mental health or learning disability nurse to detain an inpatient for a maximum period of up to six hours in order for their assessment under the Mental Health Act. The policy provides information on how and who can implement it. The aims of this policy are to: • Ensure staff are aware of their individual and collective responsibilities when considering and assessing individuals before implementing holding powers. • Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983. • Ensure that statutory requirements under the Mental Health Act 1983 are met Practitioners should have due regard to the Mental Health Act Code of

		Practice generally and specifically to the Guiding Principles when they are considering the use of nurses' holding power. This would ensure that considerations are given as to whether the objectives can be met in a less restrictive way.
4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory[2] and the UHB's 'Shaping Our Future Wellbeing' Strategy provides an overview of health need[3].	**Related policies/information -** Mental Health Act 1983, Code of Practice for Wales (Revised 2016), Welsh Language Act 2016, Mental Health Wales Measure 2010, Deprivation of Liberty Safeguards, Equality Act 2010 **Stakeholders -** Service Users, Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators, Approved Mental Health Professionals, Qualified nursing staff and other professionals working within mental health services. **Age -** 20 per cent of children have a mental health problem in any given year, and about 10 per cent at any one time. A quarter of older people in the community have symptoms of depression that require an intervention, and this increases to 40 per cent of care home residents (Mind "Our Communities, Our Mental Health) Older people (aged 60 and above) are more vulnerable to mental health problems, depression is a common disorder amongst this population and it has been estimated that 7% of older people suffer with uni-polar depression (World Health Organisation, 2016). Further Older people are more likely to experience a combination of physical and mental health issues (WHO, 2016).

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

		Younger adults are susceptible to mental health issues, with 6.2% of 16-24 year olds attempting suicide in their lifetime and 16.4% experiencing neurotic symptoms (Young Minds, 2016). Further, student populations are disproportionately affected by mental health issues, with an estimated 1 in 4 reporting mental health problems. Poor mental health amongst young people can lead to reduced life chances and impact on their education, social participation and ability to find and sustain employment. Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:- Results from the 2015 survey found that 13% of adults (aged 16 and older) living in Wales were reported to have received treatment for a mental health problem, an increase from 12% reported in 2014. Unlike other illnesses, the percentage who reported being treated for mental ill health did not increase with age, however trends suggest that an increase in treatment towards middle age before decreasing in retirement age. These rates have not significantly changed since the 2014 health survey. The total number of CAMHS referrals to treatment in Wales doubled between April 2010 (1,204) and July 2014 (2,342). Young people awaiting outpatient's treatment has the highest numbers (2,410) compared to adults (1,291) and those in later life. The Mental Health Act relates to all patients suffering from a mental disorder who meet the criteria for detention, irrespective of age. **Disability -** Physical illness more than doubles the risk of depression,

		and between 30 per cent and 50 per cent of adults with learning disability in the UK have mental health problems. (Mind "Our Communities, Our Mental Health) Sensory loss: Sensory loss currently affects 1 in 5 people in Wales, with 1 in 6 people affected by hearing loss and an estimated 115,000 people living with sight loss which has a significant impact on their daily lives (Sensory Loss in the Adult population in Wales, 2012). Those affected by sensory loss are more susceptible to the development of mental health issues, especially older people. Older people with sight loss are three times more likely to experience depression than people with good vision (Depression and Anxiety in Visually Impaired Older People, 2007) with the British Medical Journal reporting that sight loss is one of the top three causes of suicide among older people The proposed policy will apply to all patients detained regardless of disability, as the policy is reference to the scrutiny of the documents completed by staff rather than the processes. All documents will have been completed in conjunction with consideration of the Mental Health Act, Mental Capacity Act, DoLS and the Mental Health Wales Measure. **Gender -** There are clear differences in the way women and men experience mental health problems. Women are more likely to report common mental health problems. Girls are also more likely than boys to self-harm, and eating disorders are more common in young women compared to young men. Men are more likely to have undiagnosed depression, be detained under the Mental Health Act and take their own life compared to women. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016:-

		A higher percentage of women report being treated for a mental health problem than men (16% vs 10%). Treatment figures show an increase of 1% for both men and women from 2014 statistics. Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men's Health Survey With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men's health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. This policy will apply regardless of gender. **Gender Reassignment -** Trans people are at increased risk of depression and self-harm, and a third of trans people have attempted to take their own life.(Mind, "Our Communities, Our Mental Health") This policy will apply regardless of whether patients have transitioned or not.

		Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. The NHS Centre for Equality and Human Rights (CEHR) has published a new guide for all staff in NHS Wales. *"It's Just Good Care – A guide for health staff caring for people who are trans*"* aims to help health staff provide trans* people with the respectful and appropriate care they are entitled to. The document is available for downloading from the staff intranet. Also available on the intranet is a Top Tips for Making your Service Inclusive and Welcoming for Trans People **Human Rights -** The proposed policy promotes human rights in ensuring that all patients are detained lawfully. **Pregnancy and Maternity -** Mental health problems affect between 10 and 20 per cent of women at some point during the perinatal period (pregnancy and one year after birth). Poor maternal health can also increase the risk of mental health in children. Within the Mind report the following issues are also identified as contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. (Mind, "Our Communities, Our Mental Health") Results of Welsh Health Survey 2015 – reported in Mental Health Foundation Fundamental Facts 2016

