Bundle Mental Health and Capacity Compliance Committee 29 July 2022

1.0 OPENING ADMINISTRATION

1.1 MC22/27 Welcome, introductions and apologies for absence - Chair - Information - Verbal report

1.2 MC22/28 Declarations of interest on current agenda - Chair - Decision - Verbal Report

1.3 MC22/29 Minutes of last meeting – 29 April 2022 - Chair - Decision - Paper

MC29 - Minutes MHCCC 29.4.22 v.02 LR revisions.docx

1.4 MC22/30 Action log - Chair - Decision - Paper

20220525 Table of actions LIVE.doc

2 STRATEGY

2.1 MC22/32 Approval of All Wales Approved Clinicians and Section12 (2) Doctors - Executive Medical Director - Consent - Paper

MC32 AC and S12 Report July 2022 Mental Health Capacity and Compliance Committee meeting.docx

2.2 MC22/33 Update on reforming the Mental Act - Divisional Director of Mental Health and Disability Service - Information - Paper

MC33 - New Mental Health Act Update - July 2022.docx

3 QUALITY SAFETY AND PERFORMANCE

3.1 MC22/34 Deprivation of Liberty Safeguards quarterly report - Director Of Safeguarding And Public Protection - Assurance - Paper

3.2 MC22/35 Associate Hospital Managers update report - Mental Health Act Manager - Assurance - Paper

MC35 - Associate Hospital Managers Update Report t july 2022.docx

3.3 MC22/36 Mental Health Act Performance Report Mental Health Act Manager - Assurance - Paper

MC36 - Coversheet MHA Performance Report july22 t.docx

MC36a - MHAct Report.pdf

MC36b - Divisional S136 Report June 22.pdf

MC36c - CAMHS S136 Report June 22.pdf

MC36d - Appendix 4 Quartely Activity Data.docx

3.4 MC22/37 Mental Health Legislation Risk Register - Assistant Director Of Information Governance & Risk - Assurance - Paper

MC37 -MHACC Committee Coversheet - Corporate Risk Register v1.0.docx

MC37a - Appendix 1 - MHCC Corporate Risk Register Report.pdf

MC37b - Appendix 2 - Full List Corporate Risks V.9.pdf

MC37c - Appendix 3 - Risk Key Field Guidance V2-Final.pdf

3.5 MC22/38 Criminal Justice Liaison report - Criminal Justice Service Manager - Assurance - Paper

MC38 - MHCaCC July 2022 CJLS - t.docx

3.6 MC22/39 Report on the use of restraints - Director of Mental Health Learning and Disability Service - Assurance - Verbal

3.7 MC22/40 Report on Medium Secure Unit - Director of Mental Health Learning and Disability Service - Assurance - Verbal

4 ANNUAL REPORTS

4.1 MC22/41 Court of Protection - Acting Associate Director Of Quality, Patient Safety and Experience - Assurance - Verbal

5 LEARNING FROM THE PAST

5.1 MC22/42 Quarterly Mental Health Act rolling audit report - Mental Health Act Manager - Assurance - Paper

MC42 - Audit Report and coversheet july 22 t.docx

5.2 MC22/43 Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit - Acting Associate Director Of Quality, Patient Safety and Experience - Assurance - Paper

MC43 - HIW Monitory Report_july 22_t.docx

MC43a - Quality Check Summary BCUHB 21101.pdf

6 CHAIR'S ASSURANCE REPORT

6.1 MC22/44 Chairs Assurance Reports - Information - Paper

7 CLOSING BUSINESS

7.1 MC22/27 Issues Discussed in Previous Private Session - Chair - Assurance - Verbal

There was no private session at the 29 April 2022 MHACC

7.2 MC22/27 Date of Next Meeting - Chair - Information - Verbal

4 November 2022

7.3 MC22/27 Exclusion of Press and Public - Chair - Information - Verbal Report

Mental Health Capacity and Compliance Committee (MHCCC)
Draft minutes of the meeting held on 29.4.22 via Teams

Present:	
Lucy Reid	Health Board Vice Chair (Chair)
John Gallanders	Independent Member
In Attendance:	
Louise Bell	Assistant Director Children and Adolescent Mental health Services (CAMHS)
Wayne Davies	Locality Manager, Welsh Ambulance Services Trust (part meeting)
Michelle Denwood	Director of Safeguarding and Public Protection
Simon Evans-Evans	Interim Director of Governance (part meeting)
Gill Harris	Executive Director Integrated Care / Deputy Chief Executive (part meeting)
Matthew Joyes	Interim Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience
Ruth Joyce	Criminal Justice Liaison Service Manager, MHLD
Wendy Lappin	Mental Health Act Manager, MHLD
Teresa Owen	Executive Director of Public Health
Justine Parry	Assistant Director Risk and Information Governance (part meeting)
Anna Reid	Head of Legal Services
Dr Alberto Salmoiraghi	Consultant Psychiatrist/Medical Director, MHLD
Helena Thomas	Associate Hospital Manager
Gaynor Thomason	Interim Executive Director of Nursing and Midwifery
Diane Davies	Corporate Governance Manager – for minutes

Agenda item	**Action**
MC22/0 Welcome The Chair welcomed to their first MHCC Committee meeting the newly appointed Interim Executive Director Nursing & Midwifery, Head of Legal Services and Associate Hospital Manager representative.	
MC22/1 Patient Story and Patient Experience update - **MC22/1.1** The Acting Associate Director of Quality Assurance introduced this item which described the struggle Eleni's son, Paolo, had experienced in trying to access mental health support in Wrexham and the impact on her as his carer.	

MC22/1.2 The Committee was concerned to hear of 'Eleni''s Carer experience with her adult son 'Paolo' and the variety of support and quality of services that were provided to each of them when they moved home to a different area within BCU's geographical area. The waiting times, lack of care co-ordination, communication with the carer and treatment plans were of significant concern to the Committee, and especially the family's decision to wish to relocate across the border in order to receive the level of service they needed. This was particularly concerning given that the family had advised that their first experiences within a different area of BCU had been supportive.	
MC22/1.3 The Committee questioned how advocacy services were offered across BCU which was explained by the MH Medical Director and the Interim Associate Director of Quality Assurance. It was noted that third sector organisations were also signposted for support provision. The MH Director also advised that the newly formed Clinical Senate was exploring patient pathways that included issues highlighted in primary care monitoring the effects of medications issued in respect of mental health. The Executive Director of Public Health undertook to explore further improving signposting communication in regard to advocacy.	TO
MC22/1.4 In response to the Committee's question regarding Carer's needs and involvement, discussion ensued on BCU's Carers strategy, shared responsibilities with local authorities and communication. The MH Medical Director also clarified that pathway sign off should involve the patient and family.	
MC22/1.5 The Interim Executive Director Nursing and Midwifery questioned whether an action was in place that included references to advocacy and the need to address shared learning across the organisation. The Committee concurred with the Director of Safeguarding and Public Protection that more organisational attention was required on ensuring advocacy signposting within services. The Together 4 Mental Health Programme Board would raise this for discussion in partnership.	TO/LR
MC22/1.6 The Committee Chair summarised her concerns in regard to the purpose of the story, the difference in quality of services across different areas served by the Health Board and the lack of an action plan provided to the Committee to demonstrate learning was being monitored and thereby providing assurance and greater confidence in current practice. She stated there was a recurrent theme of concern emerging regarding appropriate Treatment and Care plans in regard to accuracy and timeliness. The Committee remained concerned that the knowledge around the Mental Health Act was perceived as an area within the MH portfolio, however this was required across all of the Board's services and needed to be embedded appropriately.	
MC22/1.7 It was agreed that the Committee Chair would write to assure the family that that this experience had been listened to by Board members and further learning would be disseminated across the	AR

organisation. An invitation to discuss this with senior officers would also be extended. **It was resolved that** the Committee noted the patient story and agreed the following actions be followed up ▪ Lack of Treatment plan is a wider thematic issue (not only MH) – provide assurance and how learning will be disseminated across organisation in all services ▪ Variation in quality of patient experience in the MH Services encountered across areas ▪ Provide assurance the action plan has been addressed and learning embedded ▪ Clarify the key responses ▪ Clarify staffing issues ▪ Provide assurance that robust processes are in place to ensure advocacy service is referenced in relation to MH Act and wider services and is appropriately communicated.	TO
MC22/2 Patient Story Follow up – Children and Adolescent Mental Health Service (CAMHS) **MC22/2.1** The Assistant Director CAMHS presented the report which followed up actions agreed at the meeting held on 24.9.21 in regard to the CAMHS Patient Experience update and young person's patient story. She advised that many improvements had been introduced and that listening was the key issue. Thanks to the patient's ability to articulate her experiences well a much better understanding of patient trauma was helping to improve the organisation's approach which also needed to be shared outside MH services. **MC22/2.2** Outside of Area placements were an issue for young people and the Committee was pleased to understand that a Patient Experience and Family Co-Ordinator role had been appointed and a detailed action plan was in place to move work forward. However, it would be important to ensure the organisation did not view this as solely the individual's responsibility in this area. *The Executive Director Integrated Care joined the meeting* **MC22/2.3** The Committee questioned how patients were supported in moving from CAMHS to Adult Mental Health services, especially in regard to trauma informed approach. The MH Medical Director explained ongoing developments and training with examples. The Criminal Justice Liaison Service Manager also stated the importance of taking into account trauma experience when a CAMHS patient was involved with North Wales Police. **MC22/2.4** It was agreed that the Director of Safeguarding and Public Protection would share information on the Sammy Woodhouse, Rotherham case with Committee members and Assistant Director CAMHS for information. It was also agreed that the Assistant Director CAMHS would advise whether risks regarding CAMHS / MH Act were recorded on	MD

a risk register and that Group Terms of Reference were provided before the next meeting. The Executive Director of Public Health agreed to provide analysis of repeat S136s linking in with the CJL Service Manager, Interim MH Director and Director of Safeguarding and Public Protection for discussion at a future Together for Mental Health Partnership Board (T4MHPB) meeting. **It was resolved that** the Committee noted the learning from the patient story follow up	LB TO
MC22/3 Apologies Apologies had been received from Cheryl Carlisle, Chris Stockport, Hilary Owen, Iain Wilkie and Mike Smith.	
MC22/4 Declarations of Interest None were declared	
MC22/5 Draft minutes of the meeting held on 17.12.21 The minutes were confirmed as an accurate record.	
MC22/6 Matters arising and table of actions There were no matters arising from the minutes and the table of actions updates were accepted with exception of MC21/24 which was re-opened to address the issues as detailed within the minutes of the patient's experiences, especially in regard to communication.	MJ
MC22/7 Report of the Chair The Committee Chair reported that the Terms of Reference and Workplan for the Committee needed to be progressed. The governance around the Regional Partnership Board (RPB) and T4MHPB was being discussed and the Committee will be updated as appropriate.	
MC22/8 Report of the Lead Executive The Executive Director of Public Health stated that there was work to do to ensure the Mental Health Act was more embedded within other areas of the Health Board.	
The Future **Developing Strategies and plans** **MC22/9 Reforming the Mental Health Act White Paper**	

It was noted that the timescale for the introduction of the revised MHA white paper was currently unknown, however it was understood that there would be phased implementation. The Interim MH Director and Workforce and OD colleagues were aware of the resource impact and the Chair advised that there had been robust discussion at T4MHPB in regard to the revision.	
MC22/10 Liberty Protection Safeguards (LPS) Update **MC22/10.1** The Director of Safeguarding and Public Protection advised that there had been delay to the Code of Practice which resulted in the consultation period ending on 14.6.22. Work was continuing within BCU to prepare for the impacts including training however, the delay had impacted the organisation's action plan. She stated it would be key that BCU recognised the challenge ahead and supported the Group whose TOR had been approved. **MC22/10.2** The Committee Chair emphasised that the enormity of LPS was important to understand, and its impact would be very significant across the organisation. **MC22/10.3** The MH Medical Director commented that the new LPS practice would potentially increase clinician workload by 30% which included areas that already had capacity issues. **It was resolved that the Committee** noted the LPS verbal update	
MC22/11 Mental Health Policy : MHLD 0026 – Policy for admission, receipt and scrutiny of statutory documentation The Committee Chair commended the work undertaken within the EQIA. The Executive Director of Integrated Care undertook to discuss the governance route required to approve the policy which appeared to be overly lengthy. **It was resolved that the Committee** approved the policy	GH
Monitoring Existing Strategies or plans	
MC22/12 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales **It was resolved that the Committee** noted the report	
MC22/13 Update on Section 12(2) Doctors **MC22/13.1** The Executive Director of Public Health provided background to the update which had been requested by the Committee Chair due to a concern over availability of Section S12(2) doctors. The MH Medical	

Director advised that progress had been made in various areas. The Committee was supportive of actions being progressed by the Executive Team in moving forward more robust arrangements for the provision of Section 12(2) doctors. **MC22/13.2** The Committee Chair requested that the T4MHPB be kept abreast of developments. In discussion of the issue that training posts recommended by HEIW had not been funded, it was agreed that the MH Medical Director escalate the issue to the Executive Medical Director on behalf of the Committee. The Executive Director of Public Health undertook to raise this externally also. **It was resolved that the Committee** • acknowledged the report and progress on the matter • supported the actions detailed in the report – so that the detail could be further progressed by operational teams.	AS AS TO
THE PRESENT for assurance	
MC22/14 Corporate Risks **MC22/14.1** The Assistant Director Risk and Information Governance presented the paper and took on board the Committee Chair's comments regarding the length of the paper. The Executive Director of Integrated Care advised that discussion would shortly be taking place between herself, the office of the Board Secretary and a new Governance lead to move forward risk reporting. **MC22/14.2** It was agreed that the Executive Director of Public Health would work with the Executive Medical Director and Interim MH Director to advise how changes to the Mental Health Act risks would be monitored in BCU. In addition the MH Medical Director would feedback how national forums were dealing with risk in regard to changes to the Mental Health Act. **It was resolved that the Committee** agreed the recommendations **:** 1. Review, note and approve the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1: a) Note the transfer of this risk to the MHCC for future oversight from the QSE Committee on 11th January 2022. b) Note the controls have been updated to include the successful bid from Welsh Government for interim funding to support increased bespoke Mental Capacity Act training in primary and community settings and to increase physical capacity in the out of hours (OOH) service delivery. c) Note an additional assurance has been included to cover the monitoring and reporting of training compliance and DoLS backlog by the Safeguarding and Performance Governance Group and Welsh Government.	TO AS

d) Note the ET recognise the progress in the management of the risk including the alignment with the Intermediate Medium Plan to support additional resources and the strengthening of the governance arrangements for the Liberty Protection Safeguards (LPS) Implementation Group in preparation for the publication of the LPS Code of Practice. e) Note the clarification regarding the inherent risk score being lower than the current risk score due to the unforeseen significant increase in activity (44%). f) Note the completion of the Actions ID15705, 15709, 18983 and 18984 approved by ET, so that they will be archived and removed from the next report, recognising that a new action has been captured to support the increase in activity within Safeguarding until the LPS Code of Practice is published. 2. Note there are no new risks being presented to this Committee for escalation approval at this time. 3. Note there are no risks being presented to this Committee for closure or de-escalation consideration at this time.	
MC22/15 CAMHS Transformation & Improvement Programme - Crisis Care Response for Children and Young People **MC22/15.1** The Assistant Director CAMHS presented this item, drawing attention to the improvement plan and pilot schemes which were underway. She advised that the Delivery Unit Crisis Care review would be imminently available. She acknowledged that there would be more work to do. **MC22/15.2** A discussion ensued on the sanctuary scheme in which the CJL Manager stated that the soft launch had been low in uptake and also described recruitment issues. The MH Medical Director concurred with the current poor psychiatry cover however he stated that mitigation was in place. It was noted that the Director of Safeguarding and Public Protection highlighted the need to address that 55% of S136 presentations occurred out of hours. **MC22/15.4** In response to the Committee, the Assistant Director CAMHS undertook to provide the Child pathway of journey presenting at ED to provide assurance. Following discussion, the Executive Director of Public undertook to feedback on how a child's psychological therapy and social care needs were met to ensure no gap, and how that risk is monitored within BCU. In discussion of RPB involvement in this area, it was noted that a Children's Sub Group was now in place, of which the Director of Safeguarding and Public Protection was Vice Chair. She advised this to be an everyday risk and pressure. **It was resolved that the Committee** noted the report	LB TO

MC22/16 Deprivation of Liberty Safeguards (DoLS) Quarterly Report January 2022 **MC22/16.1** The Committee commented that there had been a significant increase in DoLs and legal issues and sought assurance on how any further increase would be dealt with. The Director of Safeguarding and Public Protection advised that WG had provided some financial support to drive the agenda forward and had reduced backlog. In addition a training plan was in place however, staff would also need to be in place by the last quarter to ensure OOH and 7 day working could be addressed. In response to the Committee, the Executive Director of Integrated Care confirmed that a potential for financial claims was captured in a risk register. **MC22/16.2** A discussion arose regarding physical restraint, in which an Independent Member commented on potential differences between English / Welsh organisations and it was agreed that the Executive Director of Integrated Care would provide assurance on how physical restraint monitoring and risk management was effectively carried out across BCU services and accounted for at BCU's Committees. The Executive Director of Public Health agreed to research how other Health Boards monitor physical restraint and associated risk. **MC22/16.3** The Committee Chair requested that the Head of Legal Services link in with the team regarding Capacity assessments to support the wider organisation. **It was resolved that the Committee** resolved to • accept the Deprivation of Liberty Safeguards Quarterly Report and the identified activity for the period of Q4 2021-22. • receive the DoLS Action Plan and progress. • accept the position in preparation for the implementation of Liberty Protection Safeguards (LPS).	GH TO AR
MC22/17 Associate Hospital Managers Update Report **It was resolved that the Committee** noted the report	
MC22/18 MHA Performance Report **MC22/18.1** The Committee questioned why the East was an outlier in regard to Section 2 (5) Admissions for Assessment. A discussion ensued and it was agreed that the MH Medical Director and MHA Manager would analyse the data in respect of the East outlier to consider if any underlying issue, not associated with population density, could be identified. **MC22/18.2** The Assistant Director CAMHS undertook to explore data to ascertain if there was any underlying issue with the very unbalanced gender split on Appendix 3 S136 following an observation raised by the	WL/AS LB

Committee. Following a discussion around potential domestic violence and female offending behaviours, the Executive Director of Public Health also agreed to explore this with her Public Health team. **It was resolved that the Committee** noted the report	TO
Learning from the Past **MC22/19 Healthcare Inspectorate Wales (HIW) monitoring reports** **MC22/19.1** The Committee Chair requested that as the Tan Y Coed implementation actions had not been provided, the report be resubmitted to the next meeting along with an updated action plan. **MC22/19.2** The Director and Safeguarding and Public Protection questioned how incident training/learning was being taken forward and undertook to discuss this further with the Interim MH Director. The Interim Associate Director of Quality Assurance also agreed to link in with the Director of Safeguarding and Public Protection to share recent work undertaken on razor blades. **MC22/19.3** Following an observation by the Committee regarding a previous learning point of the Ockenden report, the need to put in place a robust monitoring process to ensure learning was embedded and sustained was emphasised. In order to ensure that any unembedded learning was identified by the organisation at an earlier stage rather than by the findings of an adhoc external inspection. **MC22/19.4** The Executive Director of Public Health stated the MH Improvement Plan would be key to ensuring embedded learning was addressed. **It was resolved that the Committee** noted the report.	TO MD MJ
MC22/20 Compliance with the Mental Health Act quarterly report The Committee Chair was concerned with recurrent themes regarding accurate completion of care and treatment plans which she emphasised was a legal requirement. The Committee also noted that there was variation across different areas of the Health Board. Following discussion regarding ongoing work to address the issue and the fragility of current workforce levels (with sickness rates at its highest since the commencement of the pandemic), it was agreed that the Executive Director of Public Health would discuss the variation and quality of Care and Treatment plans, along with process efficiency, with the Interim MH Director to make improvements. The current staffing pressures were acknowledged by the Committee. **It was resolved that the Committee** noted the report.	TO
MC22/21 Power of Discharge (POD) Group report	

The Committee was disappointed to note the poor attendance at the previous meeting and quoracy issues. In response to the MHA Manager, the Executive Director of Public Health undertook to seek clarification with the Board Secretary whether two Associate Hospital Managers were required to be present at each MHCCC meeting or one present and another nominated as deputy in respect of the Terms of Reference. **It was resolved that the Committee** • noted the report • approved three new POD appointments • supported in principle that PODG and Associate Hospital Managers be provided with overnight accommodation to attend an all Wales event on 11.5.22 and progression of their IT requests	TO
MC22/22 Court of Protection update **MC22/22.1** The Committee was pleased to welcome the newly appointed Head of Legal Services who would be joining future meetings to present regular Court of Protection reports in this new role. The Committee Chair welcomed Committee focus in this area and recognised both patient and reputational risks for BCU. **MC22/22.2** The Interim Associate Director of Quality Assurance provided a verbal update on two current cases, one at Ysbyty Glan Clwyd and the other in the West area. He reported that BCU was currently compliant with both and informed that, moving forward, the Interim Secondary Care Nurse Director was recruiting Complex Care Co-Ordinators. The Executive Director Integrated Care reflected on the lengthy development time of these roles and the importance of understanding how lengthy recruitment processes impacted services and also the requirement to manage risks in the interim period to appointment. **MC22/22.3** The Committee Chair welcomed news of the new roles and improvements in monitoring Court of Protection judgements. She asked that future reports include assurance that judges' directions and any issues highlighted had been dealt with. **It was resolved that the Committee** noted the verbal report.	AR
MC22/23 Agree items for referral to Board / Other Committees None were identified.	
MC22/24 Review of risks highlighted in the meeting for referral to Risk Management Group To be considered following the meeting.	-

MC22/25 Agree items for Chairs Assurance report To be considered following the meeting.	
MC22/26 Review of meeting effectiveness To be considered following the meeting.	
MC22/27 Date of next meeting 17.6.22 Post meeting note – to be deferred to July date TBA	

BCUHB Mental Health Capacity and Compliance Committee Table of actions – last updated 22/07/2022 19:16				
Executive Director	**Minute reference and action agreed**	**Original timescale**	**Latest update position**	**Revised timescale**
17.12.21 meeting				
Matt Joyes	**MC21/24 Patient Story and Patient Experience update – Z's story** • Circulate a member briefing to explain how the issues discussed were being taken forward (see minutes)	19.4.22	In response to the Committee's questions on the service, we can advise that it is now operated on a national basis, commissioned by the Welsh Health Specialised Services Committee and hosted by Cardiff and Vale University Health Board. The new Welsh Gender Service was first announced by the Health Minister, Vaughan Gething MS in 2017. Since the Health Minister's announcement, the Welsh Gender Service (WGS) was created and is based at St David's Hospital in Cardiff with outreach Local Gender Teams (LGT) based in each health board area. The Local Gender Teams are made up of a doctor, who prescribes hormone therapies and a speech and language therapist, who are both located closer to the patient's home. The Welsh Gender Service are a multidisciplinary administrative and clinical team, made up of Consultants, Gender Clinicians, Clinical Psychologists, Speech and Language Therapists and Management. The service aim to work together to provide holistic patient-centred care focussing on hormonal, psychological, and social aspects of	Action to be closed

Matt Joyes	**29.4.22 Re-opened** MC21/24 Re-opened to address the issues as detailed within the minutes of the patient's experiences, especially in regard to communication.		transition. The Medical Director for MHLD has advised that the new service has improved access to specialist clinical skills and improved clinical governance.	
Teresa Owen	**MC21/32 Terms of Reference** The Executive Director of Public Health undertook to verify if staffside groups were included in all the new Committee ToRs following the Integrated Governance Review	19.4.22	This action will be considered at the next CBMG meeting – when staff side attendance will be discussed for all committees given need for a consistent and clear approach.	
Wendy Lappin	**MC21/36 Mental Health Act Performance report** Discussion ensued on S136 data for Young People in which it was highlighted that, due to the low numbers involved, there might appear to be a skew within certain Local Authority area presentations, it was agreed this would be explored further.	19.4.22	Following discussion it was agreed that further clarity in regards to the tables and information would be provided verbally at the next meeting. A verbal update to be provided as per agenda item. 4.5.22 Recirculate and close	21/4/22
Teresa Owen	**MC21/39 Mental Health Act risk register** The Committee acknowledged the next steps to be undertaken in order to assign Tier one risks to the Committee, however the Committee Chair questioned whether Risk "*CRR21-14 There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients"* should be transferred from the Quality, Safety and Experience Committee as this might 'fit' with both Committees. The Executive Director of	19.4.22	Further work is required on the risk register. Verbal update to be provided alongside the risk paperwork for the Committee. *Teresa – was this updated at the meeting, I can't find notes to cover it- unless it was accepted that the CRR item closed it?*	21/4/22

	Public Health agreed to seek further guidance from the Interim Director of Governance on this matter.			
29.4.22 Meeting				
Teresa Owen	**Patient Story - Paulo** **Follow up on:** ▪ Lack of Treatment plan is a wider thematic issue (not only MH) – provide assurance and how learning will be disseminated across organisation in all services ▪ Variation in quality of patient experience in the MH Services encountered across areas ▪ Provide assurance the action plan has been addressed and learning embedded ▪ Clarify the key responses ▪ Clarify staffing issues ▪ Provide assurance that robust processes are in place to ensure advocacy service is referenced in relation to MH Act and wider services and is appropriately communicated.	31.5.22		
Matt Joyes	**Patient Story - Paulo** Draft letter for Committee Chair to offer a meeting with senior officer of the Health Board to listen to their experiences, and know their story has been shared with Board members at a Committee meeting.	13.5.22		
Michelle Denwood	**CAMHS follow up Patient Story** Share Sammy Woodhouse information with Committee members and Louise Bell	13.5.22		
Louise Bell	**CAMHS follow up Patient Story**	20.5.22		

	Check risk on register re CAMHS / MHAct Revisit 21/24 Provide ToRs before next meeting			
Teresa Owen	**CAMHS follow up Patient Story** Provide analysis of repeat S136s linking in with Ruth Joyce/Mike Smith/Michelle Denwood for presentation to the T4MHPB	20.5.22		
Gill Harris	**MC22/11 MHLD 0026 policy** Discuss with Board Secretary the length of policy approval process to consider if can be shortened	20.5.22		
Alberto Salmoiraghi	**MC22/13 S12(2) Doctors** • Continue to update T4MHPB on progress • **Escalate the issue that training posts recommended by HEIW had not been funded to the Executive Medical Director on behalf of the Committee	13.5.22		
Teresa Owen	**MC22/13 S12(2) Doctors** • Raise the above ** issue externally	13.5.22		
Teresa Owen	**MC22/14 Corporate Risks** • Together with Nick Lyons and Iain Wilkie advise how changes to the Mental Health Act risks will be monitored in BCU	13.5.22		
Alberto Salmoiraghi	**MC22/14 Corporate Risks** • Feedback how national forums are dealing with risk in regard to changes to the Mental Health Act	13.5.22		
Louise Bell	**MC22/15 CAMHS Pathway** • Provide the Committee with Child pathway as assurance of journey from ED.	13.5.22		
Teresa Owen	**MC22/15 CAMHS Pathway** • Feedback how a child's psychological therapy and social care needs are met to ensure no gap, and how risk is monitored	20.5.22		

	within BCU.			
Gill Harris	**MC22/16 DoLs quarterly report** • Provide assurance on how physical restraint monitoring and risk management is effectively carried out across BCU services and accounted for at BCU's Committees	20.5.22		
Teresa Owen	**MC22/16 DoLs quarterly report** • Research how other Health Boards monitor physical restraint and associated risk	20.5.22		
Anna Reid	**MC22/16 DoLs quarterly report** • Link in with team regarding Capacity assessments to support the wider organisation	20.5.22		
Alberto Salmoiraghi/ Wendy Lappin	**MC22/18 Performance report** Analyse data in respect of East outlier to consider if underlying issue not associated with population density	13.5.22		
Louise Bell	**MC22/18 Performance report** LB to explore data to explore any underlying issue with very unbalanced gender split on Appendix 3 S136	20.5.22		
Teresa Owen	**MC22/18 Performance report** Following a discussion around potential domestic violence and female offending behaviours, the Executive Director of Public Health also agreed to explore this with her Public Health team.	20.5.22		
Teresa Owen	**MC22/19 HIW monitoring** Resubmit to next Committee meeting Tan Y Coed report and implementation actions	7.6.22		
Michele Denwood	**MC22/19 HIW monitoring** Explore with Iain Wilkie how incident training/learning is being taken forward	31.5.22		

Matt Joyes	**MC22/19 HIW monitoring** Link in with MD to share recent work undertaken on razor blades.			
Teresa Owen	**MC22/20 Compliance with MHA Audit** Discuss with IW variation and quality of Care and Treatment plans, along with process efficiencies, to make improvements	20.5.22		
Teresa Owen	**MC22/21 PODG** Seek clarification with Board Secretary whether 2 Associate Hospital Managers are required to be present at each MHCCC meeting or 1 present and another nominated as deputy re ToRs	20.5.22		
Anna Read	**MC22/22 Court of Protection** Ensure future reports include assurance that judges' directions and any issues highlighted have been dealt with	7.6.22		

Cyfarfod a dyddiad: **Meeting and date:**	Mental Health, Capacity and Compliance Committee. 29th July 2022
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Nick Lyons Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Mrs Heulwen Hughes All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors
Craffu blaenorol: **Prior Scrutiny:**	The report has been scrutinised by Dr Nick Lyons prior to submitting to the Committee.
Atodiadau **Appendices:**	Appendix 1 – Additions and Removals to the All Wales register of Approved Clinicians –14.04.2022 - 08.07.2022 Appendix 2 – Additions and Removals to the All Wales register of Section 12(2) Doctors – 14.04.2022 - 08.07.2022 Appendix 3 - Breakdown of Section 12(2) GPs currently approved in Wales as at 08.07.2022.

Argymhelliad / Recommendation:

To note for assurance purposes that appropriate governance arrangements, processes and activities are in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Sefyllfa / Situation:

Betsi Cadwaladr University Health Board is responsible for the initial approval, re-approval, suspension and termination of approval of Approved Clinicians and Section 12(2) Doctors for all Health Boards in Wales.

Cefndir / Background:

The change introduced to the Mental Health Act 1983 was the abolishing of Responsible Medical Officers (RMOs) and Community Responsible Medical Officers (CRMOs) and the introduction of Approved/Responsible Clinicians (ACs and RCs) in their place.

