Bundle Mental Health and Capacity Compliance Committee 10 February 2023

1 OPENING ADMINISTRATION

1.1 MHA1 - Welcome, introductions and apologies for absence - Chair - Information - Verbal report

1.2 MHA2 - Declarations of interest on current agenda - Chair - Decision - Verbal Report

1.3 MHA3 - Minutes of last meeting – 4 November 2022 - Chair - Decision - Paper

- Draft MHAC Minutes 4.11.22 - V0.2.docx

1.4 MHA4 - Action log - Chair - Decision - Paper

- Table of actions - updated 08.02.23.doc

1.5 MHA5 - Patient Story - Acting Associate Director of Quality, Patient Safety and Experience - Information - Paper

Item withdrawn

1.6 MHA6 - Terms of Reference - Associate Director of Governance - Decision - Paper

Item withdrawn

2 STRATEGY

2.1 MHA7 - Approval of All Wales Approved Clinicians and Section12 (2) Doctors - Executive Medical Director - Consent - Paper

- 7 - All Wales AC and S12 Report FV - Feb 2023 MHCC Committee meeting.pdf

2.2 MHA8 - Update on reforming the Mental Health Act - Divisional Director of Mental Health and Disability Service - Information - Verbal

3 QUALITY SAFETY AND PERFORMANCE

3.1 MHA9 - Deprivation of Liberty Safeguards Quarterly Report - Director Of Safeguarding and Public Protection - Assurance - Paper

- 9 - MHCC Committee DoLS MCA LPS Report and Action Plan Q3.docx

3.2 MHA10 - Associate Hospital Managers' update Report - Mental Health Act Manager - Assurance - Paper

- 10 - Associate Hospital Managers Update Report - Cover Paper.docx
- 10.1 - Appendix 1 - Associate Hospital Managers Update Report.docx
- 10.2 - Appendix 2 - AHM Scrutiny Report 2022 FINAL.doc

3.3 MHA11 - Mental Health Act Performance Report - Mental Health Act Manager - Assurance - Paper

- 11 - MHA Performance Report - MHCACC Cover Paper.docx
- 11.1 - Appendix 1 - MHAct Report.pdf
- 11.2 - Appendix 2 - S136 BCUHB Report Dec 22.pdf
- 11.3 - Appendix 3 - S136 BCUHB Report Dec 22.pdf

3.4 MHA12 - Mental Health Legislation Risk Register - Assistant Director of Information Governance & Risk - Assurance - Paper

Paper to follow

- 12 - MHCCC Committee Coversheet - Corporate Risk Register v4.0.docx
- 12.1 - MHACC Appendix 1.docx
- 12.2 - Appendix 2 - Newly Escalated risks.docx
- 12.3 - Appendix 3 - Full List Corporate Risks (002).docx
- 12.4 - Appendix 4 Risk Key Field Guidance V2-Final.docx

3.5 MHA13 - Criminal Justice Liaison Report - Criminal Justice Liaison Manager - Assurance - Paper

- 13 - Criminal Justice Liaison update report - MHCACC Cover Sheet.docx
- 13.1 - Appendix 1 - Criminal Justice Liaison update report (MHCACC).docx

3.6 MHA14 - Restraints Report (Mental Health Act) - Director of Mental Health - Assurance - Paper

- 14. - Cover Paper Restraints Report - MHCACC 01.02.23.docx
- 14.1 - Appendix 1 - Update Report MHCACC 01.02.2023.docx
- 14.2- Appendix 2 - Terms of Reference and Operating Arrangements.docx
- 14.3 - Appendix 3 - PICCS Feedback.docx

3.7 MHA15 - Court of Protection Report - Criminal Justice Liaison Manager - Assurance - Paper

15 - MHCCC - Feb 2023 - Court of Protection.docx

3.8 MHA16 - Section 17 Leave Policy - Divisional Director of Mental Health and Disability Service - Approval - Paper

16 - Mental Health Act Section 17 Policy - Cover Paper.docx

16.1 - Appendix 1 - BCU EQIA - S17 Leave of Absence Policy V3.docx

16.2 - Appendix 2 - MHLD 0044 Section 17 Leave of Absence Policy v4 Review.doc

4 LEARNING FROM THE PAST

4.1 MHA17 - Quarterly Mental Health Act rolling Audit Report - Mental Health Act Manager - Assurance - Paper

17 - Audit Report - MHCACC Cover Paper.docx

17.1 - Appendix 1 - Compliance with the Mental Health Act Quarterly Audit 2021 - 2022.docx

4.2 MHA18 - Consideration of any HIW/Inspection Reports/Audit Reports - Acting Associate Director of Quality, Patient Safety and Experience - Assurance - Paper

18 - Healthcare Inspectorate Wales (HIW) Monitoring Report - MHCACC Cover Paper.docx

5 CHAIR'S ASSURANCE REPORT

5.1 MHA19- Chair's Assurance Reports - Information - Paper

• *Power of Discharge Group Chairs*

19 - POD Chairs Assurance Report.docx

19.1 - Appendix 1 - Power of Discharge Group 13012023.docx

6 CLOSING BUSINESS

6.1 MHA20 - Issues Discussed in Previous Private Session Chair - Assurance - Verbal

6.2 MHA21 - Date of Next Meeting – 18 March 2023 - Chair - Information - Verbal

6.3 MHA22 - Exclusion of Press and Public - Chair - Information - Verbal

Mental Health Act Committee (MHAC)
DRAFT Minutes of the meeting held on 4.11.22 via Teams

Present:	
Lucy Reid	Health Board Vice Chair (Chair)
Cheryl Carlisle	Independent Member
John Gallanders	Independent Member
In Attendance:	
Louise Bell	Assistant Director Mental Health
Louise Cunliffe	(Observing)
Michelle Denwood	Director of Safeguarding and Public Protection
Matt Joyce	The Deputy Director of Quality
Wendy Lapin	The Mental Health Act Manager
Paul Lumsdon	Interim Director of Nursing
Chris Lynes	Deputy Director of Nursing
Phil Meakin	Associate Director of Governance
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (Minutes)
Peter Roots	Clinical Director / CAMHS Consultant Psychiatrist
Alberto Saimoiraghi	Consultant Psychiatrist/Medical Director
Helena Thomas	HEIW

Agenda item	**Action**
MHA22/46 Welcome and apologies **MHA22/46.1** The Chair welcomed everyone to the meeting. **MHA22/46.2** Apologies were received from Chris Stockport, Executive Director of Transformation and Planning, Angela Wood, Executive Director of Nursing and Midwifery, Iain Wilkie, Interim Director of Mental Health. **MHA22/46.3** The Consultant Psychiatrist/Medical Director advised that he needed to leave the meeting between 10:00 – 10:45.	
MHA22/47 Declarations of Interest **MHA22/47.1** No declarations of interest were received.	
MHA22/48 Minutes of the last meeting held on 29.7.22 to be approved. **MHA22/48.1** The minutes were approved as an accurate record of the meeting held on 29 July 2022.	

MHA22/49 Action Log **MHAC22/49.1** The summary action log was reviewed and updated accordingly.	
MHA22/50 Patient Story **MHA22/50.1** The Committee received a carer story highlighting the difficulties she experienced while caring for her husband with dementia, the deterioration of his condition and interactions with the Mental Health Team. **MHA22/50.2** The Committee noted that to ensure the voice of an un-paid carer was heard, the Patient and Carer Experience Team continue to capture carer stories to share with services for learning. **MHA22/50.3** NEWCIS and Carers Outreach are now based in the PALS Hubs across sites weekly, working very closely with PALS to promote their services to both patients and carers. **MHA22/50.4** BCUHB are currently in discussions with Carers Trust about looking to pilot the Triangle of Care model within the Health Board. A model that is currently being followed by English NHS Trusts but not in Wales so the Health Board would be the first to roll this model of good practise out. The Triangle of Care model is an approach to involve carers in at the earliest stages possible in the patients care. We would look to pilot this within the mental health service initially. **MHA22/50.5** Independent Members raised concerns at the case presented to them questioning where the carers assessment had been but noting what was now in place to ensure this did not happen again. **MHA22/50.6** The Deputy Director of Quality advised that the Triangle of Care model being trailed in the Health Board would be the first time this had been seen in Wales. **MHA22/50.7** An Independent Member queried if those from the third sector carers services sitting within the discharge teams were being utilised. The point of practical help for carers was highlighted rather than leaflets. **MHA22/50.8** It was agreed that an example of carers using the Mental Health Services should be brought back under the Patient and Carers Experience Report to the March QSE. **MHA22/50.9** It was agreed that the CAMHS update paper should be put in the right place within the agenda pack.	 MJ PPJ
MHA22/51 Approval of All Wales Approved Clinicians and Section 12 (2) Doctors – Executive Medical Director	

MHA22/51 The Committee noted for assurance purposes that appropriate governance arrangements, processes and activities were in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.	
MHA22/53 Deprivation of Liberty Safeguards quarterly report **MHA22/53.1** The Director of Safeguarding presented the quarterly report noting that Welsh Government money was being used, that there was an improvement on the back log of Deprivation of Liberty applications and that on a national footprint the Health Board was the most improved. Detail was shared about the inaccuracies and errors in documentation and how this was being acted upon immediately. **MHA22/53.2** A discussion took place around a Court of Protection Deprivation of Liberty case noting that a plan is in place to review governance at the forthcoming Local Partnership Forum. **MHA22/53.3** Attendees discussed the training programme from Welsh Government noting that the final code of practice was yet to be agreed. **MHA22/53.4** A discussion took place around the delays in dealing with the Deprivation of Liberty's, staffing, funding implications including the IMNCA grant. **MHA22/53.5** It was resolved that the Committee: 1. Accepted the Deprivation of Liberty Safeguards Quarterly Report and the identified activity for the period of Q2 2022-23. 2. Received the Deprivation of Liberty Safeguards Action Plan and progress. 3. Accepted the position in preparation for the implementation of Liberty Protection Safeguards (LPS).	
MHA22/54 Associate Hospital Managers Update Report **MHA22/54.1** The Mental Health Act Manager presented the report. It was noted that since July, patients have been asked how they want their hearings to be held, there had been 28. The theme identified within the report was the lack of attendance from the Local Mental Health Teams, which had been raised in the Power of Discharge Chairs Report. The Committee noted that for the next meeting an audit of the patient feedback forms would be included to identify if patients who had attended were happy with the process of the meeting. The Hearing kpi's have improved with 82% of the meetings being held. It was noted that iPad's had been distributed and that it was essential that everyone who needed a laptop should be able to have access to one. **MHA22/54.1 It was resolved** that the Committee noted the report.	
MHA22/55 Mental Health Act Performance Reports	

MHA22/55.1 The Mental Health Act Manager presented the report, highlighting that the report covered a four-month period due to a change in meeting dates. The Committee noted that there had been two lapses in Section 2's which were detailed in the report, doctors had been included in weekly emails to clarify what sections ware due to expire that week, as clinicians were previous excluded. The expired 136 was highlighted and the explanation as to why noted. **MHA22/55.2** The Mental Health Act Manager identified that there had been a decrease in errors and that the benchmarking report highlighted this, the committee noted that the benchmarking report highlighted that the Health Boards Standards were higher. **MHA22/55.3** With regards to 136 suites, it was noted that there had been a number of young people held and that a number of detentions were long. These were being investigated and datixed. Further clarification was highlighted around a couple of very complex cases with a task and finish group being set up to understand the detail and a better pathway. The Interim Director of Nursing and Criminal Justice Liaison Service Manager advised that they would like to be involved in the review. Following discussion, it was agreed that the aim was to ensure that there is the best provision for young people. **MHA22/55.4 It was resolved** that following discussion the Committee noted the report.	
MHA22/56 Mental Health Legislation Risk Register **MHAC22/56.1** The Associate Director of Governance presented the risk register. It was agreed that the level of reporting was not required at the Mental Health Act Committee, only the actual risk as QSE had oversight. The Committee reviewed the risks in appendix 1 and agreed the scoring. The risks relating to ligatures were to be discussed at the December 2022 meeting. **MHAC22/56.1 It was resolved** that the Committee noted the report.	
MHA22/57 Quarterly Mental Health Act rolling Audit Report **MHA22/57.1** The Mental Health Act Manager presented the quarterly Audit Report nothing that there had been some improvement and a few declines, improvements being in the areas of patient's rights being recorded and in their language of choice and that information being visible in their notes. Cefni was seeing a frequent declineand further measures and further input had been given by the Mental Health Act Manager, which upon re-audit, showed vast improvements along with a new Ward Manager. Further detailed feedback was reported on other sites. **MHA22/57.2** The Executive Director of Public Health advised that she was grateful to the team for the additional work that had been put in with the West and that she would liaise with colleagues to give an update on care and treatment plans at the next meeting. No update from TO in Action Log or risk rating **MHA22/57.3 It was resolved** that the Committee noted the report.	TO

MHA22/58 Consideration of any HIW/Inspection reports/Audit reports **MHA22/58.1** The Mental Health Act Manager presented the report noting that updates and monitoring of actions have been included. It was agreed that the report should continue to be received at the Committee until the actions are closed down. The Interim Director of Nursing advised that he would be meeting with the Deputy Director of Quality that afternoon to pick up the outstanding actions to ensure that the learning is in place and replicated across the whole of the Health Board. **MHA22/5.2 It was resolved** that the Committee noted the report.	
MHA22/59 Report on the Use of Restraints **MHA22/59.1** The Interim Director of Nursing presented the report on restraints highlighting that all restraints were reported and broken down, he advised what was lacking was analysis and regular over view. It was noted that the Health Board needed to take a review on how this should be undertaken and look into safe wards as this was the best tool that could be utilised against restraints. The Chair advised that the Corporate Health and Safety team had been involved in restraint work and should be linked in. **MHA22/59.2** The Interim Director of Nursing advised that he would like to pull together a small group with some Terms of Reference to take the matter forward, it was agreed that for Mental Health the group should report into the MHAC but for the wider work it should report into the QSE Committee. **MHA22/59.3** It was resolved that the Committee: • Noted the activity on restraint across Mental Health wards since February 2022 to September 2022. • Recommended the establishment of a MHLD Restraint Reduction Group with the wider report on restraints returning to the QSE Committee	PL
MHA22/60 Policies **MHA22/60.1 Admission to Hospital Policy under Part II of the Mental Health Act 1983** The Chair advised that she felt further work was required with regards to the policy to enable clarity on what circumstances the policy is applied. It was agreed that further work would be done and cleared by Chairs Action if possible. **MHA22/60.2 Section 17 Leave Policy** The Committee reviewed the policy, concern was raised that different settings had different Section 17 Leave Policies and that it would make sense to join them up and have one. It was agreed that internal governance processes would be	

reviewed to ensure that they are correct and return this policy to the next Mental Health Act Committee. **MHA22/60.2 It was resolved** that the Policies were not approved but that the Admission to Hospital Policy may be able to be signed off by Chairs Action and the Section 17 Leave Policy should return to the Committee in February 2023.	
MH22/61 Court of Protection Report **MH22/61.1** The Committee received the report nothing that there was nothing to highlight by way of escalation. The paper described the changes that have been made including the formation of a new legal team. **MH22/61.2** The Committee noted that there were no individual cases to be escalated and all existing ones were being managed and that there were no budgetary implications albeit a significant amount of money is being spent on these matters. **MH22/61.3** The risk on the Risk Register is about last minute requests and further work is being undertaken to strengthen this. It was noted the details of these matters could not be shared in an open meeting, and where appropriate or necessary should return in private. **MH22/61.4** It was noted that there was a learning event taking place Chaired by the Interim Deputy Medical Director which depending upon the outcome could report into either MHAC or QSE. **MH22/61.5 It was resolved** that the Committee noted the report.	
MH22/62 Chair's Assurance Reports **MH22/62.1** The Chairs Assurance Reports were received from the Power or Discharge Group noting that the Terms of Reference had been updated and highlighting expressions of interest. **MH22/62.2 It was resolved** that the Committee approved the Terms of Reference.	
MH22/63 Issues Discussed in Previous Private Session **MH22/63.1** It was noted that there was no private session held at the last meeting.	
MH22/64 Date of next meeting **MH22/64.1** It was noted that the next meeting of the next Mental Health Act Committee would take place on 10 February 2023	

BCUHB Mental Health Capacity and Compliance Committee Table of actions – last updated 08/02/2023 11:55					
No	**Lead**	**Minute reference and action agreed**	**Original timescale**	**Latest update position**	**Revised timescale**
1	Teresa Owen / Gill Harris	**MC22/34.2 Deprivation of Liberty Safeguards Quarterly Report.** The Committee sought assurance that when comments, as noted in the report, state 'can result in non-compliance', that the organisation will not get into non-compliance. TO agreed to take this forward and discuss the process and risks involved, with Gill Harris.	4.10.22	MD and TO to meet.	
2	Wendy Lappin	**MC22/36.1 Mental Health Act Performance Report.** With regards to Wales still using 'wet' signatures and not accepting any digitalized forms using electronic signatures (as used in England), WL was to bring to the next Mental Health Managers' Forum and if no progress made there, agreed to advise TO in order to escalate.	4.10.22	WL updated in the meeting on 4/11/22 noting that WG had advised that due to capacity TO to write to WG on the matter with support from WL **Update 03/02/2023** Information forwarded to TO, WG have stated that they would look at changes to coincide when the MHA is revised and in place.	
3	Iain Wilkie / Alberto Salmoiraghi	**MC22/36.2 Mental Health Act Performance Report.** With regards to paragraph at bottom of Pg. 12 of report (the patient required to remain in ED due to AMHP not attending), the Committee requested assurance that the	1.9.22	WL – The AMHP did not refuse to come out there was no bed, they were going to go when the bed was available – the Datix system was inaccurate. Matt to follow up confusion as to whether there	

		situation had been rectified. The Interim Director, MHLD agreed to clarify the situation with Dr. Alberto Salmoiraghi, on his return from annual leave and provide an update to The Chair.		was a bed available or not. IW believed this is now clarified from the above so no further action is planned. Suggest Close	
4	Iain Wilkie	**MC22/36.3 Mental Health Act Performance Report.** In answer to a query concerning the number of patients who book into ED and leave before support is provided and then re-present with mental health issues which should have been picke/d up at ED, IW confirmed no such data was currently routinely captured at Triage, however he felt it should be and that he would discuss with colleagues the best way to go about this.	4.10.22	This is currently being reviewed with Libby Ryan Davies and herself and key colleagues are seeking to ascertain what information is available in terms of performance reporting and what information can be extrapolated to achieve the required results. This was chased up mid January and is still being worked through.	
5	Gaynor Thomas	**MC22/36.3 Mental Health Act Performance Report.** GT agreed to look at the possible progress in relocating the assessment suite away from the Paediatric ED in YGC		IW is pursuing with the IHC director in Central and will provide an update once actions agreed Currently being discussed by IHC Directors at last check in January. No update from them as yet.	
6	Iain Wilkie	**MC22/36.3 Mental Health Act Performance Report.** Regarding the positioning of an adult Mental Health Assessment area within the Paediatric waiting area at YGC, IW was asked to find out what had been done to mitigate the situation where adults in mental distress, waiting to be assessed,		IW is pursuing with the IHC director in Central and will provide an update once actions agreed Currently being discussed by IHC Directors at last check in January. No update from them as yet.	

		are being placed next to children – as witnessed by a Committee member on an unannounced visit recently. The possibility of relocating the room was discussed.			
7	Teresa Owen	**MHAC22/38.2 Criminal Justice Liaison Report** The Committee was concerned for the service provision and what appeared to be an increase in frequency of evening/early morning incidents and whether to service is meeting when the demand arises. TO agreed to take this concern to Ruth Joyce	4.10.22	This report is on the agenda. Suggest close	
8	Wendy Lappin	**MHAC22/42.3 Quarterly Mental Health Act Rolling Audit Report** WL, noting that the Carreg Fawr ward Manager was putting together a paper with regards to the requirement for administrative support not being allowed to work from home, when paper files were involved, agreed to follow this up to see how this had progressed.		There has been a significant positive increase with regards to Carreg Fawr paperwork – waiting for an update with regards to the ward clerk being on the unit. **Update 03/02/2023** – An SBAR has been created for additional ward clerk support for Forensic services with a plan that some of the hours could be utilised for a day cover at Carreg Fawr. This needs agreement from the forensic SLT.	
4 November 2022					
11	Louise Bell	**MHA22/50 Patient Story** The CAMHS Patient Story Follow up paper to be removed from this section of the agenda bundle and circulated in an appropriate way.		Paper removed from agenda item on 4.11.22. Suggest close	

12	Louise Bell	**MHA22/55 Mental Health Act Performance Reports** LB to include invite those interested to the Task and Finish group being set up out of the rapid learning panel around the use of 136 suites with children.		The task and finish group meetings took place during December 2022 with representation from MHLD, CAMHS and Corporate Safeguarding. All actions from RLP have been addressed. External investigation completed following interviews around specific case of 11 year old in 136 now known to services following social care breakdown (NHSE child looked after in Wales) full report is being complied to respond RLP actions with recommendations from the external investigation . Deadline for submission 17.2.2023.	
13	Teresa Owen	**MHA22/57 Quarterly Mental Health Act rolling Audit Report** With regards to the West, TO to liaise back with AS, IW and the team on care and treatment plans for the next meeting			
14	Paul Lumsdon	**MHA22/59 Report on the Use of Restraints** Once the work PL is completing is undertaken in the round on restraints the element that reflects MH returns to the committee with the wider report to go to QSE		This paper is on the agenda Suggest close	
15	Wendy Lapin	**MHA22/60Policies** Admission to Hospital policy to be reworked following comments made in Committee and shared for Chair's Action		This was returned to Lucy Reid 16/01/2023	

16	Wendy Lapin	**MHA22/60Policies** Section 17 Leave policy to be reworked, governance followed and brought to the Meeting in February for approval.		This policy is on the agenda Suggest close	

RAG Status	
P	Complete
G	On track
A	Slippage on delivery
R	Delivery not on track

Cyfarfod a dyddiad: Meeting and date:	Mental Health, Capacity and Compliance Committee. 10th February 2023
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 Meryl Roberts 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 – 13.10.2022 – 19.1.2023 Appendix 2 – Additions and Removals to the All Wales register of Section 12(2) Doctors – 13.10.2022 – 19.1.2023 Appendix 3 - Breakdown of Section 12(2) GPs currently approved in Wales as at 19.1.2023.