		Mental health problems affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on new mothers and their families. According to a 2014 report from the London School of Economics and the Centre for Mental Health, in the UK, 20% of women are affected by mental health problems during the perinatal period. In Wales, 70% of people have no access to specialist perinatal mental health services; a figure significantly higher than the UK average of 40%. According to NHS Choices website If you have had in the past, or now have, severe mental health problems, you are more likely to become ill during pregnancy or in the first year after giving birth than at other times in your life. Severe mental health problems include bipolar affective disorder, severe depression and psychosis. After giving birth, severe mental illness may progress more quickly and be more serious than at other times. This policy will apply regardless of whether patients are pregnant at the time of being detained. In relation to staff there are no changes to be made in relation to applying holding powers. Wards will have completed risk assessments in relation to staff. **Race/ Ethnicity or nationality –** A disproportionate number of people admitted as inpatients in mental health services come from BAME groups. In 2010, 23 per cent of inpatient admissions were from a BAME background. According to the mental health organisation 'Mind', the admission rate for 'other black' groups is six times higher than average, suggesting discrimination within the mental health system.

		Black African and Caribbean people living in the UK have lower reported rates of common mental health problems compared to other ethnic groups, however they are more likely to be diagnosed with severe mental health problems. Black African and Caribbean people are also much more likely to be detained under the Mental Health Act compared to other ethnic groups. According to Black Mental Health UK, people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts.Young women from ethnic minorities are much more likely to take their own life than White British women. (Mind, “Our Communities, Our Mental Health”) The proposed policy will apply regardless of the race / ethnicity of patients or staff. Health inequalities are further linked to unequal access to healthcare. Some BAME groups face considerable barriers to healthcare. In 2009 the Department for Communities and Local Government noted that Gypsies and Travellers face particular difficulties accessing healthcare. Many of them felt that health workers and doctors misunderstood their needs and circumstances. Additionally, Gypsy and Traveller access to healthcare can also difficult if there is an inability to provide proof of identity. The West Midlands Strategic Health Partnership noted, in 2010, that migrant populations faced significant barriers accessing healthcare including difficulties that were related to registering, contracting and commissioning processes as well as a lack of knowledge about services

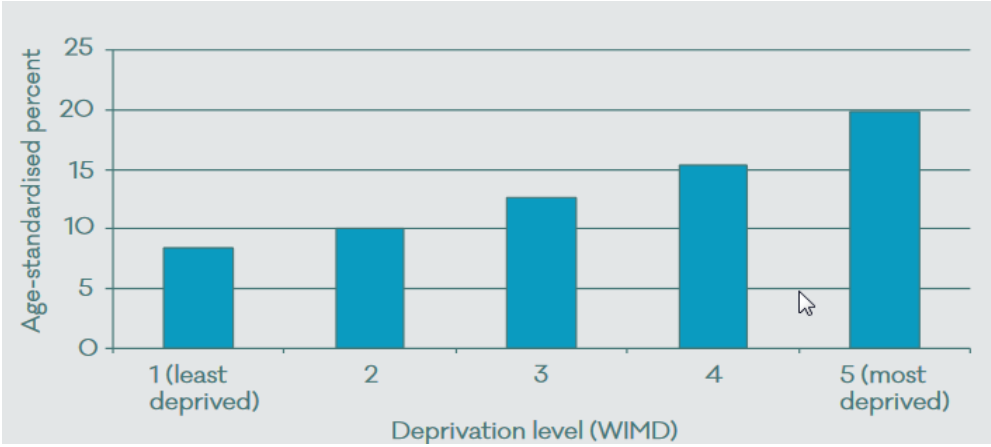
		available. Other common difficulties included poor continuity of care and the experience of not having the same doctor in the practice. A Cultural Competency Toolkit, was developed by Diverse Cymru, with assistance from UHB staff. Its aim is to help staff better interact with clients with mental ill health who are from different cultures A proportion of patients first language may not be English or Welsh. The statutory documents in relation to the Mental Health Act are provided by Welsh Government are only available in English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Access to an interpreter is available and translation of written information can be obtained as and when required. **Religion or Belief -** Spiritual awareness, practices and beliefs (of any religion or for those engaging in spiritual practices without a particular faith) is associated with psychological benefits, including subjective wellbeing (Mind, Our Communities, Our Mental Health”). There are religious beliefs and practices that have been shown, across all the cultures studied, to have some salutary effects on well-being. Other ways in which culture may impact on the relations between religion and well-being have been less consistently documented. The recent growth of interest in positive psychology, and in the relations between religion and spirituality, and maturity, morality and virtue has not yet incorporated a marked focus on cultural issues. Religious beliefs

		and practices supported in one culture may appear disturbed to people (including mental health professionals) from another, affecting diagnosis and treatment. Many commonly held ideas about the role of religion in shame, guilt and anxiety (including obsessive-compulsive disorder), voices, visions and spirit possession require closer examination in the light of evidence from different cultural groups. Clinical practitioners are keen to reach a better understanding of the roles played by religious factors in different cultures, in affecting mental health. The proposed policy will apply regardless of the religion or belief of patients or staff. **Sexual Orientation -** Lesbian, gay and bisexual people are at increased risk of mental health problems, including self-harm and attempted suicide. Lesbian, gay and bisexual people have a 1.5 fold increased risk of depression and anxiety. (Mind “Our Communities, Our Mental Health”). Health (and social care) services have a duty to treat people fairly and equally. However, the Stonewall **Unhealthy Attitudes 2015** report highlights some major gaps in the knowledge and training of staff relating to lesbian, gay, bisexual and trans (LGBT) people, which is resulting in unfair treatment of both LGBT patients and colleagues. Gay and Bisexual Men’s Health Survey. With 6,861 respondents from across Britain, the 2013 report is the largest survey ever conducted of gay and bisexual men’s health needs in the world. However, it demonstrates that many of those needs are not being met and that there are areas of significant concern – most particularly in mental health and drug use – that have been overlooked