The Minister for Health and Social Services agreed that as of the 3rd November 2008, Wrexham Local Health Board (LHB) would act as the Approval Body for Approved Clinicians and section 12(2) Doctors on behalf of the LHBs in Wales. The transfer of function from Wrexham Local Health Board to Betsi Cadwaladr University Health Board took place on 1st October 2009.

Asesiad / Assessment & Analysis

Strategy Implications

It is important to ensure the highest standards of governance for approving and re-approving practitioners who are granted these additional responsibilities, which apply when people may be mentally disordered.

Options Considered

This is a factual report on the numbers of applications and therefore, options are not considered relevant for this purpose.

Financial Implications

The Approvals Team receive a ring-fenced budget from Welsh Government to support the monitoring and approvals of Clinicians in Wales.

Risk Analysis

To ensure that all Clinicians are approved and reapproved within the agreed timescales, the All Wales Approval Panel assesses applications according to the Procedural Arrangements agreed with Welsh Government.

Legal and Compliance

The Approval Process meets the legislative requirements of the Mental Health Act 1983 (as amended 2007) and the Mental Health Act 1983 (Approved Clinicians)(Wales) Directions 2018.

Impact Assessment

An impact assessment is considered unnecessary for this update paper. The Approval Process is part of the legislative process

Service Developments

1. Approved Clinician and Section 12(2) Induction and Refresher Training

The February 2022 Induction and Refresher training was held via Webinar. The next induction and refresher training will take place 6th, 7th and 8th September 2022 and will also be facilitated via Webinar. Training dates have been agreed up to February 2023.

2. Temporary Arrangements for the re-approval of Approved Clinicians and Section 12(2) Doctors during Covid-19

Following discussions with Welsh Government, a letter was sent via email in June 2020 to all ACs and S12 (2) doctors informing of and clarifying details for a temporary variation in the arrangements for re-approval during the Covid19 pandemic. The variation applied to ACs/S12(2) doctors who were due to apply for re-approval during the pandemic advising that the Team were able to continue to offer Webinar-based refresher training compliant with social distancing requirements during Covid-19. This would enable clinicians to meet the extant requirements of re-approval. Welsh Government agreed that it would also be prudent to make a temporary and minor variation in the event that the refresher training could not be delivered or where a clinician had been unable to attend due to Covid-19 related reasons. In that exceptional circumstance, the Approving Board may grant approval, on condition that the clinician attends refresher training within 12 months of the start date of the new approval period.

To date, all applicants have attended refresher training and there has, therefore, been no need to use the temporary arrangements.

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

14th April 2022 to 8th July 2022

New Applications Received:	**5**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	0
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	5
Number of ACs already approved in England	3
Number of applications with panel (including portfolios)	1
Number of applications not approved	0
Re-approval Applications Received (5 Yearly):	**20**
Number of applications with panel	2
Number of applications approved	18
Number of applications not approved	0
Number of ACs reinstated	1
Number of re-approvals which have come to an end:	**11**
Expired	0
Retirement	4
No longer working in Wales	5
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	0
Awaiting CCT	0
Suspended	2
RIP	0
Total Number of Approved Clinicians	**369**
Total Number of Approved Clinicians from previous report	**373**

APPENDIX 2

Additions and Removals to the all Wales register of Section 12(2) Doctors

14th April 2022 to 8th July 2022

New Applications Received	**8**
Applications from GPs	0
Applications from Psychiatrists	8
Application from Forensic Medical Examiner	0
Number of Applications Approved	7
Number of Applications Not Approved	0
Number of Applications with Panel	0
Incomplete Applications	1
Re-approval Applications (5 years)	**0**
Applications from GPs	0
Applications from Psychiatrists	0
Applications from Forensic Medical Examiners	0
Number of Applications Approved	0
Number of Applications Not Approved	0
Number of Applications with Panel	0
Transferred from AC register	**1**
Transferred from England	**1**
Number of Approvals which have come to an end:	4
Ended	0
Become an Approved Clinician	1
No longer working in Wales	2
No longer registered	1
Registered without a licence to practise	0
Retired	0
Under Police Investigation	0
Suspended from Medical Performers' List	0
Total Number of S12(2) Doctors currently approved	**184**
Total Number of S12(2) Doctors from previous report	**181**

APPENDIX 3

Breakdown of Section 12(2) Doctors currently approved in BCUHB

As at 8th July 2022

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	5	1	0	1	3	**13**
Section 12(2) Psychiatrists	0	8	4	3	2	10	**27**
Approved Clinicians *(Includes non-medics)*	3	17	18	10	13	18	**78**

Number of 12(2) GPs per Health Board

As at 8th July 2022

BCUHB	13
ANEURIN BEVAN	5
CARDIFF & VALE	5
CWM TAF MORGANNWG	0
HYWEL DDA	1
POWYS	2
SWANSEA BAY	1

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 29.07.2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Update on Reforming the Mental Health Act
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The committee is asked to discuss the update and note this report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**	√	**Er gwybodaeth For Information**	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

This report is intended to inform the Committee of progress relating to the Reform of the Mental Health Act further to an update on the Government Website.

The Mental Health Act is a prescriptive legislation in law. The decision to change the Mental Health Act legislation will come from Government. The Health Board will be required to comply with any changes when these legislative changes occur.

This report is highlighting progress following the publication of the Draft Mental Health Bill on the 27th of June 2022.

Sefyllfa / Situation:

The Government response to the consultation was published July 2021.

The Draft Mental Health Bill, explanatory notes, impact assessment and a memorandum from the Department of Health and Social Care and Ministry of Justice to the Delegated Powers and Regulatory Reform Committee was published on the 27th June 2022 and can be found here: Draft Mental Health Bill 2022 - GOV.UK (www.gov.uk).

Cefndir / Background:

The Independent Review of the Mental Health Act was commissioned by Government in October 2017.

The Independent Review was conducted throughout 2018 and involved engagement with service users, carers and professionals facilitated through surveys, meetings and conferences. The academic literature review allowed the latest evidence on themes under the Mental Health Act to be gathered.

An interim report was published in May 2018, with the final report and recommendations published on the 6th of December 2018.

These being:

- choice and autonomy – ensuring service users' views and choices are respected
- least restriction – ensuring the Act's powers are used in the least restrictive way
- therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the Act
- people as individuals – ensuring patients are viewed and treated as rounded individuals

The White Paper: '*Reforming the Mental Health Act*' was published by the UK Government for consultation following the independent review undertaken in 2018, with a consultation deadline date of the 21st of April 2021.

The Draft Mental Health Bill was published by UK Government on the 27th of June 2022.
The Bill is currently in draft and will be subject to scrutiny by a pre-legislative parliamentary committee before the final version is drawn up, and introduced into Parliament. The Bill extends to England and Wales with some clauses extending UK wide, the care and treatment clauses are not extendable into Wales with Wales having the Mental Health Measure - which is deemed suitable.

Asesu a Dadansoddi / Assessment & Analysis

Strategy Implications

The Draft Mental Health Bill informs the changes that will occur within the Mental Health Act 1983. Government has accepted the majority of the changes identified within the independent review recommendations. These include a wide range of changes to shift the balance of power from the system to the patient, putting service users at the centre of decisions about their own care. The purpose being to reform and modernise Mental Health, to provide an effective framework for services to support people experiencing the most serious mental health conditions.

Changes confirmed in the Draft Bill which affect Wales:

- ***Autism and Learning Disability*** – people with a learning disability and / or autism will only be able to be detained for treatment under Part 2 of the MHA if they satisfy the conditions set out in section 3 of the MHA, which includes that they are suffering from a co-occurring mental disorder, which is not learning disability or autism. These changes will not apply to those detained under Part 3 of the MHA (i.e., individuals accused of, or servicing a sentence for committing a crime).
- ***Criteria for detention*** – the criteria for detention or renewal has been strengthened, to ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others.
- ***Appropriate medical treatment*** – there is a new requirement for treatment to also be in line

with therapeutic benefit this is also extended to CTOs.

- ***Treatment decisions*** – the new section 56A introduces a duty on the clinician in charge of the patient's treatment to consider certain matters including the patient's wishes and feelings regarding medical treatment.
- ***Section 58 Consent to treatment period*** – this period will be shortened from three months to two months.
- ***Urgent treatment removal of S62*** – urgent treatment under s62 will no longer be permissible if the patient has capacity or competence to decide not to accept the treatment. This does not apply to those that lack capacity. Capacity throughout the bill refers to those aged 16 or older, competence is applicable to those under the age of 16.
- ***Community Treatment Order (CTO)*** - Removal of automatic referrals when a CTO patient is readmitted to hospital.
- ***Nominated person*** – a nominated person will replace the nearest relative which will include three new powers and rights:
    - The right to be consulted about care and treatment plans
    - The right to be consulted about transfers between hospitals, renewals and extensions to the patient's detention or CTO
    - The power to object to the use of a CTO

  The nominated person can be nominated by the patient or in some circumstances will be nominated by the AMHP.
  The nominated person will also be extended to include Part 3 MHA sections although restricted sections will have limitations.
- ***Detention periods*** – will change to three months, renewable for three months, renewable for six months, then renewable yearly. These will also apply to some unrestricted Part 3 patients but the majority remain as the previous timescales. Patients subject to guardianship remain at the previous timescales.
- ***Application to Tribunals*** – the timeframe for a section 2 application has been extended from 14 days to 21 days. Section 3 patients can appeal within the first three months and within each subsequent period. Part 3 conditionally discharged patients can appeal between 12 months and 2 years and thereafter every two years.
- ***Automatic referrals*** - An automatic referral for those detained under section 2 or 3 will be at the three month period from detention and on the 12 month date from which the patient was first detained and therefore on the expiry of every 12 month period of detention. The automatic referrals for CTO patients would be at 6 months, 12 months and then yearly. An automatic referral is no longer required if a CTO is revoked. Part 3 patients to move to yearly reviews. Part 3 conditionally discharged patients to have automatic reviews at 4 yearly intervals.
- ***Transfers from prison to hospital*** - A statutory time limit of 28 days for immigration removal centres and prisons transfers to a secure hospital has been agreed.
- ***Removal of police stations and prisons as a place of safety*** – Police stations will no longer be able to be used as a place of safety under S135/S136. Direction is made to the courts to consider exercising section 35 rather than remanding to prison under the Bail Act 1976 for a person's safety.
- ***Title*** – the Bill's short title is as 'the Mental Health Act 2022'.

The above is not an exhaustive list and there are many minor changes to parts of the Act. The committee will receive further updates, as detail emerges.

Opsiynau a ystyriwyd / Options considered

Not applicable for this paper.

Goblygiadau Ariannol / Financial Implications

The proposed changes will require additional administrative work for clinicians, nursing staff and the Mental Health Act office. This will result in the need for extra staffing.

The explanatory notes (detailing the Impact Assessment) outline the potential costs and implications for bodies and organisations – given the proposed measures. In the healthcare arena, the ongoing costs for resourcing the reforms and upfront training, and costs for existing staff are estimated in the central scenario to total £436m, and when fully implemented are estimated to cost an additional £100m per annum for all services.

It is noted that the full implementation of these reforms are expected to take around ten years, largely due to the lead in time required to train additional clinical and judicial staff.

Dadansoddiad Risk / Risk Analysis

The proposed changes will:

- Strengthen assurances that patients are detained appropriately, and strengthen assurance that patients have access to an IMHA.
- Require additional administrative tasks for the Mental Health Act office staff.
- Require additional reports and assessments by professionals.
- Require increase data assurance and enable comparisons and benchmarking.
- Enable additional monitoring and checks.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Draft Mental Health Bill applies to England and Wales, aside from the clauses in associate with Care and Treatment Plans as Wales works within the Mental Health Measure 2010 framework.

Asesiad Effaith / Impact Assessment

An impact assessment has been completed in relation to the Bill, and this is available on the government website Draft Mental Health Bill 2022 - GOV.UK (www.gov.uk).

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 29.07.2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Associate Hospital Managers Update Report (February 22 – May 2022)
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Hilary Owen, Head of Governance and Compliance MHLD Iain Wilkie, Interim Director, Mental Health & Learning Disability Division
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	☒	**Ar gyfer sicrwydd For Assurance**	☒	**Er gwybodaeth For Information**	☒
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

This report does not inform strategic decisions, it relates to the day to day operations of the Associate Hosptial Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.

Sefyllfa / Situation:

The Associate Hospital Managers update report provides details regarding the Associate Hospital Managers activity within the Health Board for the detailed period. The report describes activities in the following areas of: Hearings, Scrutiny, Training, Recruitment, Forums and Meetings and Key Performance Indicators.

Cefndir / Background:

Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'. In Wales, NHS hospitals are managed by Local Health Boards. The Local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.

Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)

In practice, most of the decisions the Hospital Managers are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)

In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels. They are directly accountable to the Board in the execution of their delegated functions. (CoPW 37.6).

This report provides assurance that the individuals who form the Hospital Manager Discharge Panels (namely **Mental Health Act Associate Hospital Managers** (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards.

The report details the activity of the Associate Hospital Managers in relation to hearings and activity undertaken, concerns raised and improvements to the division or service to which they have input for the period February 2022 – May 2022,
Due to a change in the schedule for the Mental Health Capacity and Compliance Committee, this report covers a four month period rather than the usual three month period.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The use of the Mental Health Act is determined by patient needs, and the least restrictive option is at the forefront of all professional practice. The Associate Hospital Managers have a duty as independent persons to ensure that the Health Board only detains patients who meet the criteria for detention.

Opsiynau a ystyriwyd / Options considered

Not applicable for this report the functions of the Associate Hospital Managers are governed by legislation, the Associate Hospital Manager panels are a requirement of the law.

Goblygiadau Ariannol / Financial Implications

The Associate Hospital Managers are paid a sessional fee for each activity. Additional safeguards in relation to Information Governance, has an impact on financial costings due to security requirements for posting reports. Hearings held via virtual means has reduced the claims for travel, but has incurred additional costs given ‘back up’ arrangements. Since the last quarterly report, there have been no changes to these arrangements.

Dadansoddiad Risk / Risk Analysis

The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level.

Hearings for patients should be conducted as close to the renewal date as possible. If a patient requests a hearing this should be given priority. Risks associated with not conducting a hearing as close as possible to the relevant date, would be:

- Transfers impacting on hearings with the potential for a hearing to be missed or rearranged.
- The Associate Hospital Managers Discharge Panel may not agree with the professionals and feel that patient should be discharged any delay in the hearing may result in the patient being detained for longer than necessary.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.

Asesiad Effaith / Impact Assessment

All policies in relation to the Associate Hospital Managers have been equality impact assessed.

Quarterly Activity

1 Hearings

At the time of writing (13.06.2022) hearings continue to be held remotely via Microsoft Teams.

A total of 25 hearings were held during the months February – May 2022. The hearings consisted of four Community Treatment Orders (CTO) renewals, 20 section 3 renewals and one patient appeal.

Two patients were discharged by the Hospital Managers.

Five patients appealed their detentions this period, three hearings were not held due to one discharge, one regrading and one transfer to another unit. One hearing was held and one was postponed due to the solicitor being double booked, the patient was subsequently regraded to informal prior to the new hearing being held.

A breakdown of the hearing activity is detailed below:

February

- ***Seven hearings arranged (Five held)***
  All hearings were in relation to renewals. Two hearings were for community patients.

  Two hearings were cancelled – The Responsible Clinician (RC) discharged one patient and one patient's CTO was revoked.

  Outcomes of hearings held

  - All detentions were upheld.

March

- ***Nine hearings arranged (Six held)***
  All hearings were in relation to renewals. One hearing was for a community patient.

  Three hearings were cancelled – The Responsible Clinician (RC) discharged one patient, one patient was regraded to informal and one patient was transferred to another unit.

  Outcomes of hearings held

  - Five detentions were upheld.
  - One patient was discharged by the Hospital Managers.

April

- ***Nine hearings arranged (Six held)***

All hearings were in relation to inpatient renewals.

Two hearings were cancelled – One patient was regraded by the Mental Health Review Tribunal and one patient was transferred to another unit.

One hearing was adjourned - the solicitor was unavailable to attend, the hearing was rescheduled for May, the patient subsequently was regraded to informal.

Outcomes of hearings held

All detentions were upheld

May

- ***12 hearings arranged (Eight held)***
  Six hearings were in relation to inpatient renewals, one hearing was for a community patient and one a patient request to appeal their detention.

  Four hearings were cancelled – One patient was transferred to another hospital, one patient was regraded to informal. One hearing was postponed due to the Legal Rep and IMHA availability and one was postponed due to an oversight by the MHA office in confirming the date and documents.

  Outcomes of hearings held

  Five detentions were upheld, one patient was discharged and two hearings were adjourned due to legal representation being required.

Hearing KPIs

Following a renewal, there is no timeframe specified within the Mental Health Act of when a hearing must be held, only the confirmation that one 'must' be held. Good practice suggests this should be undertaken as close to a renewal date as possible. The Division has set a KPI at one month following the renewal date. An analysis of the hearings held this quarter is detailed below.

The Responsible Clinician can renew a detention two months prior to the section expiry date. In some instances when the paperwork has been returned in advance the hearing will be held prior to the renewal date.

In instances where the patient appeals their detention, the hearing should be held as close as possible to the appeal date. The KPI for appeals focused on working days to allow for reports to be produced and distributed.

There were no applications from patients this quarter to measure within the KPI, and there were no 'barring' hearings. 64% of hearings were held within the KPI.

Renewal Date	Hearing Date	KPI (31 days)
23/10/2021	18/02/2022	118
05/12/2021	17/02/2022	74
18/01/2022	01/02/2022	14

20/01/2022	11/02/2022	22
27/01/2022	17/02/2022	21
15/02/2022	04/03/2022	17
02/03/2022	29/04/2022	58
02/03/2022	03/03/2022	1
09/03/2022	20/04/2022	42
11/03/2022	30/05/2022	61
12/03/2022	31/03/2022	19
14/03/2022	06/04/2022	31
16/03/2022	29/03/2022	13
24/03/2022	03/03/2022	Held before
27/03/2022	14/04/2022	18
01/04/2022	04/04/2022	3
05/04/2022	20/05/2022	45
12/04/2022	18/05/2022	36
14/04/2022	11/03/2022	Held before
20/04/2022	25/04/2022	5
20/04/2022	06/05/2022	16
05/05/2022	16/05/2022	11
15/05/2022	30/05/2022	15
Appeal by Patient Date	**Hearing Date**	**KPI (31 days)**
10/03/2022	13/05/2022	46
31/03/2022	16/05/2022	32

Issues which have extended the KPI dates are in relation to Covid 19, particularly in the East area and being able to arrange for all professionals, the patient and the solicitors to be present.

2 Scrutiny

Scrutiny was reinstated in March 2022 and is conducted on a monthly basis within the three psychiatric units, Heddfan, Ablett and Hergest. Bryn Y Neuadd, Ty Llywelyn, NWAS, Tan Y Castell, Coed Celyn, Cefni, and Bryn Hesketh are audited on a quarterly basis by the Administrators as part of a wider audit reported to the Mental Health Capacity and Compliance Committee.

3 Training

The 'All Wales Hospital Managers Conference' hosted by Cardiff and Vale and Edge training was attended by four managers and two mental health act staff on the 11th of May. Detail of this training was shared and discussed in the forum held in June.

Managers have expressed their views on training needs for the cohort. Discussions are required to be held with the Board secretary in regards to reinstating the six monthly training programme for the managers.

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:

20 persons of which 18 are actively involved in hearings. The active cohort consists of seven male and 11 female members, of which three are Welsh speakers.

Of the active members, there are nine chairpersons, (four male and five female), of which two are Welsh speakers.

A hospital manager who had decided not to participate in remote hearings has confirmed due to family issues they will not be returning in the future.

Interviews were held in March. Four individuals were appointed and are going through the recruitment process.

5 Forums and Meetings

The Associate Hospital Managers Forum meeting is held on a quarterly basis. This is linked in with training to allow the Associate Hospital Managers to get together and discuss any relevant information, and receive updates about changes within the Health Board that is relevant to their role.

The last meeting on the 9th of June involved discussions relating to: the Associate Hospital Managers cohort, mental health act staff changes, Covid plans in relation to hearings, the 'All Wales Conference' and feedback, sharing of recent activity and support/debrief provisions. The next meeting is due to be held on the 8th of September.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 29.07.2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health Act Performance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 MHA Committee Performance Report February – May 2022 Appendix 2 S136 BCUHB Report – June Appendix 3 S136 CAMHS Report – June Appendix 4 Quarterly report area activity data December 2019 – May 2022

Argymhelliad / Recommendation:

The Committee is asked to discuss and note the report and appendices.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	☑	**Ar gyfer sicrwydd For Assurance**	☑	**Er gwybodaeth For Information**	☑

Sefyllfa / Situation:

The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during February – May 2022. A four month period has been reported on due to a change in meeting dates.

Cefndir / Background:

The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections.

Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation.

Lapsed sections are reported as 'exceptions' throughout the report, and invalid detentions recorded as 'fundamentally defective'. Any lapses or fundamentally defective sections are datix'd and investigated.

Up to date S136 reports are submitted to the Committee along with any ad hoc requests for information.

Asesiad / Assessment & Analysis

Strategy Implications
The use of the Mental Health Act is determined by patient need, and the priority is always to care for the patient under the least restrictive option.

Options considered
Not Applicable

Financial Implications
The increase in Mental Health Act detentions has financial implications.

Risk Analysis
The patient information recorded to produce the reports required for the Health Board, Welsh Government, and North Wales Police also assists the Health Board in the management of the Mental Health Act functions such as expiry dates, consent to treatment, patient history, movements and deadlines. This data is currently recorded within excel databases which have been identified as unsustainable and difficult to future proof due to the amount of data held and detentions the Health Board experiences. This has been raised as a concern by the Chair of the Mental Health Capacity and Compliance Committee and by the Performance department. Discussions are ongoing as to a more safe and robust way of storing and reporting data between Performance and Information Technology (IT), with a recent demonstration and presentation in regards to WCCIS being provided, this system appears to cover the majority of what is recorded currently but a timescale of potentially 12 months to implementation was advised.

The Mental Health Act detentions fall into categories of being either legal or illegal (invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked for validity, and any invalid detentions are reported through Datix, investigated and escalated as appropriate.

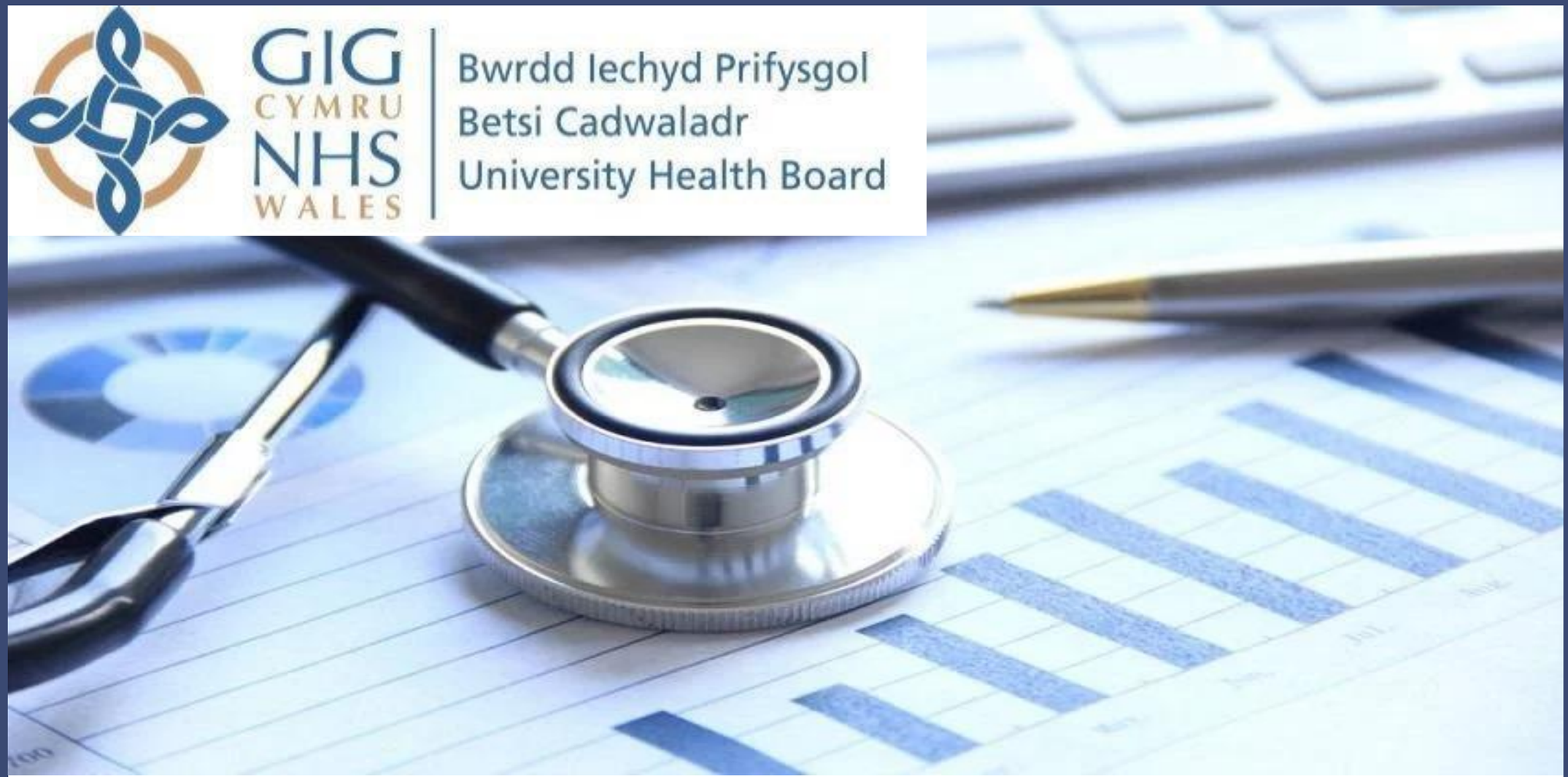
Within this reporting period there were five fundamentally defective sections and five sections which lapsed. These are reported as exceptions within the report.

Legal and Compliance
This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.

Impact Assessment
The use of the Mental Health Act Sections apply to all persons All policies in relation to the use of the Mental Health Act have been equality impact assessed.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Mental Health Capacity and Compliance Committee Performance Report

May 2022

CONTENTS:

Report to Mental Health Capacity and Compliance Committee Additional Appendices will be included as requested.

This report provides assurance to the Mental Health Capacity and Compliance Committee of our compliance against key sections of the legislative requirements of the Mental Health Act 1983 as amended 2007.

Seven Domains

We present performance to the committee using the 7 domain framework against which NHS Wales is measured. This report is consistent with the 7 domain performance reporting for our Finance and Performance Committee and Quality, Safety and Experience Committee. The Mental Health Capacity and Compliance Committee are responsible for scrutinising the performance for Mental Health indicators under Timely Care and Individual Care.

It is recognised that during the Covid 19 pandemic the service followed a different pathway with Ablett being the admissions unit prior to transfer regardless of the demographics a person hails from this affects admission and transfer statistics from March 2020 to January 2021.

Advisory Reports & Exception reports Each report for the Mental Health Act will be presented as an advisory report. This report covers a four month period due to a change in the meeting dates.

Exceptions are noted throughout the report within this four month period five sections lapsed: 1 x S3 lapsed due to confusion over responsibility of a patient on section 17 leave and who should instigate the Community Treatment Order (ID 3386) follow up processes did not include verbal communication, staff have been informed of correct processes for future reference. A S136 lapsed due to the detained person not being fit for assessment (INC300678) it was concluded an extension would not have allowed for assessment, the detained person was discharged following hospital treatment and has not become subject to any further detentions to date. A S5(4) lapsed due to the incorrect view that if the patient was settled at the four hour point an assessment was not required, staff have been educated in regards to the law and process and a S5(2) ended during the assessment which was being undertaken, the patient was not made subject to a further detention. A S2 lapsed due to the patient having Covid and an assessment being unable to be completed.
There are five fundamentally defective sections to report:Three section 2's were found to be invalid on direct admission from England out of hours, for two the medical recommendations contained the typed name of the medic and for one the AMHP name was typed, this is a process allowed in England but not in Wales, legal advice was obtained to clarify that these were indeed invalid in Wales (ID1746 and ID2433) this has been included in the checklists for duty staff to be aware of. 1 x S3 was invalid due to the AMHP stating they were acting on behalf of another authority that had not given permission and 1 x S2 was invalid due to the medical recommendations not being 5 clear days apart (INC300220), all instances of fundamentally defective sections were admitted out of hours and identified during the MHA administrators scrutiny process.

Section 5(4) Nurses Holding Power (up to 6 hours): Criteria: "…the patient is suffering from mental disorder to such a degree that it is necessary for his health and safety or for the protection of others for him to be immediately restrained from leaving the hospital". Secondly the nurse must believe that "…it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2)

Section 5(2) Doctors Holding Power (up to 72 hours): Criteria is: that an application for compulsory detention "ought to be made". Patient must be in-patient, can be used in general hospital.

Section 4: Admission for emergency (up to 72 hours): Criteria: "it is of urgent necessity for the patient to be admitted and detained under section 2" and that compliance with the provisions relating to application under that section "would involve undesirable delay"

Section 2: Admission for assessment (up to 28 days): Criteria needs to be met:
a) is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period;
b) ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons

Section 3: Admission of treatment (up to 6 months, renewable for 6 months, 12 monthly thereafter): Criteria
a) is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital;
b)it is necessary for the health and safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless he is detained under this section;
c)appropriate medical treatment is available for him/her

Section 17A: Supervised Community Treatment, also referred to as a CTO – its duration is up to 6 months, renewable for 6 months and 12 months thereafter.

Section 17E: Recall – the recall can last for up to 72 hrs. The clinical team must decide to release from Recall, Revoke or Discharge

Section 17F: Revocation. Once a patient has been revoked, essentially the Section 3 comes back into force - which can last up to 6 months, renewable for 6 months, then 12 monthly thereafter.

Section 135 Warrant to search and remove: Section 135(1) – warrant to enter and remove: Section 135(1) empowers a magistrate to authorize a police constable to remove a person lawfully from private premises to a place of safety. Section 135(2) – warrant to enter and take or retake. Section 135(2) concerns the taking into custody of patients who are unlawfully absent.

Section 136 Place of Safety (up to 24 hours): The powers of section 136 provide authority for a police officer who finds a person who appears to be suffering from mental disorder, in any place other than a private dwelling or the private garden or buildings associated with that place, to remove or keep a person at, a place of safety under section 136(1) or to take a person to a place of safety under section 136(3)

Section 35: Remand to hospital for report on accused's mental condition – for up to 28 days but can be extended to a maximum of 12 weeks.