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 November 2022 Induction and Refresher training was held via Webinar. The next induction and refresher training will take place on 7th, 8th and 9th February 2023 and will also be facilitated via Webinar. Training dates have been agreed up to November 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

13th October 2022 to 19th January 2023

New Applications Received:	**3**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	0
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of ACs already approved in England	3
Number of applications approved	3
Number of applications with panel (including portfolios)	0
Number of applications not approved	0
Re-approval Applications Received (5 Yearly):	**27**
Number of applications with panel	2
Number of applications approved	21
Number of applications not approved	0
Number of ACs reinstated	4
Number of approvals which have come to an end:	**12**
Expired	7
Retirement	0
No longer working in Wales	3
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	1
Awaiting CCT	0
Suspended	0
RIP	1
Total Number of Approved Clinicians	**365**
Total Number of Approved Clinicians from previous report	**370**

APPENDIX 2

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

13th October 2022 to 19th January 2023

New Applications Received	**6**
Applications from GPs	0
Applications from Psychiatrists	6
Applications from Forensic Medical Examiners	0
Number of Applications Approved	6
Number of Applications Not Approved	0
Number of Applications with Panel	0
Incomplete Applications	0
Re-approval Applications (5 years)	**6**
Applications from GPs	1
Applications from Psychiatrists	5
Applications from Forensic Medical Examiners	0
Number of Applications Approved	6
Number of Applications Not Approved	0
Number of Applications with Panel	0
Transferred from AC register	**0**
Transferred from England	**1**
Number of Approvals which have come to an end:	**5**
Expiry	2
Become an Approved Clinician	0
No longer working in Wales	1
No longer registered	0
Registered without a licence to practise	1
Retired	1
Under Police Investigation	0
Suspended from Medical Performers' List	0
Total Number of S12(2) Doctors currently approved	**186**
Total Number of S12(2) Doctors from previous report	**184**

APPENDIX 3

Breakdown of Section 12(2) Doctors currently approved in BCUHB As at 19th January 2023:-

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	Independent c/o Home Address	TOTAL
Section 12(2) GPs	3	4	0	0	2	3	N/A	**12**
Section 12(2) Psychiatrists	1	6	5	3	2	12	1	**30**
Approved Clinicians *(Includes non-medics)*	3	16	16	11	13	19	N/A	**78**

Number of 12(2) GPs per Health Board As at 19th January 2023:-

BCUHB	12
ANEURIN BEVAN	5
CARDIFF AND VALE	5
CWM TAF MORGANNWG	0
HYWEL DDA	1
POWYS TEACHING	1
SWANSEA BAY	1

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Capacity and Compliance Committee** 10/02/2023
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA); and the Implementation of the new Liberty Protection Safeguards (LPS) Legislation Q3 Update**
Cyfarwyddwr Cyfrifol: Responsible Director:	Michelle Denwood, Director of Safeguarding and Public Protection Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Hayley Lloyd, DoLS/MCA/LPS Regional Team Manager Chris Walker, Head of Adult Safeguarding (MHLD) supported by Michelle Denwood, Director of Safeguarding and Public Protection
Craffu blaenorol: Prior Scrutiny:	Due to the alignment of the cycles of business, this quarterly report is submitted directly to the MHCCC. Deprivation of Liberty Safeguards is within the portfolio of the Executive Director of Nursing and Midwifery and this update has been reviewed by; Michelle Denwood, Director of Safeguarding and Public Protection; and Angela Wood, Executive Director of Nursing and Midwifery
Atodiadau Appendices:	Appendix 1: Deprivation of Liberty Safeguards/MCA Action Plan Appendix 2: Dissemination of the MCA Materials Appendix 3: Learning from Clinical Case Discussions Appendix 4: Business Case Analysis

Argymhelliad / Recommendation:

The Committee is asked to:

1. Accept the Deprivation of Liberty Safeguards Quarterly Report and the identified activity for the period of Q3 2022-23.
2. Receive the Deprivation of Liberty Safeguards Action Plan and progress.
3. Accept the position in preparation for the implementation of Liberty Protection Safeguards (LPS).
4. To consider the impact of the Corporate Safeguarding Business Case.

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						No	

Sefyllfa / Situation:

Governance

The activity recorded provides oversight and organisational assurance in relation to BCUHB's statutory duty under the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) 2005 for the period of Q3 2022-23. The activity includes key actions and activities to ensure that DoLS/MCA, and the future Liberty Protection Safeguards (LPS) as part of the wider Corporate Safeguarding agenda, remains paramount to service delivery across BCUHB.

Deprivation of Liberty Safeguards reports throughout the organisation in accordance with the Safeguarding Reporting Framework.

This framework reinforces organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group, and key Forums and Committees. As a result of the new BCUHB Operating Model the revised Draft Safeguarding Reporting Framework was presented at the Safeguarding and Governance and Performance group on the 24. 01.2023 for discussion and agreement and is following due process to ensure ratification.

Legislation Activity

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) Code of Practice has been amended to create new statutory regulations known as Liberty Protection Safeguards (LPS). A new Code of Practice and regulations to accompany the Act were due to be in place by October 2022, however due to the delay in receiving the MCA Code of Practice 2005 for England and Wales from UK Government, and the Regulations for Wales from Welsh Government (WG) we await confirmation of the new date for implementation.

On the 21st October 2022 the Welsh Government published a Newsletter on the recent consultation on the draft Regulations for Wales, responses are not expected until March or April 2023. Before publication, Welsh Government have reported there are a considerable number of amendments required to the Regulations for Wales and to the MCA Code of Practice 2005 for Wales and England.

On the 1st December 2022, the National Workforce Group met and all Health Boards and NHS Trusts in Wales discussed their current LPS implementation plans and progress made by each respective organisation relating to DoLS Backlogs (legal term for applications awaiting authorisation) and MCA Training. WG confirmed that further funding will be available in 2023-24 and will be dedicated to address the DoLS Backlog and MCA/LPS activity. WG will communicate the next round of funding and priorities in February 2023.

Current BCUHB Position

In partnership with other Health Boards, the National Workforce Groups aim is to identify areas where preparatory actions can take place while awaiting the new Code of Practice and Regulations. A further meeting is arranged for Q4.

The BCUHB LPS Strategic and Operational Implementation Group held the inaugural meeting in Quarter 1. The Group will meet again at the end of Q4 2022-23. Before we can proceed further, we require further detail by UK and Welsh Government. Monthly Safeguarding MCA/LPS Bulletins providing real time updates on the consultation process.

As previously reported the implementation of LPS will have an impact across all BCUHB services and the need to continue to support all clinical staff to improve their application of the MCA remains vital. This will ensure staff are able to act in accordance with the principles of the Act and evidence operational understanding.

The responsibility for assessment under LPS will be with frontline staff. We continue to await training programmes from the WG (we understand that training programmes have been published for tender by WG). All public service organisations have been given a clear direction that we must not develop individual training programmes.

The key activity for this period remains the delivery and improvement of organisational understanding of the MCA and to address the DoLS backlog. The DoLS backlog is a legal term recognised by the Welsh Government referring to the number of applications awaiting authorisation. The Health Board will look to secure additional time limited funding from WG to support this work from February 2023.

As of the 1st of January 2023 the DoLS Backlog stands at 20 (see table 1). Prior to WG funding the Health Board had a Backlog of 144 cases. The reduction is a testament to the work undertaken by the Corporate Safeguarding Team. Our Best Interest Assessors and Section 12(2) Doctors complete additional DoLS Assessments during evenings and weekends to ensure BCUHB patients are protected by the Legal Framework.

Table 1

Urgent Applications (1-7 Days)	31
Extended Applications (8 - 14 days)	14
Backlog	**20**
Applications Allocated to BIA	19
Applications Allocated to Section 12(2) Doctors	11
Applications Under Scrutiny	2
Applications Pending Authorisation	9

Mental Capacity Act educational materials, items such as banner pens that hold the principles of the MCA, Coffee Mugs with MCA guidance, MCA booklets for employees, MCA easy read guides for patients and carers, posters and other useful resources to promote MCA awareness are now available to all staff. In Quarter 3, we commenced the dissemination of these items across BCUHB as part of the wider Corporate Safeguarding Team's activity during the National Safeguarding Awareness Week. We have included some images in Appendix 2 of BCUHB staff receiving MCA materials, (Authorisation for the photographs is in place).

The response has been extremely positive, resulting in proactive engagement and requests from front line colleagues to access training and initiate discussions.

In late December we were informed that the Mental Health and Learning Disabilities Services had agreed to an increase in the Section 12(2) Approved Doctors fees for Mental Health Act Assessments. This agreement did not include the DoLS Mental Health and Eligibility Assessments. This has resulted in proactive discussions with the aim to gain clarity and agree resolution. For assurance the team liaised with other Health Boards and Local Authorities in Wales to obtain their current fee rates and expectations of the role. We have included the fees as part of our Business Case Analysis in Appendix 4. Further work is required to address the difference in payments and work expectations in NHS organisations in Wales.

Cefndir / Background:

Performance and Activity

It remains evident that the annual trend for DoLS applications is an upward trajectory within BCUHB. This is in line with the National picture.

During Q3 2022/23, a total of 419 DoLS applications were submitted. This is a 14.8% increase on the number of applications submitted during Q2. We can anticipate the overall 2022-23 annual figure to be comparable to 2021-22. **The increase in activity since 2018-19 recorded a 219% increase in activity without any additional investment**.

We are currently reporting a four (4) week delay between receipt of a DoLS application and the subsequent standard authorisation. This position is not unique to BCUHB. Other Health Boards and Local Authorities are in a similar position. Welsh Government have responded to organisational challenges and the financial support offered to address the DoLS Backlog has resulted in a reduction in authorisation times.

Business Case

The Deprivation of Liberty Safeguards Tier 1 Corporate Risk was reported at the Risk Management Group (RMG) on the 4th October 2022. The actions to reduce the risk of an unlawful detention are in response to the risks associated with the increase of activity, complexity, demand within the Court of Protection and the required preparation for the awaited implementation of the Liberty Protection Safeguards and the organisations understanding and lawful application of the Mental Capacity Act.

The Safeguarding Reporting Framework ensures all risks are discussed as a mandatory agenda item in all BCUHB Safeguarding and Public Protection Forums. Welsh Government recognises the risks for all organisations resulting in the potential unlawful detention of service users. As noted in this report, non-recurring monies from the Welsh Government has been received to support NHS organisations to support the reduction of any compliance challenges regarding the legal process, which could result in an unlawful detention.

The Safeguarding/DoLS Business Case is included within the IMPT for Board consideration. Detailed funding requirements have been formally submitted, these have been determined by the current and future activity and progress made regarding the LPS National Code of Practice. This detailed proposal has undergone consultation and obtained financial oversight. In January 2023 we were again asked to review and revise the Business Case which is supported with an implementation plan, which is cross referenced against the risk register and is in line with the organisations cycle of business and will be again considered in February by the Executive Board.

Risk Reduction

Risk ID 2548 CRR21.14. Based upon the proposed implementation of this Business Case the trajectory to support a reduction in the risk associated with DoLS, MCA and LPS is calculated and has demonstrated that we will see a reduction in the risk rating from a score of 20 to an expected risk rating of 12 by May 2023. In August 2023 the trajectory is to achieve a further improved position with a risk rating of 8. However, without additional and recurring financial resources the risk rating will not reduce, as the service requires resources to address the current challenges.

A brief summary of the Corporate Safeguarding Business case has been included under Appendix 4.

Welsh Government (WG) Monies
Non-recurring funding is in place from the Welsh Government to support key activities during Q3 and Q4. WG have also confirmed that non-recurring funding will be available during 2023-24 and 2024-25, in line with a bidding process. To meet WG expectations and due to recruitment challenges, we have developmental opportunities for trained staff within the current team to support the strategic and operational management of the implementation of Liberty Protection Safeguards. However, recurring funding is required to implement initiatives and stabilise the service provision.

As a result of the organisational and staffing challenges the team were unable to maintain a true 24/7 service or undertake a planned scoping exercise in relation to the need for an 'out of hours' MCA support service in Q3. During Q4 the team will undertake a short exercise to evaluate the need for a 24/7 MCA service. An 'out of hours' service will offer an increased level of assurance and provide staff with the necessary support when considering the MCA in practice Our report in Q1 2023-24 will report back on the findings of this activity.

Asesu a Dadansoddi / Assessment & Analysis

Strategic Implications Assessment and Analysis
The following are aligned to the agreed strategic objectives identified within the Corporate Safeguarding Governance and Reporting Activity to support performance and obtain assurance against compliance with Safeguarding legislation and statutory guidance.

DoLS Documentation Audit
The latest audit undertaken in Q3 of the 419 DoLS applications received, demonstrated an improvement in the quality of the paperwork with a 20% reduction in applications having contained some issues resulting in them having to be initially returned to the Managing Authority (Wards).

Analysis
The majority of the issues, in most applications, were minor with minimal amendments required.

The submitted applications continue to identify four (4) main themes.

- No inclusion of the Mental Capacity Assessment Form. The findings from the audit reported in almost all cases the Managing Authority had completed the Form but had included it as part of the initial set of paperwork.
- Mental Capacity Assessments are completed incorrectly. Similar to the omission of Mental Capacity Assessments the forms suffered from minor inaccuracies such as a lack of address, or date of birth. These we resolved immediately by the Managing Authority.
- The DoLS application documentation was not completed correctly. It was reported that it was not signed, and/or was not dated correctly. Again, the oversight was the omission of a signature on the form.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority should provide current medical information. Some detail was included, however to fully adhere to the legal framework the Managing Authority must provide all necessary information. This issue was addressed immediately by the Managing Authorities.

The improvement in the legal paperwork is in line with the dissemination of the MCA materials across BCUHB.

The MCA/DoLS Team play a leading role in the scrutiny of the documentation and this is included within the Corporate Safeguarding Business Case as an area that requires strengthening. A short case study highlighting good practice has been included as Appendix 3.

Training
MCA/DoLS training is delivered on a monthly basis by the MCA/DoLS Team. Where non-compliance or concerns with regard to the completion of paperwork is identified the Team offer bespoke MCA awareness raising sessions delivered directly to the staff and wards.

BCUHB Mandatory MCA Training compliance has seen an improvement during Q3 (see below).

Safeguarding Module	Q2 2022-23	Q3 2022-23	Trajectory
MCA – Level 1	79%	80.1%	↑
MCA – Level 2	79.5%	80.9%	↑

Analysis
Safeguarding training compliance is a key target for Corporate Safeguarding with a targeted approach in place for areas or departments with reduced compliance. A revised virtual training programme is also available and remains in place to encourage ongoing training. MCA training is also included within the mandatory Adult Level 2 Safeguarding Module to utilise all available opportunities.

The additional MCA materials funded by WG appear to have been successful and there appears to be improved knowledge and awareness specific to the MCA in daily practice. The audit undertaken in Q3 2022/23 evidenced improvement with the DoLS paperwork.

Court of Protection (CoP)
The Team respond to and support front line colleagues when cases have been referred to the Court of Protection (CoP) for the following reasons:

- **Section 21A Challenge:** Patients have a right in law to challenge the detention if the patient feels it is unlawful. (Article 5(4) ECHR).
- **Section 16 MCA (2005):** Relating to welfare decisions.

The number and complexity of cases engaged in the Court of Protection arena remains on the increase. Legal challenge has resulted in intensive Court of Protection activity and as a result, external legal services are commissioned in some cases, to support the Court process.

Court of Protection – Deprivation of Liberty (CoP DoL)
A recent case has highlighted the need to strengthen the organisations procedures in relation to CoP DoL cases within community placements. This includes all known and unknown activity specific to the CoP DoL Legal Framework. After undertaking a National scoping exercise, the need to strengthen this activity is not unique to BCUHB.

As part of our ongoing work across BCUHB the MCA/DoLS Team will complete a piece of work to support the development of a Standard Operating Procedure (SoP) to reflect the legislative policy and, to ensure good practice and governance is in place.

Actions to date include:

- Supporting services to complete a comprehensive audit of all patients in community placements to identify where a deprivation of liberty should be authorised. Positive progress has been made.
- Introduced the consideration of a deprivation of liberty as part of the funding panel process ensuring any new packages of care, or changes to packages of care that would require a review of funding or where there is a question relating to the deprivation of liberty or any changes to authorised deprivations are identified.
- Work is ongoing with Legal & Risk Services to develop a bespoke short training package to deliver issue specific training to identified services.
- Work is underway to support the development of a risk management tool to enable appropriate prioritisation of cases and assessment of resources and in addition develop a process for renewing authorisations annually or as required.

. This work will continue during Q4.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications
There are no financial implications for this report. The Safeguarding Business Case is supporting the identification for an increase in financial resource, and is following the organisational process.

Risk Analysis
The risks associated with the Deprivation of Liberty Safeguards are included within the Tier 1 Corporate Risk Register.

Risk CRR21-14. There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients.

Risk Calculation. 4 [major/high] x 5 [almost certain, will undoubtedly happen or recur, possibly frequently] = 20

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

- The Deprivation of Liberty Safeguards Code of Practice supplements the main Mental Capacity Act 2005 Code of Practice.
- The Supreme Court Judgment, P v Cheshire West Council [2014] and P & Q v Surrey County Council [2014] UKSC 19.
- The Supreme Court Judgment D [A Child] judgement given on 26th September 2019.

Asesiad Effaith / Impact Assessment
n/a

Appendix 1

Betsi Cadwaladr University Local Health Board (BCUHB)
Mental Health Capacity and Compliance Committee Report Action Plan 2021-2022

Corporate Safeguarding MCA/DoLS Team (previously completed actions have been removed)

RAG Rating- Red [Red] Out of Time Frame. Amber [Amber] Within Timeframe. Green [Green] Completed.

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	To create a BCUHB Liberty Protection Safeguards (LPS) Implementation Group, which will include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019, **Mental Capacity Act 2005)** and code of practice relating to the LPS.	• Development and Ratification of the LPS ToR. • Engagement in Local, Regional and National meetings/groups: a) LPS Workforce and Training Group b) LPS in relation to 16 and 17 year olds Group c) LPS Monitoring and Reporting Group d) LPS Transition Group e) LPS Welsh Government Strategic Implementation Steering Group NHS Wales LPS/MCA/DoLS Task and Finish Group	CW HL	Update: 13/01/2023 UK and Welsh Government have not provided any LPS updates. National Groups have not reconvened. An 'All Wales' meeting took place on December 1st 2022 to review current progress amongst organisations. The BCUHB Liberty Protection Safeguards (LPS) Implementation Group has agreed ToR and has had an inaugural meeting. The Strategic LPS Implementation Task and Finish Groups will meet again in Q4.	**31.03.2023**	**Amber**

2.0	Implementation of the Safeguarding Business Case to support service delivery and provide a 7 day service.	• Weigh up the benefits and negatives to the costings of providing a seven day service. • Consultation with staff and appropriate services i.e. workforce. • Assessment of staff members, working days, working hours. • Task and Finish Group with agreed reporting framework.	CW HL	Update 13/01/2023 The Corporate Safeguarding Business Case requesting agreement for resources to support a 7 day service has been submitted for Executive and Board approval. Temporary WG monies are to support the implementation of a 7 day MCA service as a pilot in Q1 2023 Financial overview and scrutiny has taken place.	**31.03.2023**	**Amber**
3.0	Engage in the application of BCUHB's IMCA contract to secure geographical IMCA services ahead of the implementation of LPS and in-line with WG guidelines.	• Engagement with National, Regional and Local Groups • Attend the All Wales Provision IMCA Contracts Meetings • Liaise with the BCUHB Procurement and Contract Teams. • Meet with the CADMHAS IMCA Service • Ensure engagement with Local Authorities as BCUHB hold geographical responsibility for the provision of the IMCA Service	CW HL	Update 13/01/2023 The appropriate advocacy service is in place for all individuals who lack capacity. BCUHB to secure additional funding to enable the strengthening of the advocacy service in preparation of the implementation of LPS and in-line with WG guidelines. Q1 2023-24 audit of RPR allocations to be undertaken as this role will end under LPS and will be replaced by the IMCA Service.	**31.03.2024**	**Amber**

				As agreed in the previous MHCC Committee meeting the Target Date has been amended as per WG guidelines.		
4.0	Welsh Government funding, actions and objectives.	• Fund additional Best Interest Assessments to reduce the DoLS Backlog. • Embed MCA training across BCUHB. • Prepare for the implementation of LPS.	CW HL	Update 13/01/2023 This action will be ongoing until March 2025 following confirmation from WG that funding is available for 3 years. We continue to undertake additional DoLS assessments, provide additional training and are engaged in preparations for the implementation of LPS. The MCA/DoLS Team have developed, commissioned and distributed a variety of MCA materials to promote the MCA across BCUHB. As agreed in the previous MHCC Committee meeting the Target Date has been amended as per WG guidelines.	**31.03.2025**	**Amber**

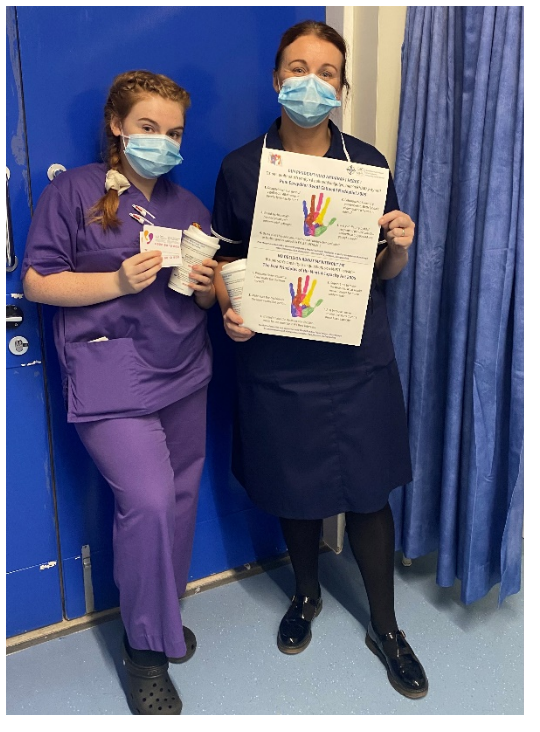
Appendix 1

5.0	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	• Further engagement with commissioning services. • Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients. • Support the development of a protocol to help manage the complex interface between the Mental Health Act and the Mental Capacity Act and review service users accessing Mental Health services (individuals who are not objecting to their care and treatment as defined under the Mental Health Act). • Review the training compliance and provide additional training support to all staff who may have patients' eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors and Commissioned Service Providers	CW HL	Update 13/01/2023 National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services to support the development of a Standard Operating Procedure is ongoing. Training Data is under review relating to key services, with the objective to develop a bespoke training provision and evidence improved identification of service users who require a legal deprivation to be in place.	**31.03.2023**	**Amber**

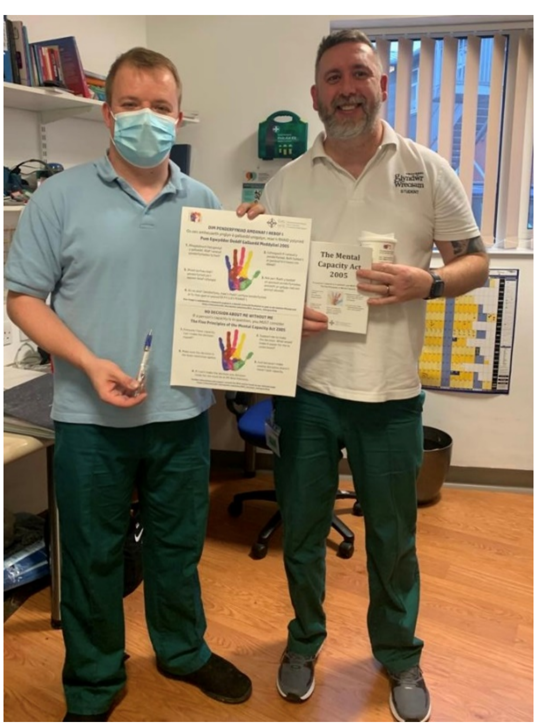
Appendix 2

A few pictures taken during the dissemination of the Mental Capacity Act materials throughout BCUHB in Safeguarding Week

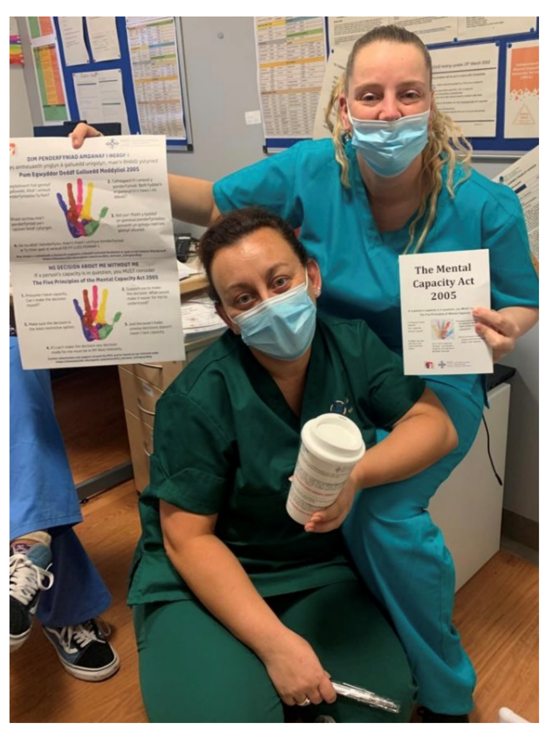
Fleming Ward, Wrexham Maelor



Occupational Therapy Team, Wrexham

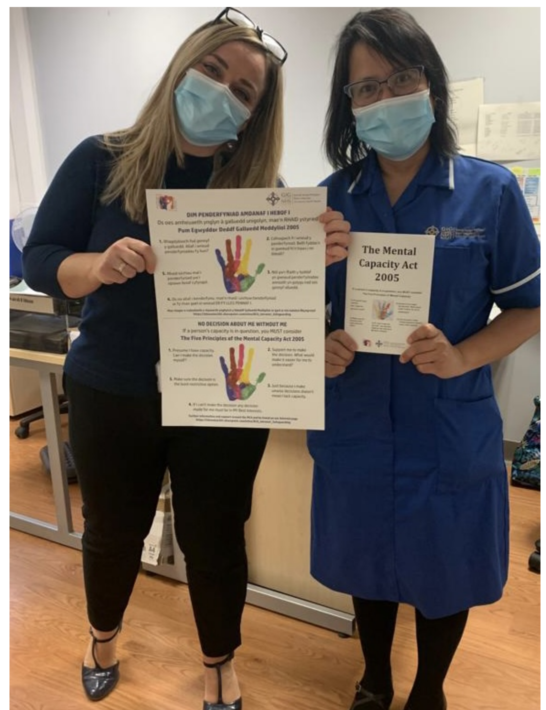


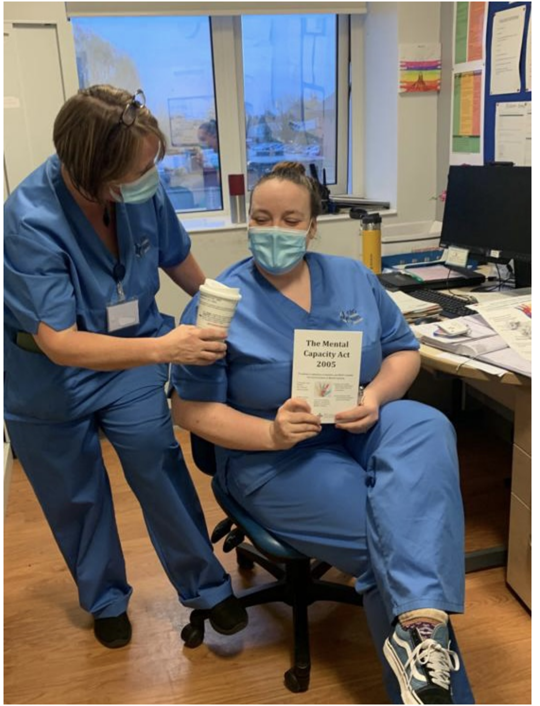
Heddfan Psychiatric Inpatient Unit, Wrexham