		by health services which too often focus solely on gay men's sexual health. This report also provides hard evidence that gay and bisexual men nationwide are more likely to attempt suicide, self-harm and have depression than their straight peers. The proposed policy will apply regardless of the sexual orientation of the patients or staff. **Welsh Language -** No evidence of disproportional representation to date, but a proportion of service users may be Welsh speakers **Welsh Language and its use in Cardiff & Vale of Glamorgan** The latest census statistics available indicate that 16% of the population of Cardiff have one or more skills in the Welsh Language (ability to read, write or/and understand Welsh). 32,000 or 11% of Cardiff's population are fluent Welsh speakers. 24.5% are within the 3-15 age group, and 12.1% within the 16-24 age groups. When the results of previous Censuses are consulted, a significant increase in the incidence of Welsh speakers amongst the youngest age groups is noticed. For the 5-15 year age group, the proportion of Cardiff's residents able to speak Welsh has increased from 6.8% in 1971 to 7.5% in 1981 and 12.7% in 1991. By 2001 this figure had increased to 24.5%. In the Vale of Glamorgan 13,189 of 122,018 people, which is 10.8% of the population, are fluent Welsh speakers. As the statutory documents in relation to the Mental Health Act are provided by Welsh Government these are in English on the Website.

		Information leaflets for the patients are available in both English and Welsh. Within the explanation of rights this now details if the information has been given in the patients preferred language and will be reported on. Welsh Language Act is a consideration. **The impact of mental ill health on employment rates** A national household survey in Great Britain conducted in 2000 found that 57% of people who have a common mental disorder are working, compared with 69% of people who do not have a common mental disorder. Just 9% of people with a probable psychotic disorder, which includes most people with a severe mental disorder, are working fulltime and a further 19% part-time (Meltzer et al., 2002)8. An earlier survey reported that 70% of those with a common mental disorder, who are unemployed and seeking work, have been unemployed for a year or more (that is 7% of all people with a common mental disorder) and are unlikely to return to work (Meltzer et al., 1995). Those who have a common mental disorder are four to five times more likely than those who have not to be permanently unable to work and three times more likely to be receiving benefits payments (Meltzer et al., 1995 and 2002). Between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Marwaha and Johnson, 2004; Schneider, 1998). Although some are in managerial or senior official positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations such as plumbing or metal work. The rate of employment in people with schizophrenia seems to have fallen from before 1990 when surveys reported that between 20% and 30% were in work. Several studies conducted at two time points seem to confirm this reduction (e.g. Rinaldi and Perkins, 2007). The reason for this is unknown but one factor might

		be a reduction in the number of sheltered employment schemes. For those who present to services for the first time, the likelihood of being in employment falls markedly over the subsequent year or two (Birchwood et al., 1992; Johnstone et al., 1986). For people with Schizophrenia, premorbid social and occupational history are associated with employment and some types of psychotic symptoms and the presence of negative symptoms are associated with unemployment. The desire to have a job is one of the best predictors of future employment (Marwaha and Jonhson, 2004). **People according to where they live**



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

There is a wealth of evidence that mental health influences a very wide range of outcomes for individuals and communities. These include healthier lifestyles; better physical health; improved recovery from illness; fewer limitations in daily living; higher educational attainment; greater productivity, employment and earnings; better relationships with adults and with children; more social cohesion and engagement and improved quality of life. These outcomes are not just or necessarily a consequence of the absence of mental illness, but are associated with the presence of positive mental health, sometimes referred to as 'wellbeing'. Improving mental health is a worthwhile goal in itself: most

		people value a sense of emotional and social wellbeing; in addition, good mental health has many other far reaching benefits. Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity. Mental health is also the key to understanding the impact of inequalities on health and other outcomes. It is abundantly clear that the chronic stress of struggling with material disadvantage is intensified to a very considerable degree by doing so in more unequal societies. An extensive body of research confirms the relationship between inequality and poorer outcomes, a relationship which is evident at every position on the social hierarchy and is not confined to developed nations. The emotional and cognitive effects of high levels of social status differentiation are profound and far reaching: greater inequality heightens status competition and status insecurity across all income groups and among both adults and children. It is the *distribution* of economic and social resources that explains health and other outcomes in the vast majority of studies. The importance of the social and psychological dimensions of material deprivation is gaining greater recognition in the international literature on poverty and informs current efforts to develop indicators that capture the missing dimensions of poverty. Both health-damaging behaviours and violence, for example, may be survival strategies in the face of multiple problems, anger and despair related to occupational insecurity, poverty, debt, poor housing, exclusion and other indicators of low status. These problems impact on intimate relationships, the care of children and care of the self. In the United Kingdom, the 20% - 25% of people who are obese or continue to