Section 36: Remand of accused person to hospital – up to 28 days but duration will be set by the Court – maximum of 12 weeks.

Section 37: Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter
Section 37/41: Hospital Order with Restrictions – made with no time limit

Section 38: Interim Hospital Order – up to 12 weeks, but duration set by the Court – maximum 12 months

Section 47/49: Transfer of sentenced prisoners (including with restrictions)

Section 48/49: Transfer of other prisoners (including with restrictions) for urgent assessment

Section 62: Emergency Treatment of a detained patient regardless of section status

Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

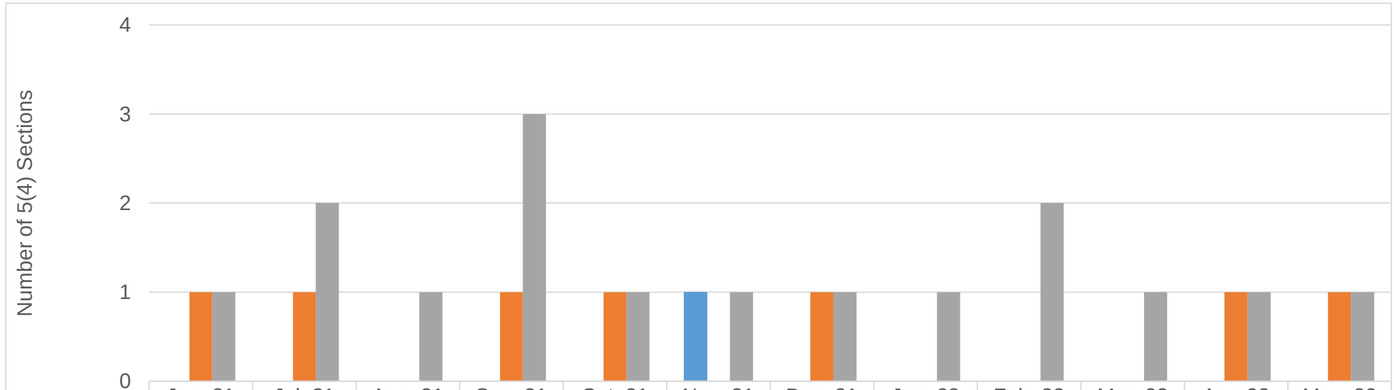
Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

Lapses of section: refers to sections that have come to the end of their time period. It is not good practice for sections to lapse and reasons are investigated.

Section 5(4) - BCUHB	May 2022	April 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	2	2	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
5	5	→	6

Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
1	East	3
2	Centre	2
3	West	0



	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	0	0	0	0	0	1	0	0	0	0	0	0
Centre	1	1	0	1	1	0	1	0	0	0	1	1
East	1	2	1	3	1	1	1	1	2	1	1	1

A Section 5(4) will be used if a staff nurse feels that it is necessary to detain a patient to await the arrival of a doctor for assessment. The 5(4) will be used if there are no doctors immediately available and the staff nurse feels this is in the best interest of the patient.

All sections this period met the criteria.

There were no instances of multiple detentions under a 5(4).

LAPSES

One section 5(4) lapsed within this period INC NO 4660 this has been investigated and the professionals have been educated in processes.

WEST

Duration (hh:mm)	Outcome

CENTRE

Month	Duration (hh:mm)	Outcome
Apr_22	01:10	Section 5(2)
May_22	06:00	Lapsed

EAST

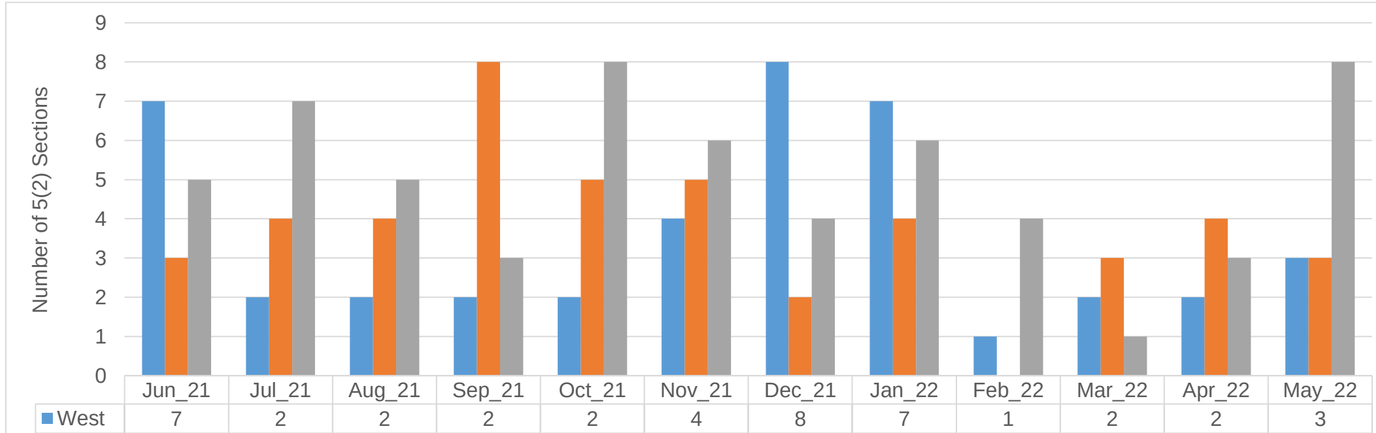
Month	Duration (hh:mm)	Outcome
Mar_22	04:51	Section 2
Apr_22	03:28	Section 5(2)
May_22	01:45	Section 5(2)
Feb-22	02:30	Informal
Feb-22	03:28	Informal

Mental Health Capacity and Compliance Committee Performance Repo

Section 5(2) - BCUHB	May 2022	April 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	14	9	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
29	36	↓	37

Area Rank by numbers of Section 5(2) during Quarter		Quarter 5(4) Sections
1	East	12
2	Centre	10
3	West	7



	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	7	2	2	2	2	4	8	7	1	2	2	3
Centre	3	4	4	8	5	5	2	4	0	3	4	3
East	5	7	5	3	8	6	4	6	4	1	3	8

Section 5(2) Outcomes

	Mar 2022	Apr 2022	May 2022
Section 2:	6	0	2
Section 3:	3	0	2
Informal:	3	3	3
Lapsed:	0	0	1
Invalid:	0	0	0
Discharged:	1	0	2
Other:	0	0	0

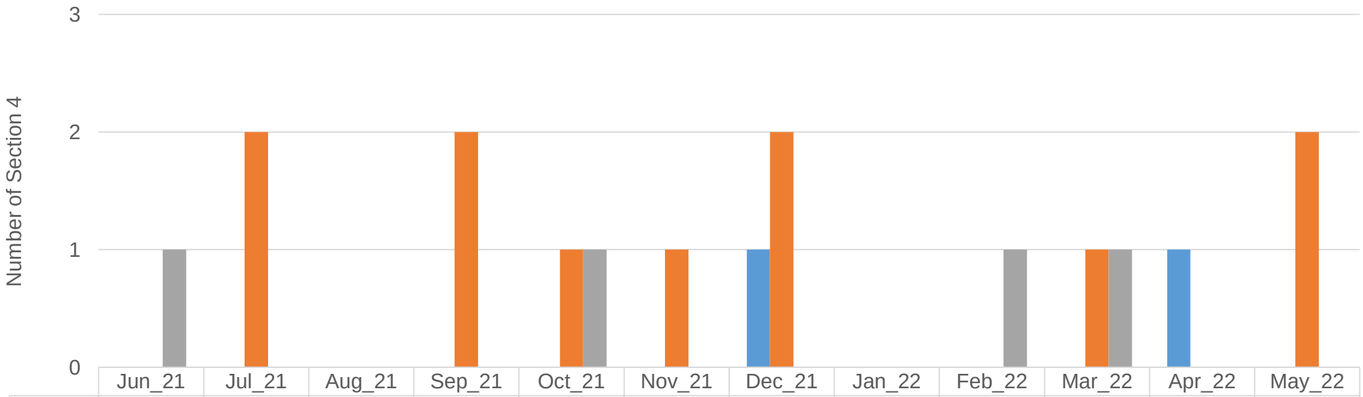
A Section 5(2) on occasions will be enacted within the acute hospital wards, during this period there were no detentions in the acute hospitals.

EXCEPTIONS
EAST: The patient was undergoing assessment which extended over the timeframe of the section 5(2) the patient was not made subject to a further detention.

Section 4 - BCUHB	May 2022	April 2022	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	2	1	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
5	4	↑	4

Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
1	Centre	3
2	East	1
2	West	1



	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	0	0	0	0	0	0	1	0	0	0	1	0
Centre	0	2	0	2	1	1	2	0	0	1	0	2
East	1	0	0	0	1	0	0	0	1	1	0	0

The use of section 4 is a relatively rare event and figures remain low.

Section 4 will be used in emergency situations where it is not possible to secure two doctors for a section 2 immediately and it is felt necessary for a persons protection to detain under a section of the Mental Health Act.

There are no exceptions to report.

The documents are considered to reveal if the S4 was used for emergency purposes or due to a lack of doctor availability. All instances this period were in relation to emergency purposes to keep the person safe in hospital. The risk of absconsion in two cases was noted as the reason why a second doctor could not be contacted and immediate admission was required.

WEST

	Duration (hh:mm)	Outcome
Apr_22	16:00	Section 2

CENTRE

Month	Duration (hh:mm)	Outcome
Mar_22	37:50	Discharged
May_22	20:49	Section 2
May_22	18:58	Informal

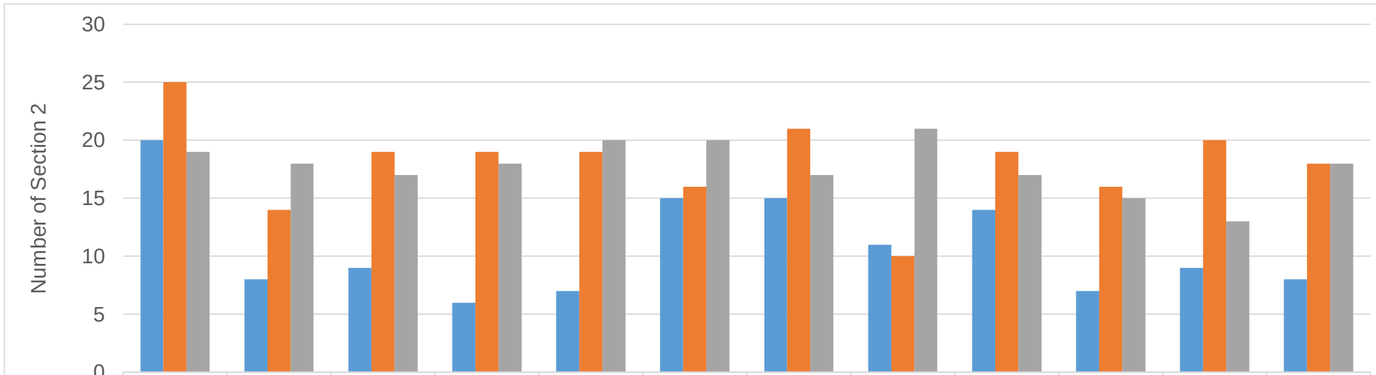
EAST

Month	Duration (hh:mm)	Outcome
Feb_22	36:00	Discharged
Mar-22	48:10	Discharged

Section 2 - BCUHB	May 2022	April 2022	Monthly Trend
Section 5: Admission for assessment	44	42	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
124	145	↓	140

Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
1	Centre	54
2	East	46
3	West	24



	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	20	8	9	6	7	15	15	11	14	7	9	8
Centre	25	14	19	19	19	16	21	10	19	16	20	18
East	19	18	17	18	20	20	17	21	17	15	13	18

* data is an as at position and is subject to change

Section 2 Outcomes

	Mar 2022	Apr 2022	May 2022
Section 3:	23	4	1
Informal:	33	4	7
Lapsed:	0	0	1
Pending:	0	0	0
Discharged:	7	3	4
Transferred:	18	8	7
Invalid and Other:	3	0	1

A section 2 will be enacted following holding powers 5(4) or 5(2) or via a regrade from a section 4 or an informal admission.

Section 2 is also used as a direct admission detention.

There were four under 18s placed on a Section 2 this period, one as a direct admission, two regraded from a S136 and one transfer from out of area.
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EXCEPTIONS:

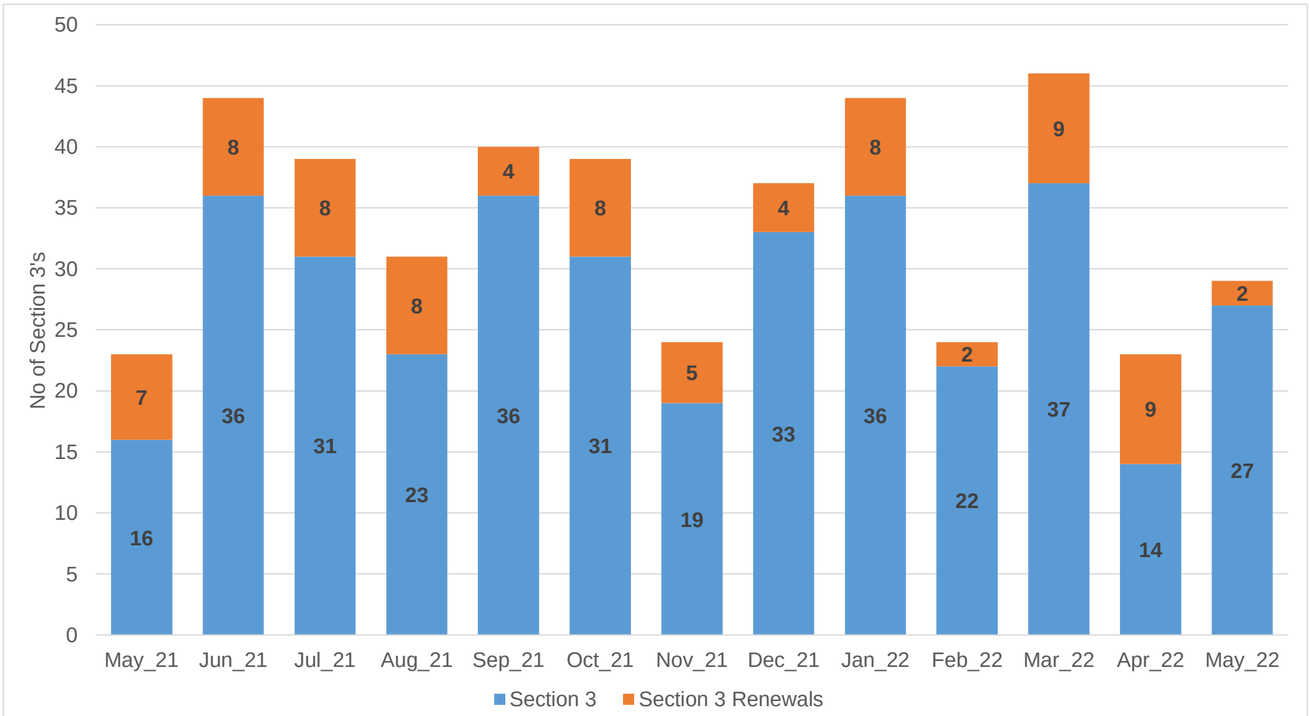
There are five exceptions to report this period.
CENTRAL: A section 2 was found to be invalid on admission due to the medical recommendations not being within 5 clear days of each other. The AMHP who completed the application has been informed for future reference. (INC300220)
CENTRAL AND WEST: Three section 2's were found to be invalid all being admissions from England, two in Central the medical recommendations contained a typed signature which is not legally allowed in Wales although it is in England and one for the West in regards to the AMHP application. For future learning this information has been included on the duty nurse checklists (1746 and 2433)
EAST: A section 3 was not completed prior to the expiry of the section 2 due to the patient having Covid, after a short period of informal status they were subsequently detained under the section 3.

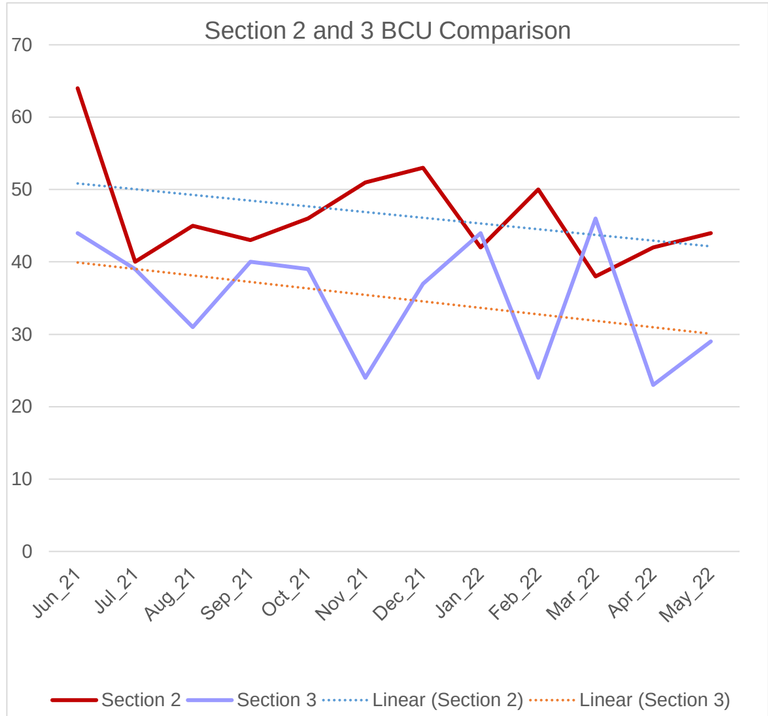
Advisory Report - Section 3

Section 3 - BCUHB	May 2022	April 2022	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	29	23	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
98	105	↓	105

Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
1	Centre	36
2	West	34
3	East	28





* data is an as at position and is subject to change

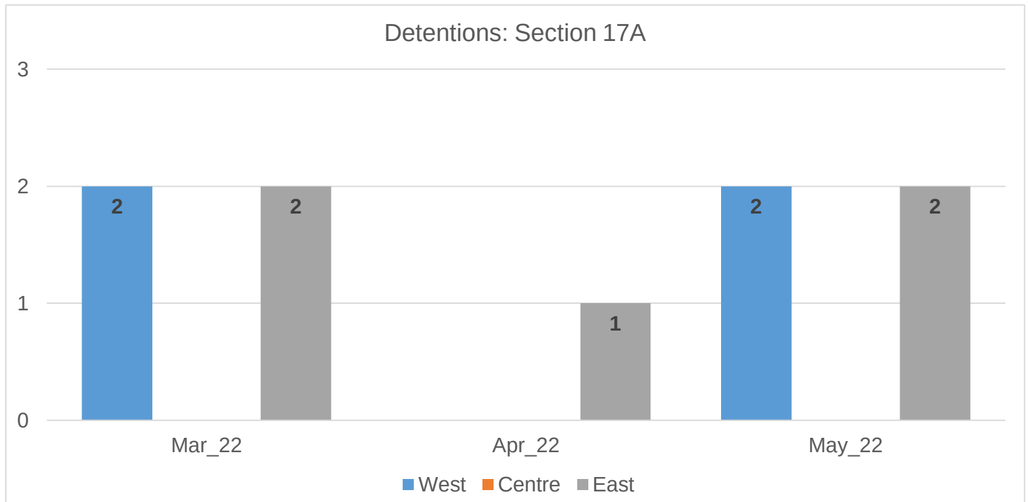
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

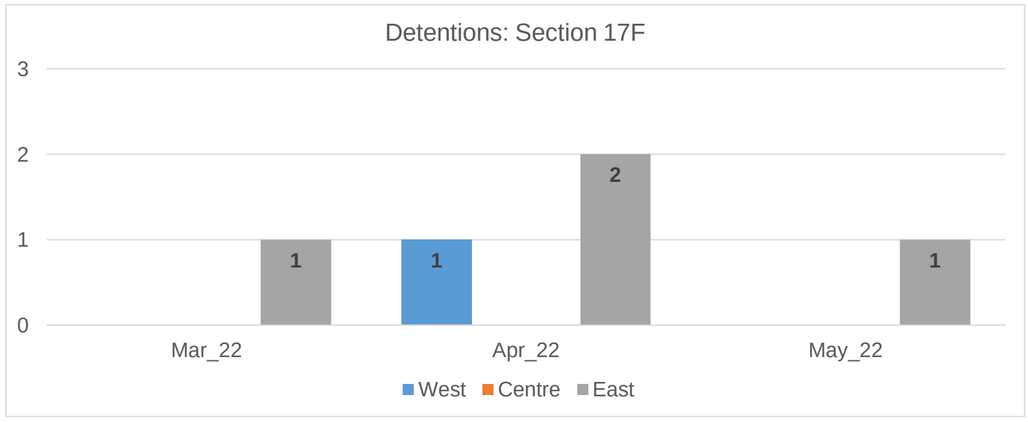
This period there were two under 18s made subject to a section 3. The trend over the 12 months at the end of May continues to be downwards for section 3 and section 2.
There are two exceptions to report this quarter. (WEST) A planned CTO was not initiated or the Section 3 renewed resulting in a lapsed detention, the RC thought the community RC was instigating. Learning has included the use of verbal communication rather than just emailing when sections are expiring and responsibility confirmation to the medics (ID 3386), a section 3 was deemed invalid as the AMHP was not acting on behalf of the correct local authority, learning has involved communication between LAs and approval being required to act on anothers behalf.

Section 17 A-F - BCUHB	May 2022	April 2022	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	6	5	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
17	15	↑	14

Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
1	East	12
2	West	5
3	Centre	0





This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section 3. There are no patients who were recalled or revoked this quarter.

The number of patients subject to a CTO at the end of May West:8, Central: 5 and East: 7.

There has been a decrease in the number of patients subject to a CTO for West and an increase for East this period.

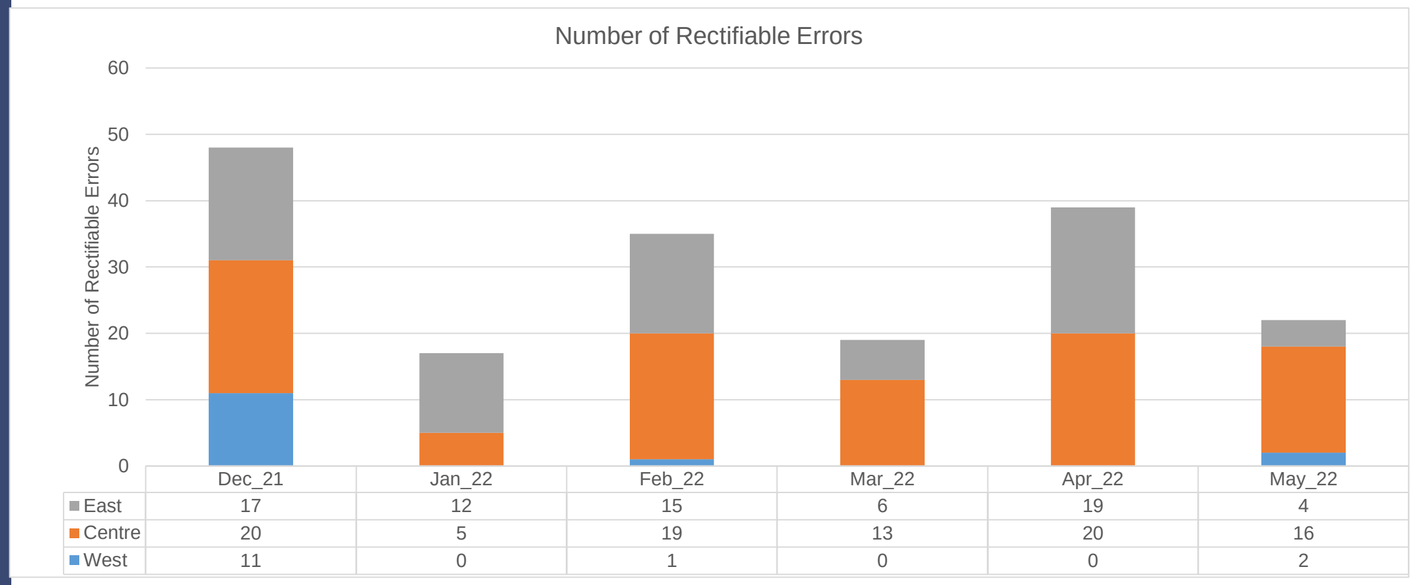
Exceptions: (WEST) A S17 leave status expired as the RC did not complete a new document on time, no adverse effects for the patient, the care home has been informed of legal status and to be mindful of expiry dates (INC300683).

Advisory Report - Mental Health Act Errors

Fundamental and Rectifiable Errors	May 2022	April 2022	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	23	41	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
76	80	↓	107

Area Rank by numbers of Errors during Quarter		Quarter Errors
1	Centre	52
2	East	29
3	West	4



	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
East	17	12	15	6	19	4
Centre	20	5	19	13	20	16
West	11	0	1	0	0	2

Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales.The latest report received covers January - March 2022.
The report confirms BCUHB is not an outlier for rectifiable errors and accounted for 27% with one Health Board accounting for 41%.

BCUHB did have more fundamentally defective applications this period which was due to cross border papers being received and different practices between Wales and England.

It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report.

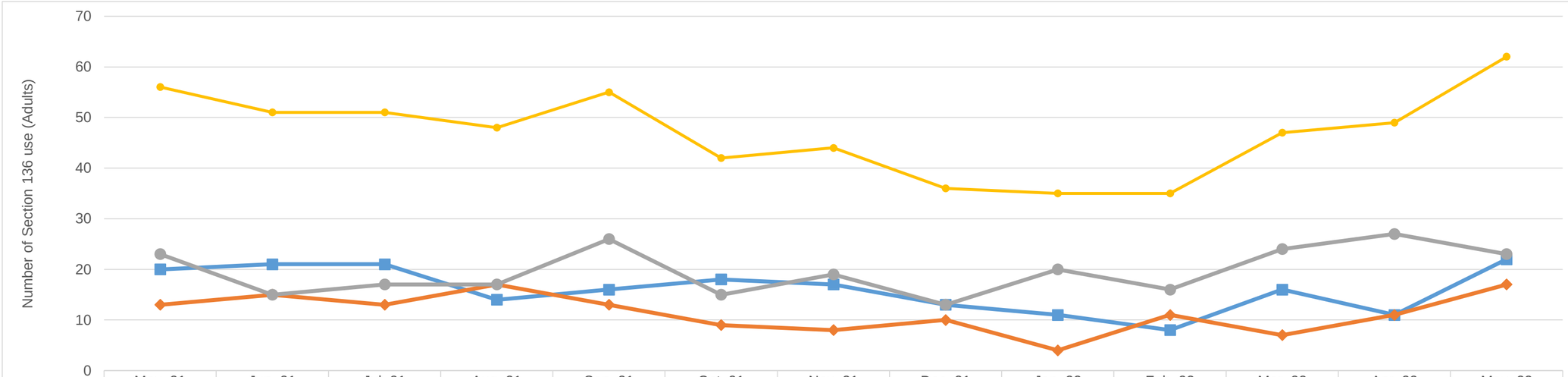
This report details a four month period for which there have been five fundamentally defective sections, four under section 2 and one under section 3.
Throughout the period there has been five lapsed Sections - a section 5(4), Section 5(2), section 2, section 3 and one section 136.

There has been a lack of AMHP availability over a weekend in May which resulted in two S136 assessments being concluded by a medic only. One patient was required to remain in Emergency Department due to the AMHP not attending it was reported this was due to a lack of beds which transpired was not correct this has been investigated by the clinical service

Section 135 - 136	May 2022	April 2022	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	62	49	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
158	106	↑	139

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	74
2	West	49
3	Centre	35



	May_21	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	20	21	21	14	16	18	17	13	11	8	16	11	22
Centre	13	15	13	17	13	9	8	10	4	11	7	11	17
East	23	15	17	17	26	15	19	13	20	16	24	27	23
BCU	56	51	51	48	55	42	44	36	35	35	47	49	62

The data above does not include S135 or under 18's.

There have been five S135 detentions this period resulting in two detentions under S2 and three under S3.
One Section 136 lapsed this quarter, INC300678 due to the detainee being unfit for assessment, this person was discharged from hospital and has not been subject to any further detentions to date.
During this period there were three custody detentions all were discharged with follow up from services.
No requests for extensions were made this period.

Section 136	May 2022	April 2022	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	62	49	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
158	106	↑	139

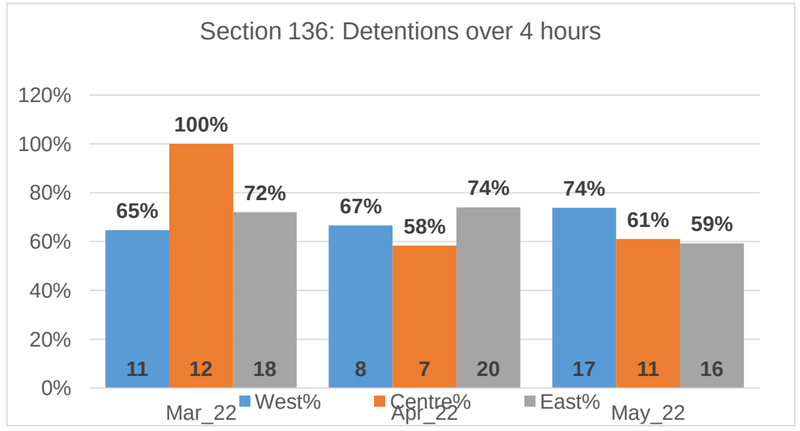
Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	74
2	West	49
3	Centre	35

Section 136 Outcomes

	Mar 2022	Apr 2022	May 2022
Discharged:	35 64.81%	35 70.00%	55 79.71%
Informal Admission:	6 11.11%	8 16.00%	10 14.49%
Section 2:	9 16.66%	6 12.00%	4 5.79%
Section 3:	3 5.55%	0 0.00%	0 0.00%
Other:	1 1.85%	1 2.00%	0 0.00%

Section 136 - Known to Service

	Mar 2022	Apr 2022	May 2022
Yes	41	34	45
Yes (percentage)	75.92%	68.00%	65.21%



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The data shows figures from outcomes recorded and whether a patient is known to service. A large proportion of 136's are discharged those with no mental disorder has historically been around 20% This period has seen a decrease in the figures.