Appendix 2

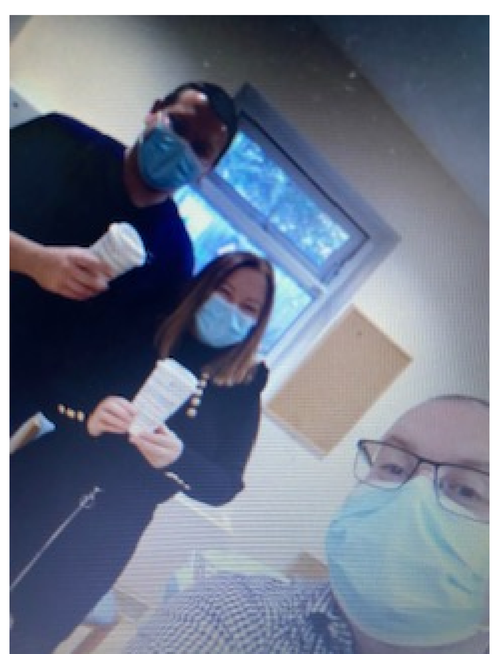
Heddfan Psychiatric Inpatient Unit, Wrexham

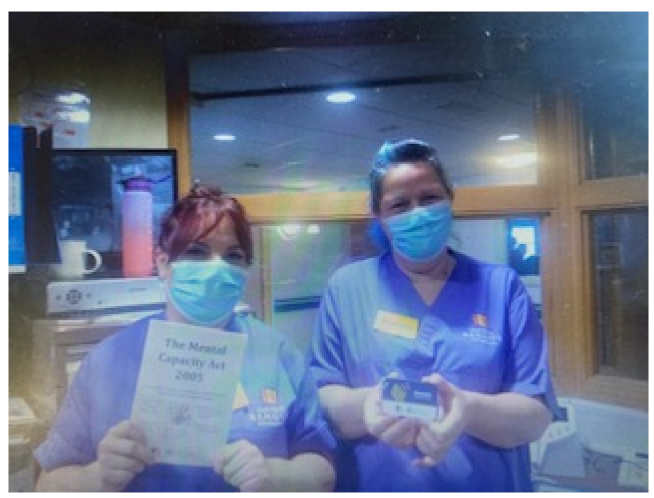




Appendix 2

Ysbyty Cefni, Psychiatric Unit, Llangefni





Health Care Support Workers Promotion Day, Ysbyty Gwynedd

Appendix 3

DoLS Case Study: Patient B

Patient B is a 19-year-old service user who was diagnosed with a moderate to severe Learning Disability. Patient B was an inpatient on a General Hospital Ward, however to meet their clinical care requirements they were transferred to a Mental Health Hospital for a further period of clinical assessment. Due to the immediate assessment of the person's Mental Capacity, the patient's care and treatment was to be provided under the DoLS Legal Framework.

The General Hospital Ward (Managing Authority) applied for an Urgent DoLS Application on the day of admission (the earliest opportunity). The Urgent Application covered an initial period of seven days, with the option to extend the authorisation by the Supervisory Body (BCUHB) to fourteen days. This ensured that Patient B was supported with the immediate and necessary safeguards and legal framework. It also provided Patient B with a route of appeal their Deprivation of Liberty to the Court of Protection in accordance with *AJ v A Local Authority* [2015] EWCOP.

Utilising Welsh Government monies a Best Interest Assessor (BIA) and a Section 12(2) Doctor were appointed and completed the necessary assessments out of normal working hours to ensure the Standard DoLS authorisation was completed within the required fourteen days.

The impact on Patient B and BCUHB:

Patient B was lawfully deprived of their liberty. This provided Patient B with a legal framework for the deprivation and a route of appeal to the Court of Protection if required. A capacity assessment, specific to DoLS, was completed and recorded in the patient notes on the day of admission. As part of the DoLS assessment, the BIA reviewed the level of deprivation on the ward to ensure any restrictions and/or restraints were the least restrictive.

By ensuring the DoLS application was completed timely and accurately, it reflected positively upon BCUHB as the Supervisory Body and the Ward as the Managing Authority. More importantly, the patient's needs were met and they were legally protected by the actions taken.

Although there was no legal challenge, or further directions by the Court of Protection, by acting immediately and in-line with legislation this reduced any legal costs and any distress experienced by the patient or the family. Learning from this case has been included within the MCA/DoLS training packages to inform staff and to emphasise the importance of completing Capacity Assessments and Legal Documentation correctly and on time.

Appendix 4

Corporate Safeguarding Business Case Analysis

Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA)

The Corporate Safeguarding Business Case outlines the proposed Safeguarding provision to enable the Health Board to implement Safeguarding, DoLS/MCA legislation and best practice guidance with recognition of the increase in activity, risk and complexity of abuse experienced by service users and their families.

The Business Case suggests a two year implementation plan with the approval for Year 1 funding sought in 2023-2024. Following a review in Q3 2023-2024 a further resubmission of the Business Case will be made to secure Year 2 funding.

The service delivery has statutory accountability and a legal duty to deliver this provision on behalf of BCUHB, with accountability on a Local, Regional and National footprint.

The Business Case has been reviewed, approved and supported by our Chief Finance Officer, and has subsequently been shared with the Integrated Medium Term Plan (IMTP) and Health Board Review Team (HBRT) leads for additional scrutiny before final submission the Board.

Corporate Risk Register Risk ID 2548 CRR21.14
Risk Specific to DoLS, MCA and LPS

Corporate Safeguarding have two risks recorded on the Corporate Risk Register.

The implementation of this Business Case is fundamental to support the downward trajectory of the risk. which has been calculated and has demonstrated that we will see a reduction in the risk rating from a current score of 20 to 12 in May and 8 in August. Failure to secure the necessary recurring funds would not support a reduction in the risk during 2023-24.

Analysis

- Despite the efforts and good will of staff for improvement within the service it remains the case that the current structure cannot meet the level of demand, complexity and challenges that are evidenced within governance reporting.
- The mitigating activities and the ongoing implementation of improvements driven by data and activity will require additional resources.
- Additional recurring funding would be utilised to support a stronger safeguarding development, educational and learning service to address gaps in training and compliance and thus reduce the current risk rating.
- The Business Case will require implementation before the effects of this can support a reduction in the current risk score. Additional recurring funding would provide greater assurance with the recorded reduced risk trajectory, which would evidence a reduction in the risk of non-compliance.
- Preparation and the implementation of LPS is dependent upon capacity, resource and expertise with the awaited revised Code of Practice.
- To support additional activity WG non-recurring monies has supported the implementation of additional roles and activities but this is time limited and spending must be in-line with WG guidelines
- 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 assurance activity has supported the identification of organisational risk and risks specific to area/service, requiring intervention, this service requires recurrent funding.

Appendix 4

- Strengthening the service will support an increase in activity and thus reducing delays resulting in a reduction of the risk.
- Local Authorities frequently develop independent local guidance, which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, and results in a variety of implementation activity and can result in reduced compliance, if delays are experienced.
- 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 and Services noting the timescales and legal duties.
- In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training, continued training and support is necessary to support this duty.
- The current commissioning arrangements of Independent Mental Capacity Advocates (IMCA) is the responsibility of Health Boards on behalf of the geographical area.
- At present there is a lack of commissioned services in place and new arrangements require establishments in terms of governance arrangements and quality monitoring.
- Non-recurring WG funding has supported the strengthening of IMCA services and it is likely that WG will fund future IMCA provision.
- However, there are no recurring resources to manage, maintain, review, audit, and supervise IMCA service across North Wales on behalf of the Health Board the 6 Local Authorities.
- The Business Case outlines plans for additional administration and professional/clinical roles to support a reduction in the identified risk and to mitigate future risks.
- The rise in the number of DoLS assessment has resulted in a 'Backlog' (This is a legal term for awaiting authorisation) of the assessment. This is a National picture and recognised by WG.
- We are currently using non-recurring WG monies to support current post holders to work additional hours, weekends and evenings and we are unable to recruit to specialist posts due to a National gap in resources enhanced by financial insecurity.
- There is a lack of governance and reporting of Court of Protection activity relating to a Community setting. This was highlighted in a Court of Protection DoLS case and it is noted that this is not unique to BCUHB. However, resource is necessary to support and implement this activity. Although immediate safeguards are in place, additional resources are required to ensure engagement and clear lines of accountabilities, escalation and governance is in place.
- There are local and national staffing challenges with regard to the recruitment of MCA and DoLS (BIA) specialist staff. This has been recognised by Welsh Government.
- There are currently no Best Interest Assessor courses available to train staff as a result of the delayed authorisation of the Legal Framework.
- We are supporting flexible working arrangements, the immediate recruitment to vacancies and current post holders (BIAs) are working enhanced hours to deliver out of hours support.
- As part of the Business Case an 'out of hours' service has been proposed to ensure that staff across the organisation have 24/7 access to MCA and DoLS support. This will reduce the risk of non-compliance and safeguard patients.
- The Team and Service is experiencing a combined sickness and vacancy position of 30%. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.
- The Business Case identifies the need to provide opportunities for learning and development within the team. Supporting staff to progress internally reduces the risk of vacancies and will result in a reduction in the overall corporate risk.
- There is a potential lack of funding as a result of a review of Section 12 (2) Doctors activities which has resulted in an increase in costs. An escalation report has been completed and the benchmarking of costs have taken place on a National basis and escalation to the executive Director of Nursing and Executive Director of Public Health (lead for Mental Health and Learning Disabilities).

Appendix 4

DoLS Data

DoLS applications have increased by 71% in 2021-22. Over the last four years DoLS applications have increased steadily with an overall increase of 219% in assessments recorded.

Analysis

- The Team lack the necessary resources to ensure that DoLS applications are completed, scrutinised and authorised within the necessary timescale.
- A full team review was undertaken and identified the need to strengthen management, frontline and administrative areas to support a reduction in the Tier 1 Corporate Risk Register.
- The increase in demand has not been replicated by additional investment in the service over the last 4-5 years.
- The challenges and difficulty in recruiting suitably qualified staff has also been highlighted. Public Health Wales - NST are currently undertaking a national survey of Safeguarding services within NHS organisations and are looking at succession planning within each organisation.
- The introduction of additional development roles within the team will provide added assurance.

Non-recurring Welsh Government Funding

Welsh Government money supports critical activity to ensure that patients are protected by the DoLS Legal Framework to prevent non-compliance that can result in Harm and both financial and reputational damage to the organisation.

- There are restrictions placed upon the use of WG funding and we are yet to receive the guidance from WG in relation to the bidding process and additional funds for 2023-24.
- This limits the remit of how we can utilise funding to support the service.
- Recurring funding would provide assurance and strengthen current arrangements.
- If we fail to secure recurring funds via the Corporate Safeguarding Business Case we will not be able to fund or complete assessments to protect patients.
- This will result in a recorded increase in the Tier 1 Corporate Risk and will prevent necessary actions to support a reduction in the current risk.
- Utilising WG money has supported a reduction in unauthorised DoLS applications and therefore the number of patients who are unlawfully deprived of the liberty whilst in hospital.
- To ensure that this does not revert back into a unmanageable ‘backlog’ of applications and therefore place the risk of reputational and financial to the Health Board we are seeking recurring funding via the Business Case.
- Non-recurring funding does not provide the facility to recruit into substantive posts.

Ockenden Recommendation 6

- The Business Case has highlighted the need to strengthen the team in accordance with recommendations 6 from the Ockenden Report highlighting the need.
- **Ockenden Recommendation 6** recorded that at the time the then Executive Director of Nursing had committed significant resources into developing sound foundations for the safeguarding structure going forward. However, it is recorded for an organisation such as BCUHB a significant amount of work was still needed to be done**.**
  This work would need continued Board scrutiny and oversight to ensure progress in the development of the service continues and if necessary reporting to Welsh Government if progress falters or slows down.

Appendix 4

- There are nationally identified challenges in relation to recruiting into short term contracts and temporary posts. The Business Case will provide necessary assurance in relation to securing permanent staff without having to be dependent upon non-recurring funding.

Court of Protection Activity

The number of cases engaged in Court of Protection activity has increased significantly. During this period, we have again seen a significant escalation of complexity in a number of Court of Protection cases. This has resulted in intensive Court of Protection activity and has required Senior BCUHB Board member attendance.

Analysis

- Court of Protection cases require an understanding and awareness of the legal framework, good governance and leadership.
- Each case can take months to support and action.
- The increase in CoP cases necessitates the need to invest now in resources to meet the growing demand.
- Without financial investment there is a risk that learning and actions to improve services may not be implemented within agreed timescales.
- This can lead to both a financial and reputational damage to the Health Board.
- The Business Case has identified the need for urgent investment to support the reduction in risk to prevent future high level legal challenges and to provide necessary training to frontline staff to support their understanding and implementation of the legal framework.

Implementation of Liberty Protection Safeguards and the transition from DoLS

LPS will replace the Deprivation of Liberty Safeguards (DoLS) for all patients who need to be deprived of their liberty. DoLS will continue as a process until all applications cease within the timeframe they are granted and then be replaced with an LPS authorisation if that is necessary. The first year of implementation will see the two processes work side by side with each other.

Analysis

- The implementation of LPS has implications financially, strategically, and operationally for BCUHB.
- There are significant risks in managing the transition from DoLS to LPS, not just the huge demand and increase in applications, which is estimated currently at **3000**, but also in ensuring that there is a strategic approach to DoLS, LPS and the MCA built within the structure of the service.

Mental Health Act Assessments

The Mental Health and Learning Disabilities Services have agreed to an increase in the Section 12(2) Approved Doctors fees for Mental Health Act Assessments.

Analysis

- The agreement in Doctors' fees does not include the DoLS Mental Health and Eligibility Assessments.
- For assurance the team have liaised with other Health Boards and Local Authorities in Wales to obtain their current fee rates and expectations of the role. We have included the outcome of this National picture in Table 1.
- The current provision of budgetary funding to undertake Section 12(2) Mental Health Act Assessments under the DoLS legal framework is insufficient and requires immediate investment to prevent a delay in the statutory process.

Appendix 4

- In addition, any agreed future increase in the funding would require further assessment, analysis and agreement to ensure that funds are available to prevent a delay in assessments that would result in an unlawful detention of a patient.

Table 1

National Picture relating to Fees for Sec (12)2 assessments

Health Board	**Fee**	**Forms completed**
BCUHB	£173.37	Form 4
Aneurin Bevan UHB	£180	Form 4 & Form 3a
Hywel Dda UHB	£180	Form 4 & Form 3a
Cardiff & Vale UHB	£182.04	Form 4 & Form 3a
Cwm Taf Morgannwg UHB	£180	Form 4 & Form 3a
Swansea Bay UHB	£180	Form 4 & Form 3a
Local Authority		
Conwy LA	£250	Form 4 & Form 3a
Denbighshire LA	£173.37	Form 4 & Form 3a
Flintshire LA	£175	Form 4 & Form 3a
Gwynedd LA	£173.37	Form 4 & Form 3a
Wrexham LA	N/K	N/K
Ynys Môn	£173	Form 4 & Form 3a

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Associate Hospital Managers Update Report (October – December 2022)</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Mental Health Capacity and Compliance Committee (MHCACC)</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">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: Hearings, Scrutiny, Training, Recruitment, Forums, Meetings, and Key Performance Indicators.

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 October 2022 – December 2022.

An appendix (Scrutiny Audit) is attached for the Scrutiny undertaken by the Associate Hospital Managers within 2022.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The committee is asked to note the report.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Wendy Lappin, Mental Health Act Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☒</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
</table>

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***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:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Mental Health Act 1983 (amended 2007) 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.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	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.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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, imminent plans are in place for the Associate Hospital Managers to have reports transferred to them electronically once Health Board devices are received.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience and Iain Wilkie, Interim Director, Mental Health & Learning Disability Division have seen the report prior to submission. The Power of Discharge Group reviewed the activity for October – December 2022 within their meeting held 13 January 2023. The Mental Health and Learning Disability Service Quality Delivery Group have had sight of the report. None of the above have made any changes.
Cysylltiadau â risgiau BAF:	None

<table>
<tr><td>(neu gysylltiadau â’r Gofrestr Risg Gorfforaethol)

Links to BAF risks:
(or links to the Corporate Risk Register)</td><td></td></tr>
<tr><td>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)

Reason for submission of report to confidential board (where relevant)</td><td>N/A</td></tr>
<tr><td colspan="2">Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations</td></tr>
<tr><td colspan="2">Rhestr o Atodiadau:

List of Appendices:
Appendix 1 – Associate Hospital Managers Update Report
Appendix 2 – Scrutiny Audit 2022</td></tr>
</table>

Mental Health Capacity and Compliance Committee
Appendix 1 - Associate Hospital Managers Update Report

Date – 10th February 2023

Quarterly Activity

1 Hearings

At the time of writing (06.01.2023) hearings continue to be held both remotely via Microsoft Teams and face to face. The hearing venue is determined by patient capacity and choice this has been the case since July 2022 and is adopted as general practice going forward.

19 hearings were held during the months October – December 2022. The hearings consisted of six Community Treatment Orders (CTO) renewals, 11 section 3 renewals, one section 47 renewal and one patient appeal.

The Hospital Managers discharged one patient during this period.

Two patients appealed their detentions this period, one hearing was not held due to the Responsible Clinician (RC) regrading the patient to informal, one hearing was held November and subsequently detailed within December data following adjournment.

A breakdown of the hearing activity is below:

October

- ***Nine hearings arranged (Seven held), one held face to face and six via Microsoft Teams.***
  All hearings were section renewals.

  Two hearings were postponed – both were scheduled face to face hearings. One could not be facilitated due to the patient contracting Covid and one patient required admission to a medical ward, both hearings went ahead in November.

  Outcomes of hearings held
  - All detentions were upheld.

November

- ***Eight hearings arranged (Six held); three held face to face and three via Microsoft Teams.***
  Five hearings were in relation to renewals. One hearing was a patient appeal.

  Two hearings were cancelled – The RC regraded one patient and one patient's appeal was rescheduled due to a query regarding capacity, this hearing was due to be held in December but did not proceed following discharge.

Outcomes of hearings held

- Four detentions were upheld.
- Two were adjourned, one to request the attendance of the care coordinator this hearing was rescheduled for December. One to request the attendance of multiple staff following a confusion regarding the venue of the hearing, the patient subsequently withdrew their appeal following discussions with their solicitor.

December

- ***Eight hearings arranged (Six held); all held via Microsoft Team.***
  All hearings were in relation to renewals. Four hearings were for community patients.

  Two hearings were cancelled – Both patients were discharged by their RC, one being a rescheduled hearing from November.

  Outcomes of hearings held
  Five detentions were upheld, one patient was discharged from their section.

Patient's views, venue choice and feedback forms
From July 2022 patients have been provided with a form to choose if they wish to have their hearing via virtual or face to face means. Patients who lack capacity and who will not be attending their hearings will automatically have a virtual hearing.

To date:

- Nine forms have been received noting the patient lacks capacity.
- Seventeen requests have been received for the renewal to be held face to face.
- Twelve requests have been received for the renewal to be held via Microsoft teams.
- One appeal against detention requested the hearing be held via Microsoft teams.
- Four appeals against detention requested the hearing be held face to face.
- Twelve feedback forms have been received stating the patient expressed how they wished their hearing to be held and that they attended (six face to face and six virtual).

Hearing KPIs

Following a renewal, there is no timeframe specified within the Mental Health Act of when a hearing is to 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 RC 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 was one application from a patient this quarter to measure within the KPI, and there were no 'barring' hearings. 57% of hearings were held within the KPI.

Renewal Date	Hearing Date	KPI (31 days)
01/09/2022	12/10/2022	41
02/09/2022	06/10/2022	34
09/09/2022	04/10/2022	25
15/09/2022	02/12/2022	78 *1
21/09/2022	05/10/2022	14
24/09/2022	14/11/2022	51 *2
25/09/2022	21/10/2022	26
25/09/2022	19/10/2022	24
30/09/2022	20/10/2022	20
30/09/2022	29/11/2022	60 *3
15/10/2022	11/11/2022	27
24/10/2022	05/12/2022	42
28/10/2022	03/11/2022	6
28/10/2022	08/12/2022	41
06/11/2022	07/12/2022	31
07/11/2022	21/11/2022	14
30/11/2022	21/12/2022	21
07/12/2022	20/12/2022	13
Appeal by Patient Date	**Hearing Date**	**KPI (31 days)**
21/09/2022	09/11/2022	49 *4

***1** The extended KPI date for the patients renewal was in relation to the patient moving address in the community and information being required in regards to how they wished the renewal hearing to be held.

***2 / *3** The extended KPI's were due to arranging the coordination of solicitors and professionals to be available.

***4** The appeal to the managers dated 21/09/2022 was not received till a couple of weeks later.

2 Scrutiny

Scrutiny has been reinstated from March 2022 and is conducted on a monthly basis within the three psychiatric units, Heddfan, Ablett and Hergest. The scrutiny report is attached as an appendix 2.

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 mandatory training list that is expected to be completed by the Health Board is under review and a number of sessions are to be recorded as not required by the Managers. The managers have been instructed to only complete relevant training. It is noted that the below training does not require completion:

1. Prevention of Adult-In-Patient Falls

2. Moving and Handling
3. Resuscitation

Discussions have been held with the Assistant Director of Quality about additional training days for Associate Hospital Managers, the cohort to inform future training have completed training needs analysis forms, a training day was due to be scheduled for February 2023 but has been put back due to a suitable venue being unavailable and concerns regarding the rise of covid.

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:
23 persons of which 22 are actively involved in hearings, four of these being new members and undertaking training via shadowing sessions. The active cohort consists of nine male and 13 female members, of which four are Welsh speakers.

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

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 meeting on the 13th of January included a training session on expenses.
The next meeting is due to be held April 2023.

6 Future developments

A number of IPADs have been received, complications have been encountered in relation to access to emails and licences this is being worked through with the service team. The laptops continue to be on order, once all have received a device the cohort will progress with going paperless for hearings.

APPENDIX 2

Quality Directorate, Legal Services Department

Mental Health Act
Associate Hospital Managers
Scrutiny Analysis
2022

Conducted by: Mental Health Act Associate Hospital Managers

Report produced by: Wendy Lappin, Mental Health Act Legislation Manager

January 2023

CONTENTS

	PAGE NO
Summary	**3 – 4**
Introduction and Aims	**4 – 6**
Standards	**6 – 7**
Methodology	**7**
Results	**7 – 11**
Conclusions & Discussions	**11 – 14**
Actions Taken	**14**
Action Plan	**14 – 15**
Recommendations / Sharing of Information	**15**

Appendices

Appendix A – Associate Hospital Managers Scrutiny Section Papers and Case notes.