		smoke are concentrated among the 26% of the population living in poverty, measured in terms of low income and multiple deprivation of necessities. This is also the population with the highest prevalence of anxiety and depression. It is already well established that mental illness, across the spectrum of disorders, is both a direct cause of mortality and morbidity and a significant risk factor for poorer economic, health and social outcomes, although these adverse outcomes vary by type of disorder and socioeconomic status (WHO 2005; 2006).[3] However, it is now becoming clear that the presence or absence of positive mental health or 'wellbeing' *also* influences outcomes across a wide range of domains. These include healthier lifestyles, better physical health, improved recovery, fewer limitations in daily living, higher educational attainment, greater productivity, employment and earnings, better relationships, greater social cohesion and engagement and improved quality of life (WHO 2004b; Barry and Jenkins 2007; Jane-Llopis et al 2004). This policy will apply regardless of where a person lives. (From: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf **Homeless** Affordable and safe accommodation brings stability and security; provides a gateway to access health services like GPs; enhances social and community inclusion; and provides the basis for the right to private

		and family life. Put simply, a home is vital for good mental and physical health, allowing people to live in safety, security, peace and dignity. Whilst there is no such 'right to housing' in itself, the right to an adequate standard of living, including housing, is recognised in the UN Covenant on Economic, Social and Cultural Rights. Of course, there are numerous factors which can cause people to become homeless, many of which are beyond individual control, such as lack of affordable housing, disability and poverty. But what really needs to be highlighted is the two-way relationship between homelessness and mental health. Homelessness and mental health often go hand in hand, and can be a self-fulfilling prophecy. Having a mental health problem can create the circumstances which can cause a person to become homeless in the first place. Yet poor housing or homelessness can also increase the chances of developing a mental health problem, or exacerbate an existing condition. In turn, this can make it even harder for that person to recover – to develop good mental health, to secure stable housing, to find and maintain a job, to stay physically healthy and to maintain relationships. It is a fundamental fact that single homeless people are much more likely to have mental health problems compared to the general population. In 2015, 32% of single homeless people reported a mental health problem, and depression rates, for example, are over 10 times higher in the homeless population. Unfortunately, other psychological issues such as complex trauma, substance misuse and social exclusion

		are also common This policy will apply regardless of where a person lives. **Asylum Seekers** Some asylum seekers will have been subjected to torture, as well as witnessing the consequences of societal breakdown of their home country – with consequences for their mental health. Culturally, mental illness may not be expressed or may manifest as physical Complaints. Stigma may also be attached to mental ill-health. Furthermore, Western psychological concepts are not universally applicable to asylum seekers. Mental health problems such as depression and anxiety are common, but post-traumatic stress disorder is greatly underestimated and under diagnosed and may be contested by healthcare professionals. Children are particularly neglected in this area. A shortage of mental health services for asylum seekers has been recognised. http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf **Prisoners** 10% of men and 30% of women have had a previous psychiatric admission before they entered prison. A more recent study found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis. The rate among the general public is about 4%. 26% of women and 16% of men said they had received treatment for a mental health problem in the year before custody. Personality disorders are particularly prevalent among people in prison. 62% of male and 57% of female sentenced prisoners have a personality disorder.

		49% of women and 23% of male prisoners in a Ministry of Justice study were assessed as suffering from anxiety and depression. 16% of the general UK population (12% of men and 19% of women) are estimated to be suffering from different types of anxiety and depression. 46% of women prisoners reported having attempted suicide at some point in their lives. This is more than twice the rate of male prisoners (21%) and higher than in the general UK population amongst whom around 6% report having ever attempted suicide. http://www.prisonreformtrust.org.uk/ProjectsResearch/Mentalhealth **Information in relation to multiple protected characteristics -** Mental health issues can affect anyone among the population at any stage of life. However, national statistics show that that there are higher incidences of mental health issues among certain protected groups. Mind's report "Our Communities, Our Mental Health" identified the following contributory risk factors:- Trauma and stressful events, poverty, unemployment and housing insecurity, social isolation and loneliness, discrimination and inequality. These risk factors may be present in any protected group.
5.	Who will be affected by the strategy/ policy/ plan/ procedure/ service	Mental health issues affect the whole population, though some protected groups are disproportionately represented among service users**.**

		The policy addresses administrative issues and responsibilities in relation to the direct care and treatment of patients. The section 5(4) policy applies to inpatients who are receiving hospital treatment for mental disorder. Hospital managers must ensure that those acting on their behalf are competent to do so and receive suitable training to ensure they exercise their functions appropriately to ensure the functions are carried out on a day to day basis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	This policy aligns with legislative requirements. All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. It will be the responsibility of each person enacting this policy to ensure that it is implemented fairly and equitably, with dignity and respect. A search of similar policies elsewhere indicated a neutral or positive impact in relation to protected groups:- https://www.google.co.uk/search?q=section+5%284%29+policy&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&dcr=0&ei=eqPoWdTDKcqAkgX6g5TIAQ

Action Plan for Mitigation / Improvement and Implementation

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

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.4 What are the next steps? Some suggestions:- • Decide whether the strategy, policy, plan, procedure and/or service proposal: o continues unchanged as there are no significant negative impacts o adjusts to account for the negative impacts o continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so) stops. • Have your strategy, policy, plan, procedure and/or service proposal approved • Publish your report of this impact assessment • Monitor and review	No significant negative Impact. The policy will be submitted to the Mental Health and Capacity Legislation Committee for approval. Once the policy has been approved the documentation will be placed on the intranet and internet. The EHIA and Policy will be reviewed three years after approval unless changes to terms and conditions, legislation or best practice determine that an earlier review is required.	N/A	N/A	N/A Hospital managers should monitor the use of section 5(4), including: • How quickly patients are assessed for detention and discharged from the holding power • The proportion of cases in which applications for detention are, in fact, made following use of section 5(4). • Ensure the patients are made aware of their rights under section 132 of the Mental Health Act.