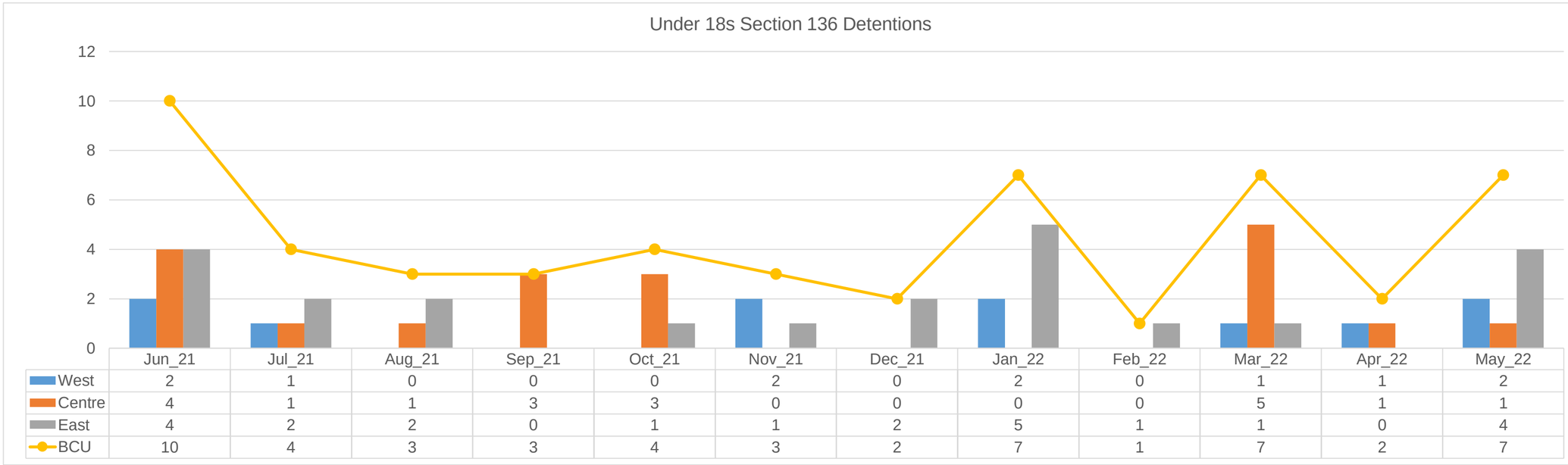
Total percentages of all detentions for those discharged with no mental disorder are:
March 7.4%
April 10%
May 7.24%

Data below shows the percentage of the detentions that are discharged with followed up by services or new referrals into services:
March 46.29% discharged with follow up and 11.11% referred to services.
April 40% discharged with follow up and 16% referred to services.
May 55.07% discharged with follow up and 17.39% referred to services.

The Criminal Justice Liaison Service has been working out of North Wales Police Headquarters and in the community since January 2020. The service has been actively involved in assisting the police and signposting people in crisis to other avenues rather than the police using the S136 power. Since January this has been recorded and 247 people have not become detained on a S136 due to CJLS intervention. This period accounts for 25 of those figures.
Data is now being recorded in relation to those that do progress to being detained on a S136 following consultation, since September 2020 there have been 105 instances.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	May 2022	April 2022	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter		Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	7	2	↑	16	10	↑	13	1	Centre	7
								2	East	5
								3	West	4



	Jun_21	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22
West	2	1	0	0	0	2	0	2	0	1	1	2
Centre	4	1	1	3	3	0	0	0	0	5	1	1
East	4	2	2	0	1	1	2	5	1	1	0	4
BCU	10	4	3	3	4	3	2	7	1	7	2	7

A total of 17 under 18's were assessed this period between the ages of 13 and 17 years. One assessment resulted in an admission initially to the adult unit prior to transfer to the adolescent services. 15 assessments resulted in discharge with follow up to services and one discharge was noted due to no mental disorder.

The tables below shows the ages of young persons assessed and the outcomes for the year period April 22 - March 23.

Under 18 Assessments	
AGE	Number of Assessments
12	0
13	0
14	2
15	1
16	0
17	6

Outcome of Assessments	
Outcome	Number
Returned Home	4
Returned to Care Facility	5
Admission to childrens ward	0
Admission to Adult ward / S136 suite	0
Admission NWAS / CAMHS	0
Admission OOA	0
Other (Friends, Hotel, B&B)	0

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
February	Heddfan	Discharged	CAMHS	9:00:00	13
March	Ablett	Discharged	CAMHS	20:54:00	14
March	Ablett	Discharged	CAMHS	17:40	14
March	Heddfan	Discharged	CAMHS	05:40:00	16
March	Hergest	Discharged	CAMHS	12:40	17
March	Ablett	Admission	CAMHS	23:15	17
March	Ablett	Discharged	CAMHS	13:35	17
March	Ablett	Discharged	CAMHS	17:00	17
April	Hergest	Discharged	CAMHS	17:31	14
April	Ablett	Discharged	CAMHS	11:40	17
May	Heddfan	Discharged	CAMHS	07:00	17
May	Wrexham	Discharged	CAMHS	17:00	17
May	Heddfan	Discharged	CAMHS	06:21	17
May	Ablett	Discharged	CAMHS	03:40	17
May	Hergest	Discharged	CAMHS	01:55	17
May	Heddfan	Discharged	CAMHS	19:05	14
May	Hergest	Discharged	CAMHS	13:20	15

Out of the 17 young persons assessed 12 originated from their own home and five from a placement.

13 of the detentions were initiated out of hours.

The Assistant Area Directors of the CAMHS service are notified straight away if a young persons, 15 and under who is detained under a S136. Within hours the MHA office notify, out of hours the responsibility lies with the duty staff.

Average PoS hours: 14:53 hrs this is an increase on the previous quarter figures of (14:02 hrs).

Under 18's admitted to Adult Psychiatric Wards

There was one admission to an Adult Psychiatric unit this quarter from a S136. The young person remained in the S136 suite prior to transfer to an appropriate unit for 2 days and 45minutes. There was a direct admission to a unit under section 2 of a young person for a total of 2 days and 13:45 hours prior to transfer.

The table below shows the county that the young persons originated from and where they were assessed for the period April 21 - March 22

County Originated from and where assessed:

	East	Central	West
Wrexham	3	0	2
Flintshire	0	1	0
Denbighshire	1	0	0
Conwy	0	0	0
Gwynedd	0	0	0
Ynys Môn	0	1	1
Out of Area	0	0	0

Section	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
Section 35:	0	0	0	0	0	0	1	1	0	0	0	0
Section 37:	0	1	0	0	1	1	1	1	0	1	1	1
Section 37/41:	9	9	8	8	8	8	8	8	8	8	8	7
Section 38:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47:	0	2	2	2	1	1	1	1	1	1	2	2
Section 47/49:	2	3	3	3	3	3	3	3	3	3	2	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	1	0	0	0	1	1	1	1	2	2	2
Section 3:	4	4	4	4	4	4	5	5	4	3	3	3
Section 45A	0	0	0	0	0	0	0	0	0	0	0	0
Total:	15	20	17	17	17	18	20	20	17	18	18	18

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility.
The nature of the forensic sections does not always generate rapid activity. There are times when section 3 patients will be detained within the unit.

There are no exceptions to report.

Total Transfers for the Quarter

	Mar 2022	Apr 2022	May 2022
Internal Transfers	12	16	13
External Transfers (Total)	4	4	3
External Transfers (In)	1	2	1
External Transfers (Out)	3	2	2

Internal Transfers
This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway. Due to the changes for the admissions process there have been a larger number of patients transferred internally.

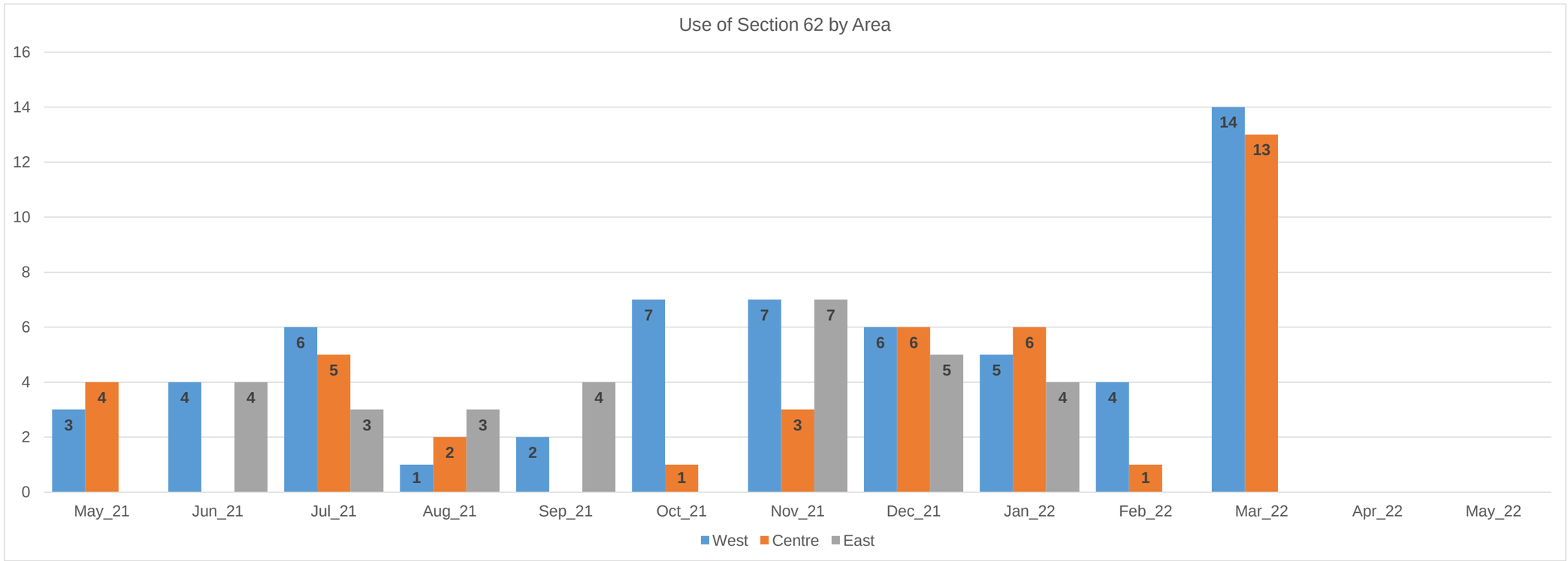
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised care.

The table details IN - where the patient has come from and their local area and OUT where the patient has gone to.

Patients detained in Independent Hopsitals (in Wales and outside of Wales)
There are a number of persons who will be detained in independent hospitals that are offering services required. Currently there are 72 detained patients within independent hospitals this one less than last reported. 29 of these are outside of Wales ie out of area placements, this is one less than last reported.

Month	Transfers In
Mar_22	Spinney Manchester (Gwynedd)
Apr_22	Carmarthen (Gwynedd)
Apr_22	Ty Grosvenor (Wrexham)

Month	Transfers Out
Mar_22	To Broadoak (Repatriated)
Mar_22	Priory Birmingham (Repatriated)
Mar_22	Medlock Ward, Moorside Unit, Trafford General Hospital (Repatriated)
Apr_22	Springview unit, Wirral (Flintshire)
Apr_22	Priory Hospital, Cheshire (Repatriated)
May_22	Llanarth Court (Gwynedd)
May_22	St Andrew's Healthcare, Essex (Wrexham)



Monitoring of section 62 is a requirement of the Code of Practice (25.38)

Reason for S62 use:
Medication changes
Patient no longer able to give consent to treatment or refusing consent
ECT
Awaiting a Second Opinion Appointed Doctor (SOAD) to arrive and three month consent to treatment has expired.

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APPENDIX 2

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

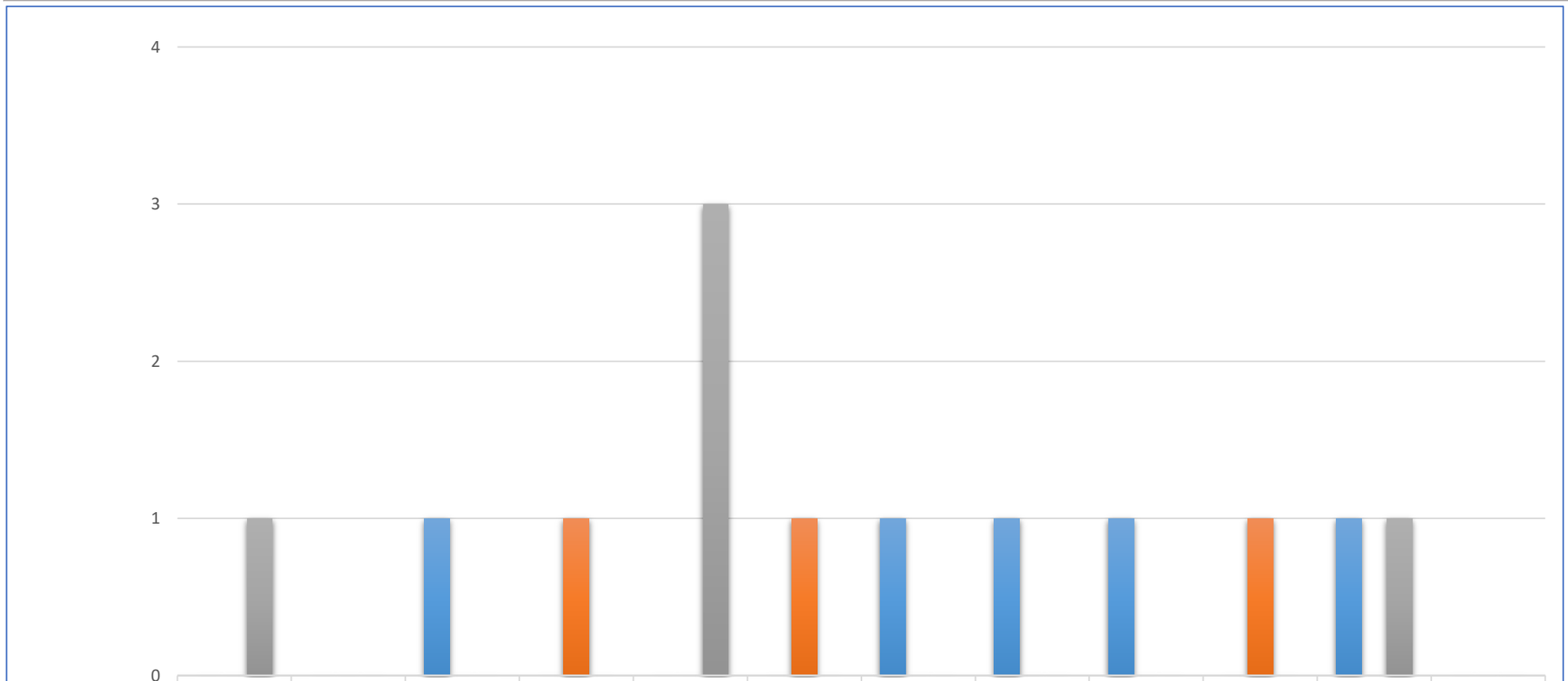
S.136/135 use in BCUHB

KPI Report for: June 2022

Data Source:	BCUHB MHA Database
Report Created on:	01/07/2022
Report Created by:	Performance Directorate

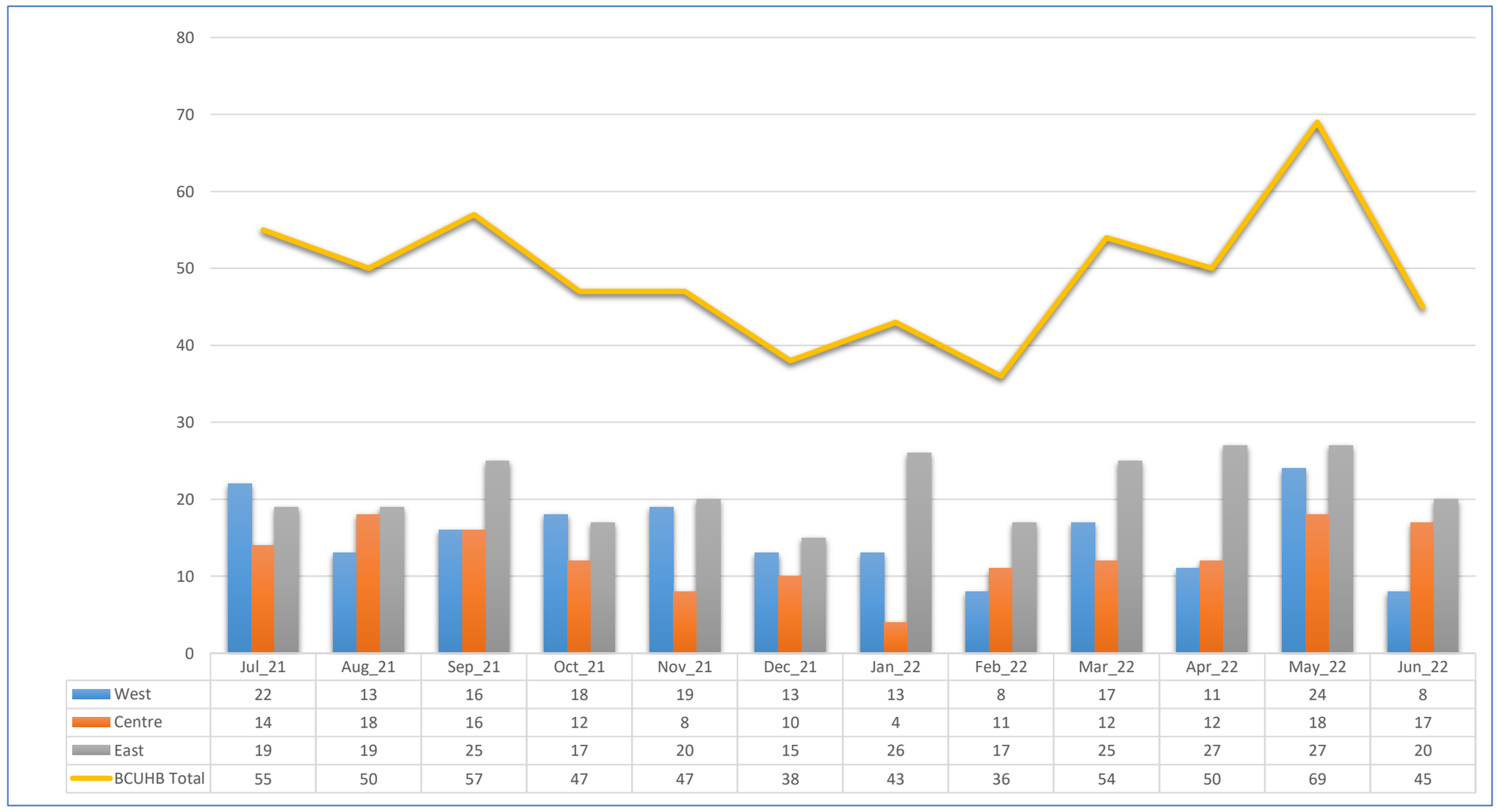
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Jun_22



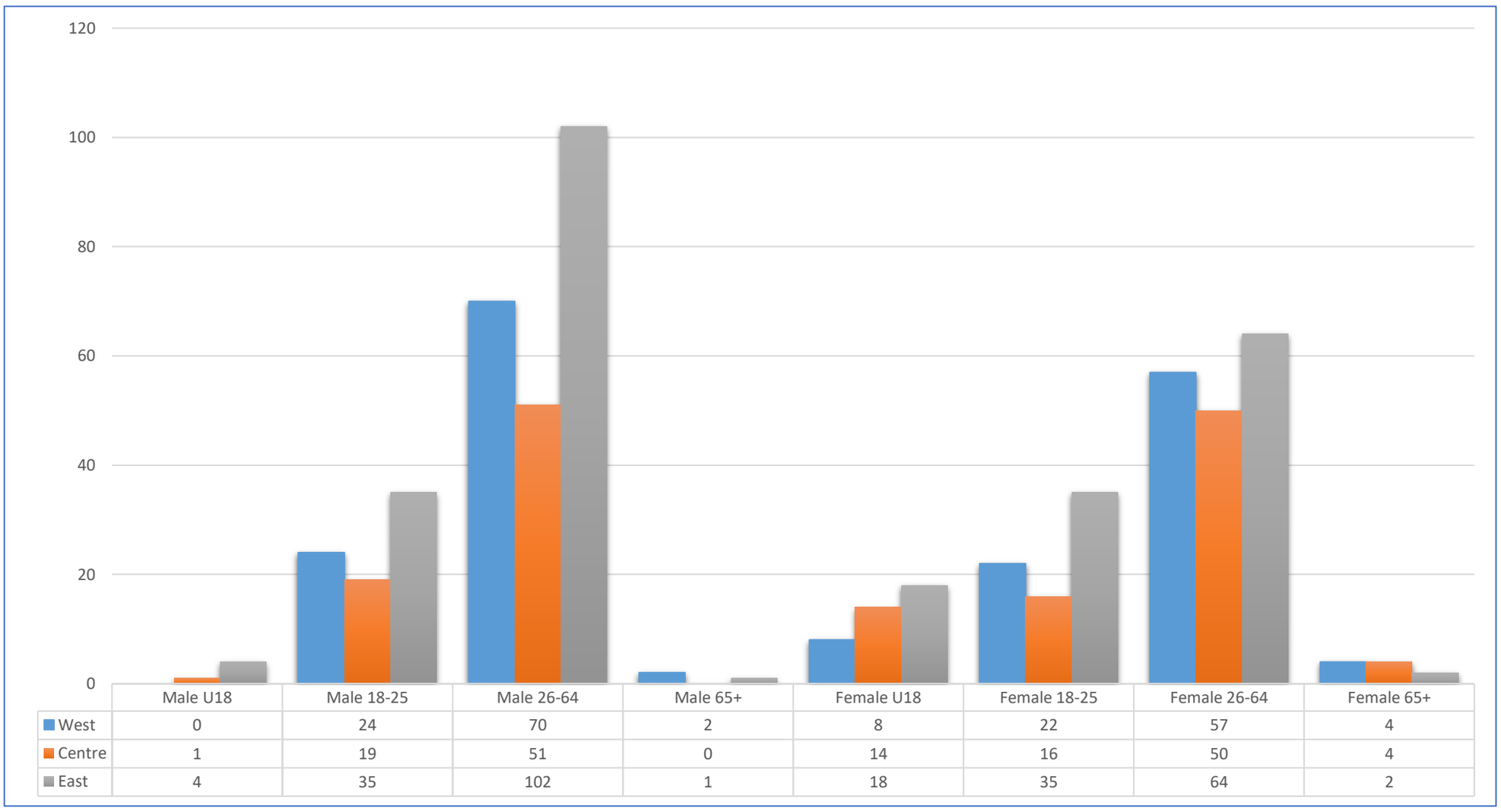
	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	0	0	1	0	0	0	1	1	1	0	1	0
Centre	0	0	0	1	0	1	0	0	0	1	0	0
East	1	0	0	0	3	0	0	0	0	0	1	0

2.1: Section 136 twelve month trend up to and including Jun_22



	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	22	13	16	18	19	13	13	8	17	11	24	8
Centre	14	18	16	12	8	10	4	11	12	12	18	17
East	19	19	25	17	20	15	26	17	25	27	27	20
BCUHB Total	55	50	57	47	47	38	43	36	54	50	69	45

3.1: 12 month combined S.135 and S.136 split by Gender and Age bands for all areas



	Male U18	Male 18-25	Male 26-64	Male 65+	Female U18	Female 18-25	Female 26-64	Female 65+
West	0	24	70	2	8	22	57	4
Centre	1	19	51	0	14	16	50	4
East	4	35	102	1	18	35	64	2

4: 1st Place of Safety 12 month trend up to and including Jun_22

Area Split - 1st Place of Safety by category

	Jun_22			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	2	9	9	52	46	72
Ward	0	0	0	0	0	1
PICU	0	0	0	0	0	0
136 Suite	5	7	20	128	102	190
Hospital	1	0	0	1	0	0
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	0	0	0	1	3	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	0	0

4.2: 12 month trend A&E and 136 Suite as 1st Place of Safety split by Area

1st Place of Safety: A&E Split	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	6	1	7	4	4	2	4	3	5	3	11	2
Centre	1	5	6	4	0	2	1	2	7	3	6	9
East	2	6	9	2	7	6	7	4	6	8	6	9

1st Place of Safety: 136 Suite Split	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	16	13	8	14	15	11	9	5	12	9	11	5
Centre	13	13	10	8	8	8	3	9	5	7	11	7
East	17	13	17	14	12	9	18	13	18	19	20	11

5: County in which person was actually detained under s.136

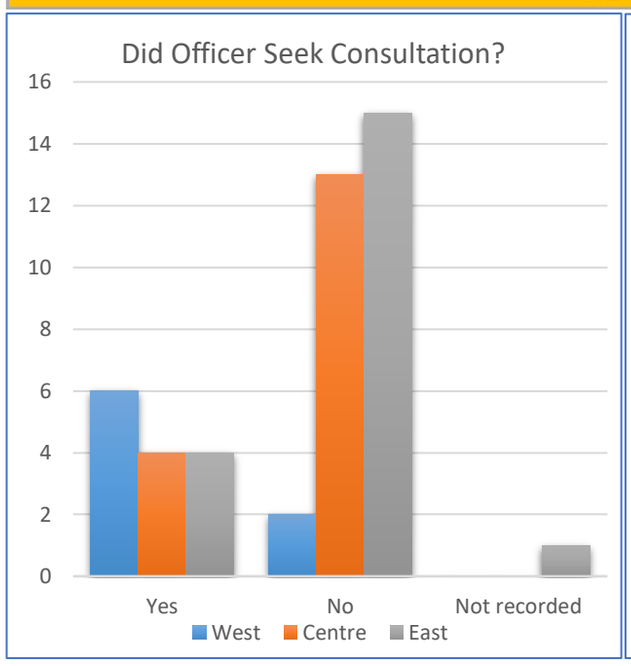
5.1: Area split 3 month table up to and including Jun_22 and latest 12 month total

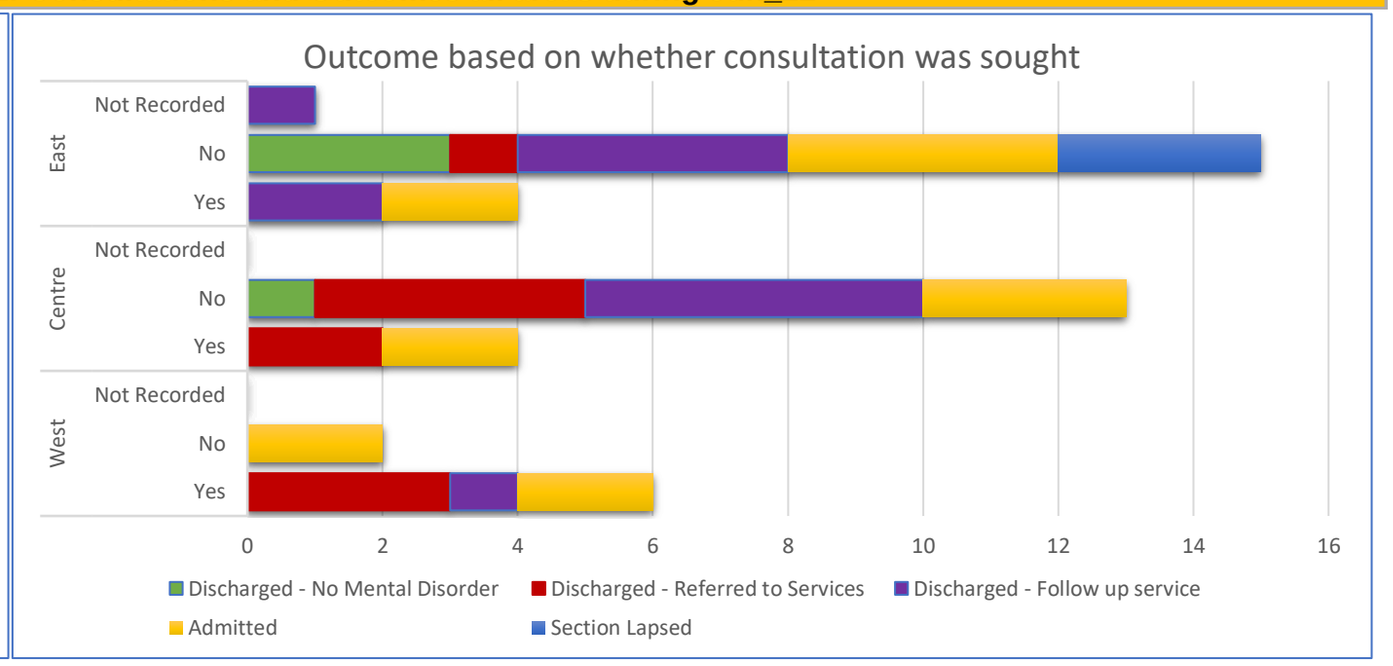
West	Apr_22	May_22	Jun_22	**12 Month Total**	**Centre**	Apr_22	May_22	Jun_22	**12 Month Total**	**East**	Apr_22	May_22	Jun_22	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	2	3	3	**42**	Ynys Mon	0	2	1	**7**	Ynys Mon	1	1	0	**7**	Ynys Mon	**7.98**
Gwynedd	4	12	0	**72**	Gwynedd	1	2	3	**21**	Gwynedd	3	1	2	**15**	Gwynedd	**8.73**
Flintshire	0	0	0	**6**	Flintshire	3	1	1	**18**	Flintshire	8	7	7	**81**	Flintshire	**6.78**
Wrexham	2	3	2	**12**	Wrexham	0	2	1	**12**	Wrexham	13	14	11	**114**	Wrexham	**9.92**
Conwy	2	2	2	**30**	Conwy	2	5	2	**31**	Conwy	0	0	0	**14**	Conwy	**6.42**
Denbighshire	2	3	1	**17**	Denbighshire	6	6	9	**62**	Denbighshire	2	4	0	**23**	Denbighshire	**10.68**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	0	**0**	OOA	0	0	0	**0**	OOA	0	0	0	**0**	OOA	**#N/A**
Incident Rate per 10,000 population	0.62	1.19	0.41	**9.23**	Incident Rate per 10,000 population	0.56	0.85	0.80	**7.11**	Incident Rate per 10,000 population	0.92	0.92	0.68	**8.64**	BCUHB	**8.34**

***Please note:** due to County Detained was only captured from November 2017, residents per detention by county detained will only be accurate from November 2018 onwards. Area data is accurate from April 2016