SUMMARY

The Associate Hospital Managers reviewed a number of files (208) during 2022 over a period of 10 months, looking specifically at the medical recommendations, application by an Approved Mental Health Professional (AMHP), and case notes which included the explanation of rights form and the detail contained within:- namely how the explanation was given and documented and if a referral / offering the Independent Mental Capacity Advocate (IMHA) service was undertaken.

Two of the units did not reach 100% compliance for the questions relating to medical recommendations due to the documents not being in the current files this was largely due to recent admissions (within the week) in all instances it was clarified with the MHA office that these documents had been forwarded for filing and were legal and had been checked.

The lack of 100% in relation to the AMHP applications was again due to recent admissions and the document not being received at the time. Scrutiny of renewals also contributed as there is no AMHP report for a renewal of a section 3.

For future audits recent admissions will not be counted as part of the compliance as this may be automatically showing a negative impact on the audit standards for the AMHP applications.

For the five questions relating to the case note audit, there were mixed results with some standards seeing an increase in compliance and some reporting a decrease. A total of 116 files (56%) produced a return of 100% for all five questions including that the patient was offered the explanation in their language of choice. This is an increase of 9% from the previous audit.

In many instances it was recorded that the explanation of rights form was not within the file or not completed correctly therefore the Associate Hospital Managers could not determine an answer for questions 2 and 3 which produces a negative for these questions automatically as there is no evidence to the contrary.

Comments were also received that due to recent admissions Care and Treatment Plans (CTPs) were not present, a CTP as noted within the Code of Practice for parts

2 and 3 of the Mental Health Wales Measure '*should be provided as soon as is reasonably practicable after the individual has become a relevant patient and the care coordinator has been appointed.. (4.86). Whilst the Part 2 Regulations do not specify a time limit for the production of a Care and Treatment Plan it is recommended that in most cases it should be produced within 6 weeks of the appointment of a care coordinator and disturbed within 2 weeks of its completion (4.87).* Future audits will need to take into consideration those records following recent admissions for patients not previously known to services, to which some documentation may not be available, it is noted that if someone is known to services a Care Coordinator should already be in place and therefore the CTP only require updating.

There has been continued increase year on year and improvements in the explanation of rights being given and recorded, the explanation being given in the patients language of choice and referral to an IMHA. It is evident though that further work needs to be done to maintain a high level of compliance to ensure this progress is maintained and as such a number of actions are detailed in the action plan.

INTRODUCTION AND AIMS

This Associate Hospital Managers Scrutiny Analysis is an audit of scrutiny sessions conducted throughout a time period. This audit process began in 2017 and audits have been produced on a yearly basis. Covid 19 has an impact on the scrutiny conducted by the Associate Hospital Managers which was suspended in 2020 and re-instated in June 2021. This audit covers the time period March – December 2022.

The Associate Hospital Managers conduct scrutiny on the three adult psychiatric units (Ablett, Heddfan and Hergest) situated on the main District General Hospital sites, initially this decision was made due to the units being able to provide a safe room, not within the ward areas, for the Associate Hospital Managers that allowed for social distancing and their protection against possible contraction of Covid 19. The Mental Health Act Administrators conduct quarterly (monthly when required) scrutiny on the outlying units within the Health Board (Coed Celyn, Carreg Fawr, Ty Llywelyn, Foelas, Tan Y Coed, Bryn Hesketh, Mesen Fach, NWAS, Cefni and Tan Y Castell). It is felt that this works well as the turnover of patients is greater within the Ablett, Heddfan and Hergest and some of the outlying units do not have admin

support which the MHA office staff then contribute to, this has achieved a positive outcome for many of the units.

The Mental Health Act Associate Hospital Managers assist Betsi Cadwaladr University Health Board, Mental Health Act Department. They are independent persons who are appointed to sit on Managers Discharge Panels for the Health Board to decide unanimously whether a patient is still liable for detention and as such confirming that the Health Board is appropriately detaining patients under the least restrictive option. An additional duty the Associate Hospital Managers fulfil is one of scrutiny.

Betsi Cadwaladr University Health Board holds various forms of scrutiny in relation to the Mental Health Act, (statutory documents and local documents) to monitor and be satisfied that professionals are detaining patients legally and ensuring patients are advised of the rights they are entitled to and are aware of help they can receive.

The Policy for admission, receipt and scrutiny of statutory documentation (MHLD 0026) details how scrutiny is conducted and the requirements as below:

Admin/Pharmacy Scrutiny – Relates to medication forms. The form is checked by the Mental Health Act Office that all areas are completed and signed. Pharmacy check the medication is written up correctly within the correct doses and routes for administering.

Admin / Electroconvulsive Therapy (ECT) Scrutiny – Relates to ECT forms. The form is checked by the Mental Health Act Office that all areas are completed and signed. ECT check the maximum numbers of ECT, including under S62 (Emergency Treatment Certification) and consider the capacity of the patient.

Medical Scrutiny – A senior Medic will scrutinise section papers and renewal papers to be satisfied that the patient has been admitted under the least restrictive option and that the use of the Mental Health Act was an appropriate decision due to the patient's presentation and needs.

Approved Mental Health Professional (AMHP) Scrutiny – A Senior AMHP will check the AMHP paperwork and report to ensure that the correct process was followed in relation to identifying the nearest relative and the papers are completed correctly.

Associate Hospital Managers Scrutiny – The Managers conduct scrutiny within the ward areas looking at sections papers and case notes. This consists of a checklist (Appendix A) which covers documents completed by Medics, AMHPs, nursing staff and the provision of help highlighted to the patients. The general order of the documents is also considered and whether these are contained within the files.

This structure of scrutiny provides the Health Board with assurance that errors are highlighted at the earliest opportunity and informs where improvements are needed.

Previous reports showed an improvement in all areas compared to the initial report in 2017, the aim of this report is to show within 2022 the results of the scrutiny sessions which will highlight whether improvement have continued to be made and any areas that may need further guidance.

STANDARDS

The standards used for the purpose of this audit are:

1. The Mental Health Act 1983 as amended 2007
2. The Mental Health Act Code of Practice for Wales (revised 2016)

"The power to detain a person under Part II of the Mental Health Act is permitted following the completion and receipt of prescribed forms, those set out in schedule 2 of the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008. The forms must also be scrutinised to ensure all information contained is accurate and meeting the requirements".

"Hospital Managers should formally delegate their duties to receive and scrutinise admission documents to a limited number of officers, who may include clinical staff on wards. Someone with the authority to receive admission document should be available whenever patients may be admitted to the hospital. A manager of appropriate seniority should take overall responsibility on behalf of the hospital managers for the proper receipt and scrutiny of documents". (CoPW 35.8)

"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)

METHODOLOGY

Data from the period March to December 2022 in regards to the Associate Hospital Managers Scrutiny has been collected. The data was collected from the checklists (Appendix A).

Within the period the three adult psychiatric units (Ablett, Heddfan and Hergest) were visited for Scrutiny only, this decision was made due to the units being able to provide a safe room, not within the ward areas, for the Associate Hospital Managers that allowed for social distancing and their protection against possible contraction of Covid 19.

A total of 25 scrutiny sessions were held with a total of 208 files were scrutinised consisting of 167 persons on a Section 3, 35 on a Section 2 and 6 on a section 37/41.

RESULTS

Each part of the Scrutiny form has been considered in relation to the answers obtained e.g. Yes (positive) or No (Negative). These have been broken down into the relevant sections on the form to discover the percentage of compliance as a whole but also for the units scrutinised. As some records did not distinguish between the ward scrutinised the results have been displayed as units rather than being broken down to the wards. Feedback has been given to each ward/unit scrutinised following the attendance of the Associate Hospital Managers this is therefore a collective and retrospective report.

1 Medical Recommendations

Each scrutiny form was analysed. The table below shows the number of positive responses in relation to the five relevant questions for the areas scrutinised.

1. Do the doctors appear to be independent of each other?
2. Has the doctor stated why informal admission is not appropriate?
3. Have all forms been completed correctly?

4. Are dates of examination no more than five clear days apart? (not including the dates of the examinations)
5. Are you satisfied with the recommendation(s)?

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	Q3	Q4	Q5
Heddfan (8)	66	63	63	61	63	63
Ablett (9)	100 (94*)	94	94	94	94	94
Hergest (8)	42	41	41	41	41	41
TOTALS	**202**	**198**	**198**	**196**	**198**	**198**

COMMENTS

Ablett

- (94*) only 94 records were included as 6 were in relation to 37/41 questions are therefore not relevant, it was noted that the Associate Hospital Managers were satisfied with the documentation.

Hergest

- Recent admission waiting for papers to be filed.

Heddfan

- Two files missing detention paperwork regrade from S2 to S3
- Two recommendations contain mistakes
- Recent admissions documents not within the files

2 Application by the AMHP

Each scrutiny form was analysed. The table below shows the number of positive in relation to the two relevant questions for the areas scrutinised.

1. Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)
2. Has the AMHP given sufficient explanation of his / her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2
Heddfan (8)	66	60	58
Ablett (9)	100 (94*)	92	92
Hergest (8)	42	37	37
TOTALS	**202**	**189**	**187**

COMMENTS

Ablett

- (94*) as above due to Section 37/41 no AMHP report required
- One renewal scrutinised which meant there was no AMHP report
- One recent admission AMHP report not received yet conversion from S2 to S3
- Detailed AMHP report

Hergest

- Three recent admissions awaiting AMHP reports
- One recent admission all documents missing

Heddfan

- AMHP assessment report – excellent, detailed, well written
- AMHP reports missing from recent admissions

3 Case notes

Each scrutiny form was analysed. The table below shows the number of positive in relation to the relevant questions for the areas scrutinised, question 2b is shown as a negative if the patient was not offered the explanation in their primary language and no reason was recorded.

1. Has Ethnicity been recorded in the case notes? (Admission Form)
2. Has an Explanation of Rights been given to the patient and recorded in the notes?
   a) Was the Explanation offered in the patient's primary language?
   b) If not have reasons been recorded?
   (MHA Section)
3. Has the patient been referred to the IMHA?
   (MHA Section)

4. Is there an up to date Care and Treatment Plan?
   (Care Planning Section)
5. Are the section papers filed in the correct place in the case notes?
   (MHA Section)

Area / Sessions	No of files scrutinised (total files)	Q1	Q2	2a	2b	Q3	Q4	Q5
Heddfan (8)	66	55	47	39	-26(1)	39	55	60
Ablett (9)	100	79	99	93	-7	97	93	98
Hergest (8)	42	36	37	33	-8(1)	31	38	39
TOTALS	**208**	**170**	**183**	**165**	**-41(2)**	**167**	**186**	**197**

COMMENTS

Ablett

- No CTP as recent admission
- Explanation of Rights notes patient not able to demonstrate understanding further explanation to be offered at a future date documented
- Explanation of Rights mentioned in pathway document but no actual form vision
- Well ordered files
- Ethnicity located in AMHP reports only

Hergest

- Care plans not signed although within the files
- Recent admissions so no CTPs for some patients
- Rights forms missing and referral to IMHA part not completed correctly.

Heddfan

- Patient's explanation of rights forms missing or only part completed.
- Recent admissions documentation was not in the file although this may have been completed.
- Mostly excellent files with all documents present and filed correctly.
- Good set of case notes
- CTPs not reviewed only Covid 19 plans
- Duplicate copies of documents

CONCLUSIONS & DISCUSSION

Medical Recommendations

It would be expected that the Medical Recommendations section should be at 100% for all questions whilst the documentation was not within the files the originals are held within the local Mental Health Act Offices and had been checked for legality.

The lack of 100% compliance for two of the units was due to recent admissions, at the time this information was highlighted to staff and these filed immediately.

Application by AMHP

During this audit it has been highlighted that there are instances where the AMHP report was not on the file, when investigated these were still to be forwarded by the AMHP due to recent admissions. Renewals do not require an AMHP report therefore this also affected the audit. The AMHP application will initially be part of the section documentation with the AMHP report on occasions received at a later date, the reports are routinely chased up by the offices if not received within a timely manner.

Case notes

From the 208 files scrutinised no area produced a return of 100% for all questions. A total of 116 files (56%) produced a return of 100% for all five questions including that the patient was offered the explanation in their language of choice. This is an increase of 9% from the previous audit.

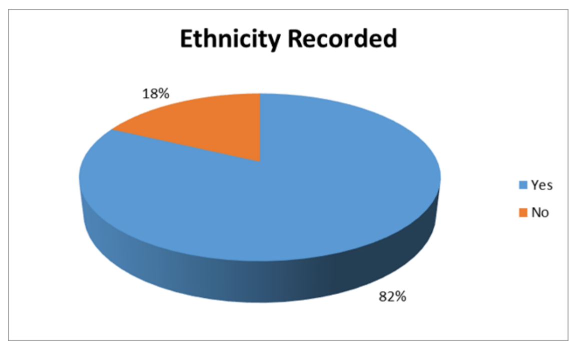
In many instances it was recorded that the explanation of rights form was not within the file or not completed correctly therefore the Associate Hospital Managers could not determine an answer for questions 2 and 3 which produces a negative for these questions automatically as there is no evidence to the contrary.

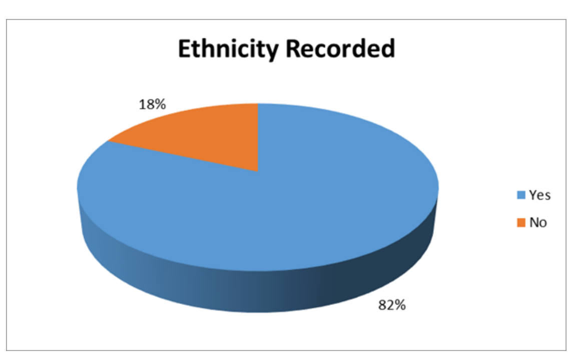
Comments were also received that due to recent admissions CTPs were not present, a CTP as noted within the Code of Practice for parts 2 and 3 of the Mental Health

Wales Measure '*should be provided as soon as is reasonably practicable after the individual has become a relevant patient and the care coordinator has been appointed.. (4.86). Whilst the Part 2 Regulations do not specify a time limit for the production of a Care and Treatment Plan it is recommended that in most cases it should be produced within 6 weeks of the appointment of a care coordinator and disturbed within 2 weeks of its completion (4.87).*

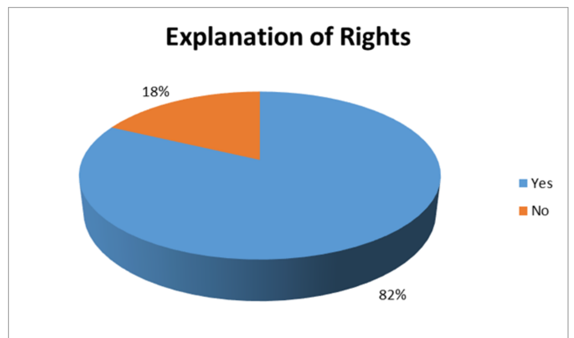
The charts below show the percentages for each question for the areas scrutinised in comparison to the results obtained from the last audit in 2021.

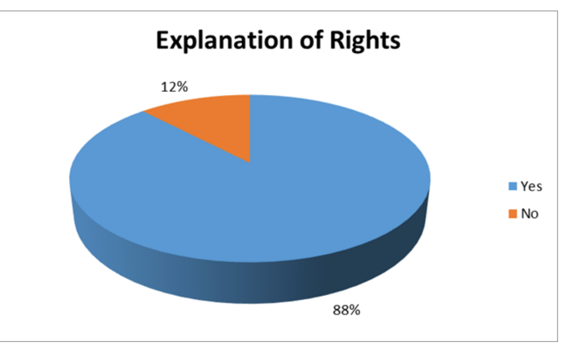
2021 **2022**



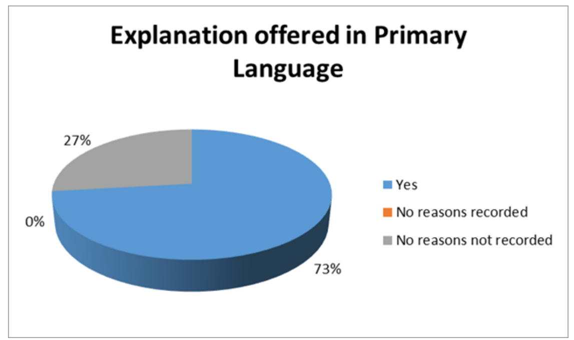


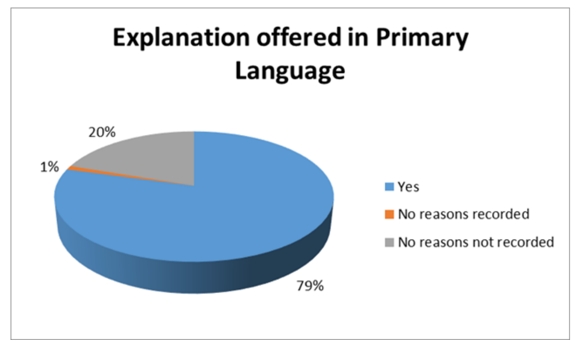
There has been no improvement in relation to ethnicity being recorded within the files.



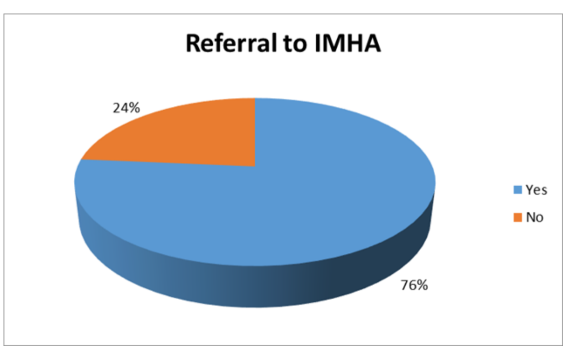


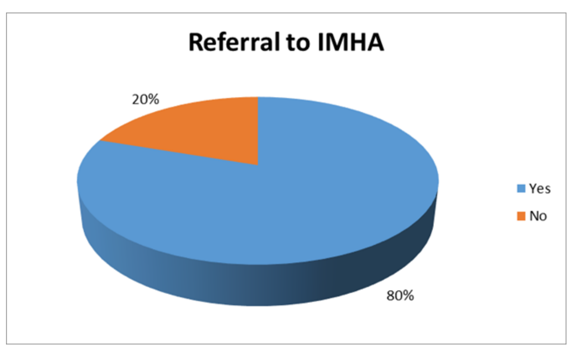
There has been an improvement in relation to the explanation of rights by 6%. This follows an improvement also seen in 2021. It was noted many of the files scrutinised the explanation of rights forms could not be found this would therefore have had an impact on this question.



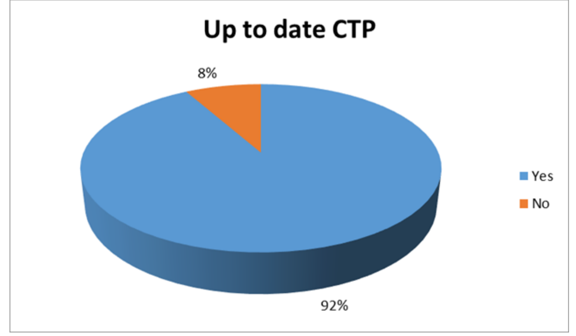


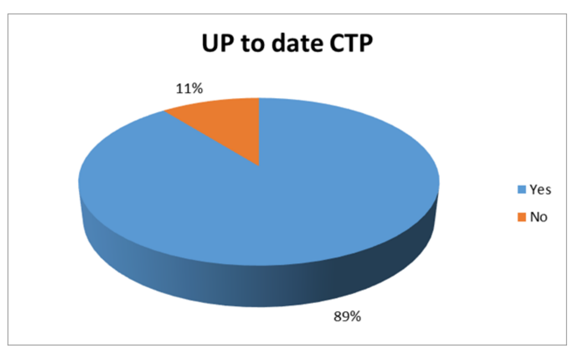
There has been an improvement in evidence of the explanation of rights being offered in the primary language of the patient by 6%. There has been an increase in the reasons being recorded for when explanation has not been given in the primary language. This follows an improvement also seen in 2021. It is noted that the explanation of rights form has to be within the file to be able to answer this question.



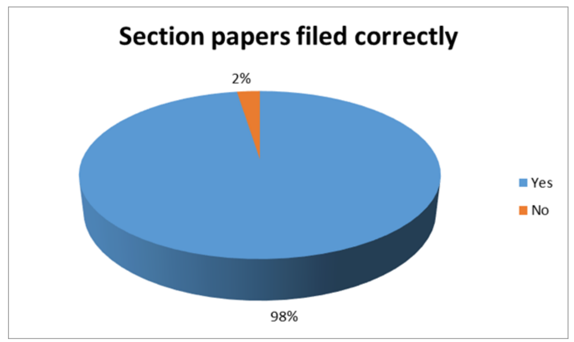


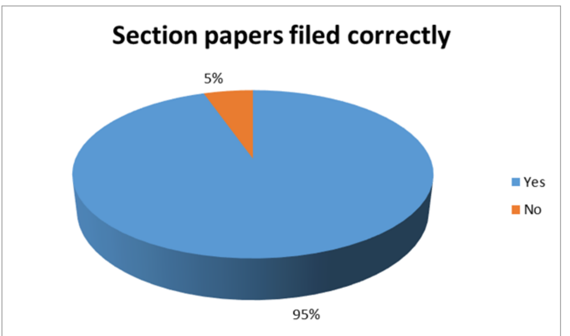
There has been an improvement of 4% in evidence of referrals to IMHA being made in 2022 this again is a continued increase since 2021. It must still be noted that the lack of explanation of rights forms within the files will have had an impact on this question.





There has been a decrease by 3% in relation to an up to date CTP within the files, the number of recent admissions could have an impact on this record.





There has been a decrease in the percentage of section papers filed correctly by 3% the lack of some documents in files may have accounted for this decrease.

Whilst improvements have been seen within the case note section there are a number of standards which have decreased slightly, future audits will need to take into consideration those records following recent admissions to which some documentation may not be available.

ACTIONS TAKEN

Following each scrutiny session the areas have been informed of their results and areas of concern highlighted.

All issues raised by the Associate Hospital Managers have been looked into, assurance provided that everything is in order or amendments and corrections made immediately.

ACTION PLAN

Target Area	Action Required	Lead	Evidence of completion	Target Date
Explanation of Rights Referral to IMHA	The MHLD 0030 Policy for Information to Patients (S132/3 MHA) to be redistributed through area monthly Quality and Safety Group meetings for dissemination to staff.	MHA Manager Governance Leads	Confirmation from the Governance lead for each area this is on the agenda.	01.03.2023
Explanation of Rights	The Mental Health Act office at the end of each month when	Area MHA Administrators	Confirmation within the monthly stats that	Monthly 28.02.2023

	conducting their monthly stats to request any outstanding Explanation of rights forms. The number of those outstanding to be documented onto the monthly stat form.		all current patients have an explanation of rights form.	
Audit Standards	If a monthly audit results in a concerning return a further follow up audit of that ward to be undertaken the following month and reported as a separate undertaking.	Associate Hospital Managers	Audit results received by the MHA Manager and reported to the ward in question.	Monthly 31.03.2023

RECOMMENDATIONS / SHARING OF INFORMATION

Scrutiny to be conducted for 2023, the MHA office staff inform the areas prior of the attendance of the Associate Hospital Managers and they are given the opportunity to select a timeframe or change a date if necessary. It is therefore recommended that unless a serious incident occurs or Health Inspectorate Wales (HIW) attend for an unannounced visit the scrutiny should proceed as planned.

The report will be shared with the Mental Health Capacity and Compliance Committee, Associate Hospital Managers, the Head of Operations, Clinical Operations Managers and Heads of Nursing for each unit.

The Information to Patients Policy to be highlighted to staff by the Heads of Nursing in relation to Explanation of Rights and the process, work still needs to be undertaken to ensure that the forms are fully completed. This policy with the form can be accessed and is available on the intranet. MHLD 0030 Policy for information to patients (s132/3 MHA).

The audit will be shared with the Business Support Managers in relation to filing so that this can be shared in admin meetings with administration staff.

A yearly audit to be conducted.