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Section 5(4) Nurses' Holding Power Procedure
Mental Health Act, 1983

Introduction and Aim

This document supports the Section 5(4) Nurses' Holding Power Policy, Mental Health Act, 1983.

To ensure staff are aware of their individual and collective responsibilities when considering use of the nurses' holding power under section 5(4).

To Provide clear guidance to staff in relation to their legal responsibilities under the Mental Health Act 1983 as amended by the MHA 2007.

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

Objectives

This procedure describe the following with regard to a nurses' holding power:

- The purpose of a nurses' holding power
- The process for assessing the suitability for the use of a nurses' holding power
- The duties of the practitioners and agencies involved in the management of patients subject to a nurses' holding power

Practitioners must have due regard to the Mental Health Act Code of Practice generally and specifically to the Guiding Principles when they are considering the use of a doctors holding power. This will ensure that considerations are given as to whether the objectives can be met in a less restrictive way.

Scope

This procedure applies to all of our staff in any inpatient setting where a person is receiving inpatient treatment in hospital and is not already liable to be detained or who is subject to a community treatment order (CTO).

Patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005 (MCA) may be detained under section 5(4).

This power can only be used in respect of patients who are receiving hospital treatment for mental disorder; it is not sufficient for the patient to be merely suffering from a mental disorder. Although the power can be invoked in any hospital where the patient is receiving treatment for mental disorder, it is unlikely that a non-psychiatric ward will be staffed with nurses' of the "prescribed class".[1]

Equality and Health Impact Assessment	There is potential for both positive and negative impact. The procedure is aimed at improving services and meeting diverse needs. Mitigation actions are already in place to offset any potential

[1] http://www.legislation.gov.uk/wsi/2008/2441/article/2/made

	negative outcome, e.g. through the monitoring of the procedure. There is nothing, at this time, to stop the procedure from being implemented.
Documents to read alongside this Procedure	• The Mental Health Act 1983 (as amended by the Mental Health Act 2007) • Mental Health (hospital, guardianship, community treatment and consent to treatment)(Wales) regulations 2008 • The Mental Capacity Act 2005 (including the Deprivation of Liberty Safeguards delegated to this Act under the Mental Health Act 2007) • The respective Codes of Practice of the above Acts of Parliament • The Human Rights Act 1998 (and the European Convention on Human Rights) • Domestic Violence, Crime and Victims Act, 2004 All Cardiff and Vale policies on the Mental Health Act 1983 as appropriate including: Section 5(4) Nurses' Holding Power Policy Section 5(2) Doctors' Holding Power Policy Section 5(2) Doctors' Holding Power Procedure Hospital Managers' Scheme of Delegation Policy Hospital Managers' Scheme of Delegation Procedure
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	*Mental Health Clinical Board Director of Operations*
Author(s)	*Mental Health Act Manager*

Disclaimer

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

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	*26/06/2018*	*02/07/2018*	*New document*

2			*Removal of glossary of terms.* *Inserted section to clearly explain the duties and responsibilities of qualified nurses and the procedure in relation to receiving the HO13 on behalf of the Hospital Managers.* *Inserted section in relation to support from the independent Mental Health Advocacy Service.* *Inserted:* • *Appendix 1 – Informal to 5(2)/5(4) flowchart* • *Appendix 2 – HO13 example*

CONTENTS

1. INTRODUCTION

Under section 5(4) nurses' of the prescribed class may detain a hospital inpatient who is already receiving treatment for the mental disorder for up to six hours. The decision to invoke the power is the personal decision of the nurse, who cannot be instructed to exercise the power by anyone else. This power may only be used where the nurse considers:

- The patient is suffering from mental disorder to such a degree that it is necessary for the patient to be immediately prevented from leaving the hospital, either for the patient's health or safety or the protection of other people.
- The patient is not an informal patient who is also subject to a community treatment order.
- It is not practicable to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).

If a patient has been allocated a hospital bed and is occupying that bed he or she is an "in-patient" for the purposes of section 5(4). The internal classification of the patient is not legally relevant because whether a patient is an in-patient is a question of fact.

A patient does not lose their inpatient status until they have physically removed themselves from the hospital (which includes the hospital grounds).

2. PROCEDURE STATEMENT

This procedure has been developed to guide staff on the implementation and management of nurses' holding powers (Section 5(4)) in accordance with the Mental Health Act 1983 as amended by MHA 2007. This guidance has been developed in line with the Mental Health Act 1983 Code of Practice for Wales 2016 (Code of Practice).

Holding powers when implemented authorises the detention of the patient in the hospital for a maximum of six hours so the patient can be assessed with a view to an application for detention under the Act being made.

3. SCOPE

The Health Board has in place appropriate governance arrangements to monitor and review the exercise of functions under the Act on its behalf. The Mental Health and Capacity Legislation Committee is specifically for this purpose.

This procedure is applicable to all qualified nurses' within all mental health inpatient settings.

4. DUTIES AND RESPONSIBILITIES OF NURSES' OF THE PRESCRIBED CLASS

A nurse of the prescribed class is defined in the Mental Health (Nurses') (Wales) Order 2008 as a nurse registered in sub-part 1 or 2 of the nurses' part of the Register of the Nursing and

Midwifery Council, with a recordable qualification in mental health or learning disability nursing as follows:

A nurse registered in	**Sub-part 1** of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing **Sub-part 2** of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing **Sub-part 1** of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing **Sub-part 2** of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing

5. ASSESSMENT PRIOR TO IMPLEMENTATION

Before using the power, nurses' should make as full as an assessment ~~an~~ as possible in the circumstances, but sometimes it may be necessary to invoke the power on the basis of only a brief assessment e.g. when events occur very quickly and the patient is determined to leave, the result of which could potentially have serious consequences if the patient was successful in leaving.