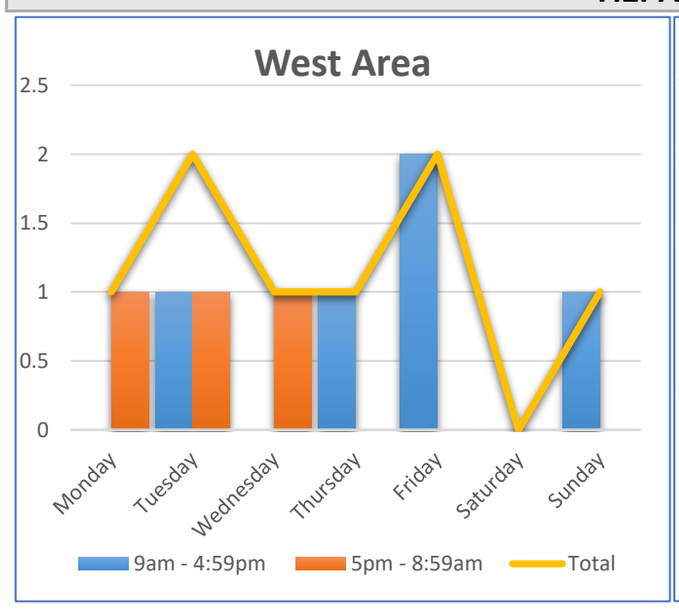
Section B: 12 Month Data for Jun_22

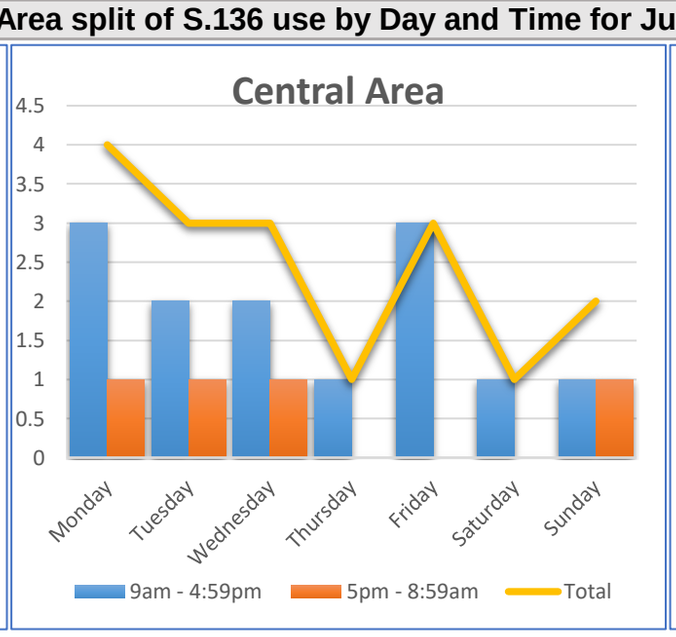
6.1: Consultations and Outcomes all areas during Jun_22

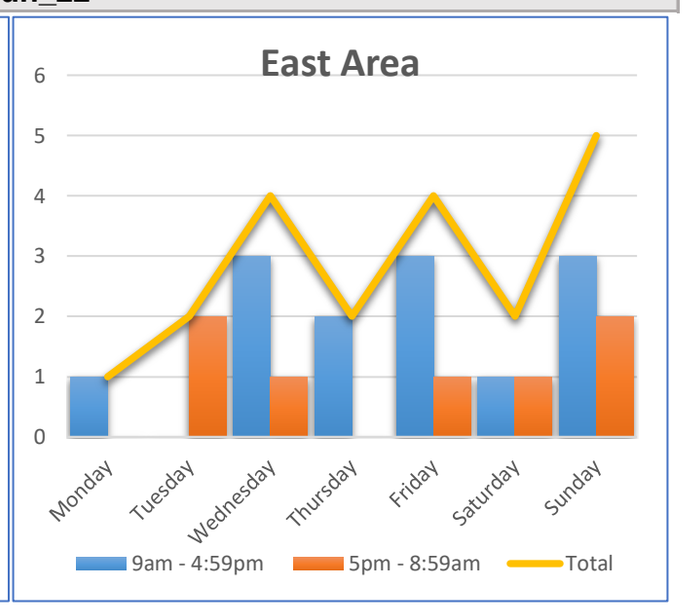




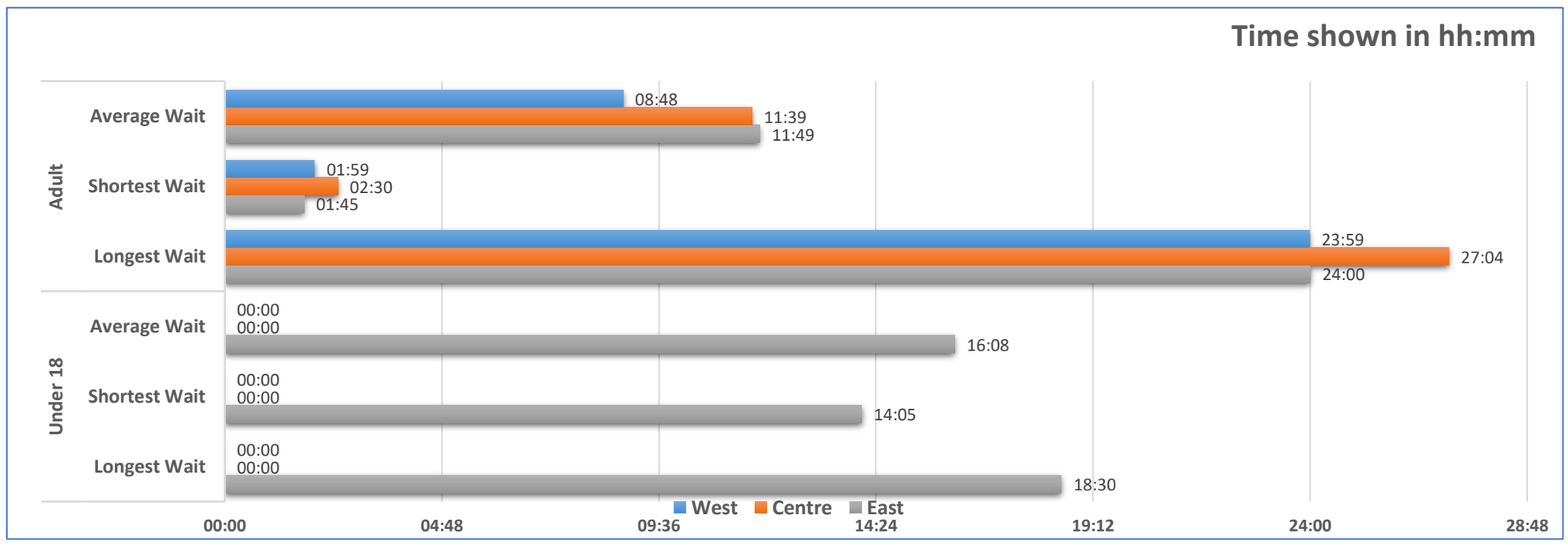
7.1: Area split of S.136 use by Day and Time for Jun_22



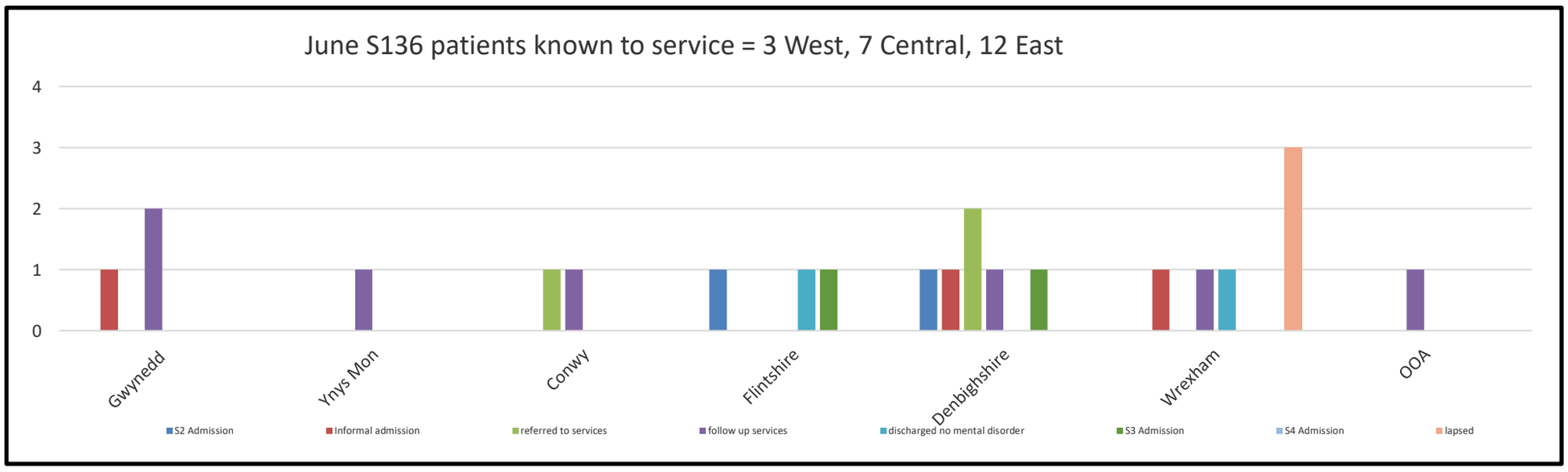




8.1: Duration in S.136 Suite for Jun_22



There were three lapsed S136s this month all due to the patients not being fit for assessment, all patients have not been subject to a detention at the time of writing this report.
There were two extensions both were assessed within the 36 hour timeframe.
38 assessments were noted to be delayed, 10 due to the detainee not being fit for assessment, 17 had no reason noted, six due to AMHP availability, and five due to doctors avaiabliity.



The table below shows the area that someone originates from, where they were detained and which S136 suite they were taken to. Out of the 45 S136 detentions 13 people were not seen within the closest S136 suite.

Five were noted to be due to no capacity within the closest suite, two due to the suite being closed and six had no reason recorded.

Local Authority Originates from	Detained in	S136 Suite assessed at
Conwy	Llandudno	Ablett
Conwyu	Conwy	Ablett
Flintshire	Flintshire	Ablett
Ynys Mon	Ynys Mon	Ablett
Flintshire	Wrexham	Ablett
OOA	Gwynedd	Ablett
Conwy	Denbighshire	Hergest
Wrexham x 2	Wrexham x 2	Hergest
Gwynedd x 2	Gwynedd x 2	Heddfan
Gwynedd x 2	Gwynedd x 2	Ablett

The Criminal Justice Liaison Service have been actively involved in the police control rooms with qualified nursing staff on hand to assist the police with advice prior to the use of S136.

Instances where the use of S136 does not occur due to the person being diverted to another form of help following consultation either with the Duty Nurse or the Criminal Justice Liaison Service are monitored along with consultations which have lead to a S136.

Within the month of June the Mental Health Act Office has received notification that there have been five instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.
There were seven consultations with the service which lead to a S136 detention.

There were 31 instances where the police did not consult.
These resulted in the outcomes as below:

S2 admission x 4
S3 admission x 1
Informal admissions x 4
Discharged no mental disorder x 4 (total for the month = 4)
Discharged referred to services x 5
Discharged with follow up x 10
Lapsed detention x 3

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 3

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

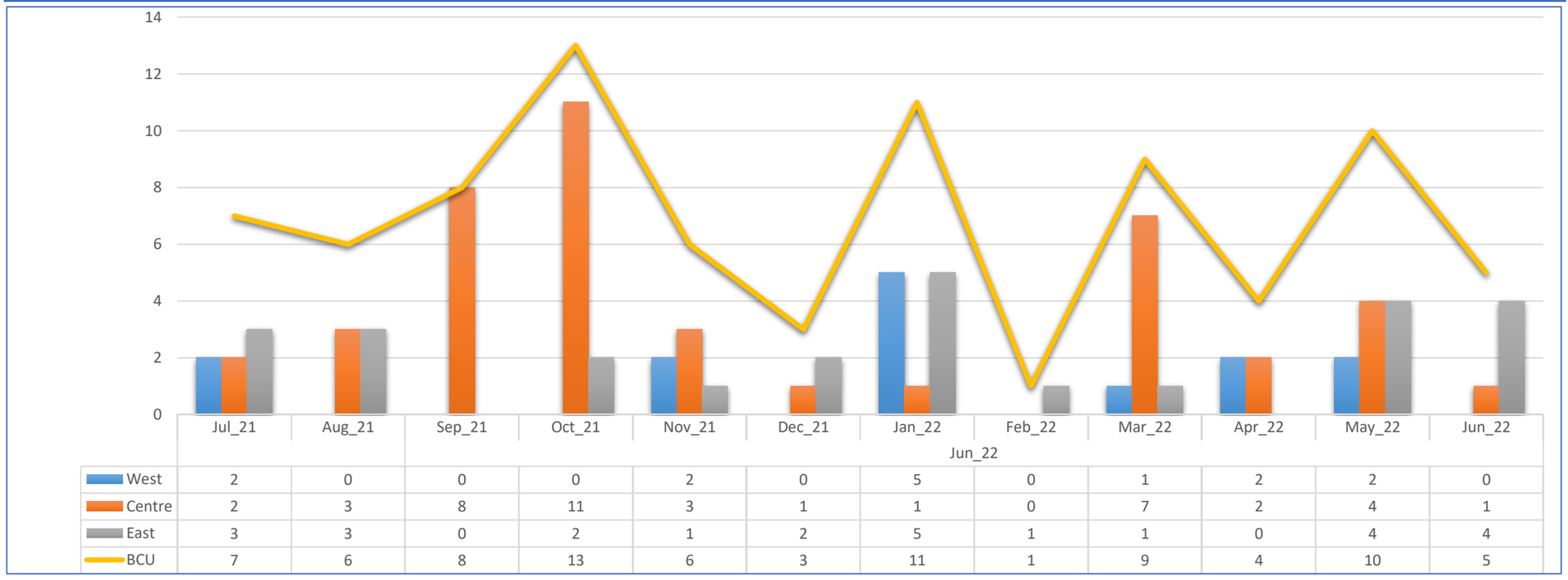
Under 18's detentions in North Wales

KPI Report for: June 2022

Data Source:	BCUHB MHA Database
Report Created on:	01/07/2022
Report Created by:	Performance Directorate

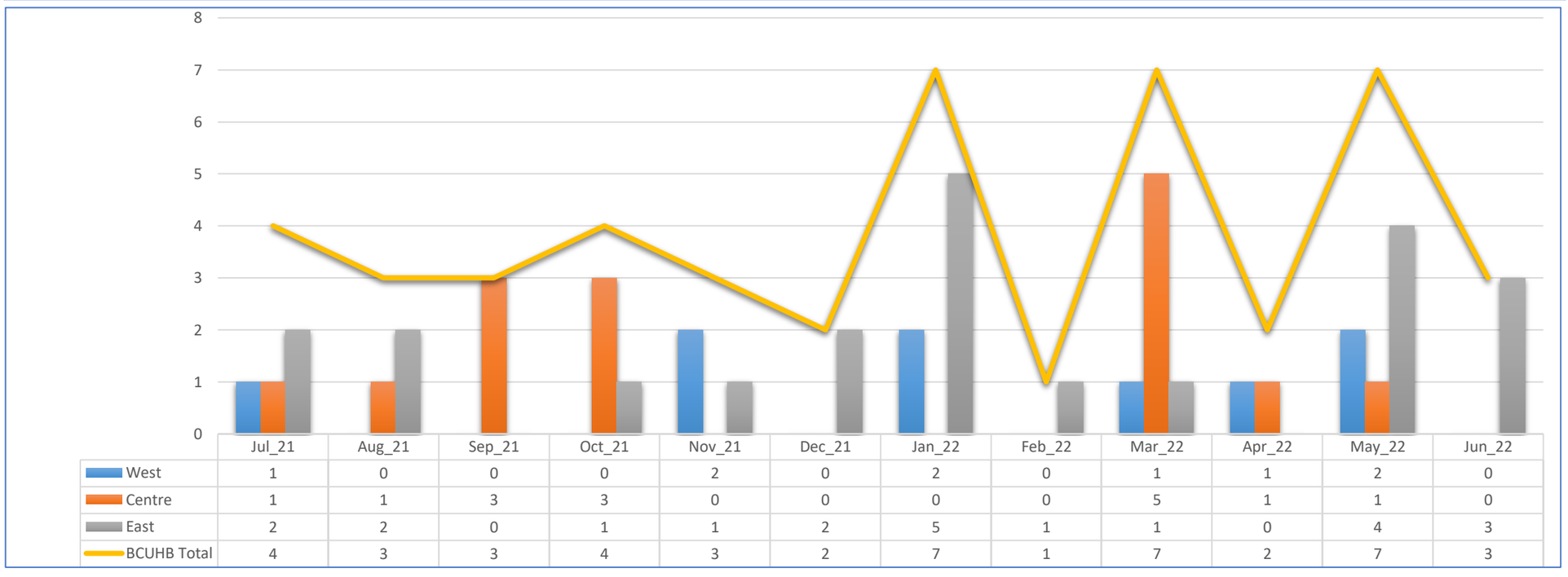
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Jun_22



	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
	Jun_22											
West	2	0	0	0	2	0	5	0	1	2	2	0
Centre	2	3	8	11	3	1	1	0	7	2	4	1
East	3	3	0	2	1	2	5	1	1	0	4	4
BCU	7	6	8	13	6	3	11	1	9	4	10	5

2.1: Section 136 twelve month trend up to and including Jun_22

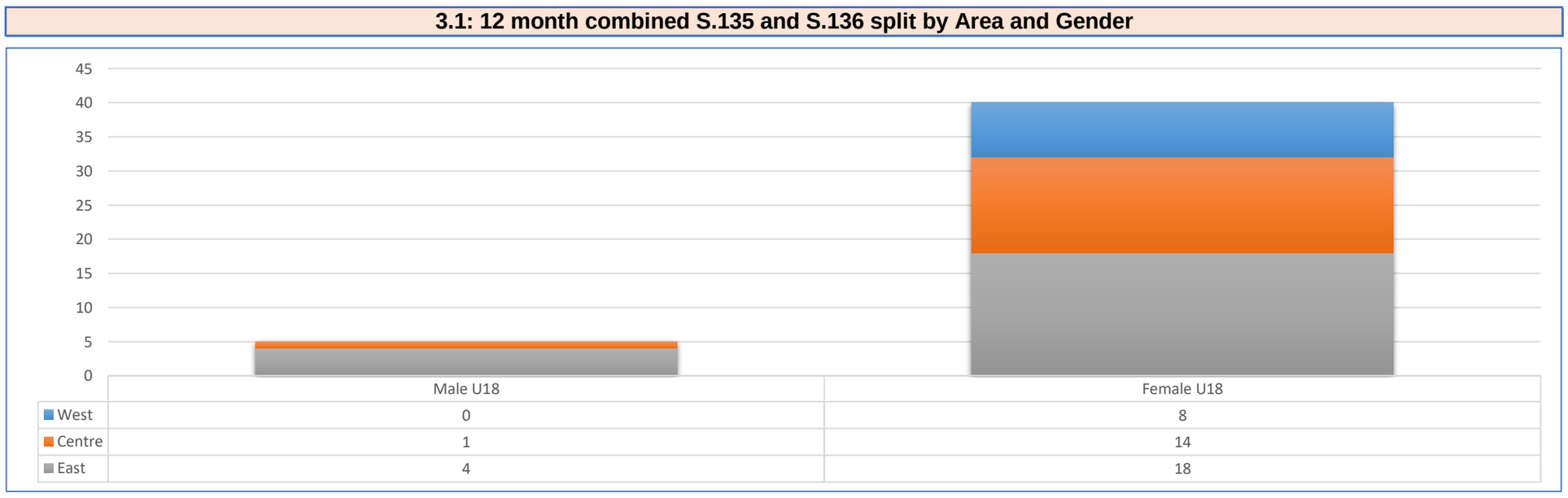


	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	1	0	0	0	2	0	2	0	1	1	2	0
Centre	1	1	3	3	0	0	0	0	5	1	1	0
East	2	2	0	1	1	2	5	1	1	0	4	3
BCUHB Total	4	3	3	4	3	2	7	1	7	2	7	3

2.2: Section 136 Outcomes twelve month trend up to and including Jun_22

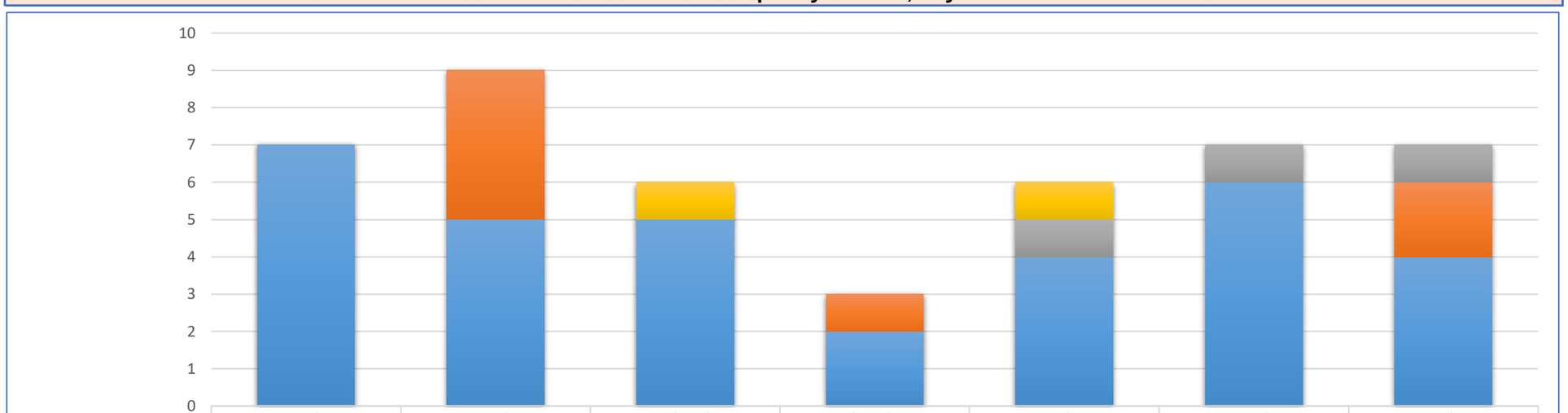
Outcome of 136 detention	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
Discharged - No Mental Disorder	1	0	0	0	0	0	1	1	0	0	0	1
Discharged - Referred to Services	2	0	0	1	0	1	0	0	0	0	0	0
Discharged - Follow up service	1	1	2	2	3	1	5	0	6	2	7	2
Admitted	0	2	1	1	0	0	1	0	1	0	0	0
Section Lapsed	0	0	0	0	0	0	0	0	0	0	0	0

3.1: 12 month combined S.135 and S.136 split by Area and Gender



	Male U18	Female U18
West	0	8
Centre	1	14
East	4	18

3.2: 12 month combined S.135 and S.136 split by Gender, day and time band of admission



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Male 5pm - 8:59am	0	0	1	0	1	0	0
Male 9am - 4:59pm	0	0	0	0	1	1	1
Female 5pm - 8:59am	0	4	0	1	0	0	2
Female 9am - 4:59pm	7	5	5	2	4	6	4

4: 1st Place of Safety 12 month trend up to and including Jun_22

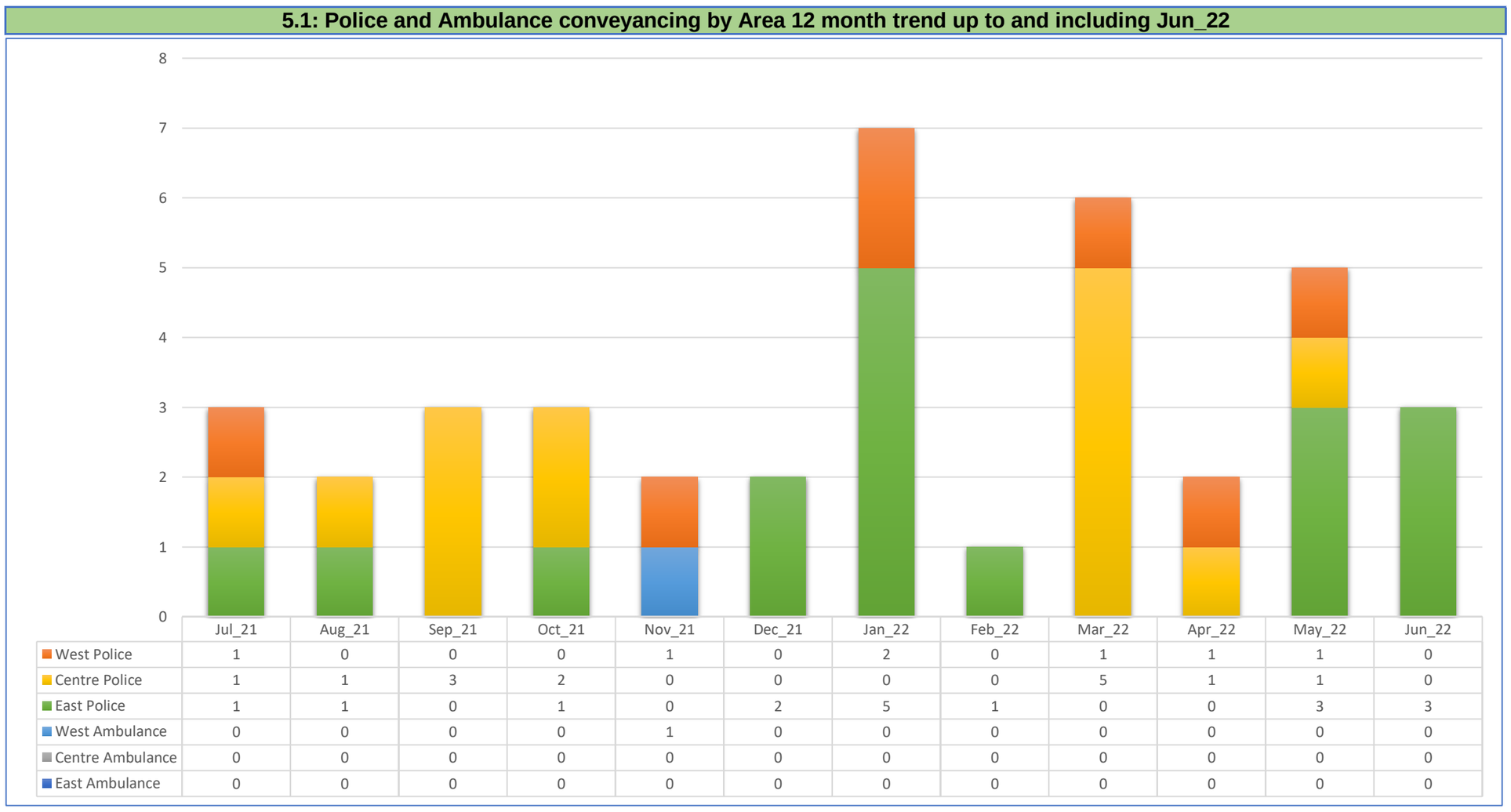
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
A&E	1	2	2	3	2	1	4	0	5	1	2	0
Ward	0	0	0	0	0	0	0	0	0	0	1	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	3	1	1	1	1	1	3	1	2	1	4	3
Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Independent Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0	0	0	0	0	0	0
Police Station (Custod)	0	0	0	0	0	0	0	0	0	0	0	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0	0	0	0	0	0	0
Any other place	0	0	0	0	0	0	0	0	0	0	0	0

4.2: A&E as 1st Place of Safety split by Area

1st Place of Safety: A&E Split	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West	0	0	0	0	2	0	1	0	1	0	1	0
Centre	0	1	2	2	0	0	0	0	3	1	0	0
East	1	1	0	1	0	1	3	0	1	0	1	0

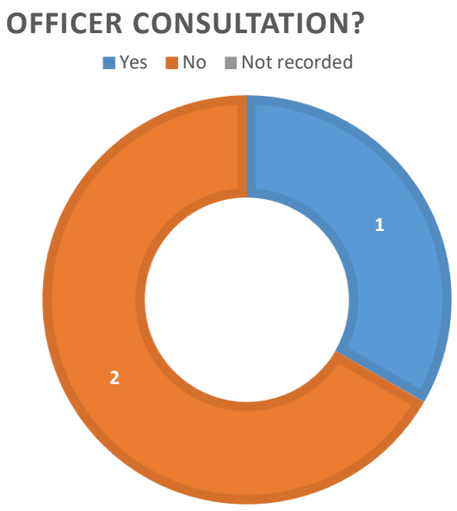
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Jun_22

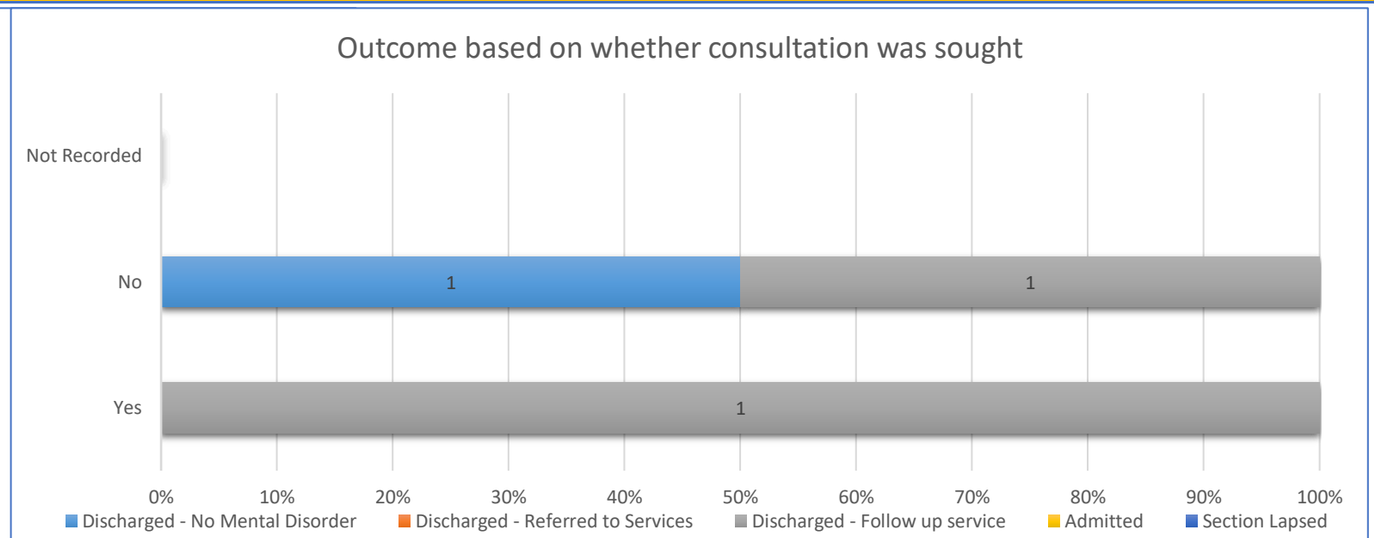


	Jul_21	Aug_21	Sep_21	Oct_21	Nov_21	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22
West Police	1	0	0	0	1	0	2	0	1	1	1	0
Centre Police	1	1	3	2	0	0	0	0	5	1	1	0
East Police	1	1	0	1	0	2	5	1	0	0	3	3
West Ambulance	0	0	0	0	1	0	0	0	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	0	0	0	0	0	0	0	0	0	0