Appendix A
(Appendix 13 of Admission receipt and Scrutiny of Statutory Documentation Policy)

(Name of Unit - Hergest, Heddfan, Ablett Unit)

Associate Hospital Managers Scrutiny
Section Papers and Case notes

Venue:
Names of Managers undertaking Scrutiny:
Number of files scrutinised:
Date:
Any issues of concern which need raising:

Please note a separate page 2 and 3 of Appendix 13 should be used for each file scrutinised.

Appendix 13 p.2

Associate Hospital Managers Scrutiny
Section Papers and Case notes

Patient's Name:

Ref No: Section: Section Date:

PLEASE NOTE:

- All forms must be for the same section detailing the patients name and address identically on each form.
- Forms should be signed and dated.
- If the section papers need to be amended you will be required to check them again.

Please check the medical recommendation(s) for the following:

		Yes	**No**
1	Do the doctors appear to be independent of each other?	☐	☐
2	Has the doctor stated why informal admission is not appropriate?	☐	☐
3	Have all forms been completed correctly?	☐	☐
4	Are dates of examination no more than five clear days apart? (not including the dates of the examinations)	☐	☐
5	Are you satisfied with the recommendation(s)? If not please details reasons below:	☐	☐

____

____

____

Please check the Application by the AMHP for the following:

		Yes	**No**
1	Is the AMHP interview on the same day or after the medical recommendation? (this cannot be dated before)	☐	☐
2	Has the AMHP given sufficient explanation of his/her determination of the Nearest Relative? (unable to ascertain may be appropriate at the time)	☐	☐

Appendix 13 p.3

Please check the case notes for the following:

		Yes	No
1	Has Ethnicity been recorded in the case notes?	☐	☐
	(Admission Form)		
2	Has an Explanation of Rights been given to the patient and recorded in the notes?	☐	☐
	Was the Explanation offered in the patient's primary language?	☐	☐
	If not have reasons been recorded?	☐	☐
	(MHA Section)		
3	Has the patient been offered referral to the IMHA?	☐	☐
	(MHA Section)		
4	Is there an up to date Care and Treatment Plan?	☐	☐
	(Care Planning Section)		
5	Are the section papers filed in the correct place in the case notes?	☐	☐
	(MHA Section)		

Any further Comments:

____

____

____

____

____

Signature(s): ....

Print Name(s): ....

Date undertaken: ....

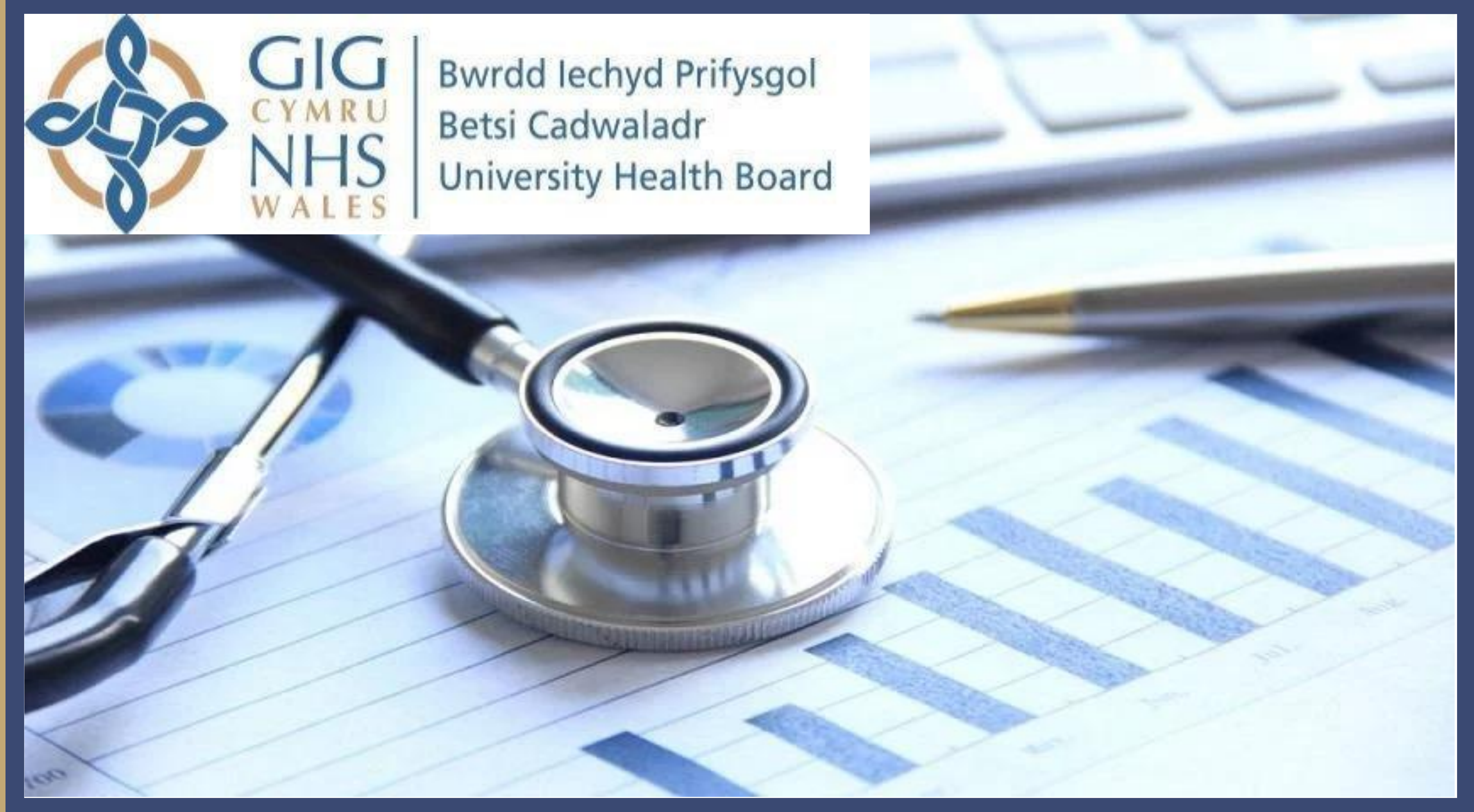
Teitl adroddiad: *Report title:*	Mental Health Act Performance Report			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee (MHCACC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 10 February 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during October – December 2022. 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 recorded on Datix and investigated. Up to date S136 reports are submitted to the Committee along with any ad hoc requests for information.			
Argymhellion: ***Recommendations:***	The Committee is asked to discuss and note the report and appendices.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	delivery of existing mechanisms/objectives	existing mechanisms / objectives	existing mechanisms / objectives	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***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:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	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.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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, a meeting was held on the 21st of November to

	explore this system and reporting requirements in detail, testing and exploring of the system is now underway to ensure it meets appropriate requirements to allow reporting and monitoring of detentions. 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 was one fundamentally defective section and four sections which lapsed. The lapsed detentions consisted of one x S5(2), 1 x S3, 1 x CTO and one x S136. These are reported as exceptions within the report. A S136 also expired during the assessment this was not reported via the Datix system as the assessment was currently underway. An audit is being undertaken in relation to the use of the S136 suite for detentions under the Mental Health Act that are not detentions under a S136 to highlight the amount of time that the suites are unavailable.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The increase in Mental Health Act detentions has financial implications.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None required
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report and data has been seen by those listed below and been submitted to the groups detailed. Iain Wilkie, Interim Director, Mental Health & Learning Disability Division Paul Lumsdon, Interim Director of Nursing, CPG Management. Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience Mental Health & Learning Disability Service Quality Delivery Group 17/01/2023
Cysylltiadau â risgiau BAF:	N/A

(neu gysylltiadau â’r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 MHA Committee Performance Report October - December 2022 Appendix 2 S136 BCUHB Report – December Appendix 3 S136 CAMHS Report – December	



Mental Health Capacity and Compliance Committee Performance Report

December 2022

CONTENTS:

Contents	2	Errors	12
Foreword	3	Section 136 (Adult)	13 - 14
Advisory Reports Definitions	4 - 5	Section 136 (Under 18s)	15 - 16
Section 5(4)	6	Forensic	17
Section 5(2)	7	Transfers	18
Section 4	8	Section 62	19
Section 2	9		
Section 3	10		
Section 17	11		

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.

T

Advisory Reports & Exception reports

Each report for the Mental Health Act will be presented as an advisory report.
Exceptions are noted throughout the report within this period four sections lapsed:
1 x S5(2) lapsed: (INC34034) the detention was enacted over the Christmas period this is currently under investigation
1 x S3 lapsed (INC27746) due to the Doctor in charge of the patients detention failing to complete renewal paperwork. The patient was reassessed and detained under a S3. Learning/mitigation has included the ward now having visible on a board expiry dates to assist in reminding.
1 x CTO (17A) lapsed (INC30112): the MHA office missed the section expiry and did not remind the clinicians involved. Learning/mitigation has included the list of CTOs which are shared with the local AMHPs now details expiry dates of the CTOs this is shared every time a change occurs to the list.
1 x S136 lapsed (INC30918) due to the patient not being fit for assessment, once fit the person was assessed and admitted to an appropriate placement.
There is one fundamentally defective section to report: (INC30903) A section 3 was found to be invalid as the AMHP application was completed on section 2 and not 3 paperwork, this was not picked up prior to a weekend, once discovered this was actioned and the detention under Section 3 was made using the same medical recommendations. Learning/mitigation has included staff being reminded to check all documents are for the right section.

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

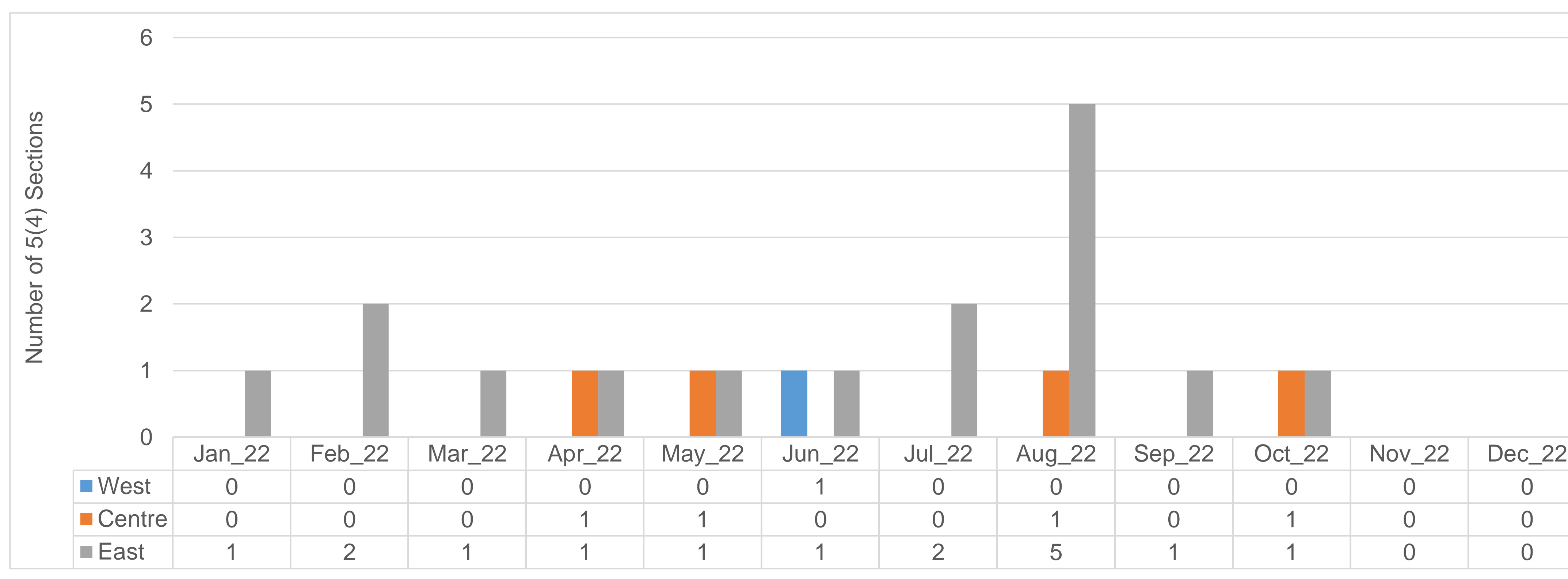
Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

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	December 2022	November 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	0	0	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter		Quarter 5(4) Sections
2	9	↓	5	1	Centre	1
				1	East	1
				3	West	0



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	0	0	0	0	0	1	0	0	0	0	0	0
Centre	0	0	0	1	1	0	0	1	0	1	0	0
East	1	2	1	1	1	1	2	5	1	1	0	0

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

There were no section 5(4)s noted to have lapsed within this period.

WEST

The data above does	Duration (hh:mm)	Outcome

CENTRE

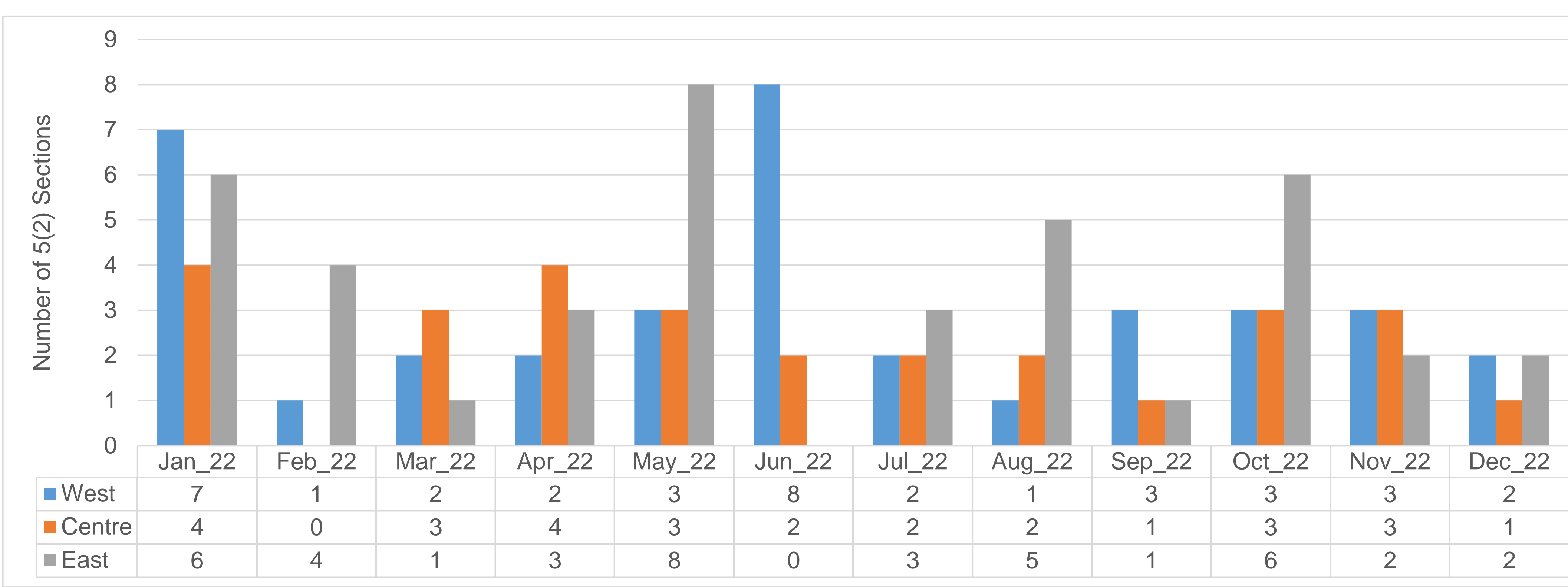
Month	Duration (hh:mm)	Outcome
Oct_22	02:00	Section 5(2)

EAST

Month	Duration (hh:mm)	Outcome
Oct_22	00:32	Section 5(2)

Section 5(2) - BCUHB	December 2022	November 2022	Monthly Trend
Section 5: Application in respect of patients already in hospital	5	8	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(2) during Quarter		Quarter 5(4) Sections
25	20	↑	27	1	East	10
				2	West	8
				3	Centre	7



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	7	1	2	2	3	8	2	1	3	3	3	2
Centre	4	0	3	4	3	2	2	2	1	3	3	1
East	6	4	1	3	8	0	3	5	1	6	2	2

Section 5(2) Outcomes

	Oct 2022	Nov 2022	Dec 2022
Section 2:	6	3	0
Section 3:	2	1	1
Informal:	1	1	2
Lapsed:	0	0	1
Invalid:	0	0	0
Discharged:	2	2	0
Other:	0	0	0

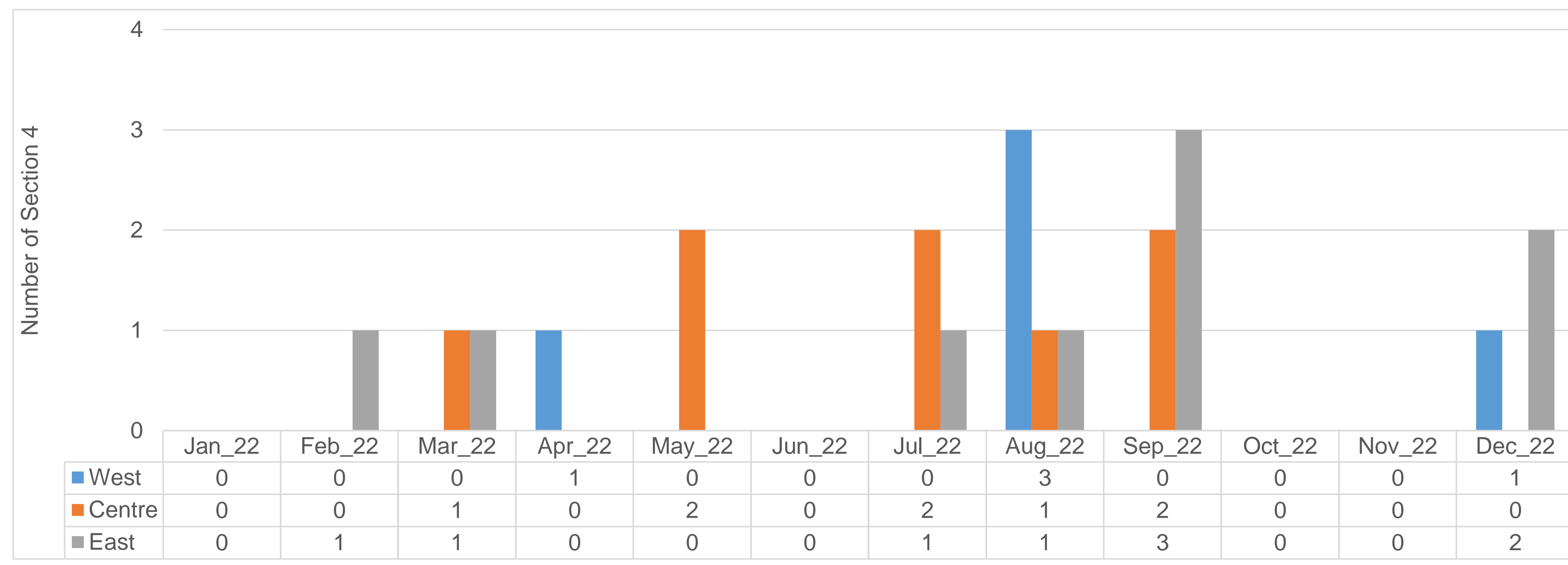
A Section 5(2) on occasions will be enacted within the acute hospital wards, during this period there was one detention in an acute hospital which resulted in a Section 2 admission.

EXCEPTIONS

There is one exception to report this period:- EAST:- the 5(2) was enacted over the Christmas period, this is still under investigation as to why an assessment was not completed INC 34034. The patient was subject to a further 5(2) later within the month no further formal detention was made on assessment.

Section 4 - BCUHB	December 2022	November 2022	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	3	0	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
3	13	↓	6	1	East	2
				2	West	1
				3	Centre	0



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	0	0	0	1	0	0	0	3	0	0	0	1
Centre	0	0	1	0	2	0	2	1	2	0	0	0
East	0	1	1	0	0	0	1	1	3	0	0	2

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 of the section 4 admissions were noted to be due to risks and safety requiring immediate admission.

WEST

Month	Duration (hh:mm)	Outcome
Dec_22	04:00	Section 2

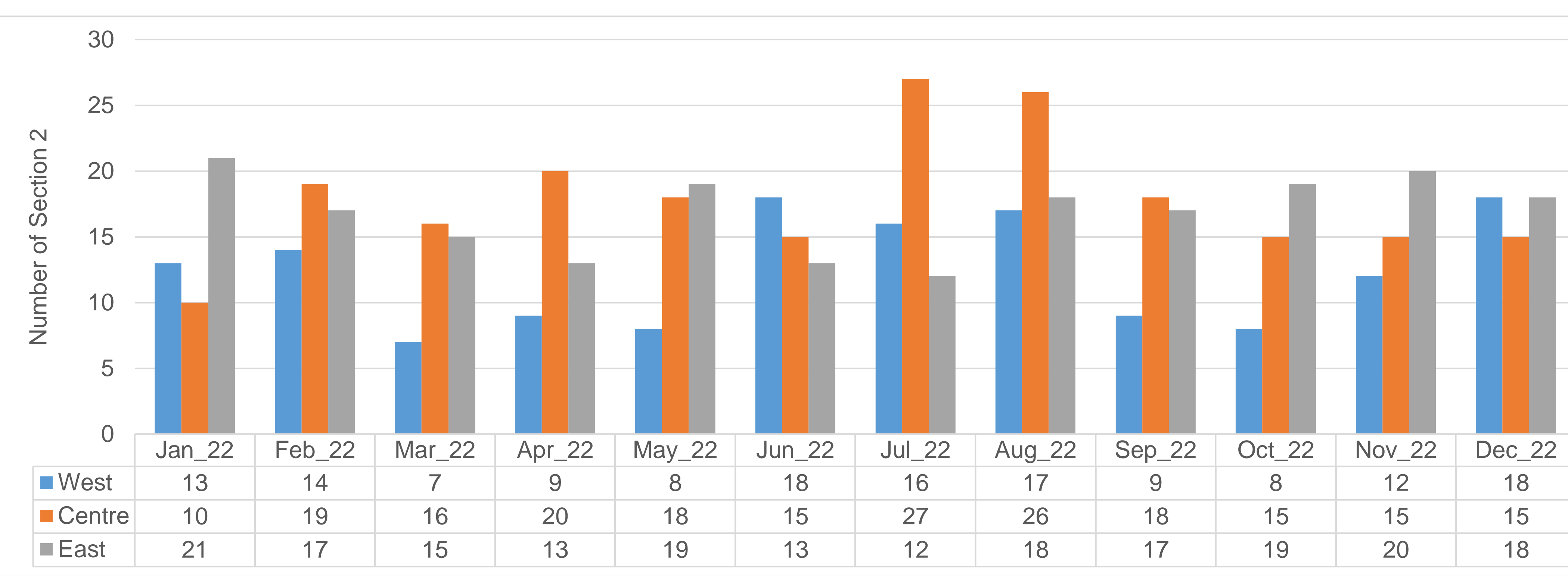
CENTRE

Month	Duration (hh:mm)	Outcome

EAST

Month	Duration (hh:mm)	Outcome
Dec_22	17:19	Section 2
Dec_22	45:00	Section 2

Section 2 - BCUHB	December 2022	November 2022	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
Section 5: Admission for assessment	51	47	↑	140	160	↓	141	1	East	57
								2	Centre	45
								3	West	38



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	13	14	7	9	8	18	16	17	9	8	12	18
Centre	10	19	16	20	18	15	27	26	18	15	15	15
East	21	17	15	13	19	13	12	18	17	19	20	18

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

Section 2 Outcomes

	Oct 2022	Nov 2022	Dec 2022
Section 3:	10	11	13
Informal:	10	19	14
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	11	9	11
Transferred:	9	10	11
Invalid and Other:	0	0	0

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 six under 18s placed on a Section 2 this period, three regraded from informal, one regraded from a 5(2) and two following S136 assessments.
.