When making a full assessment they should assess:

- The likely arrival of the doctor or approved clinician
- The likely intention of the patient to leave, as it may be possible to persuade the patient to wait until a doctor or approved clinician arrives
- The harm that might occur to the patient or others if the patient were to leave the hospital before the doctor or approved clinician arrives. In this regard, the nurse should consider all aspect of the patient's communication and behaviour, including:
    - The patient's expressed intentions
    - The likelihood of the patient harming themselves or others, or behaving violently
    - Any evidence of disordered thinking
    - Any changes to their usual behaviour and any history of unpredictability or impulsiveness
    - Dates of special significance for the patient
    - Any recent disturbances on the ward
    - Any relevant involvement of other patients
    - Any formal risk assessments, which have been undertaken
    - Any other relevant information

The use of the holding power permits the patient's detention for up to six hours or until a doctor or approved clinician with the power to use section 5(2) arrives at the place the person is being detained, whichever is the earlier. It is the responsibility of the

nursing staff to ensure a doctor or approved clinician is notified of the section 5(4). Detention under section 5(4) cannot be renewed although this does not prevent it from being used on more than one occasion if necessary.

A nurse using section 5(4) should use the least restricting intervention to prevent the patient leaving hospital.

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

The patient is detained from the moment the nurse makes the necessary record. The reasons for invoking the power and the time this was done should be entered on PARIS, the patients' electronic record. A Form HO13 is completed by the nurse.

6. DUTIES AND RESPONSIBILITIES OF QUALIFIED NURSES

~~These documents~~ Form HO13 must ~~then~~ be forwarded to the Mental Health Act Team for receipt on behalf of the Hospital Managers. ~~faxed and posted to the Mental Health Act administration team.~~

During office hours (09:00 – 17:00, Monday to Friday) detention papers must be submitted to the Mental Health Act Office in Hafan Y Coed, University Hospital Llandough to enable the team to undertake receipt and scrutiny. Other sites must make contact with the Mental Health Act Office to inform them that they have detention papers to be received and make arrangements to fax or email a scanned copy of the papers as a priority.

Outside of office hours between 17:00 and 20:30 the Shift Coordinator for the appropriate area i.e. Hafan Y Coed, MHSOP or Rehab must contacted via bleep or through the main switchboard in order to make arrangements to receive detention papers.

The Night Site Manager is the delegated officer between 20:30 and 08:30 for the purpose of receipt of detention papers and can be contacted by bleep or the main switchboard.

The ward must keep a copy of the section papers in the patients file until the final version which has been processed by the Mental Health Act Office is available.

Once the detention papers have been formally received on behalf of the Hospital Managers outside of office hours it is the responsibility of the receiving officer to ensure the detention papers are forwarded to the Mental Health Act Office, Hafan Y Coed, University Hospital Llandough immediately.

Detention papers received off site must be faxed/scanned or emailed to the Mental Health Act Office. Once confirmation has been received the original detention papers must be sent to the Mental

Health Act Office in the internal mail system.

Detention papers received on the Hafan Y Coed site must be placed in an envelope and delivered to the Mental Health Act Office letterbox for staff to collect on the next working day.

The nurse should ensure that the patient is made aware of their rights under the Act and this is documented in the patients' notes. Information and leaflets are available on the Mental Health Act page, Cardiff and Vale intranet.

~~A nurse using section 5(4) should use the least restricting intervention to prevent the patient leaving hospital.~~

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

~~The nurse should ensure that the patient is made aware of their rights under the Act and this is documented in the patients' notes. Information and leaflets are available to download from the Cardiff and Vale, Mental Health Act intranet page.~~

Hospital managers should ensure suitably qualified, experienced and competent nurses' are available to all wards where there is a possibility of section 5(4) being invoked.

7. DOCTOR/APPROVED CLINICIAN RESPONSIBILITIES

The use of section 5(4) is an emergency measure, and the doctor or approved clinician with the power to use section 5(2) in respect of the patient should treat it as such and arrive as soon as practicable. The doctor or approved clinician should not wait the maximum time of six hours before attending.

The power to detain lapses once the doctor or approved clinician arrives to assess the patient. The time at which the patient ceased to be detained under section 5(4) should be recorded in the patient's record, together with the reasons and outcome.

8. MENTAL HEALTH ACT ADMINISTRATOR RESPONSIBILITIES

~~The Mental Health Act administrator will ensure that all relevant documents are received within the Mental Health Act Administration department.~~

The Mental Health Act administrator will carry out the scrutiny of documents and ensure that the forms are compliant with the MHA ~~comply with guidance~~ and the persons completing the forms are authorised to do so.

The Mental Health Act administrator will ensure that the original detention papers are filed in the patients' statutory file within the Mental Health Act administration department and ~~are~~ uploaded to PARIS.

9. CONDITIONALLY DISCHARGED PATIENTS

There is nothing to prevent the holding powers contained in section 5(4) from being used on a conditionally discharged patient who is being treated in a psychiatric hospital informally. If this does occur the Ministry of Justice should be notified on 020 33343335 and 0300 303 2079 (outside of office hours).