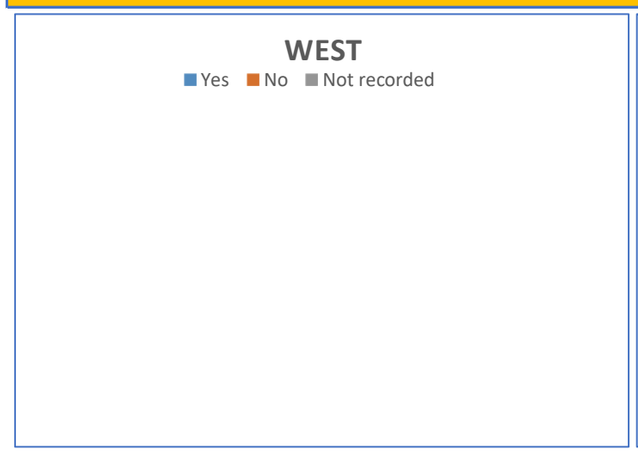
Section B: Data for Jun_22

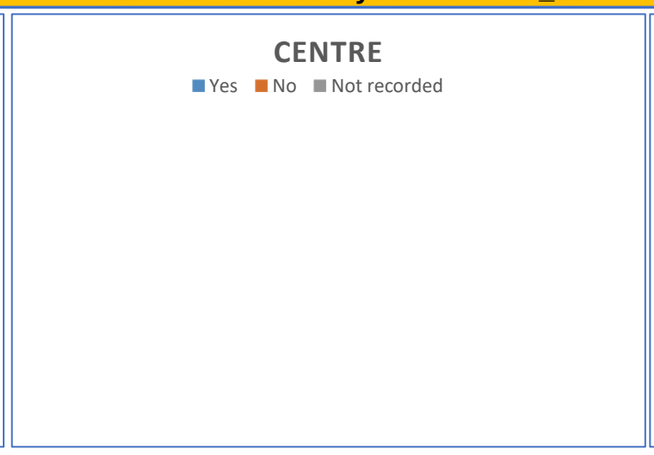
7.1: Consultations and Outcomes for Jun_22

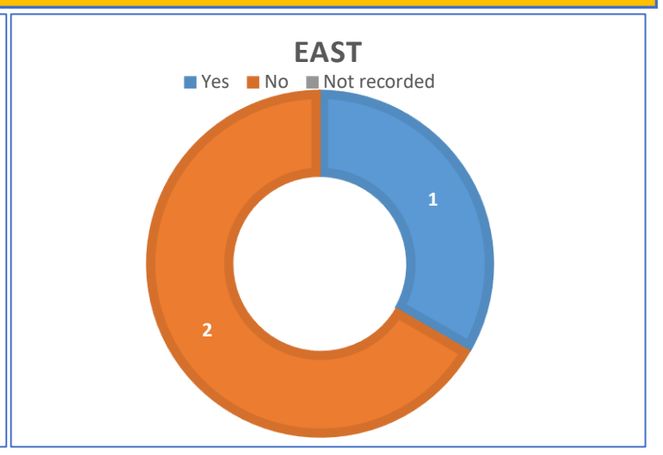




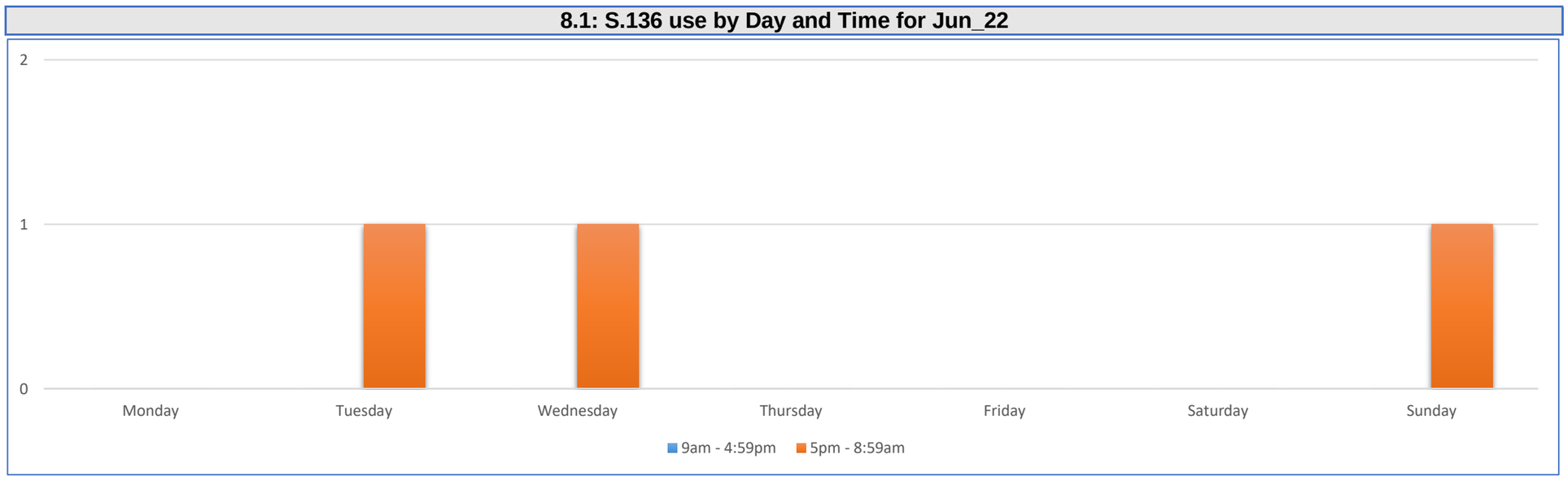
7.2: Consultations by Area for Jun_22



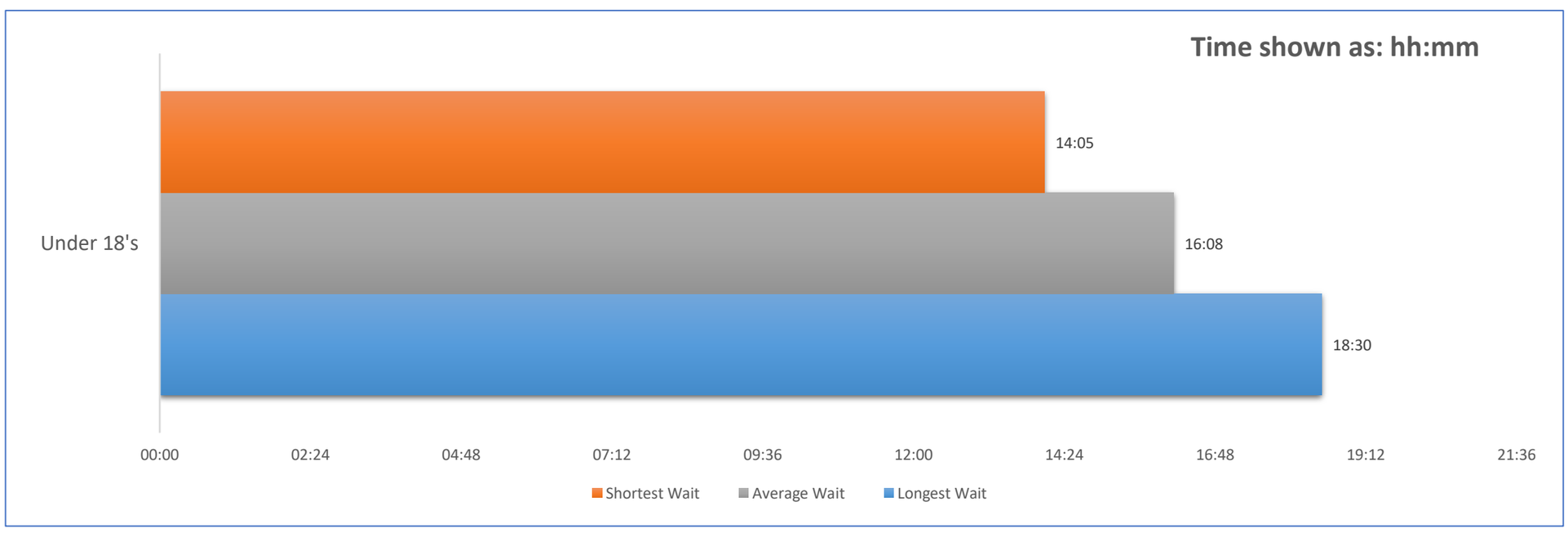




8.1: S.136 use by Day and Time for Jun_22

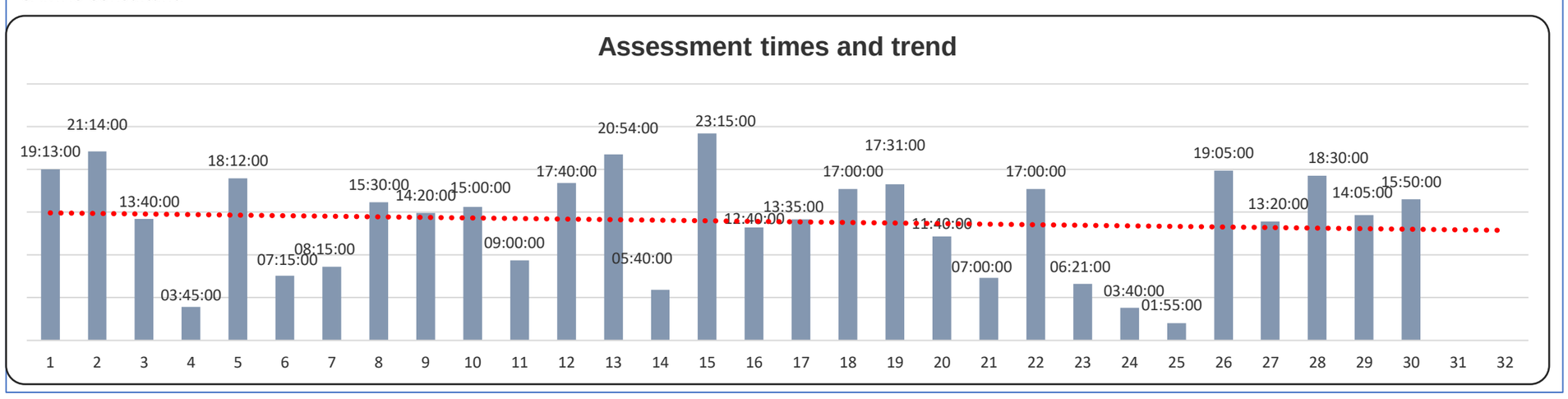


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Jun_22



10.1: Narrative for Jun_22

There were five detentions recorded this month. Two under section 2, both direct admissions. Three detentions were under a S136.
The chart below details the length of time that young people have been detained under a S136 and a trend line for the last 30 detentions. All assessments were conducted by a CAMHS Consultant.



The below information details the detentions in June
The time the S136's were applied by the police and the transfer time to being accepted into a place of safety when the clock then commences.

Reference	S136 applied	S136 Accepted /clock started	OOH/Within hours
28 - 18:30	19:07	21:00	OOH
29 - 14:05	20:58	21:00	OOH
30 - 15:50	19:55	21:40	OOH

Appendix 4

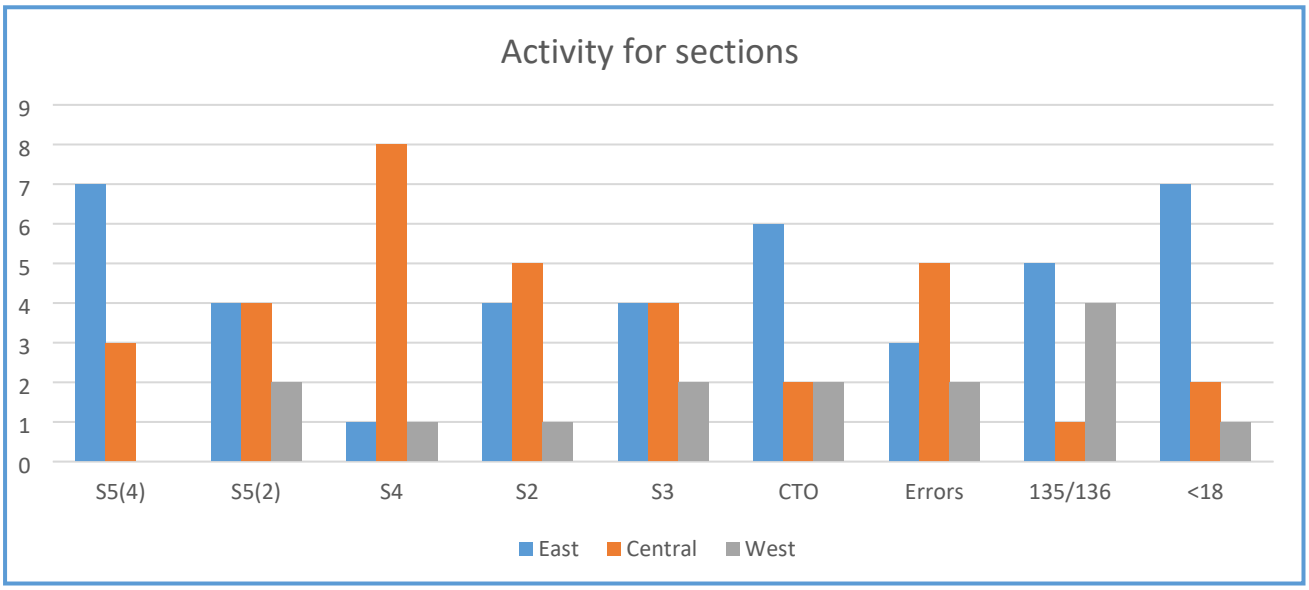
Quarterly report area activity data December 2019 – May 2022

Activity is noted within the quarterly reports for East, West and Central and ranked in order of 1st to 3rd for each report. The Mental Health Capacity and Compliance Committee requested the areas be compared over a longer period to consider if activity under certain sections was consistently higher for any specific area.

Activity concerns the number of detentions enacted within a particular area, there are several factors which can contribute to the rankings including the availability of beds for community admissions, the unit sizes for renewal of sections, the availability of a doctors in connection with the use of section 4 and 5(4) and the time of the section use, and the availability of a section 136 suite. During the Covid 19 pandemic the service followed a different pathway with Ablett being the admissions unit prior to transfer regardless of the demographics a person hails from, this would have affected the admission and activity statistics from March 2020 to January 2021.

Ten committee reports have been considered, December 2019 to May 2022 covering data from October 2019 to May 2022.

The graph below details the activity for each section from the ten reports identifying the number of times the areas were ranked as 1st and leading for that section. Errors were also included in the graph.



The data shows the East area had the most activity over the time period for S5(4), CTO, 135/136 and under 18 S136 detentions.

The Central area had the most activity over the time period for S4, S2, and errors made within paperwork.

East and Central obtained joint activity for S5(2) and S3.

Considering the reporting period and Covid 19; during the time when the Ablett Unit was the admissions unit this is reflected in the activity data for sections 5(2), 4, 2 and errors with the central area ranking 1st within the reports for this timeframe (April 2020 – January 2021).

It is hard to interpret the other figures due to the afore mentioned factors that could contribute to why an admission occurred within a particular area and would require detailed scrutiny of each section enacted within the period taking all the factors into consideration.

Report title:	Corporate Risk Register Report			
Report to:	Mental Health Act Capacity and Compliance Committee			
Date of Meeting:	Friday, 29 July 2022	Agenda Item number:		
Executive Summary:	The purpose of this standing agenda item is to highlight the discussions which took place during the Risk Management Group meeting on the 5th April and 31st May 2022 and to note the progress on the management of the Corporate Risk Register.			
Recommendations:	The Committee is asked to: Review and discuss the report.			
Executive Lead:	Nick Lyons, Executive Medical Director			
Report Author:	Justine Parry, Assistant Director of Information Governance and Risk			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Link to Strategic Objective(s):	See the individual risk for details of the related links to Strategic Objectives.
Regulatory and legal implications	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	See the individual risk for details of the related links to the Board Assurance Framework.
Financial implications as a result of implementing the recommendations	The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.
Workforce implications as a result of implementing the recommendations	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Feedback, response, and follow up summary following consultation	The Risk Management Group met on the 5th April and 31st May 2022 and further updates to the risk have been incorporated. Please see the individual progress notes on the risk.
Links to BAF risks: (or links to the Corporate Risk Register)	See the individual risk for details of the related links to the Board Assurance Framework.
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps: The Risk Management Group will be meeting on the 2nd August 2022, therefore an updated position of the risks will be presented during the Mental Health Act Capacity and Compliance Committee on the 4th November 2022.
List of Appendices: Appendix 1 – Mental Health Act Capacity and Compliance Corporate Risk Register Report Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels

Mental Health Act Capacity and Compliance Committee
29th July 2022
Corporate Risk Register Report

1. Introduction/Background

1.1 The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

(NB Work is underway to redesign Committee Risk and Board Assurance Framework reports as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments)

2. Body of report

2.1 The Risk Management Group met on the 5th April and 31st May 2022 to review the Corporate Risk Register which included a "deep dive" into the risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint. For example, members noted that controls when expressed as `…policy in place` or `business case in place` were not properly articulated. They then advised that such controls be refreshed to focus on their implementation as neither a policy nor a business case in itself can mitigate a risk.

2.2 The Group also agreed that once Executive Directors have approved risks, there was no need to present them to the RMG, ET or Committees for further approval as this doesn`t align with best practice and the dynamic and timely escalation of risks. This aligns with the UK Code 2018 and the FRC Risk Guide 2014, which advise that Committees should focus on their `oversight function` and not to get involved in `risk management` by satisfying themselves that Executive Directors are consistently mitigating and managing risks in line with best practice. This will be reflected in the updated Risk Management Strategy to be presented to the Board in July 2022 for approval.

2.3 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	20	0	2	1
Tier 2 (9-12)	386	92	94	95

Tier 3 (1-8)	239	88	47	110

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the full details of individual risks in Appendix 1.

5. Equality and Diversity Implications

5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

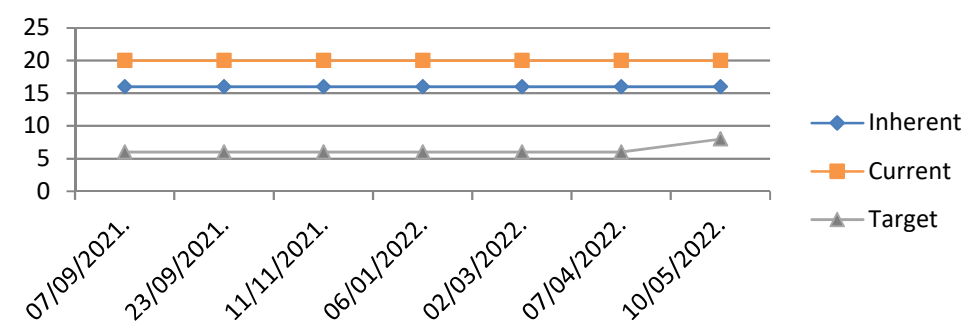
5.2 Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

CRR21-14	**Director Lead:** Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 10 May 2022
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 01 March 2022
		Target Risk Date: 31 October 2023

This may be caused by the increased number of patients who are refusing admission or who have mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

This is due to the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and increase in financial cost, poor patient experience and reputational damage for BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2022.	Unchanged		

Controls in place	Assurances
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory adult at risk training levels 2 and 3 is in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting.

4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 7. Welsh Government interim monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients.	4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the Safeguarding Governance and Performance Group reported into Welsh Government. 7. Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the Safeguarding Team, which is reported to the Mental Health and Capacity Compliance Committee.

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised code of practice. A business case has been approved as part of the Integrated Medium Term Plan 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. 3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention. 4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies. 5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator to wards noting the

timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training.

Progress since last submission
1. Controls and Assurances reviewed to reflect current risk position. 2. Gaps in Controls reviewed to reflect current risk position. 3. Terms of Reference for Liberty Protection Safeguards Strategic Implementation Task and Finish group ratified and approved by Mental Health and Capacity Compliance Committee. 4. Date set for the inaugural Liberty Protection Safeguards Strategic Implementation Task and Finish group. 5. Integrated Medium Term Plan has acknowledged funding for additional resources, awaiting allocation and remains on reserve list for release in quarter 3. 6. Action ID 15708 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. 7. Action ID 18117 - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23. 8. Action ID 18118 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. 9. Action ID 20957 – Action delayed, due to UK and Welsh Government for release of code of practice, consultation due for July 2022. Anticipated due date for local implementation plan by end of August 2022. 6. Identification of new action ID 23066 to improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	15708	The Deprivation of Liberty Safeguards Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing	Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business	31/10/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention. May 2022 progress - Action delayed, consultation completed, governance	Delay

		Authority and Supervisory Body.	Support Manager		approval following the Health Board's policy on policies is in progress.	
	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	Additional resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. May 2022 progress update - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23.	Delay
	18118	Implement and monitor a Court of Protection Engagement and Standard Operating Procedure for Deprivation of Liberty Safeguards / Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the Court of Protection and meet the needs and safeguards of service users. May 2022 progress - Action delayed, consultation completed, governance approval following the Health Board's policy on policies is in progress.	Delay
	20957	Development of implementation plan in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. May 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Consultation had now commenced, end date is July 2022. Anticipated	Delay

					due date for local implementation plan by end of August 2022.	
	21213	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan.	On track
	23066	Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.	Michelle Denwood, Director of Safeguarding and Public Protection	30/11/2022	Welsh Government monies will support additional resource and educational tools to inform the workforce regarding capacity and harm which will reduce risk and improve patient care.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	20
CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	Executive Director of Workforce and Organisational Development	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	16
CRR21-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR21-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-20	There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents.	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR21-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16
CRR21-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Appendix 3 - Risk Key Field Guidance / Definitions of Assurance Levels V2

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee – 29/7/22**
Cyhoeddus neu Breifat: Public or Private:	*Public*
Teitl yr Adroddiad Report Title:	Criminal Justice Liaison Service (CJLS) update
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Ruth Joyce, CJLS Manager
Craffu blaenorol: Prior Scrutiny:	*MHLD - West SLT* *MHLD- (Divisional) QSE*
Atodiadau **Appendices:**	*None - Attached full report*

Argymhelliad / Recommendation:

The MHCaCC members are asked to note this update report.

(*The data covers the period February – April 2022 – as data is not yet validated for the period to June 2022*)

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer **penderfyniad /cymeradwyaeth For Decision/** **Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth For Information**	**X**

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This paper will give a summary of the period February-April 2022 performance data, along with details of the planned focus of activity for the coming 6-12 months.

This report also evidences the potential savings due to the CJLS practitioners diverting inappropriate use of S136 during consultation and offering the least restrictive outcome for the individual.

Cefndir / Background:

This paper is for information sharing .

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This paper provides data regarding the diversion of S136 and the continuing work between partnership agencies in an attempt to increase consultations.

This data includes consultation figures on North Wales Police officer's obligation to consult wherever practicable. This report evidences that in cases where consultation was conducted with the CJLS, only 32 of the 57 consultations during this last quarter period resulted in use of S136 police powers, thus showing the benefits of consultation on reducing the inappropriate use of S136 and utilising the least restrictive intervention.

As mentioned in previous reports there is a continued commitment between North Wales Police and health to be an active partnership and to address issues around improving consultation rates across North Wales.

This is also evidenced by the recent introduction of a new mental health steering group specifically to engage with all elements of policing that CJLS work into and alongside. This meeting is in its infancy, and terms of reference are to be agreed.

The team is currently opperating with a 0.5 vacancy. Discussions are underway with the senior leadership team in the west as there may be an opprtunity to further develop the service to incorporate a team leader role.

Opsiynau a ystyriwyd / Options considered Not applicable.

Goblygiadau Ariannol / Financial Implications

CJLS is funded via Welsh Governement funding - this is additional to the existing legacy CJLS service.

- Legacy provision establishment figures were one Whole time equivalent (WTE) band 7 and three WTE band 6.
- Current establishment provision is one WTE service manager band 8a, 6.5 WTE band 6 pratitioners and one 0.5 band 2 admin support.

Dadansoddiad Risk / Risk Analysis

As with many teams, there has been a reduced availability of the service due to covid-19 sickness and occasional redeployment to assist in-patient setting activity.

The team leader role needs to exploration in order to ensure the strategic direction and development of the service.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

No legal and compliance implications in regard to this paper.

Asesiad Effaith / Impact Assessment

Impact assessment submitted previously as per standard operational protocol within Division.

Criminal Justice Liaison Service (CJLS) Senior Leadership QSE Quarter report February-April 2022

Background:

The service has been operational since January 2019. The service covers a 09:00 – 17:00 Monday-Friday pattern providing mental health assessments in three North Wales Police custody suites (Llay, Caernarfon and St Asaph) and the three North Wales Magistrates court (Mold, Llandudno and Caernarfon).

The team cover a 12.5 hour shift in Force Communication Centre (FCC) St Asaph, from 11:30-00:00hrs.

The service in FCC continues to offer advice to officers and staff dealing with mental health incidents. CJLS practitioners can access health databases and liaise with services to ascertain if individuals have accessed services along with psychiatric liaison records for West and Central areas.

Performance:

During this previous quarter, CJLS have documented involvement with 523 calls/events received in the Force Control Centre (FCC), which is slightly lower than previous reports. Data from North Wales Police states that within the last quarter the FCC received 24,615 emergency calls and 48,340 non-emergency calls. The 101 and 999 calls showed a slight decrease compared to last quarter data.

This data equates to CJLS being involved in 2.1% of emergency calls, which is a slight decrease on the previous quarter, and just under 1% of total calls whilst on duty in FCC.

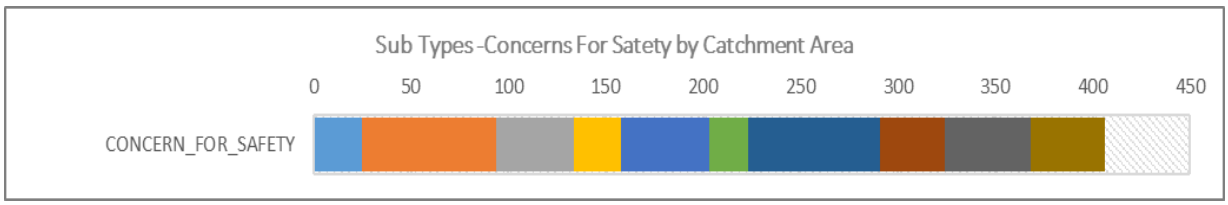
Whilst this may seem a small number, these are often complex calls and can take a large portion of a single practitioner's shift and events are dealt with as per police priority to preserve life.

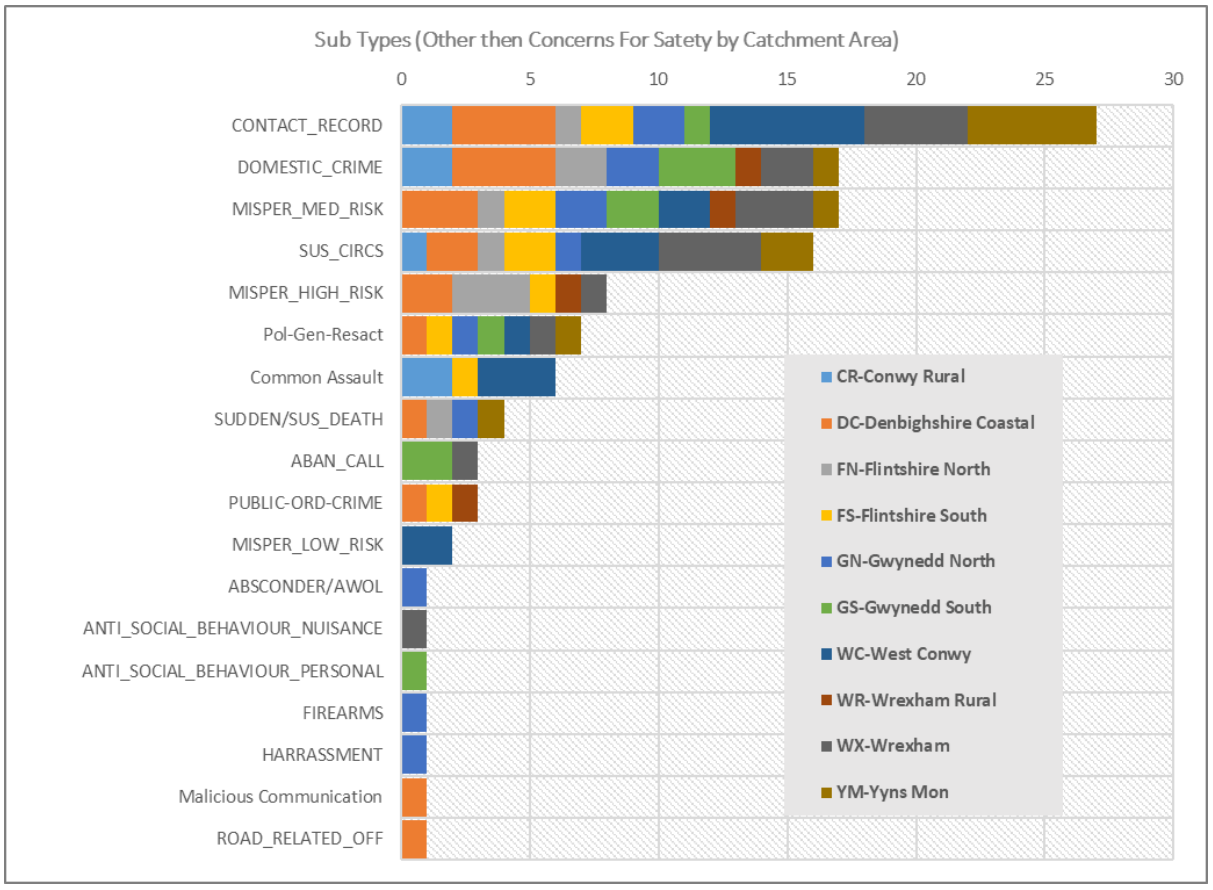
This is an area of work explored within the strategic Public Protection of Vulnerable Persons Unit (PVPU). This includes the recent introduction of the mental health steering group, along with exploring the development of an electronic S136 document which has been developed in other policing areas. A task and finish group was established with involvement from health, the Mental Health Act office, police and IT from both organisations to ensure this captures Welsh Government reportable data and police data.