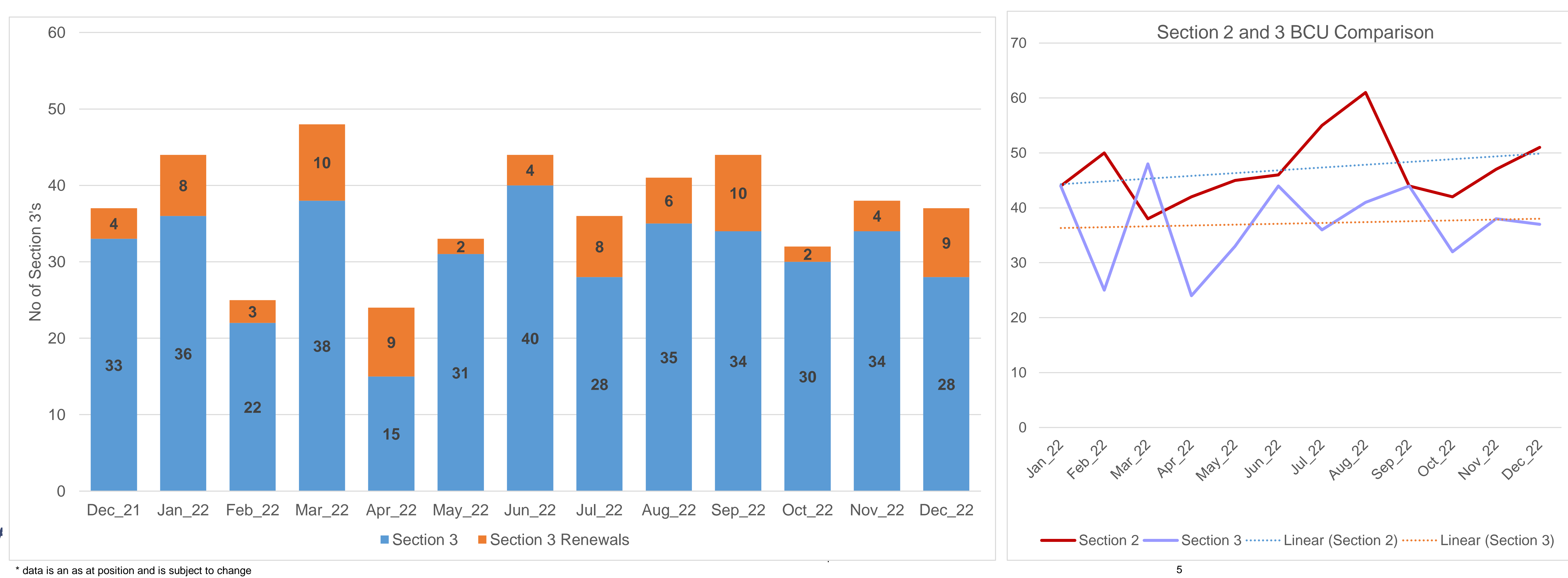
EXCEPTIONS:

There are no exceptions to report this period.

A

Section 3 - BCUHB	December 2022	November 2022	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	37	38	↓

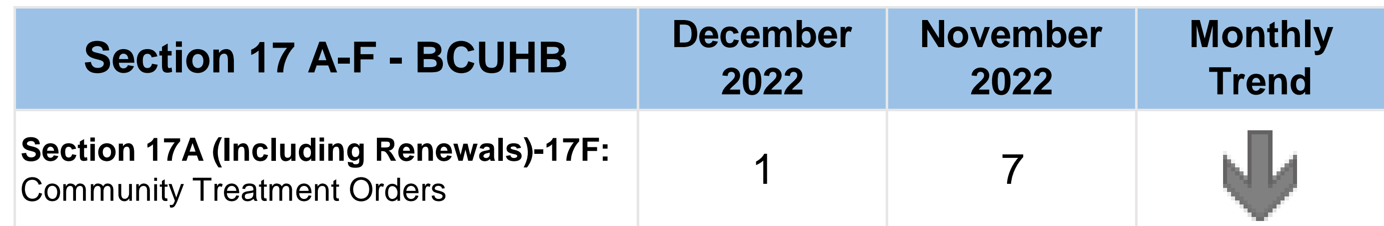
Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
107	121	↓	112	1	Centre	52
				2	East	37
				3	West	18



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

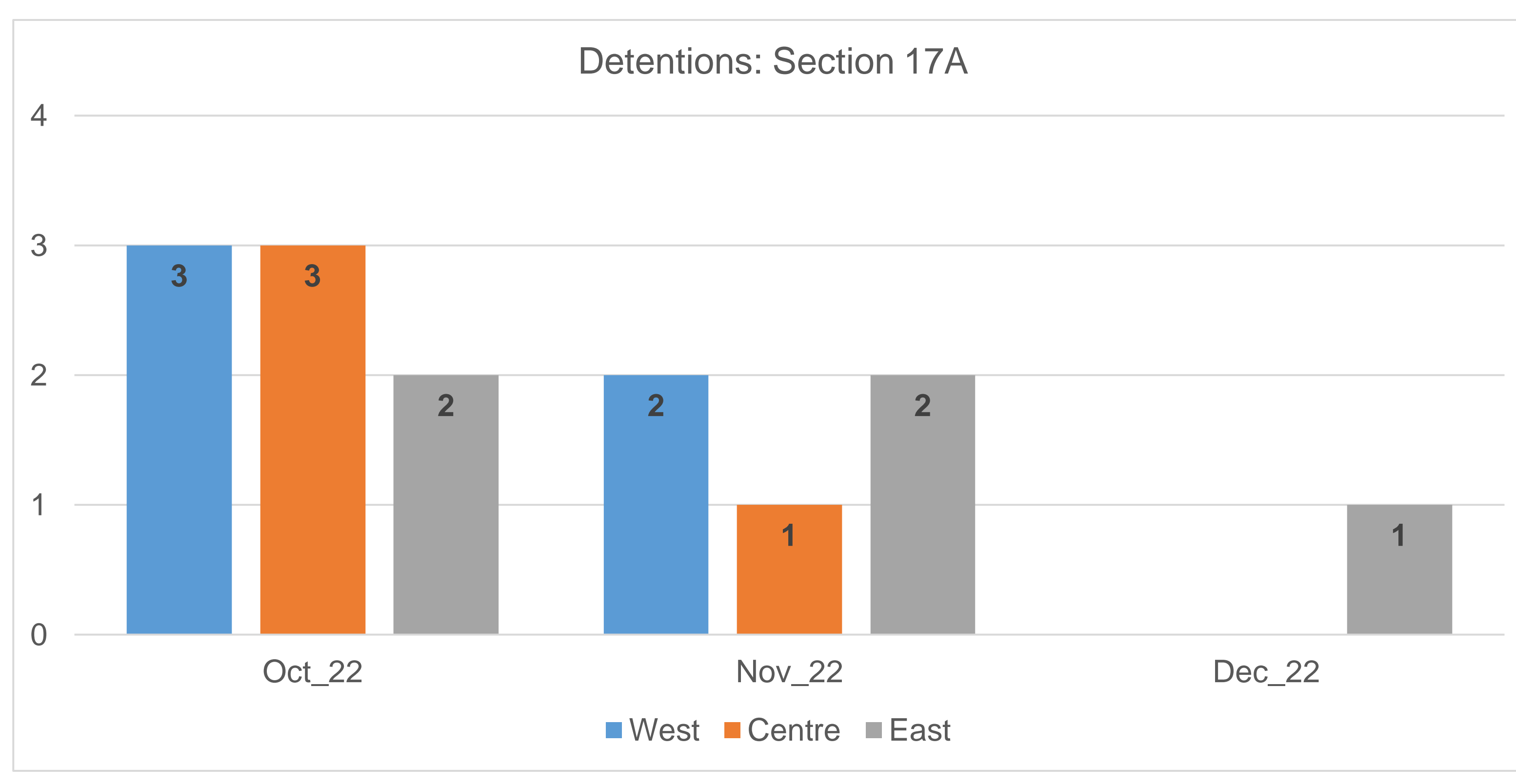
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

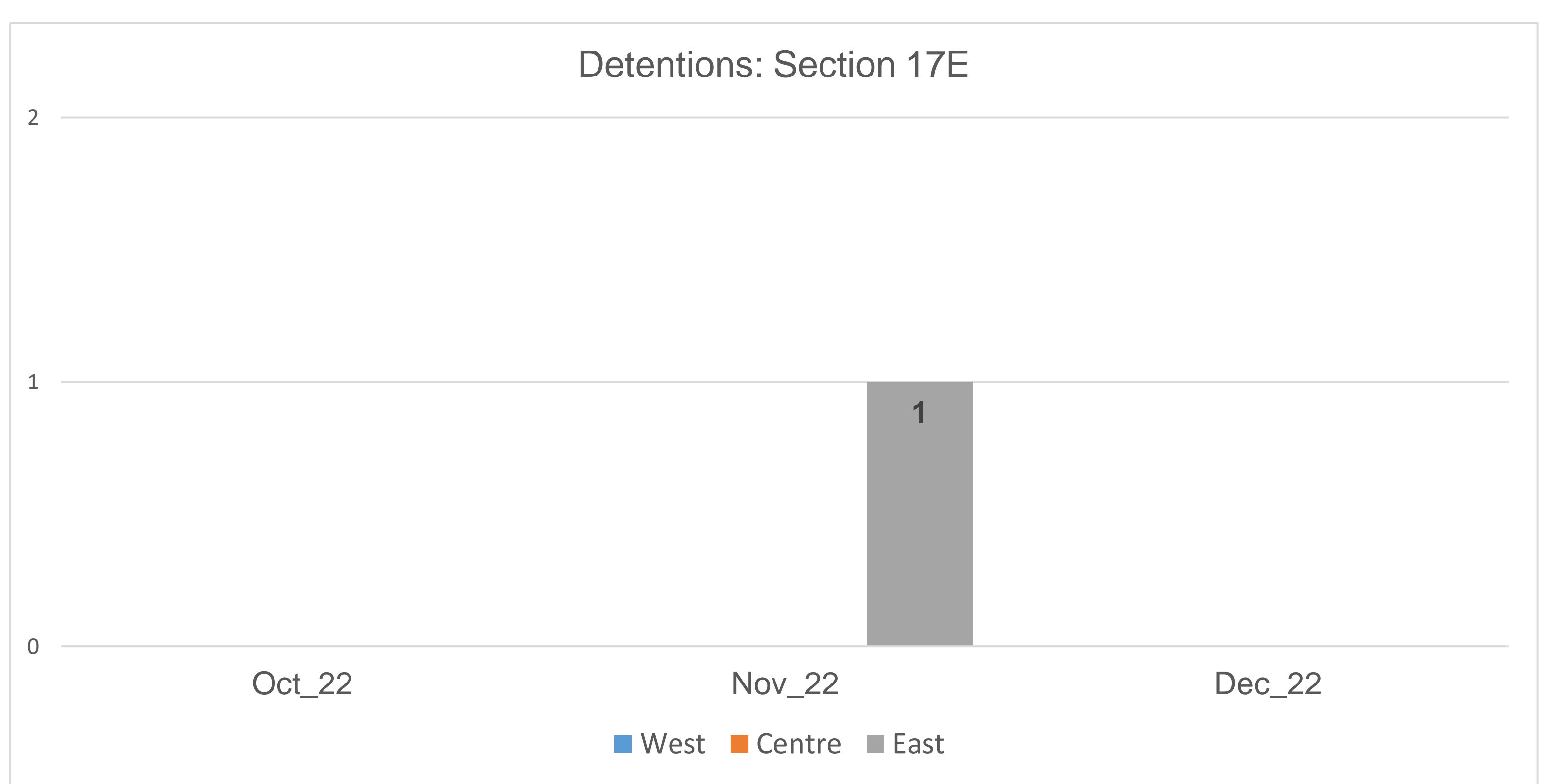
This period there were five under 18s made subject to a section 3. Two were regraded from a section 2, and three from admission. The trend over the 12 months at the end of December continues to rise for section 2 detentions.
There are two exceptions to report this period. CENTRAL: A section 3 was invalid due to the AMHP application being made on section 2 paperwork INC 30903. EAST: A renewal was not completed by the RC INC27746.

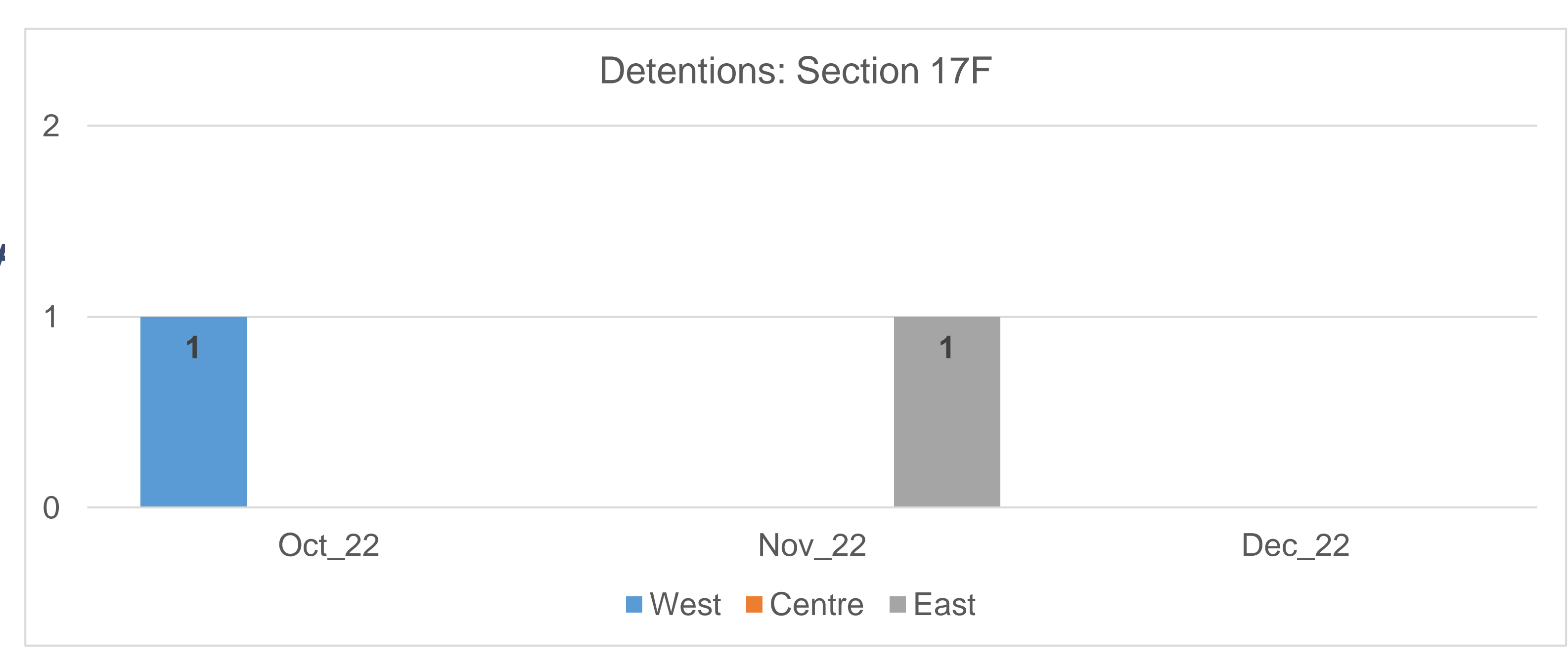


Section 17 A-F - BCUHB	December 2022	November 2022	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	1	7	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
17	14	↑	17	1	East	7
				2	West	6
				3	Centre	4







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.

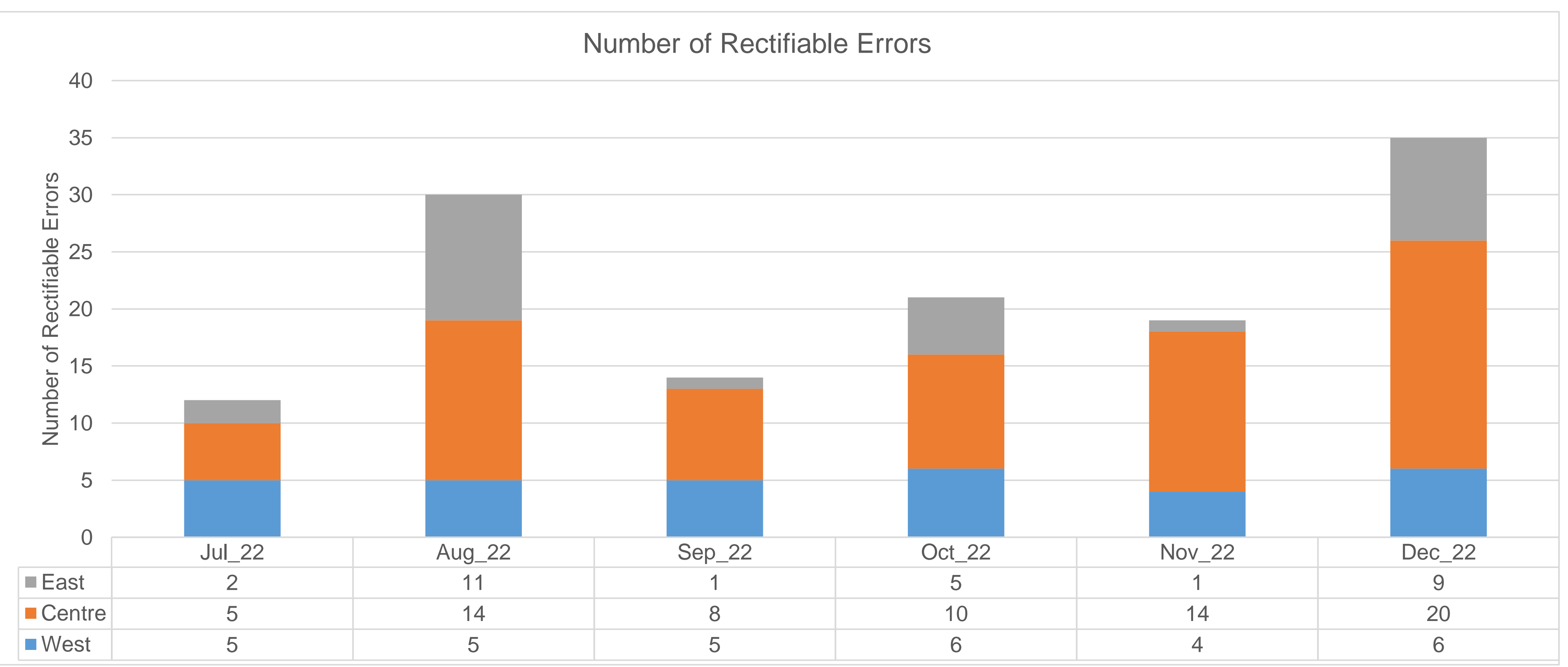
The number of patients subject to a CTO at the end of December West:10, Central: 6 and East: 9.

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

Exceptions: EAST: One CTO lapsed due to the RC and AMHP not being reminded of the expiry date of the detention INC30112.

Fundamental and Rectifiable Errors	December 2022	November 2022	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	36	19	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	Centre	45
				2	West	16
				3	East	15



	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
East	2	11	1	5	1	9
Centre	5	14	8	10	14	20
West	5	5	5	6	4	6

Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales.The latest report received covers July - September 2022.

The report confirms BCUHB:
* accounted for the highest number of inpatient detentions.
* was ranked 2nd for inpatient detentions when considering Health Board population.
* is not an outlier in relation to CTO or S135 detentions.
* accounted for the highest number of S136 detentions.
* is not an outlier for fundamentally defective applications and accounted for 14% with one Health Board accounting for 29%.
* is not an outlier for rectifiable errors and accounted for 25% with one Health Board accounting for 49%.

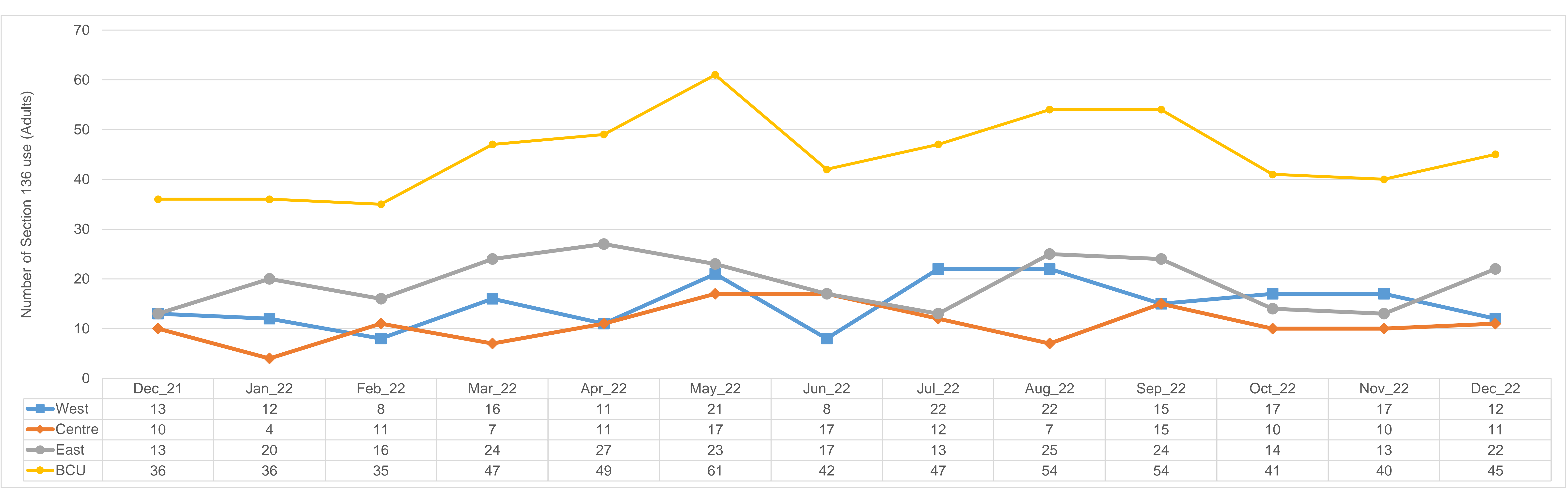
It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report the below information notes the learning/action from each incident.
Fundamentally defective x 1 (Section 3) - INC30903 all staff including the AMHP service have been reminded to check the documents all correspond for the correct section.

Lapsed: one x section 5(2) INC34034 this is currently under investigation.
One x section 3 INC27746 expiry dates are now recorded on a board in the ward as well as being flagged on a weekly email to the unit managers.
One x section 17A (CTO) INC30112 expiry dates are now added to a list of CTOs in the community that are sent to the AMHP managers everytime there is a change this also ensures that if someone on a CTO is admitted under a S136 detail is available straight away.
One x section 136 INC30918 this patient was not fit for assessment but was monitored and assessed by the liaison service.

Section 135 - 136	December 2022	November 2022	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	45	40	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
126	155	↓	138	1	East	49
				2	West	46
				3	Centre	31



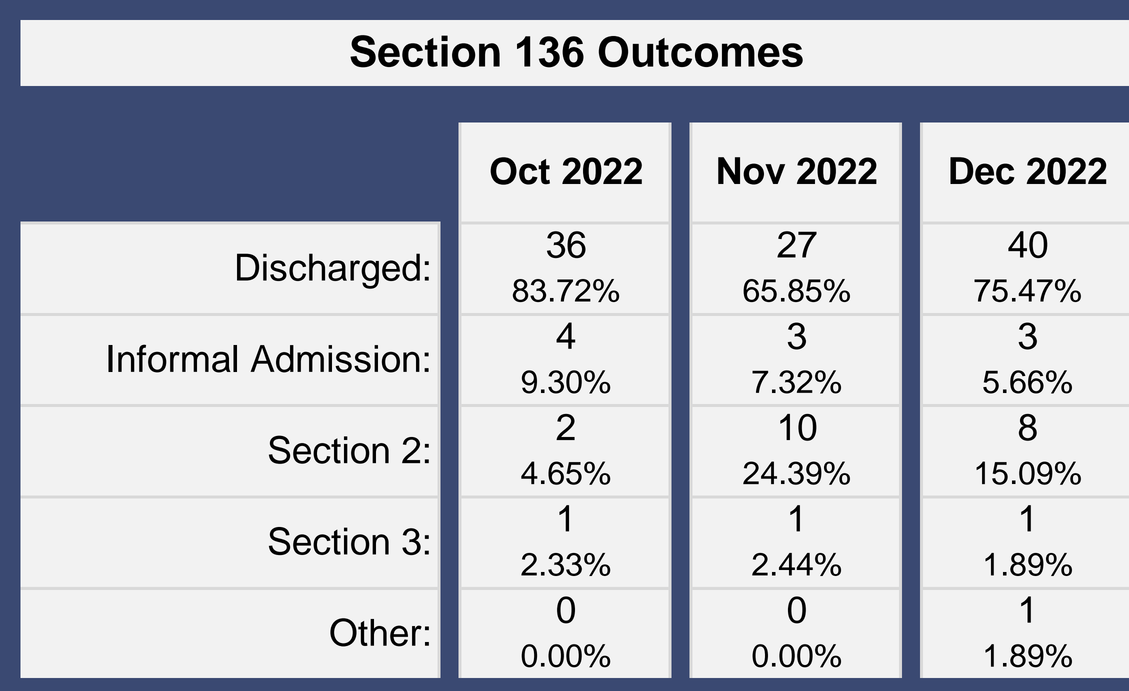
	Dec_21	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	13	12	8	16	11	21	8	22	22	15	17	17	12
Centre	10	4	11	7	11	17	17	12	7	15	10	10	11
East	13	20	16	24	27	23	17	13	25	24	14	13	22
BCU	36	36	35	47	49	61	42	47	54	54	41	40	45

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, two under S3 and one discharge.
One Section 136 lapsed this quarter, INC30903 due to the detainee not being unfit for assessment an assessment was conducted prior to discharge and informal admission agreed.
During this period there were three custody detentions noted as the first place of safety, one was discharged and two resulted in S2 admissions.
Five requests for extensions were made this period, three were discharged two resulted in detentions.