10. SECTION 17 LEAVE

A patient detained on section 5(4) cannot be granted ~~receive~~ section 17 leave. They are not detained by virtue of either an application under section 2 or section 3 and therefore do not have a Responsible Clinician to grant such leave.

11. COMMUNITY TREATMENT ORDER PATIENTS

Section 5(4) is not applicable to a patient subject to a Community Treatment Order (CTO). Patients can be recalled even during periods when they are in-patients. Therefore where it is considered necessary, the recall procedure must be used to detain the patient and within the 72 hours allowed a decision must be made whether to revoke the CTO.

Section 5(4) cannot be used to keep a patient in hospital after the end of the 72 hour recall period if the CTO has not been revoked.

12. SECTION 18 ABSENT WITHOUT LEAVE (AWOL)

A patient detained under section 5(4) who leaves the hospital is AWOL and can be retaken but only within the six hour period.

13. INAPPROPRIATE USE OF SECTION 5(4)

Section 5(4) cannot be used in the following circumstances:

- For an outpatient attending an accident and emergency department or any other out-patient facility.
- For a patient who is already liable to be detained in hospital or who is subject to a CTO.
- Is not to be used as a holding power simply for the purpose of persuading the patient to stay.

Patients should not be informally admitted with the sole intention of then using the holding power.

14. ENDING OF SECTION 5(4)

Section 5(4) holding powers last for a maximum of six hours and cannot be renewed.

Detention under section 5(4) will end if:-

- The result of the assessment is a decision not to make an application under section 2 or section 3.
- An application under section 2 or section 3 is made.
- The patient is discharged for clinical reasons before an assessment can be undertaken.

- No doctor or approved clinician able to make a report under 5(2) has attended within six hours

The doctor or approved clinician should assess the patient as soon as practicable and discharge if appropriate. They should not wait until the end of the six hours, nor, should they allow the section 5(4) to lapse.

The patient should be informed once they are no longer held under section 5(4) and advised of the reasons why. If this is because section 2 or section 3 was not applied, the patient should be informed they are free to leave hospital.

15. MEDICAL TREATMENT OF PATIENTS

Patients subject to section 5(4) are not subject to consent to treatment provisions contained in Part 4 of the MHA. If the patient is mentally capable of making a decision about treatment, the common law enables them to refuse to be treated for either a physical or mental disorder. However, if the patient is assessed as being mentally incapable of making a decision about treatment, the treatment can be provided under the Mental Capacity Act 2005 if it is deemed to be in their best interests.

16. TRANSFER TO OTHER HOSPITALS

Patients detained under section 5(4) cannot be transferred to another hospital under section 19, because they are not detained by virtue of an application made under Part 2 of the Act. This includes transfer between hospitals managed by the same hospital managers.

A patient who is subject to section 5(4) of the Act but needs to go to another hospital urgently for treatment, security or other exceptional reasons, can only be taken there if they consent to the transfer. If the patient lacks capacity to consent to the transfer, any transfer must be carried out in accordance with the MCA.

If, following transfer, the patient tries to leave the receiving hospital, a new situation will have arisen. In this circumstance, the receiving hospital may need to use section 5(4) to provide authority to detain the patient in that hospital.

In all cases, if the conditions are met, an emergency application for detention under section 4 of the Act could be made by the sending hospital. The patient could then be transferred to the receiving hospital under section 19. Alternatively, an emergency application under section 4 could be submitted to the managers of the receiving hospital.

17. APPEALS

A patient detained under section 5(4) cannot make an application to the Mental Health Review Tribunal for Wales or appeal to the hospital managers.

18. INDEPENDENT MENTAL HEALTH ADVOCACY

A patient detained under a section 5(4) is eligible to receive independent mental health advocacy services.

A qualifying patient may ask for the support of an Independent Mental Health Advocate (IMHA) at any time. It is the responsibility of the ward staff to ensure that the patient is informed that this service is available to them and how they may obtain it.

19. MONITORING

Hospital managers should monitor the use of section 5(4), including:

- How quickly patients are assessed for detention and discharged from the holding power
- The proportion of cases in which applications for detention are, in fact, made following use of section 5(4).
- Ensure the patients are made aware of their rights under section 132 of the Mental Health Act.

20. TRAINING

The health board will provide ongoing training for staff who have a delegated duty under the scheme of delegation. Details of training courses available can be found by contacting the Mental Health Act administration team or on the Mental Health Act intranet page.

21. IMPLEMENTATION

This document will be widely disseminated to staff in Cardiff and Vale University Health Board. It will be published on the organisations intranet sites and referred to during training relevant to the Act.

22. RESPONSIBILITIES

22.1 Chief Executive

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

22.2 Chief Operating Officer

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

22.3 Designated Individuals

All qualified nursing staff caring for patients on mental health inpatient wards should be familiar with the procedures detailed in the document and other related policies/procedures.