Calls/Events - Overall:

The data below shows a breakdown of all the sub types of calls as categorised on police systems. This quarter highlights the highest percentage of calls/events dealt with by CJLS as those classified as 'concern for safety'. This accounts for 400 of the 523 events entered onto SharePoint within this quarter. This figure remains consist throughout all reporting. This is further broken down by catchment areas for the events.

The category and subtypes are determined by call handlers and supervisors based on the information given during the emergency or non-emergency call.





Calls/Events- Timeline:

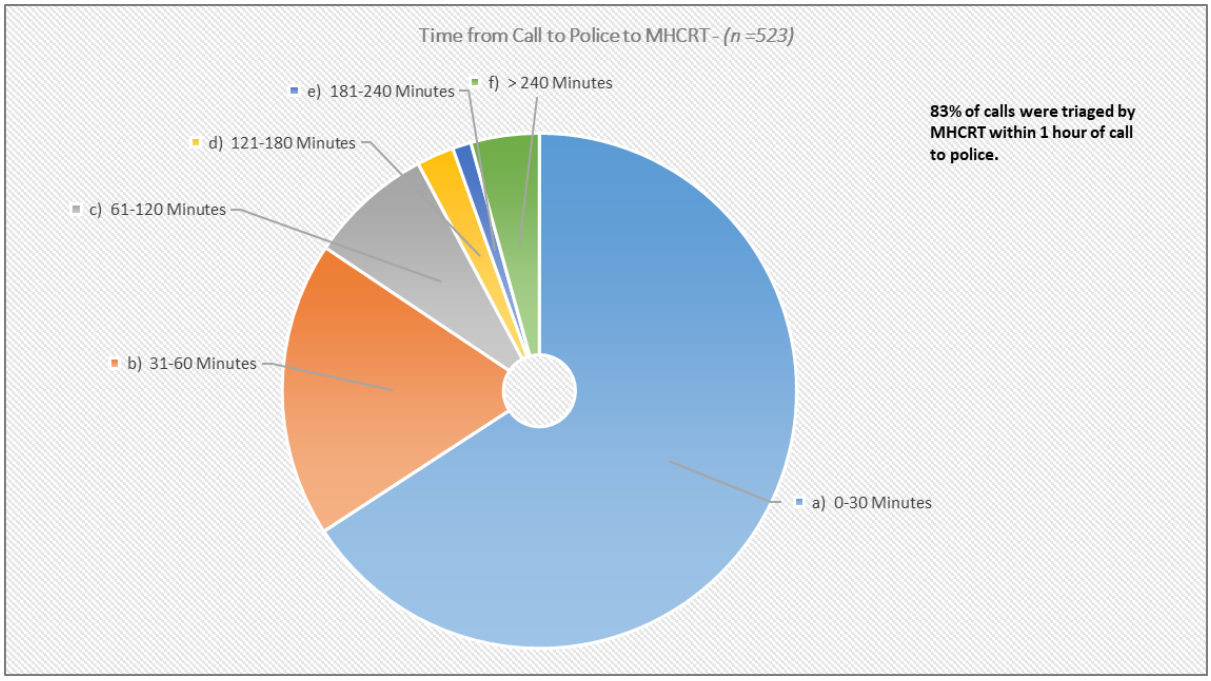
It should be noted that there are many event/incident classifications. Within each of these classifications, a call is graded in order of seriousness and response needed from P0 - immediate response to P8 - slow time enquiries. As agreed within the Standard Operational Policy, CJLS focus in the main on the P0 and P1 calls to ensure swift sharing of information and intervention where needed.

There are significant times where ‘slow time’ graded calls may be flagged to the team at a much later stage of the call/incident initially occurring. This will account for those times beyond the usual quick response.

Data collected informs the team of the average time from a call being received by FCC to CJLS involvement. This data remains the same as in previous reports for this quarter:

- 67% of calls receiving intervention within 30 minutes of the call being received by North Wales Police call handlers, and

- 83% of all calls/events requiring CJLS intervention being supported within 60 minutes.



S136 suite usage:

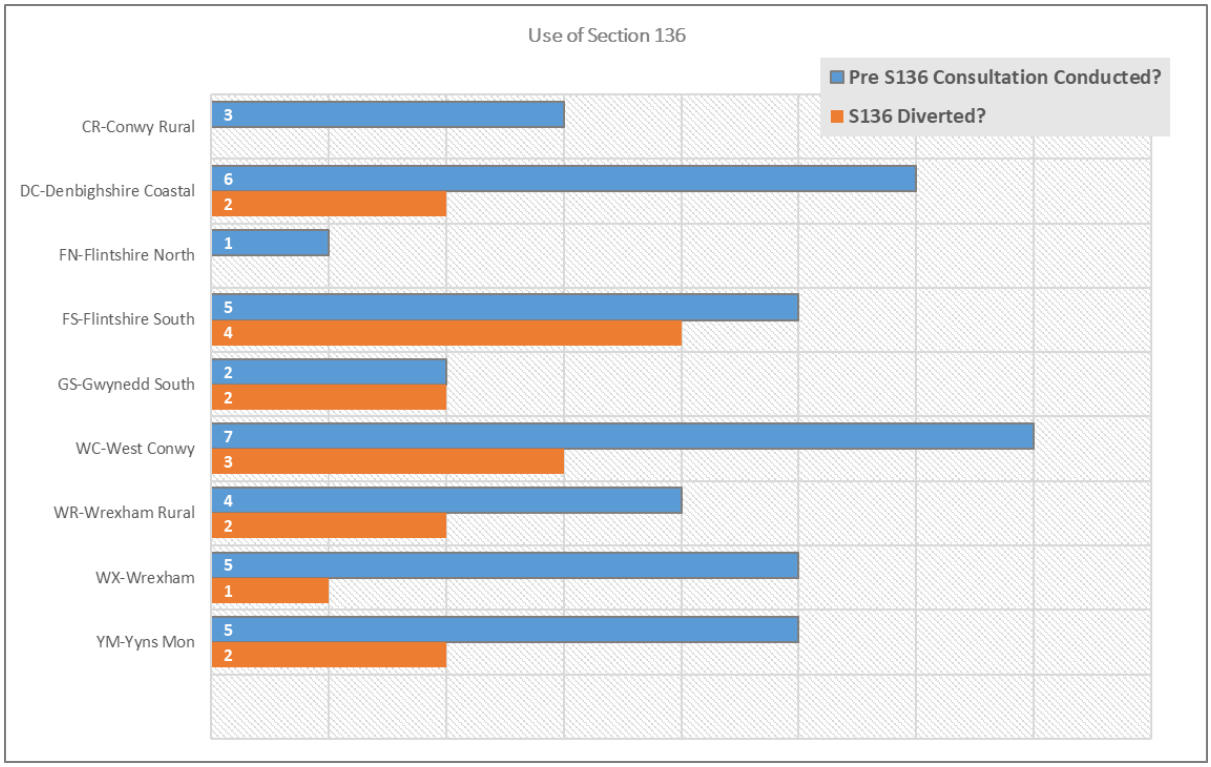
The chart below shows that the CJLS were consulted on 38 potential S136. Of those 38, there has been a documented diversion of 16. This data is further broken down by geographical area.

The Mental Health Act office data notes the overall number of S136 uses as 140 implemented in the past quarter. Therefore showing that CJLS have been involved in 27.2% of the total number of S136 in this last quarter. This is similar to the last quarter data and evidences need for improvement with regards to consultation rates.

S136 consultation is an area where CJLS are working with partners to educate officers and duty nurses regarding the use of CJLS and duty nurses as a point of consultation(as dictated in legislation). Diverts occur by discussing an alternative intervention or liaising with officers and individuals in regard to accessing services in a voluntary capacity and liaison with appropriate services to assist the individual in the least restrictive manner.

CJLS continue to explore other areas of training and meetings where we can discuss and promote use of consultation prior to consideration of S136 use. This also includes utilising officer feedback and experience from individuals who have experienced use of S136 or contact with North Wales Police during crisis or distress. CJLS plan to attend police briefings in order to promote the control room service and keep consultation at the forefront of decision process around use of S136.

Following the S135/136 monitoring group meeting, it was agreed that a small task and finish group will take work further in regard to electronic data gathering and it is hoped this will be able to incorporate a statement around consultation while also capturing the data required by Welsh Government and NW Police



Costings for S136:

For this quarter, an attempt has been made to put an average cost against the monthly detentions from both a police and health data as discussed at previous Mental Health Act Committee.

This has proved a complex area and the costings given are approximate estimates.. The service hopes to improve on this level of information.

North Wales Police routinely provide costings based on Mental Health Act office data, however this only takes into account the time period from the application of S136 by the police officer. Therefore this does not include administration time, such as the completion of forms/CID16 or populating event chronology post incident. This also does not include time pre S136 with the person in distress. The costings are usually between £6-8000 monthly, and this is a most conservative estimate.

In terms of **health**, the costings below are based on the hourly average payment for one Band 6 nurse and one band 3 health care support worker (gross pay) for the average amount of time per S136 as calculated by Mental Health Act office figures.

This is an estimated cost, and does not include attendance from the Section 12(2) Doctor and Approved Mental Health Professional, as the attendance time scale for these professionals is different for every assessment, and therefore it is difficult to calculate an average. This is therefore another conservative estimate.

	BCUHB (Band 6 and Band 3)

Month	Avg cost per detention	Number of detentions	Avg time per detention	Total cost per month
Feb -22	£241.02	36	7hrs 43	£8,676.9
March-22	£303.22	54	9hrs 43	£16,373.88
April -22	£255.02	50	8hrs 19	£12,760

Based on the above costings the CJLS can evidence the saving as below for diverted S136:

CJLS Diverts saving				
Month	Avg health cost per detention	Number of diversions	Avg time per detention	Potential saving
Feb-22	£241.02	6	7hrs 43	£1,446.12
March-22	£303.22	5	9hrs 43	£1,516.10
April-22	£255.02	5	8hrs 19	£1,275.10
			Quarter Total	£4,237.32

Court and community attendance

CJLS have adapted to meet demand in the three local magistrates courts. The service attends where demand dictates at overnight remand courts, whilst adhering to local restrictions in place due to covid management. CJLS attendance has been for planned assessment and not routinely, as was pre-covid, although this has improved dramatically. Wrexham area now has an operational overnight remand court.

For this past quarter there have been community referrals made by offender managers. Probation clinics are held in the five areas as listed below. The team have offered 71 assessment appointments during this last quarter. CJLS attend probation team meetings regularly to ensure positive communication routes and to ensure the teams are aware of how to refer or contact CJLS for advice

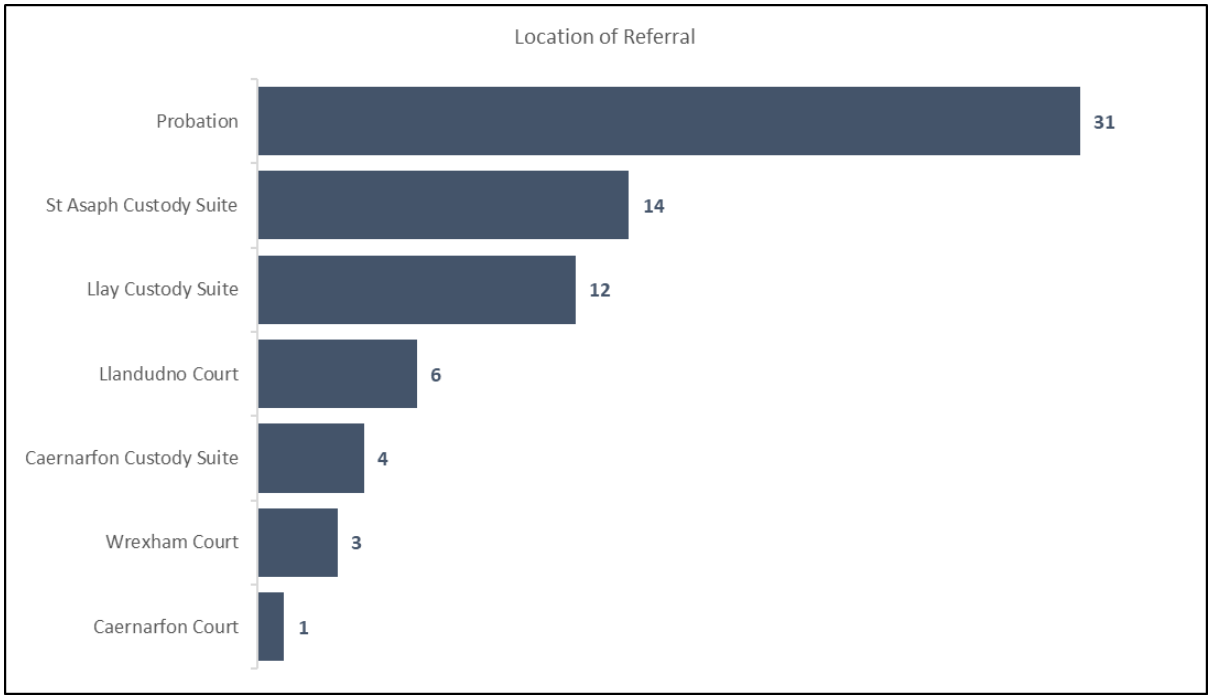
Regrettably, there continues to be a high level of non-attended appointments, CJLS attend Probation team meeting regularly to share this data which is also shared with senior probation staff. Of the 71 available assessment slots past quarter, 39 of these where not attended. This is displayed in the chart below.

	MONTH		
	Feb 2022	Mar 2022	Apr 2022

Area	Booked	DNA	Booked	DNA	Booked	DNA
Western						
Ty Newydd	1	1	0	0	0	0
Caernarfon	5	3	8	1	4	3
Llangefni	0	0	0	0	0	0
Central						
Colwyn Bay	6	2	6	4	4	4
Eastern						
Wrexham	9	3	7	3	8	3
Flint	4	2	3	1	6	2
TOTAL	**25**	**11**	**24**	**9**	**22**	**12**

Community referrals and Probation clinics:

The graphs below evidence that the source of referrals and geographical area data remain similar to previous reports with the largest area of referral being the National Probation service. These referrals are accepted from all areas of offender management.



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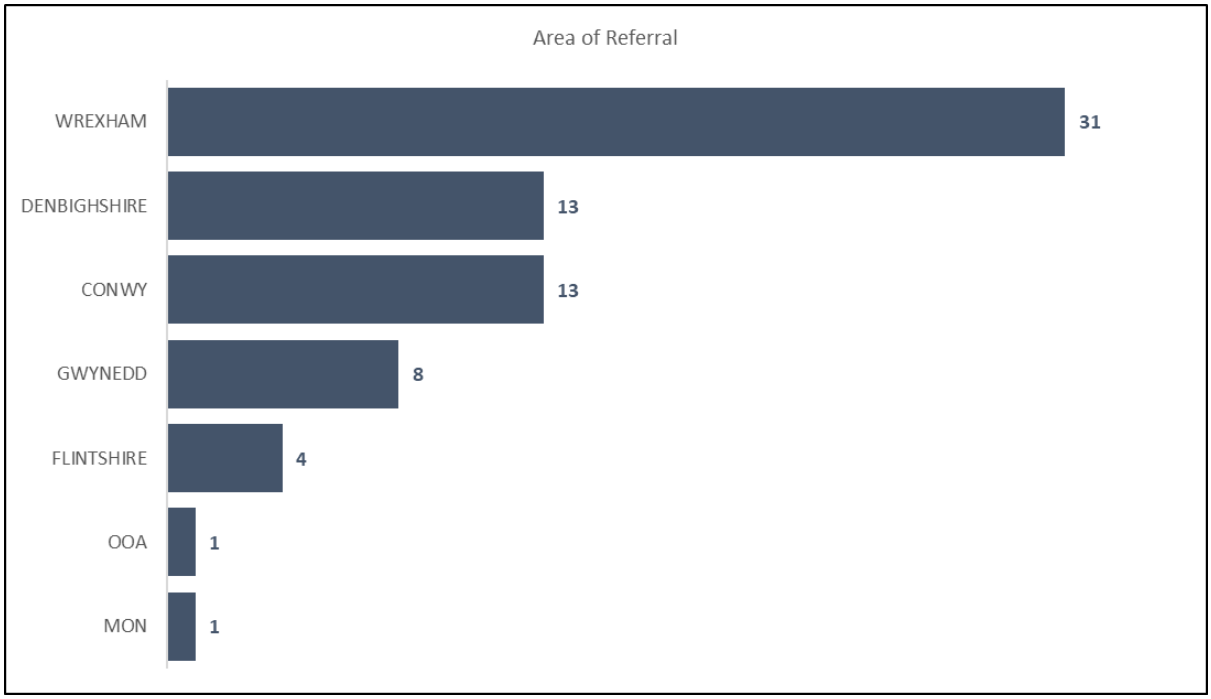
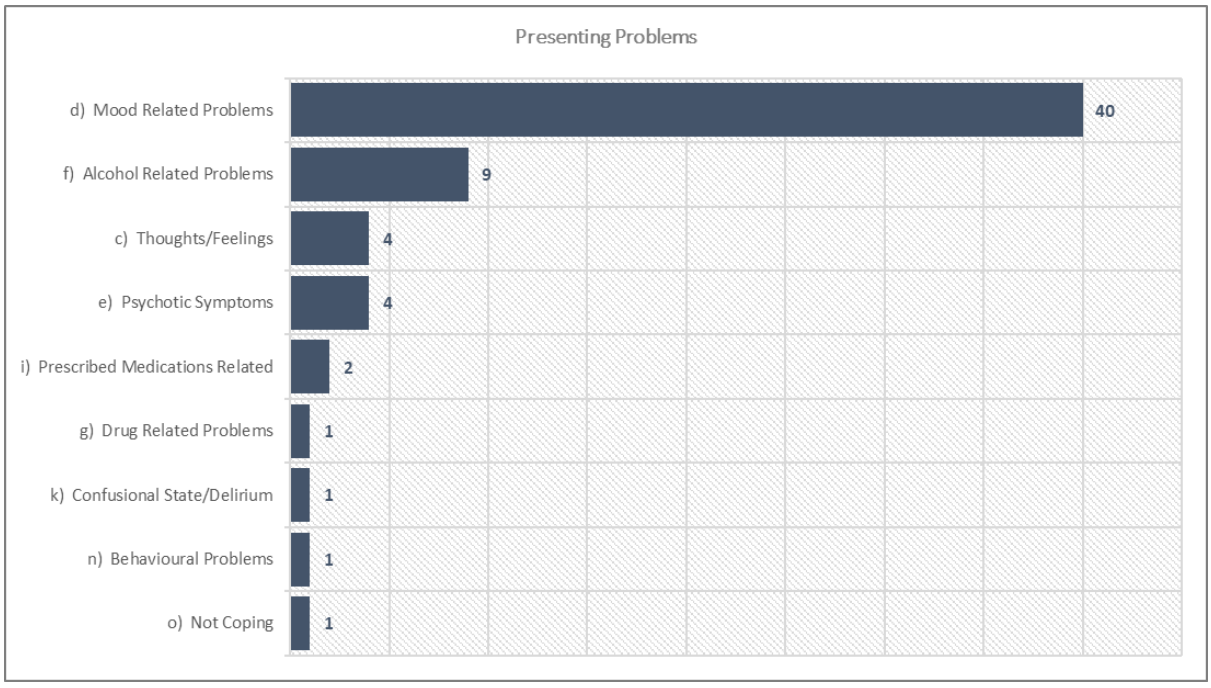
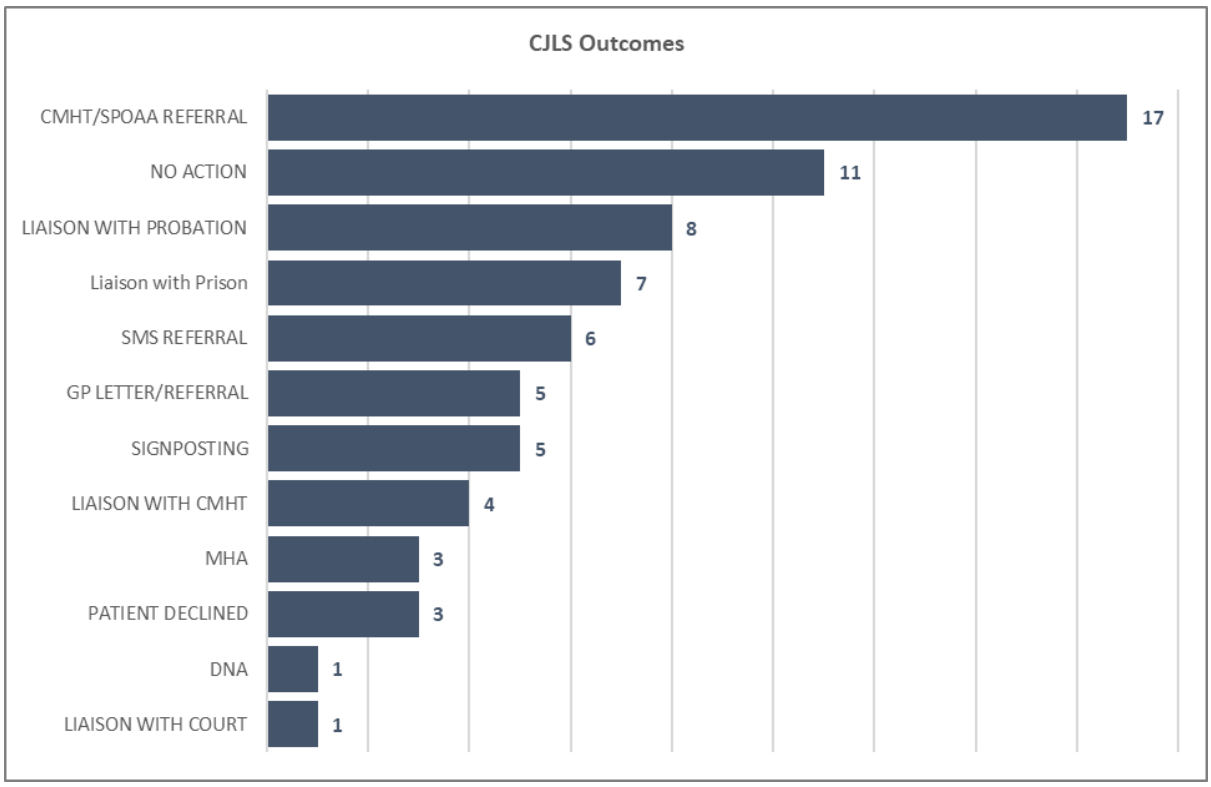




As can be seen from the graph above, the presenting categories remain similar to last quarter with very similar themes.

The outcome of the completed assessments can be diverse depending on the individuals' need and range from general advice/signposting to referral to secondary services or requesting further assessment under the Mental Health Act.



CJLS have also been working in collaboration with 'Checkpoint', a Police and Crime Commission project that is now being developed under the Prevent Hub for North Wales police. This service aims to assist individuals at first arrest in order to avoid a possible charge, while working for a set amount of time with community navigators to address areas of need. CJLS will soon be in a position to offer the Checkpoint service users assessment and onward referral where needed.

Risk

CJLS has experienced ongoing vacancies. The previous shift pattern was cited within exit interviews as a contributing factor individuals moving on jobwise. The shift allocation has recently changed to one 12.5 hour shift daily in FCC (11:30-00:00) seven days a week. The shift pattern has been seen as a positive change with the team.

Activity for coming months:

CJLS as a team continue to explore ways of working to benefit the individuals who encounter the criminal justice agencies.

The service continues to be involved in many multi-disciplinary reviews where police have engaged with health services to discuss particular cases and themes that affect both organisations and the demand put upon each service. This is an area that will continue to be active for the next 6-12 months, and there has been specific liaison about Child and Adolescence Services as demand in this area has seen an increase on CJLS force control room work leading to further multi-disciplinary reviews. This has proved a very positive area of work, and the team are cited on many crisis/safety plans, which enable the practitioners to liaise effectively with officers dealing with the young people. These plans often include information on how to approach and interact, along with a comprehensive list of agencies/individuals who will be able to support.

The team are also proud to have been involved in the initial roll out of a young persons ‘Inspire safe space’ project. This is currently operating only in the East area although CAMHS services are hopeful this will expand. The service is aimed at 14-17 year olds that do not meet criteria for use of S136 but need assistance during a time of distress and vulnerability outside of CAMHS core hours. It currently operates Monday-Thursday 18:00-00:00 and is staffed by experienced youth workers.

The S135/136 monitoring group has been recommenced as a forum for thematic review and sharing or best practice and lessons learned amongst health, local authority, Welsh Ambulance Service Trust, medical and police colleagues. The second meeting this year has recently taken place.

As previously mentioned, a continuing area of activity will be around increasing the rate of consultation with North Wales Police colleagues. This work links strongly to ensuring awareness of CJLS for all colleagues both police and health. North Wales Police had previously shared a questionnaire to scope the knowledge level about CJLS amongst key staff groups. This will allow focus on areas with limited knowledge or use of CJLS to have input- with an aim to improve knowledge rates. One way of ensuring a positive message is to share the feedback from previous interaction and from the training that CJLS provide.

CJLS will also continue to consider service reconfiguration over the next quarter as the team is now at near full establishment. This area remains a focus for the service to ensure the service can develop and utilise the full experience of the team to continue to evidence best practice.

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29/07/2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Compliance with the Mental Health Act Audit
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 – Quarterly Audit Results

Argymhelliad / Recommendation:

The committee is asked to note the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	√

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The Mental Health Act 1983 (as amended 2007) enables those who meet the criteria for detention, to become subject to a detention within suitable premises to receive assessment and treatment of their mental health for the protection of themselves and others.

Whilst subject to detention patients have a number of rights under the Mental Health Act.

The Health Board has a duty to ensure that detention paperwork is legal, and administrative timescales met, to fulfil all aspects of the Mental Health Act. This includes patients being aware of their rights to appeal, to have access to an Independent Mental Health Advocate (IMHA), and to have an up to date care and treatment plan.

"Hospital managers and local authorities should also ensure arrangements are in place to audit the effectiveness of receipt and scrutiny of documents on a regular basis". (CoPW 35.20[1])

The aim of the audit is to ensure the Health Board is upholding it's duties under the Mental Health Act in regards to documentation.

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

Cefndir / Background:

An initial audit was conducted in August 2021 for a number of units where patients are detained and a report produced in September, a follow up audit was conducted and produced November 2021 which included all units aside from Heddfan, Hergest and Ablett as these are scrutinised by the Associate Hospital Managers on a monthly basis.

The scrutiny of the units is completed on a quarterly basis by the MHA administrators, it was agreed with the audit department that to produce a quarterly audit report is not practicable and a yearly audit should be registered and produced. This report therefore details the comparisons of the previous audit to show if improvements have been made and actions undertaken as necessary.

Some units such as forensic, rehab and older persons do not have an onsite Mental Health Act Administrator. The area Mental Health Act office, situated in the closest adult psychiatric unit (Heddfan, Hergest and Ablett) will receive and hold original Mental Health Act documentation. .

All units hold an integrated file for each patient; these files are required to contain copies of the Mental Health Act documentation. In some units there is no provision of a ward clerk, this responsibility then falls to the nursing staff to ensure documentation is filed correctly.

Nine standards have been identified for audit as below and form the basis of the scrutiny and checks. Appendix 1 details the comparisons for the units from previous records and actions undertaken as necessary.

Number	Standard
1	**Section papers** The correspondence file and case notes should contain the same detention paperwork.
2	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.
3	**Explanation of Rights** The correspondence file and case notes should contain the same document.
4	**Explanation of Rights** The patient should be made aware of their rights in their primary language
5	**Explanation of Rights** The patient should be offered a referral to IMHA services
6	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.
7	**Care and Treatment Plan** The integrated file should contain an up to date Care and Treatment Plan.
8	**Mental Health Act Divider** The integrated file should contain a mental health act divider.
9	**Paperwork** The documentation should confirm that the Mental Health Act documentation is filed correctly.

Goblygiadau Strategol / Strategy Implications

Detentions under the Mental Health Act require ongoing monitoring. All documents and pathways to give consideration of the appropriateness, and aligned with a least restrictive pathway for our patients.

The Mental Health Act specifies the statutory duties that the Health Board must adhere to when depriving people of their liberty by detention.

Opsiynau a ystyriwyd / Options considered

Not applicable

Goblygiadau Ariannol / Financial Implications

There are no financial implications associated with undertaking the audit. Financial implications potentially would occur if a detention was invalid.

Dadansoddiad Risk / Risk Analysis

Risks are associated with sections not being enacted correctly and patients detentions deemed invalid. Patients have the right to be aware of their detention and the processes available to them to appeal their detentions.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Health Board must adhere to the statutory duties as set out in the Mental Health Act.

APPENDIX 1

Mental Health and Learning Disabilities Division

Compliance with the Mental Health Act

Quarterly Audit Results – June 2022

SUMMARY

There have been a number of improvements seen this audit but also a number of reductions in compliance.

Standards 6 and 7 have improved with standard 6 reaching 100% compliance this quarter.

Standard 2 and 3 have shown an improvement overall but it is acknowledged there is still work to be conducted for some units. The use of old forms has contributed to the reduction of compliance for standard 4 and administrative issues in relation to good housekeeping of the files has had a significant impact on standard 1, 8 and 9. Issues for each unit have been highlighted to those responsible and escalated as necessary

Documents which were reported as missing were identified within a matter of hours or completed, all actions have since been addressed.

The audit results will be shared with the managers following the submission to the Mental Health Capacity and Compliance Committee.

Each unit is detailed within the audit in relation to the nine standards.

Number	Standard
1	**Section papers** The correspondence file and case notes should contain the same detention paperwork.
2	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.
3	**Explanation of Rights** The correspondence file and case notes should contain the same document.
4	**Explanation of Rights** The patient should be made aware of their rights in their primary language
5	**Explanation of Rights** The patient should be offered a referral to IMHA services
6	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.
7	**Care and Treatment Plan** The integrated file should contain an up to date Care and Treatment Plan.
8	**Mental Health Act Divider** The integrated file should contain a mental health act divider.
9	**Paperwork** The documentation should confirm that the Mental Health Act documentation is filed correctly.