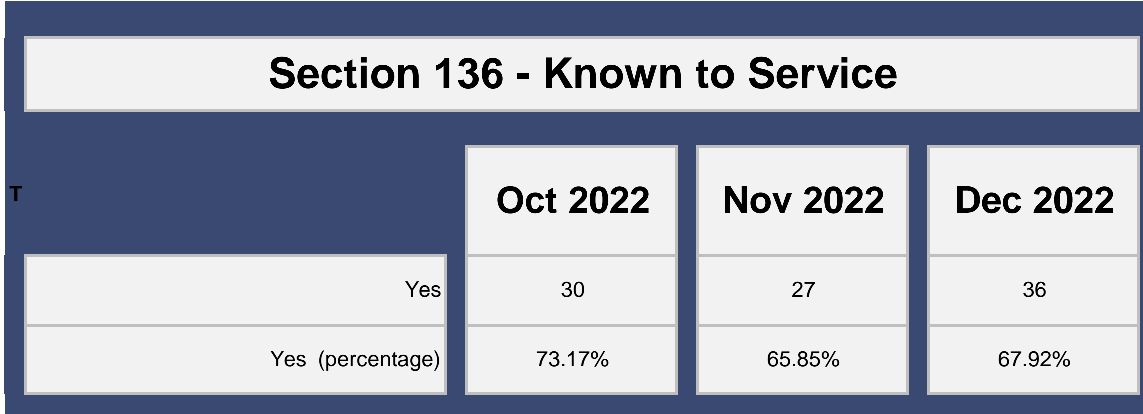
Section 136	December 2022	November 2022	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	45	40	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
126	155	↓	138	1	East	49
				2	West	46
				3	Centre	31



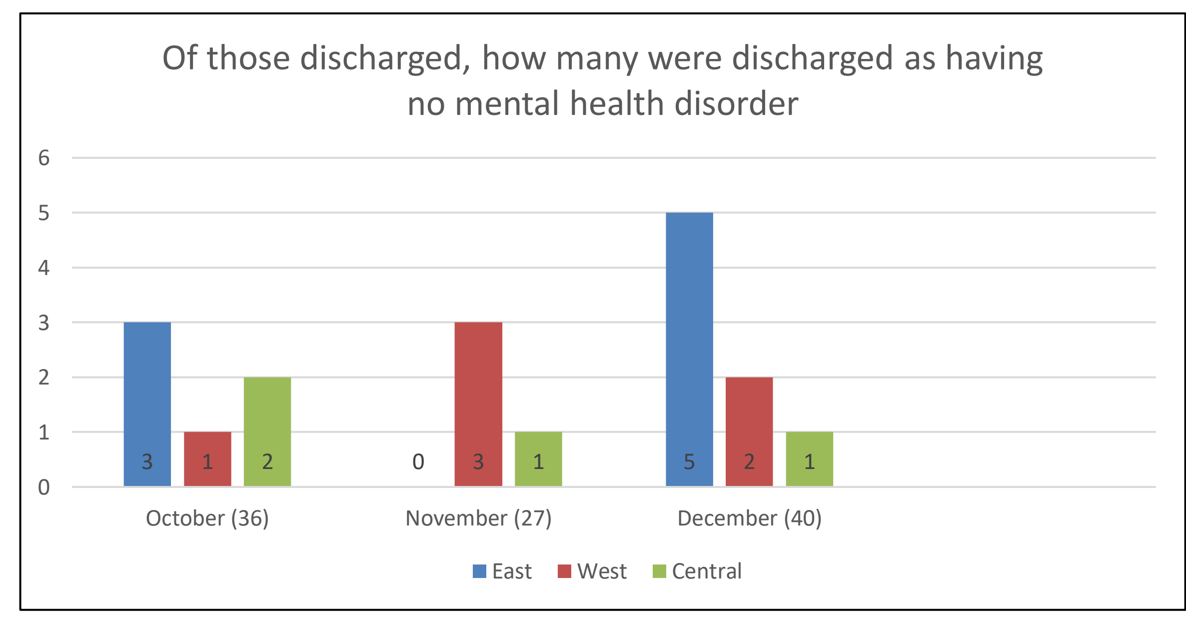
Section 136 Outcomes

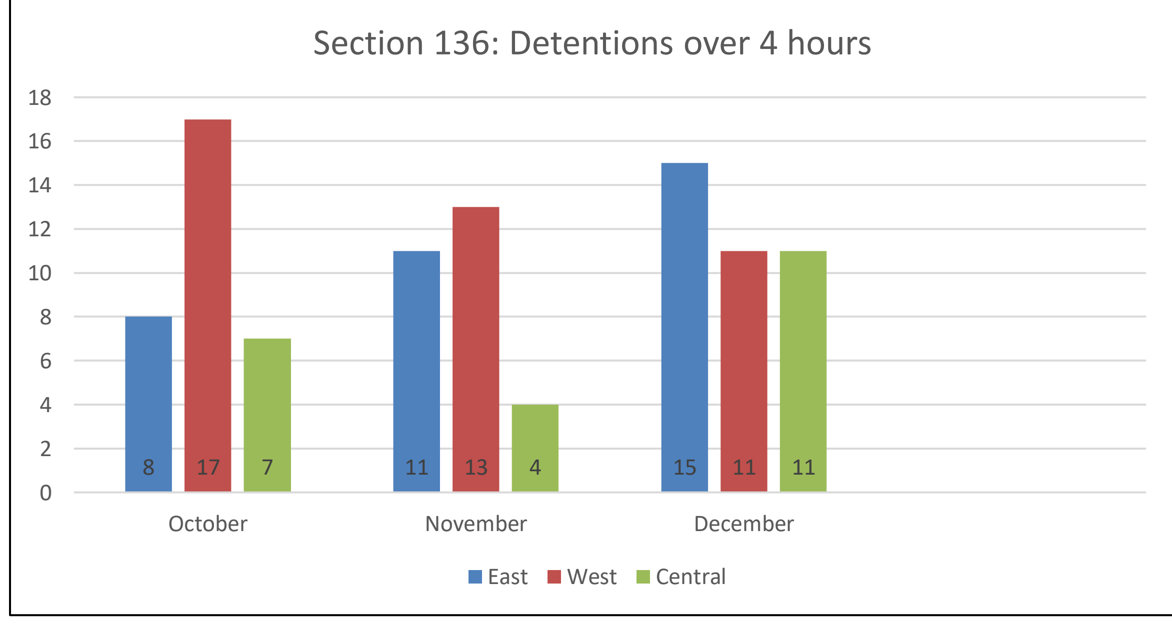
	Oct 2022	Nov 2022	Dec 2022
Discharged:	36 83.72%	27 65.85%	40 75.47%
Informal Admission:	4 9.30%	3 7.32%	3 5.66%
Section 2:	2 4.65%	10 24.39%	8 15.09%
Section 3:	1 2.33%	1 2.44%	1 1.89%
Other:	0 0.00%	0 0.00%	1 1.89%



Section 136 - Known to Service

	Oct 2022	Nov 2022	Dec 2022
Yes	30	27	36
Yes (percentage)	73.17%	65.85%	67.92%





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%.

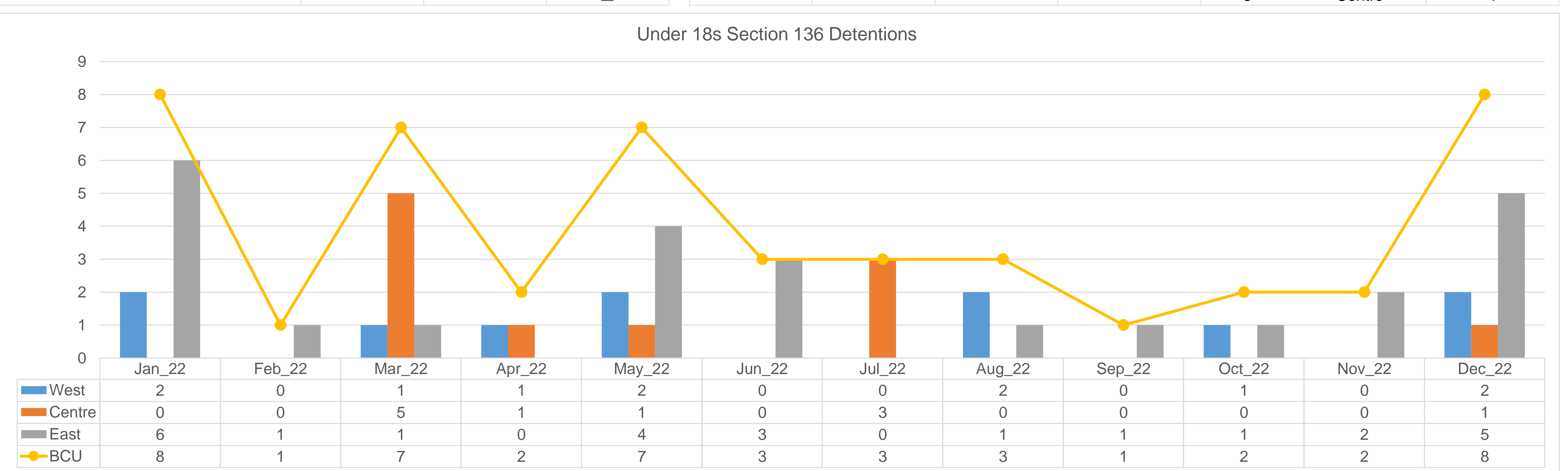
Total percentages of all detentions for those discharged with no mental disorder (rounded up) are:
October 14%
November 10%
December 15%

Data below shows the percentage of the detentions discharged that are followed up by services or new referrals into services these figures are rounded up/down as appropriate:
October 44% discharged follow up, 39% referred to services.
November 56% discharged follow up, 30% referred to services.
December 40% discharged follow up, 38% 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 278 people have not become detained on a S136 due to CJLS intervention. This period accounts for 19 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 136 instances with this period accounting for 12 of those figures.

Section 135 - 136 (Under 18)	December 2022	November 2022	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (<18)	8	2	↑

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
12	7	↑	12	1	East	8
				2	West	3
				3	Centre	1



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	2	0	1	1	2	0	0	2	0	1	0	2
Centre	0	0	5	1	1	0	3	0	0	0	0	1
East	6	1	1	0	4	3	0	1	1	1	2	5
BCU	8	1	7	2	7	3	3	3	1	2	2	8

A total of twelve under 18's were assessed this period between the ages of 12 and 17 years. Five assessment resulted in admission, two initially to the adult unit prior to transfer to appropriate services. four assessments resulted in discharge with follow up to services and three discharges were 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.

5

Under 18 Assessments	
AGE	**Number of Assessments**
11 and 12	1 and 1
13	4
14	5
15	5
16	3
17	12

Outcome of Assessments	
Outcome	**Number**
Returned Home	11
Returned to Care Facility	11
Admission to childrens ward	1
Admission to Adult ward / S136 suite	5
Admission NWAS / CAMHS	3
Admission OOA	0
Other (Friends, Hotel, B&B)	0

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
October	Heddfan	Discharged	CAMHS	09:20	16
October	Hergest	Discharged	CAMHS	05:01	12
November	Heddfan	Discharged	CAMHS	08:35	15
November	Wrexham Maelor	Admission	CAMHS	00:00	17
December	Heddfan	Discharged	CAMHS	22:35	13
December	Heddfan	Admission	CAMHS	22:36	13
December	Hergest	Discharged	CAMHS	20:25	15
December	Wrexham Maelor	Admission	CAMHS	08:30	15
December	Hergest	Admission	CAMHS	18:57	16
December	Ablett	Discharged	CAMHS	08:40	17
December	Heddfan	Discharged	CAMHS	12:20	17
December	Heddfan	Admission	CAMHS	23:25	15

Out of the 12 young persons assessed ten originated from their own home and two from a placement.
Ten 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: 15:22 hrs this is a decrease on the previous quarter figures of (19:49 hrs).
One detention lapsed whilst the young person was being assessed, total time from acceptance of S136 to conclusion was 24:10 hours.

Under 18's admitted to Adult Psychiatric Wards
Two young people remained in the S136 suite prior to thier transfer, one was transferred to an adult unit and one to NWAS.

The table below shows the county that the young persons originated from and where they were assessed for the period April 22 - March 23

County Originated from and where assessed:

	East	Central	West
Wrexham	8	1	2
Flintshire	4	1	0
Denbighshire	2	1	1
Conwy	2	1	2
Gwynedd	0	0	2
Ynys Môn	0	2	1
Out of Area/NFA	1	0	0

Section	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022
Section 35:	1	0	0	0	0	0	0	0	0	0	0	0
Section 37:	1	0	1	1	1	1	1	2	2	2	2	2
Section 37/41:	8	8	8	8	7	5	5	5	5	6	6	6
Section 38:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47:	1	1	1	2	2	2	1	2	2	2	2	2
Section 47/49:	3	3	3	2	3	3	2	2	3	3	4	3
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	1	1	2	2	2	2	2	2	2	2	2	2
Section 3:	5	4	3	3	3	4	4	4	4	4	3	3
Section 45A	0	0	0	0	0	0	0	0	0	0	0	0
Total:	20	17	18	18	18	17	15	17	18	19	19	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

	Oct 2022	Nov 2022	Dec 2022
Internal Transfers	14	17	5
External Transfers (Total)	4	2	6
External Transfers (In)	3	2	3
External Transfers (Out)	1	0	3

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 65 detained patients within independent hospitals this is less than last reported. 31 of these are outside of Wales ie out of area placements, this is more than last reported.

Month	Transfers In
Oct_22	Priory, Nottinghamshire (Conwy)
Oct_22	Pontypool (Wrexham)
Oct_22	Cygnet Nield House (Ynys Mon)
Nov_22	Ty Grosvenor (Wrexham)
Dec_22	Cygnet Godden Green, Kent (Denbighshire)
Dec_22	From Priory Hospital Nottingham (Denbighshire)
Dec_22	From Cygnet Hospital Sheffield (Flintshire)

Month	Transfers Out
Oct_22	Delfryn Lodge Mold (Conwy)
Dec_22	Hafan Y Coed (Repatriated)
Dec_22	Ancora House Countess of Chester (Wrexham)
Dec_22	Cygnet Kent (Denbighshire)

Use of Section 62 by area

Month	West	Central	East
Dec-21	2	6	2
Jan-22	0	3	0
Feb-22	5	1	2
Mar-22	4	4	4
Apr-22	5	2	3
May-22	6	4	2
Jun-22	0	3	2
Jul-22	3	1	2
Aug-22	2	4	2
Sep-22	5	0	2
Oct-22	5	4	4
Nov-22	6	4	1
Dec-22	3	4	2

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.

APPENDIX 2

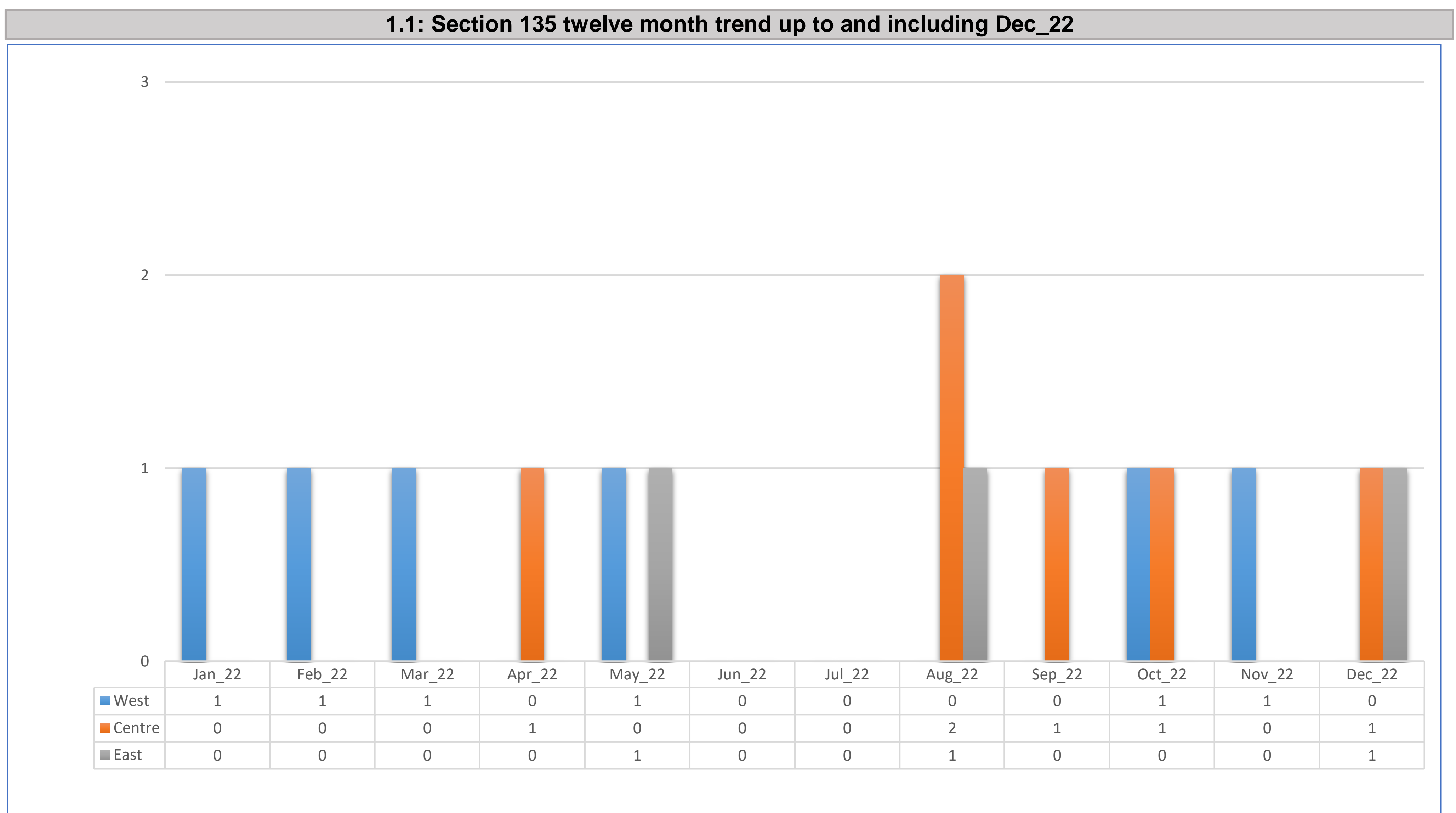
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

S.136/135 use in BCUHB	
KPI Report for:	**December 2022**

Data Source:	BCUHB MHA Database
Report Created on:	10/01/2023
Report Created by:	Performance Directorate

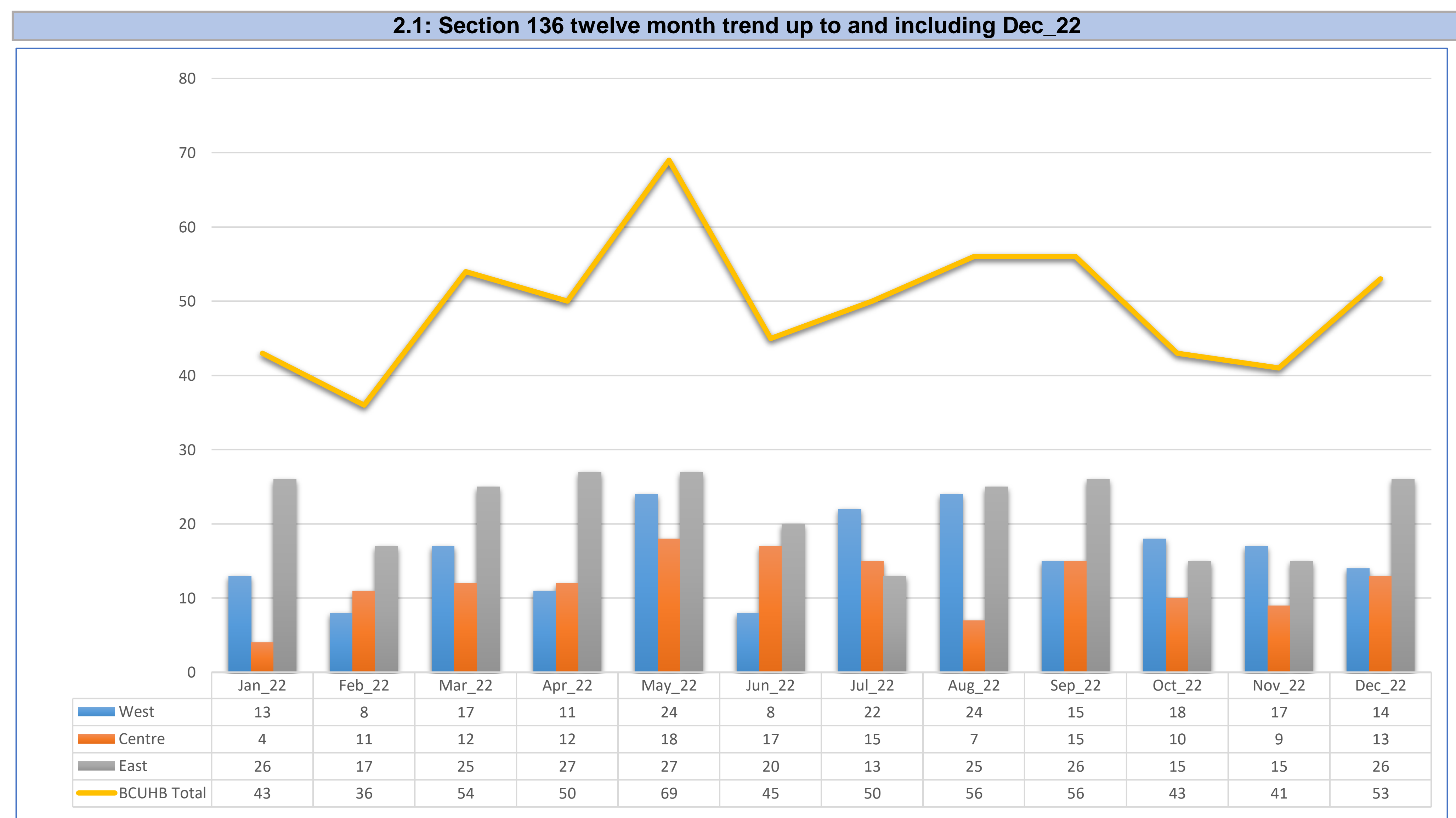
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Dec_22