23. REFERENCES

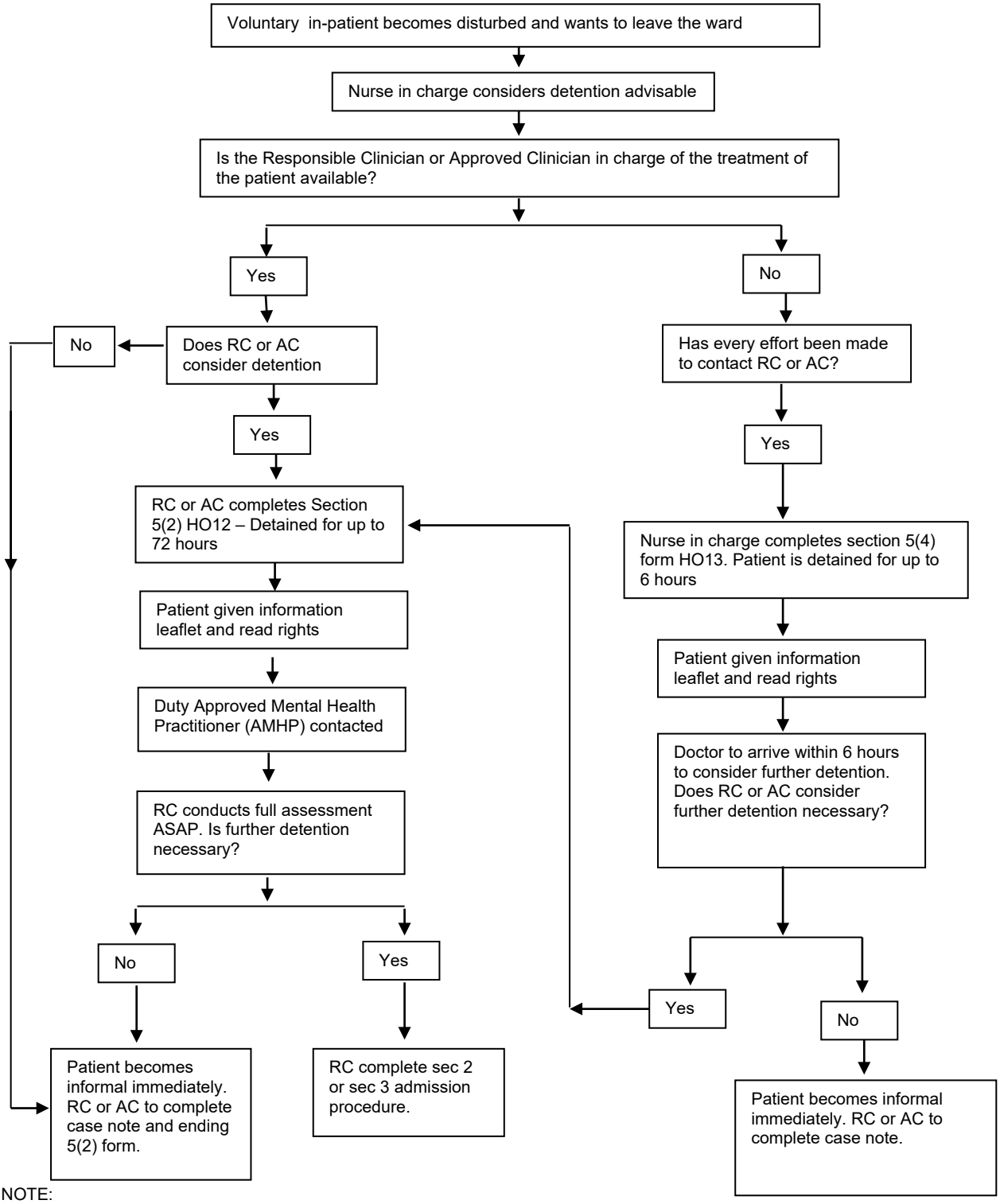
All staff will work within the Mental Health Act 1983 and in accordance with the Code of Practice for Wales 2007, Mental Capacity Act 2005, and Human Rights Act 1998.

Mental Health Act 1983 - www.legislation.gov.uk/ukpga/1983/20/contents
Mental Capacity Act 2005 - www.legislation.gov.uk/ukpga/2005/9/schedule/7
Mental Health Review Tribunal for Wales www.justice.gov.uk/tribunals/mental-health

Human Rights Act 1998 - www.legislation.gov.uk/ukpga/1998/42/contents
http://www.legislation.gov.uk/wsi/2008/2441/article/2/made

Appendix 1

Informal patient to Section 5(4) and/or Section 5(2)



NOTE:

i. Section 5(4) cannot be immediately renewed
ii. Time detained under section 5(4) becomes part of 72 hours if section 5(2) follows
iii. Section 5(2) can be used in General Hospitals
iv. Section 5(4) can be used in General Hospitals (by a nurse of the prescribed class only)
v. Cannot be used on CTO patients
vi. **All forms must be sent to MHA Office/Shift Coordinator ASAP**

Appendix 2

Form HO 13

Regulation 4(1)(h)

Mental Health Act 1983 section 5(4) - record of hospital in-patient

To the managers of

(name and address of hospital) Cardiff and Vale University Local Health Board

Full Correct Address of Hospital - Current address list can be found on the

Mental Health Act Intranet Page

(full name of the patient) Full name of the patient – No Initials

It appears to me that -

(a) this patient, who is receiving treatment for mental disorder as an in-patient of this hospital, is suffering from mental disorder to such a degree that it is necessary for the patient's health or safety or for the protection of others for this patient to be immediately restrained from leaving the hospital

AND

(b) it is not practicable to secure the immediate attendance of a registered medical practitioner or an approved clinician for the purpose of furnishing a report under section 5(2) of the Mental Health Act 1983.

(full name) I am Full name of nurse – No Initials

a nurse registered -

(a) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing

OR

(b) in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is mental health nursing

OR

(c) in Sub-Part 1 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing

OR

(d) registered in Sub-Part 2 of the register, whose entry includes an entry to indicate the nurse's field of practice is learning disabilities nursing

Signed: .....

Date: ..... **Time:** .....

Regan, Nikki 02/08/2022 12:45:48