The tables detail comparison to the previous audits showing an upward, downward or no change result.

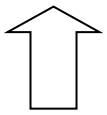
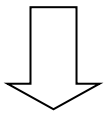
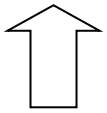
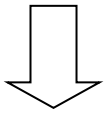
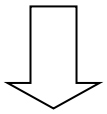
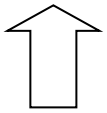
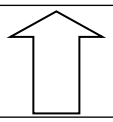
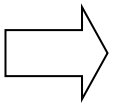
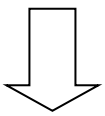
In May/June eight of the units were audited. All detained patients' files were scrutinised and cross-referenced with the Mental Health Act correspondence files held by the Mental Health Act area office.

51 files were scrutinised:

Specialism and Unit	Number of files scrutinised
Older Persons	
Cefni Hospital	11
Bryn Hesketh	5
Rehabilitation	
Tan Y Castell	6
Coed Celyn	2
Carreg Fawr	6
Forensic	
Ty Llywelyn	15

Specialism and Unit	Number of files scrutinised
Learning Disability Villas	
Tan Y Coed	0
Foelas	0
Mesen Fach	4
CAMHS	
North Wales Adolescent Service	2

1 Cefni

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**81.8%**	**18.2%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**54.5%**	**45.5%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**81.8%**	**18.2%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**63.6%**	**36.4%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**72.7%**	**27.3%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**72.7%**	**27.3%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**63.6%**	**36.4%**	

NOTES

There has been an improvement in the Care and Treatment plans within the files since the last audit. A number of documents did not match with the MHA office and the unit in relation to S17 and Explanation of rights, these were copied and corrected on the day.

2 Bryn Hesketh

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	⇨
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**60%**	**40%**	⇩
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	⇧
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**0%**	⇧
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	⇨
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	⇨
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**0%**	⇧
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**		⇨
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**		⇨

NOTES

There has been continued improvement in relation to the standards for Bryn Hesketh. Missing S17s have now been shared.

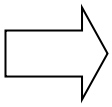
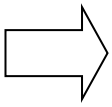
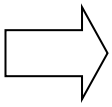
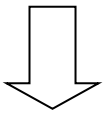
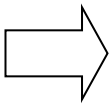
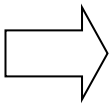
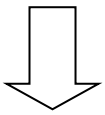
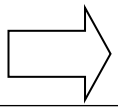
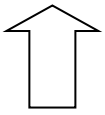
3 Tan Y Castell

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	⇨
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	⇨
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	⇨
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**0%**	⇨
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	⇨
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	⇨
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**83.3%**	**16.7%**	⇧
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	⇨
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	⇨

NOTES

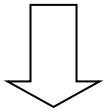
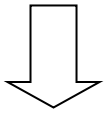
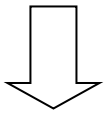
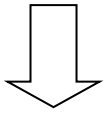
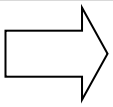
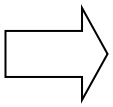
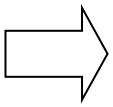
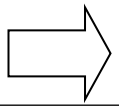
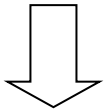
Tan Y Castell continue to maintain a high standard of functions and documents under the Mental Health Act, there was an improvement in relation to CTPs with all now being updated.

4 Coed Celyn

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**50%**	**50%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**50%**	**50%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES
Coed Celyn has made improvements in relation to the storage of documentation in the files, and continues to maintain a high standard for majority of the areas audited.

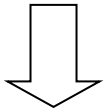
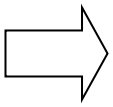
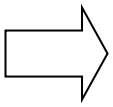
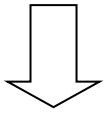
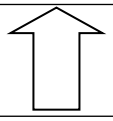
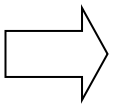
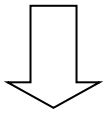
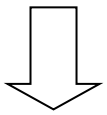
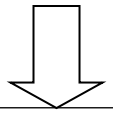
5 Carreg Fawr

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**50%**	**50%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**83.3%**	**16.7%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**50%**	**50%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**16.7%**	**83.3%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**66.7%**	**33.3%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**66.7%**	**33.3%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**66.7%**	**33.3%**	

NOTES

Carreg Fawr has seen a fall in its compliance with a number of the standards. For a short time they were supported by the MHA office but due to staffing this has not been possible over the last reporting period. It is required to be acknowledged that the standards are not the responsibility of the MHA office and should be being upheld by the ward staff and the ward clerk. This has been raised with the Clinical Site Manager.

6 Ty Llywelyn

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**66.7%**	**33.3%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**60%**	**40%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**80%**	**20%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**86.7%**	**13.3%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**40%**	**60%**	

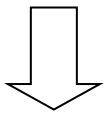
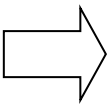
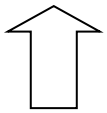
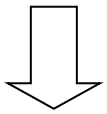
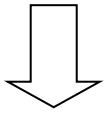
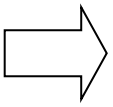
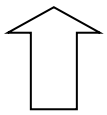
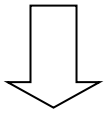
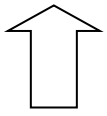
NOTES

The Mental Health Measure Department confirmed the unit is 100% compliant with their CTPs the up to date documents have now been printed by the ward managers for the files.

Filing is having a significant impact on the unit and the outcome of the audit this has been raised with the Administrative Manager as a number of safeguards were previously put in place to ensure the correct mental health act documentation was in the current files.

The use of an obsolete form affected the outcome for the Explanation of Rights and primary language standard.

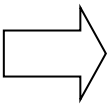
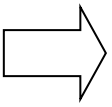
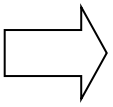
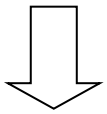
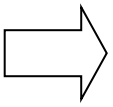
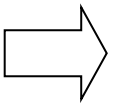
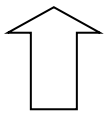
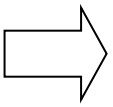
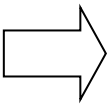
7 Mesen Fach

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**50%**	**50%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**75%**	**25%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**75%**	**25%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**0%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**75%**	**25%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**50%**	**50%**	

NOTES

There were section papers missing from files this has been corrected. The use of an old explanation of rights form affected standard 4. The missing divider was inserted at the time of the audit.

8 CAMHS – North Wales Adolescent Service

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**0%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**0%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**50%**	**50%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**0%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**0%**	
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	**0%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**0%**	

NOTES

NWAS continues to maintain high standards with MHA documentation. It was not documented on a form if the young person had received their rights in their primary language which affected standard 4.

Combined Results

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**76.4%**	**23.6%**	⇩
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**84.3%**	**15.7%**	⇧
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**92.2%**	**7.8%**	⇧
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**64.7%**	**35.3%**	⇩
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**92.2%**	**7.8%**	⇩
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**0%**	⇧
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**80.4%**	**19.6%**	⇧
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**90.2%**	**9.8%**	⇩
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**66.7%**	**33.3%**	⇩

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee 29.07.2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Healthcare Inspectorate Wales (HIW) Monitory Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Acting Associate Director Of Quality Assurance, Patient Safety and Experience
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience
Atodiadau Appendices:	Appendix 1 – Inspections Appendix 2 – Quality Check Summary BCUHB

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	√	**Ar gyfer sicrwydd For Assurance**	√	**Er gwybodaeth For Information**	√

Sefyllfa / Situation:

The paper (Appendix 1) provides an update in relation to the inspections conducted by Healthcare Inspectorate Wales (HIW) covering a period of 12 months. New and updated inspections are included.

HIW conducted a Quality Check Summary in relation to Foelas Ward on the Bryn Y Neuadd site in February 2022.

Cefndir / Background:

HIW is the independent inspectorate and regulator of all health care in Wales.

HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board, considering how the services are meeting the Health and care Standards 2015.

HIW note within their reports their purpose is '*to check that people in Wales receive good quality healthcare*'. Their values include placing patients at the heart of what they do and they are:

- Independent, Objective, Caring, Collaborate and Authoritative.

Through the inspections and their work they aim to provide assurance, promote improvement and influence policy and standards.

This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act and relevant issues highlighted under 3.1 Safe and Clinically Effective Care are followed up appropriately.

Asesiad / Assessment & Analysis

Strategy Implications
The Health Boards Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is around the quality of patient experience, the delivery of safe and, the effective care and, the quality of management and leadership.

Options Considered
Not applicable for this report.

Financial Implications
Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act and Mental Health Measure) require no financial consideration at present.

Risk Analysis
Outstanding HIW Actions are reviewed within the MHLD division area Quality Safety and Experience (QSE) meetings on a monthly basis.
Policies –Policies regularly require updating and change as statute and documents change.

The MHLD Policy Implementation Group is working to ensure policies are kept up to date and reviewed by appropriate personnel. This is reported monthly to the MHLD Senior Leadership Team QSE meeting, and reported up to the Health Board QSE committee meetings.

Legal and Compliance
The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.

Impact Assessment
This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.

Inspections within the last 12 months

New inspections, publications and updates.

1 Quality Check Summary BCUHB (Foelas Ward) NEW

Activity Date: 28 February 2022

Publication Date: 22 April 2022

HIW undertook a remote quality check for the eight bedded learning disability ward, Foelas.

Specific focus was around risk of infections and Covid 19, changes that have been made to the environment to ensure it is safe and suitable, confirmation the Health Board is meeting the needs of our Welsh speaking patients, equality and rights.

In relation to the Mental Health Act and Deprivation of Liberty Safeguards (DOLS), HIW required assurance on how the Health Board was discharging its duty of care and how the patients' rights are being safeguarded. No areas of improvement were identified under the governance of the Mental Health Act or DOLS.

2 Unannounced Visit: Tan Y Coed Villa, Bryn Y Neuadd UPDATE

Inspection Date: 19 – 20 October 2021

Publication Date: 21 January 2022

The unannounced visit was confirmed to be routine and not in response to any concerns, there were no immediate improvements required.

The report details a positive patient experience was evident with good levels of safe and effective care delivered to the patients, recommendations for improvement were suggested to strengthen existing practice in line with the Health and Care Standards. It is noted there was evidence of a well-established management team, a committed workforce and sound local governance arrangements.

There was no reference to the Mental Health Act within the report but in regards to patients' rights it was noted all patients had access to advocacy services and patient and family involvement was encouraged.

An area of improvement was noted regarding care and treatment plans and the sharing with patients and relatives.

The below actions which link in with the Mental Health Act are in relation to 3.1 Safe and Clinically Effective Care.

Improvement needed	Service Action	Responsible Officer	Timescale
The health Board must undertake an audit of the care and treatment plans on the unit, with a view to: • Ensuring that plans and objective are goal and person centred. • Ensuring evidence relating to care and treatment is appropriately and clearly documented at all times.	Each patient on the ward will have a CTP review led by their Care Coordinator and MDT to ensure that plans and objectives demonstrate positive goal planning and are person centred. CTPs will be reviewed monthly by the Care Coordinator to ensure evidence is provided against outcomes identified. 24/05/2022 This has been reviewed by inpatients, work is required to look at how the acre coordinator reviewed these, from the community teams. Tan Y Coed are due to conduct individual care planning meetings, where care coordinators can review the CTP together with the MDT including the individual. 20/06/2022 Cycle of Review of C&T plans has been agreed and is in place. Care Coordinators are supporting individuals in ensuring the Care and Treatment plans are reflective of their needs and delivered in a timely manner. Senior Leadership Team are ensuring CC are confident in delivering on this Action. A further audit of C&T plans will be undertaken By 22/07/2022 to ensure compliance with agreed action.	Ward Manager. Matron. Head of Nursing.	February 2022
The Health Board must ensure that care and treatment plans have been made accessible and communicated appropriately to patients (and relatives where applicable).	Care Coordinators will ensure that patients or their representatives are part of the development of their CTP, and that accessibility and understanding are key to the implementation of care. Utilising inpatient forums, patients will support services to develop a more inclusive approach, to make care planning documentation accessible to patients across site.	Head of Nursing	February 2022

	Update 24/05/2022 an expression of interest has been communicated to staff in TYC to look at how we develop PCP documentation within all areas, to ensure that we move forward in this area Care and Treatment Plans will be routinely shared with patients where effective and with relatives or representatives where appropriate. Ongoing work required to ensure Patients who do not engage in their own C&TPs are supported to understand how we are providing support to them.		
The health Board must explore how one-to-one observations can be strengthened to ensure that they are consistently used as an active and positive form of engagement.	A programme of work is being undertaken across the Division to enhance positive engagement as outlined in the Therapeutic Observation Policy. Therapeutic observation documentation will be audited monthly aligned to the policy and will feed into MDT meetings to inform CTP planning and effectiveness of one-to-one support, engaging patients as part of their treatment journey. Best practice around activity scheduling and therapeutic engagement to be used to inform CTPs. 24/05/2022 update. Early outcomes from the audit are that the documentation meets the required standards however, there is further required to ensure that therapeutic engagement is utilised to inform CTPs. Now that the Therapeutic Support Service is again fully functional and with the reduction in Covid alert levels in the local communities, patients are again able to access community based activities and opportunities. We have recently introduced the monthly audit of therapeutic observation plans, recommended is 6 monthly. To further improve in this area, and to ensure that we continually improve quality.	Ward Manager. Matron. Head of Nursing LD.	February 2022

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary
Betsi Cadwaladr University Health Board - 21101
Activity date: 28 February 2022

Publication date: 22 April 2022

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

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

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Healthcare Inspectorate Wales
Welsh Government
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Merthyr Tydfil
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Website: www.hiw.org.uk

Digital ISBN 978-1-80364-092-1

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check within Betsi Cadwaladr University Health Board as part of its programme of assurance work. The setting is an eight bedded learning disability ward, located within Betsi Cadwaladr University Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015.

Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

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

We spoke to members of the ward staff on 28/02/2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- **How is the risk of infection assessed and managed to keep patients, visitors and staff safe?**
- **How do you identify and effectively manage COVID-19 outbreaks / nosocomial transmission?**
- **How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made as a result of COVID-19 to the following:**
    - **Physical environment**
    - **Routines, visiting arrangements and contact with loved ones**
    - **Behaviour management**
    - **Patient access to community/leave, activities and social networks (including formal leave where the Mental Health Act applies)?**
- **How do you meet the needs of Welsh speaking patients when accessing healthcare services in the medium of Welsh?**
- **How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider health and care professionals where needed?**

- **How do you ensure that equality and a rights based approach are embedded across the service?**
- **What arrangements are in place to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) discussion and decision making is undertaken appropriately and sensitively?**
- **Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and DOLS legislation, and how are patients' rights being safeguarded?**

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors.

The key documents we reviewed included:

- Most recent environmental risk assessment/audit
- Monthly incident theme review - last 6 months
- Monthly use of restraint and seclusion review (please specify types of restraint used: physical/mechanical/use of medication) - last 6 months
- Risk assessment for mechanical restraint

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We asked staff about the changes that had been made to the ward environment as a result of COVID- 19. They informed us that additional cleaning has been implemented, with staff members responsible for keeping designated areas clean whilst on shift. In addition, all flyers on the patient noticeboard have all been laminated to make them easy to clean.

Staff informed us that most of the off- site therapeutic support services were suspended due to COVID. As a result, many activities were introduced on the ward for patients including cooking, gardening, board games and a projection screen for films.

We were also told that most visiting was stopped as a result of COVID, and was only permitted for end of life patients. Such visits were 20 minutes long and those visiting would enter through a back entrance, wearing full personal protective equipment (PPE). Due to the limited understanding of patients on the ward, some took longer to adjust to family members not being able to visit. Staff informed us that they used video call as much as possible, in

order to maintain contact between patients and their families. Staff have since been able to support patients to have visits off site in their family's homes. They also have use of a room in a different part of the hospital, where socially distanced visits can take place, depending on individual's risk assessments. Staff told us they have also ordered a gazebo to allow for visits in the garden in the summer months.

Staff told us that, even though they make every effort to socially distance from each other, patients find this difficult. Some will use touch to communicate, such as holding a staff member's hand. However, we were told that most patients don't generally interact with each other and naturally distance from each other. Also, during meal times, chairs are placed at two metre distances at either end of the tables and staff are in the process of swapping the sofas in communal areas to chairs, in order to improve social distancing.

We were informed that most ward staff have had active support training. Each patient has an individual support plan which includes all likes and dislikes of food and activities. Staff highlighted the important of finding what motivates each patient as part of their assessment process. They encourage patients to participate in activities and personal care as much as possible so to help them prepare to leave the ward and go back out into the community. Also, patients are encouraged to do their own shopping. This allows staff to complete capacity and financial assessments of the patients.

We asked staff how staff and patients are kept safe from COVID-19 risks while using transport. They informed us that all three vehicles have their own risk assessments and each patient is also individually risk assessed to use the transport. Masks are to be worn in the vehicles and we were told that one of the vehicles does allow for social distancing. Each vehicle is cleaned after every use and there is also a first aid kit and a level two PPE kit in each.

Staff informed us that positive behaviour support (PBS) plans are used to support patients with challenging behaviour. If restraint is needed, staff will use a less restrictive technique, which staff described as a no pain technique. Staff undertake Violence and Aggression training as part of the training for physical restraint, however we were told that some staff have had problems locating the relevant training on their online system. Senior staff are currently working to resolve this issue.

We were also told that compliance around practical restraint training is low at present due to the training being suspended during the pandemic. This has now been reinstated and new staff are being prioritised, however it is still a slow process due to only six people being able to do the training at a time, in order to maintain social distancing. Staff did also inform us that they have internal trainers for physical intervention training and staff are all compliant with this, having had refresher training last year, and will have it scheduled again this year when due.

We were told that one patient on the ward is currently risk assessed for use of a mechanical restraint. This is to prevent self-harm. According to staff, the use of this restraint has reduced

since the patient has been on the ward, due to them finding alternative ways to show frustrations. Staff informed us that the risk assessment for this patient is reviewed regularly.

Staff informed us that all best interest decisions are made by a multidisciplinary team (MDT), the family members of the patient and the patient themselves, if they are able. Meetings with the MDT and family members occur monthly, however the psychiatrist or psychologist can call additional meetings with the family to discuss diagnosis and care plans. Staff will also ensure family members receive minutes from any meetings they are unable to attend. Families can also contact the ward and ask staff to raise issues at meetings if they are unable to attend.

We were told that some staff are Welsh speakers and they wear relevant badges to indicate this. They are aware of courses available for any other staff wishing to learn Welsh and, due there being small numbers on the wards, patients know which staff members they can go to if they wish to converse in Welsh. Staff also keep a list of all Welsh radio channels for any patients who wish to listen to them. The ward also have access to a translation service, should they require it.

The following areas for improvement were identified:

We saw evidence of a risk assessment for the use of mechanical restraint. Although the risk assessment is detailed and regularly reviewed, we require the following information to be added:

- The rationale use of the mechanical restraint should be included in the introduction. It should also include information relating to the risk if the restraint is not used.
- risk ratings should also be completed through the risk assessment in order to confirm or determine the level of risk
- The risk assessment should also state who the individual decision makers were and should be read and signed off by all staff.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included

- Generic infection control policy and COVID-19 specific policy

- Most recent infection control risk assessment/audit

The following positive evidence was received:

We saw evidence of the infection prevention and control (IPC) policy and COVID-19 specific policy for the ward, as well as the most recent infection control risk assessment. All were complete and up to date.

Staff informed us of the changes implemented as a result of COVID–19. Changes have included minimalizing the ward environment, hand sanitizer dispensers placed throughout the ward, cleaning all areas of the ward at the start and end of each shift and cleaning the shower after each use. We were also told that there are donning and doffing champions on the ward and regular hand washing audits are completed.

Staff wear PPE masks at all times but will increase PPE if there is a COVID positive patient on the ward. There is also the option for them to wear sensitive masks to help prevent skin irritation. All staff have completed donning and doffing training and will also change into their uniform on the ward, and change back at the end of their shift before leaving.

We were informed by staff that all patients have individual risk assessments regarding PPE, however none of them will wear masks on the ward as it can hinder their ability to communicate.

Patients all undertake bi-weekly PCR testing, except for one patients who has two weekly PCR tests and daily LFT tests due to being a transplant patient. Staff must also have a negative LFD test before coming onto shift.

We were told that staff increased discussions with patients around germs and keeping people safe. They also produced easy-to-read documents for patients to help them understand what was going on during the pandemic and how to keep themselves and others safe. Staff also told us that, due to them constantly wearing masks, patients have struggled to read facial expressions. Staff have relied more heavily on Makaton to communicate and have increased their use of pictures and symbols.

Staff told us about the process used during the last COVID positive case on the ward. The patients isolated between their room and a lounge only used by them. Staff wore increased PPE and a specific risk assessment was completed. We were also informed that, at the beginning of each shift, nominated staff members were identified to solely work with this individual in order to prevent cross contamination. Also, this patient was nursed in gowns whilst positive to allow for deep cleaning and to prevent the need for laundry from this patient to be taken to the laundry room.

When asked about how lessons learned are shared, staff informed us that clinical supervisions are often used to share such information. During the first lockdown, staff had socially

distanced group supervisions so they could discuss information updates and how they could learn. Lessons learned are also communicated through 'putting things right' meetings, where minutes from specialist service meetings are also shared.

No areas for improvements were identified.

Governance / Staffing

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed.

The key documents we reviewed included:

- Brief description of the model of care for LD services including details of any residential provision
- Details on the speciality of the ward/service including number of beds and current occupancy
- Management structure (showing reporting lines from setting manager upwards)
- Number of admissions and discharges (3 months)
- "Number of patients subject to DOLS or MHA (list the actual sections patients are detained under)
- Compliance with hospital passport/health profile reviews being in place (any tool that would be passed to secondary care in case of an admission)
- Compliance with Annual Health Checks
- Current staff vacancies (listed by role)
- Current staff sickness (listed by role)
- Monthly staff agency use (3 months)
- Monthly bank staff use (3 months)
- Current percentage completion rates of mandatory training, including patient specific essential training, (listed by individual subject)
- Patient Voice data for the last 3 months
- Escalation policy
- The corporate policy/process to ensure preparedness for future pandemic emergency

The following positive evidence was received:

We saw evidence of detailed staff vacancies and staff sickness listed by role We also saw a comprehensive escalation policy and a policy to prepare for a future pandemic emergency. Both were complete and in date.

We were told that staffing levels are assessed and reviewed regularly to ensure safe staffing. Staff also informed us that bank staff are often used to help cover staff sickness and the need for bank staff increased when 15 members of staff were off sick due to COVID-19.

Staff told us that senior managers can review the online training system and chase up low compliance for mandatory training. In cases of low compliance, ward staff are asked to provide rationale for this. We were also informed that the levels of staff sickness and new staff are currently affecting compliance figures.

When asked about admissions and discharge, staff confirmed that they are still following the health board's COVID-19 policy around this. We were also told that all patients are referred for advocacy and meetings with advocates often take place over MS Teams, due to most working from home. Staff also informed us that the ward has support from the local GP who visits the ward weekly, but will also attend at additional times if needed. They will push to get hospital appointments for patients if needed and are very responsive in replying to emails and phone calls throughout the week.

We asked staff about how ethical dilemmas around individual patient care are considered and how support is sought. Staff gave us the example of the initial ethical dilemma around the decision to use soft restraint for one of the patients. They told us of the good MDT working around this case and that communication was clear between family and staff, resulting in everyone agreeing to the required outcome. In this case the patient didn't have capacity to be involved in the decision, therefore the MDT (including family members) had in depth conversations around best interest in order make the best decision for the individual.

Staff informed us that the deprivation of liberty authorisations (DOLs) are reviewed regularly and dates of such renewals are included in ward rounds. We were told that all renewals sent to Betsi Cadwaladr health board have been completed in a timely manner. Only delay was one that had to be sent to Sussex for renewal.

No areas for improvements were identified.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

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

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

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

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Improvement plan

Setting: 21101 – Betsi Cadwaladr University Health Board

Date of activity: 28/02/2022

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

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

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	We require the risk assessment for the mechanical restraint to include the following information: • The specific use of the mechanical restraint should be included in the introduction. It should also include information relating to the risk if the restraint is not used. • risk ratings should also be completed through the risk assessment in order to confirm or determine the level of risk • The risk assessment should also	Standard 2.1 Managing Risk and Promoting Health and Safety	To review the risk assessment for the mechanical restraint, to include the requested information.	Matron. Ward Manager.	Completed. Risk assessment reviewed to include the required information on the 29/03/2022. Signed by the full MDT.

	state who the individual decision makers were and should be signed off by all staff.				

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

Name: William Haydn Williams

Date: 30/03/2022

Cyfarfod a dyddiad: Meeting and date:	**Mental Health and Capacity Compliance Committee 29.07.2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Power of Discharge Group Chairs Assurance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Awdur yr Adroddiad Report Author:	Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Hilary Owen, Head of Governance and Compliance MHLD Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience.
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Committee is asked to **note** the report.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

This report does not inform strategic decisions, it relates to the Power of Discharge Group which meets quarterly to discuss the day to day operations of the Associate Hospital Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.

Sefyllfa / Situation:

The Power of Discharge Group is held on a quarterly basis to review the Associate Hospital Managers activity within the Health Board for a detailed period. The Chair's assurance report informs any issues of significance that require consideration by the Mental Health Capacity and Compliance Committee. The report discussed within the meeting covers a four month time period due to a change in dates and submission of documentation to the Mental Health Capacity and Compliance Committee.

Cefndir / Background:

Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'. In Wales, NHS hospitals are managed by Local Health Boards. The Local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.

Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are

detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)

In practice, most of the decisions the Hospital Managers take, are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)

In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels. They are directly accountable to the Board in the execution of their delegated functions. (CoPW 37.6).

The Power of Discharge Group is held on a quarterly basis, attended by ten appointed Associate Hospital Managers, Head of Governance and Compliance, Director of Nursing MHLD, Director of MHLD and the Mental Health Act Manager.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The use of the Mental Health Act is determined by patient needs, and the least restrictive option is at the forefront of all professional practice. The Associate Hospital Managers have a duty as independent persons to ensure that the Health Board only detains patients who meet the criteria for detention. The Power of Discharge Group enables the Associate Hospital Managers to review their activity over the quarterly period reported.

The Power of Discharge Group meeting was held on the 17th of June 2022. this meeting was not quorate, however as the number of Associate Hospital Managers was greater than the number of health board representatives (4:2), it was agreed that the meeting should proceed, noting that no major decisions were to be taken, it was felt due to the meeting being rescheduled this had impacted on the attendance on the day.

Discussions included:

- Electronic support for the Associate Hospital Managers.
- Power of Discharge Vacancy (*Hugh Jones has stepped down)*.
- Terms of reference and being quorate.
- The Associate Hospital Manager update report.
- The MHA performance report submitted for information only.
- The patient's choice regarding how a hearing is held.
- Patient's rights and documentation linked with the scrutiny conducted by the Associate Hospital Managers.
- Mental Health Act staffing.
- Associate Hospital Manager fees.
- Expressions of interest for the Mental Health Capacity and Compliance Committee.

The group felt the following areas required escalation and highlighting to the Mental Health Capacity and Compliance Committee.

- **Power of Discharge Group Members**
  Hugh Jones

Hugh Jones a longstanding member of the Power of Discharge Group has stepped down due to an intention to move to Mid Wales later within the year. Hugh was appointed as an Associate Hospital Manager in 2009 his resignation will be tendered at the point of his moving. It was noted Hugh will be thanked for his commitment to the POD Group, and has agreed to provide a testimonial regarding the Associate Hospital Managers role and his experience to be used as part of the recruitment pack for new members.

Laurence Naggs
A notice to retire has been received from Laurence Naggs. Laurence joined us in 2018 as an Associate Hospital Manager but stepped down from hearings due to challenges with technology during the Covid pandemic.

- **Electronic support for Associate Hospital Managers**
  Approval has been received in regards to supplying the Associate Hospital Managers with a laptop or IPAD dependent on their choice, this will be progressed following which the service will transfer reports via the NHS email rather than sending via the post, this move is positive in protecting patients data and confidentiality and will also support the managers in accessing training and updates in relation to the Health Board.

- **Hearings – face to face and virtual**
  It was confirmed that patients will be given the choice of how they wish to have their hearings held either face to face or virtually. The patient is key in this process and their views and wishes will be addressed. Virtual hearings will be held if a patient does not wish to attend their hearing and is not contesting due to time and financial effectiveness. This process will be monitored and feedback gathered.

- **Patient's Rights**
  It was acknowledged from a recent incident in the Ablett Unit that there are areas/wards within the Health Board where there is still work to be done around ensuring patients receive their rights in a timely manner. There were a number of issues highlighted and investigations are ongoing. There are some processes currently in place to assist but it is acknowledged that further work is required. Associate Hospital Managers can assist with this when conducting scrutiny.

- **Mental Health Act Staffing**
  The staffing is now up to full complement with the welcome addition of a CAMHS Mental Health Act Administrator to support children's services in training and contact between the acute hospitals and mental health services.

- **Reduction in Mental Health Act errors**
  It was noted that again we have seen a reduction in the number of rectifiable errors made within the Health Board and are no longer the outlier within Wales as reported in the All Wales Benchmarking Report (Jan- March 22).

- **Associate Hospital Manager fees**
  An agreement in principle was made at the Mental Health Divisional Senior Leadership Team meeting to increase the fees. As MHLD are no longer the budget holders for the Managers this has escalated to the Interim Director of the Quality Directorate for financial approval.

- **POD representative for the Mental Health Capacity and Compliance Committee**

Expressions of Interest to join Helena Thomas have been requested as a second representative for the MHCCC.

Opsiynau a ystyriwyd / Options considered

Not applicable for this report the functions of the Associate Hospital Managers are governed by legislation, the Associate Hospital Manager panels are a requirement of the law.

The Power of Discharge Group is to be held on a quarterly basis to allow for reporting to the Mental Health Capacity and Compliance Committee.

Goblygiadau Ariannol / Financial Implications

None noted within this report.

Dadansoddiad Risk / Risk Analysis

The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level.

The Power of Discharge Group membership includes ten appointed Associate Hospital Managers and a number of staff from the Health Board. It is a requirement of the Group that the number of Associate Hospital Managers in attendance should not be less than those attending as representatives of the Health Board.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.

Asesiad Effaith / Impact Assessment

All policies in relation to the Associate Hospital Managers have been equality impact assessed.