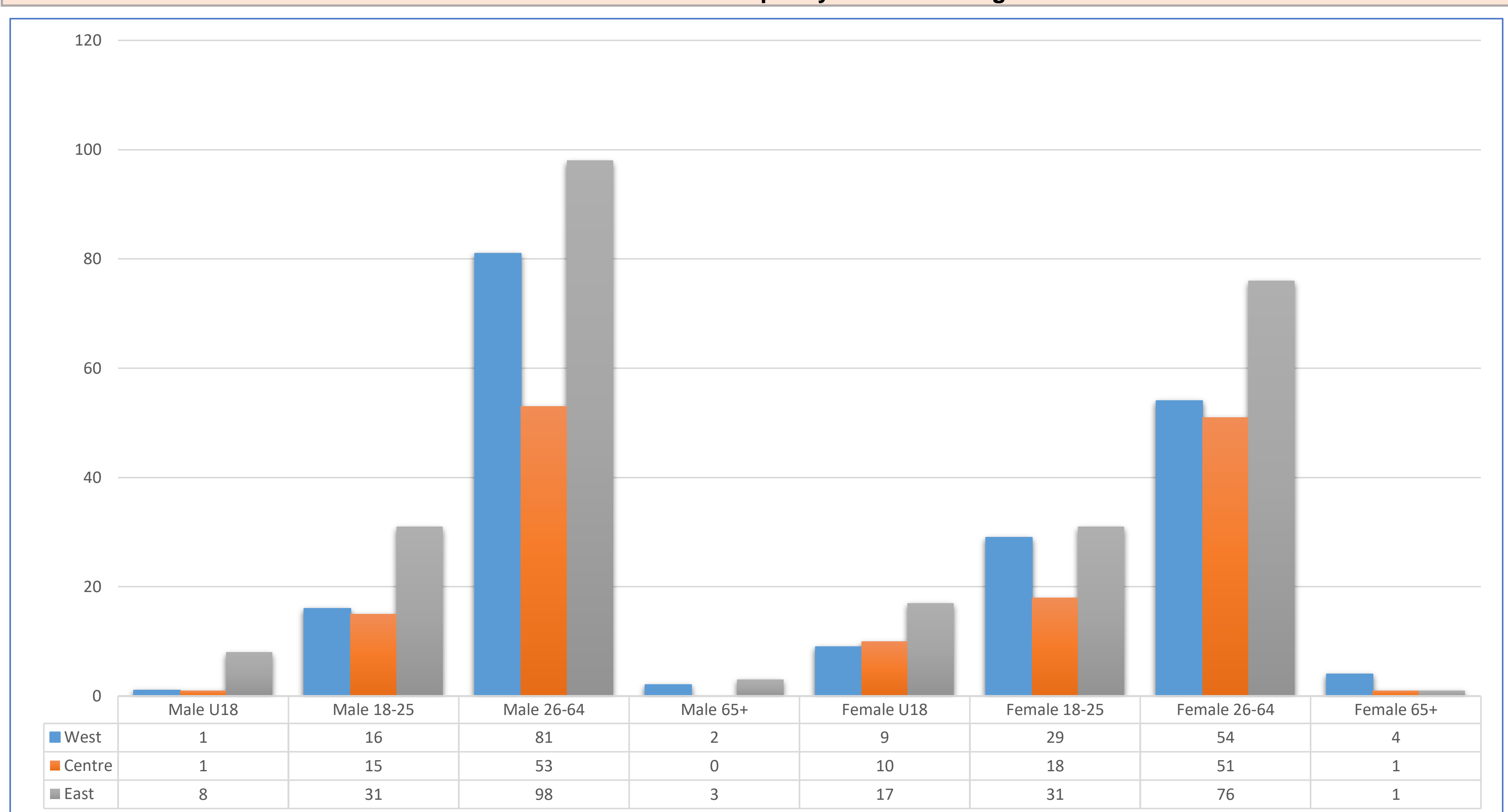
	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	1	1	1	0	1	0	0	0	0	1	1	0
Centre	0	0	0	1	0	0	0	2	1	1	0	1
East	0	0	0	0	1	0	0	1	0	0	0	1

2.1: Section 136 twelve month trend up to and including Dec_22



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	13	8	17	11	24	8	22	24	15	18	17	14
Centre	4	11	12	12	18	17	15	7	15	10	9	13
East	26	17	25	27	27	20	13	25	26	15	15	26
BCUHB Total	43	36	54	50	69	45	50	56	56	43	41	53

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	1	16	81	2	9	29	54	4
Centre	1	15	53	0	10	18	51	1
East	8	31	98	3	17	31	76	1

4: 1st Place of Safety 12 month trend up to and including Dec_22

Area Split - 1st Place of Safety by category

	Dec_22			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	5	6	14	66	54	83
Ward	0	0	0	0	0	1
PICU	0	0	0	0	0	0
136 Suite	8	5	20	121	81	180
Hospital	1	1	0	3	1	2
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	1	0	6	1
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	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	4	3	5	3	11	2	7	10	7	8	1	5
Centre	1	2	7	3	6	9	6	3	8	2	1	6
East	8	4	6	8	6	9	3	10	9	4	2	14

1st Place of Safety: 136 Suite Split	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	10	5	12	9	11	5	14	14	8	9	16	8
Centre	3	9	5	7	11	7	7	4	7	8	8	5
East	18	13	18	19	20	11	10	16	14	10	11	12

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

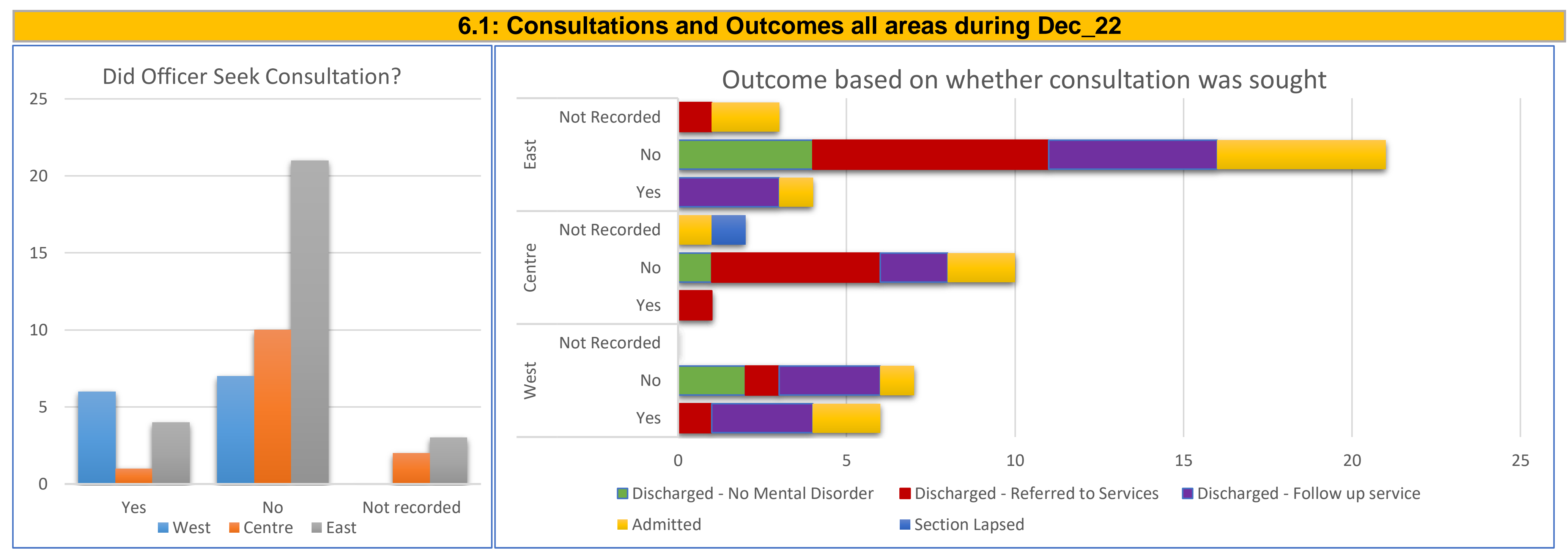
5.1: Area split 3 month table up to and including Dec_22 and latest 12 month total

West	Oct_22	Nov_22	Dec_22	**12 Month Total**	**Centre**	Oct_22	Nov_22	Dec_22	**12 Month Total**	**East**	Oct_22	Nov_22	Dec_22	**12 Month Total**	**Incident rate by county (12 mth total)**	
Ynys Mon	3	4	3	**32**	Ynys Mon	2	0	0	**11**	Ynys Mon	0	0	0	**3**	Ynys Mon	**6.56**
Gwynedd	9	8	6	**86**	Gwynedd	0	1	0	**14**	Gwynedd	1	0	1	**14**	Gwynedd	**9.22**
Flintshire	1	0	2	**8**	Flintshire	0	2	2	**13**	Flintshire	4	3	7	**76**	Flintshire	**6.26**
Wrexham	1	4	1	**17**	Wrexham	3	1	2	**16**	Wrexham	9	10	16	**135**	Wrexham	**12.07**
Conwy	3	1	0	**21**	Conwy	3	1	2	**31**	Conwy	1	0	1	**14**	Conwy	**5.65**
Denbighshire	1	0	2	**22**	Denbighshire	1	5	6	**56**	Denbighshire	0	1	1	**19**	Denbighshire	**10.15**
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	0.93	0.88	0.72	**9.60**	Incident Rate per 10,000 population	0.42	0.47	0.56	**6.64**	Incident Rate per 10,000 population	0.51	0.48	0.88	**8.88**	BCUHB	**8.40**

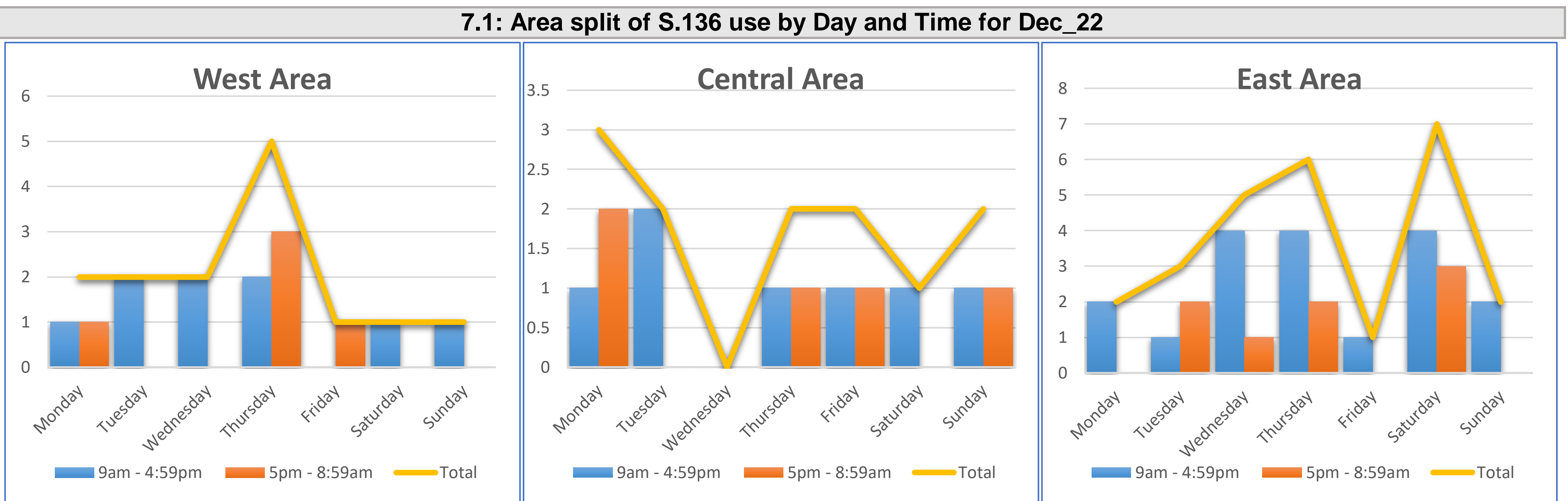
***Please note:** due to County Detained was only captured from November 2017, residents per detention by county detained will only be accurate from November 2018 onwards. Area data is accurate from April 2016

Section B: 12 Month Data for Dec_22

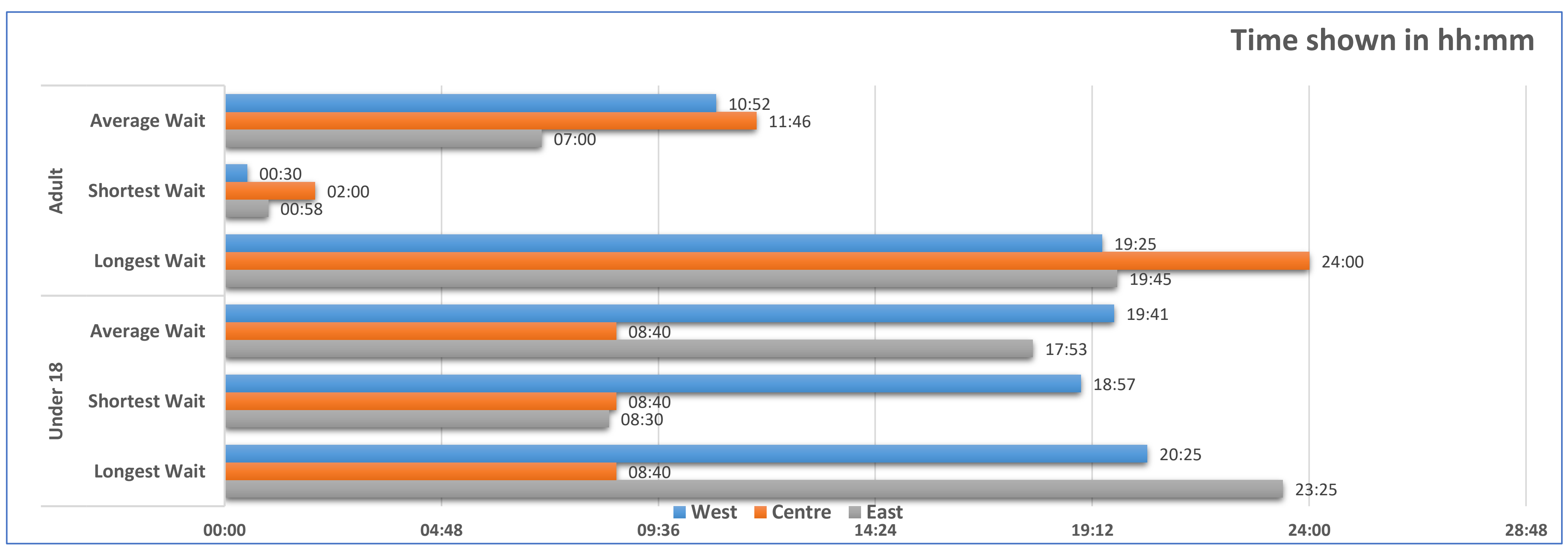
6.1: Consultations and Outcomes all areas during Dec_22



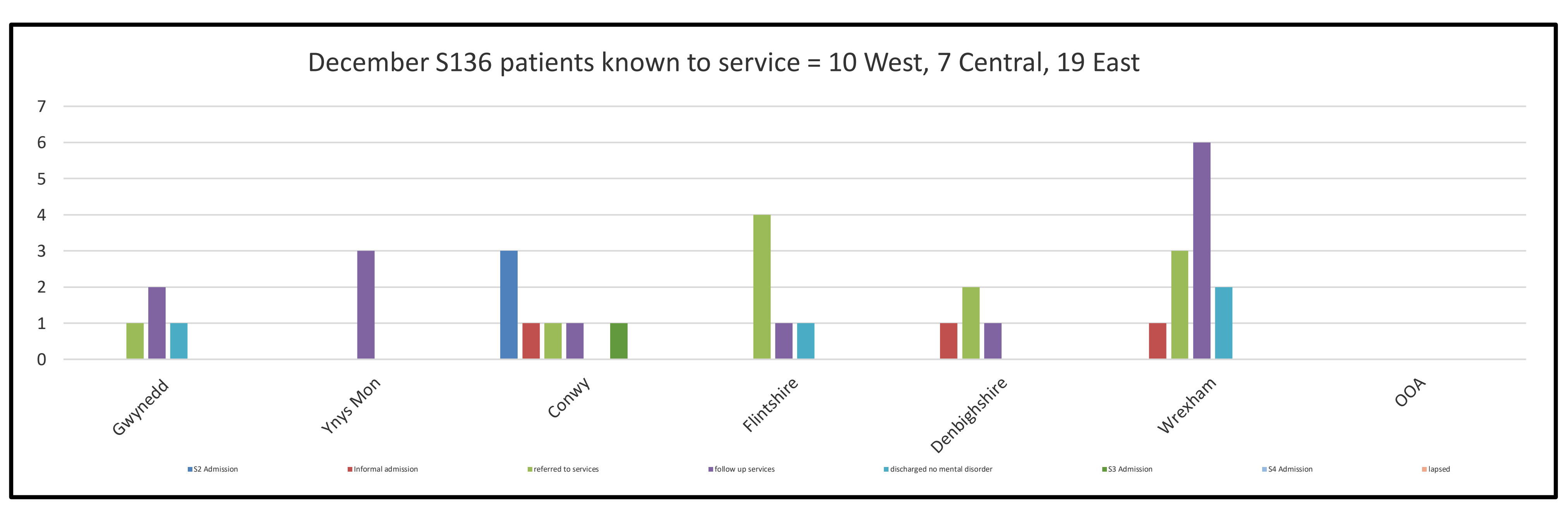
7.1: Area split of S.136 use by Day and Time for Dec_22



8.1: Duration in S.136 Suite for Dec_22



One S136 assessment this month lapsed due to the detainee not being fit for assessment INC30918. Two extension requests were made both people were assessed within the timeframe. 37 assessments were noted to be over four hours, 10 due to the detainees not being fit for assessment, 20 had no reason noted, five were due to doctor availability and two were due to the AMHP availability. The below graph shows the number of people known to services and the outcomes for the areas.



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 53 S136 detentions 11 people were not seen within the closest S136 suite.

Nine were noted to be due to no capacity within the closest suite and two had no reason recorded.

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

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

There were 42 instances where the police did not consult.
These resulted in the outcomes as below:

S2 admission x 6
S3 admission x 0
Informal admissions x 4
Discharged no mental disorder x 8 (total for the month = 8)
Discharged referred to services x 13
Discharged with follow up x 10

a

Appendix 3

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

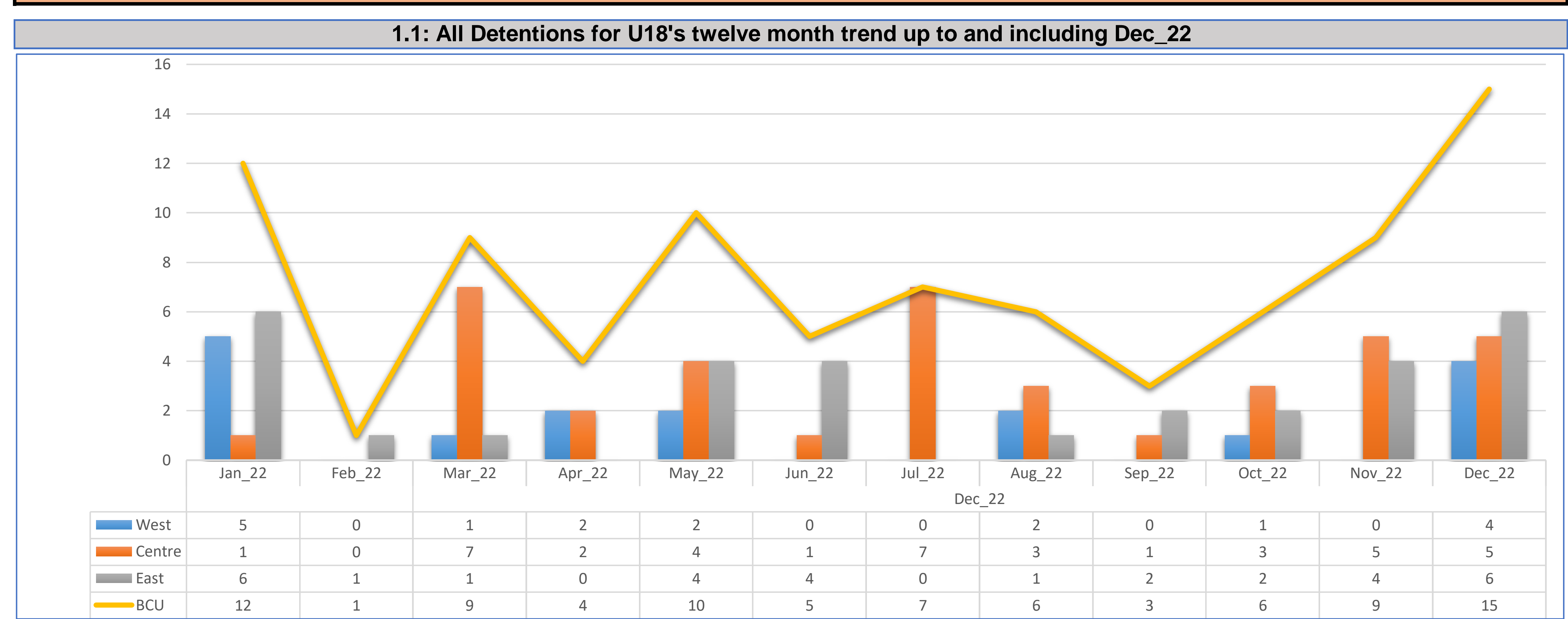
Under 18's detentions in North Wales

KPI Report for: December 2022

Data Source:	BCUHB MHA Database
Report Created on:	10/01/2023
Report Created by:	Performance Directorate

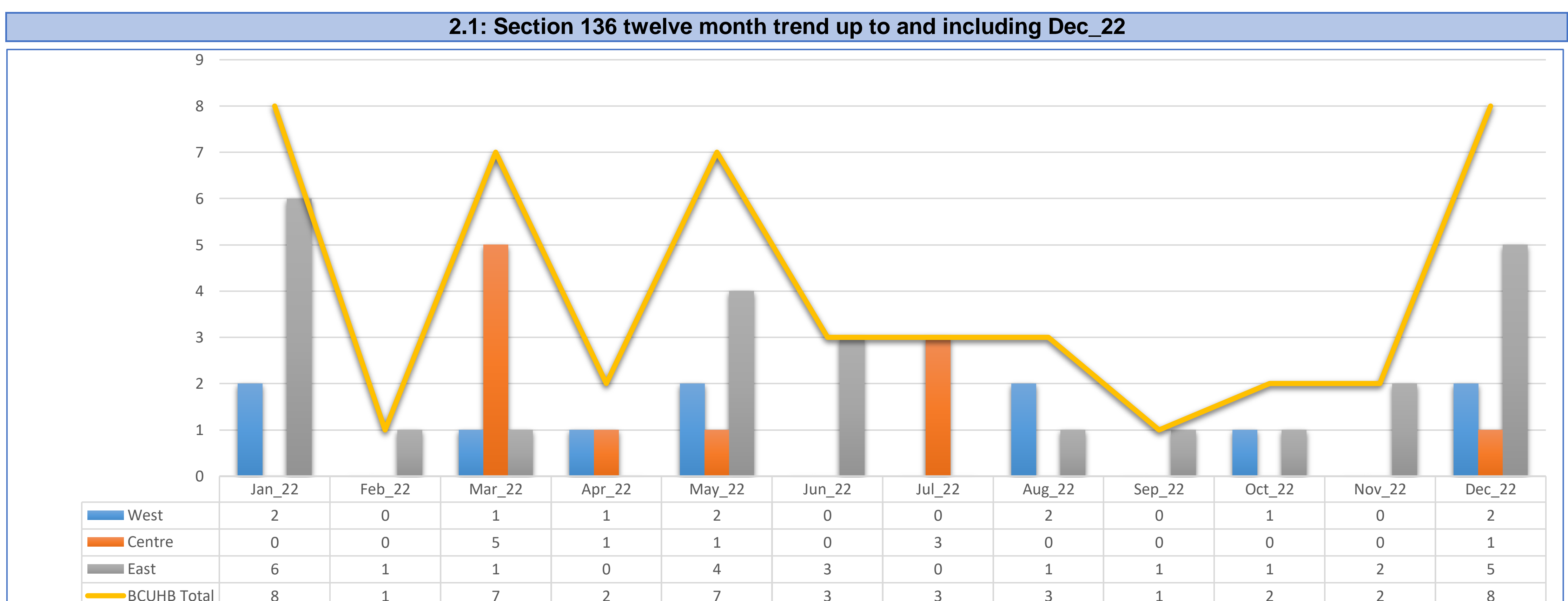
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Dec_22



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	5	0	1	2	2	0	0	2	0	1	0	4
Centre	1	0	7	2	4	1	7	3	1	3	5	5
East	6	1	1	0	4	4	0	1	2	2	4	6
BCU	12	1	9	4	10	5	7	6	3	6	9	15

2.1: Section 136 twelve month trend up to and including Dec_22

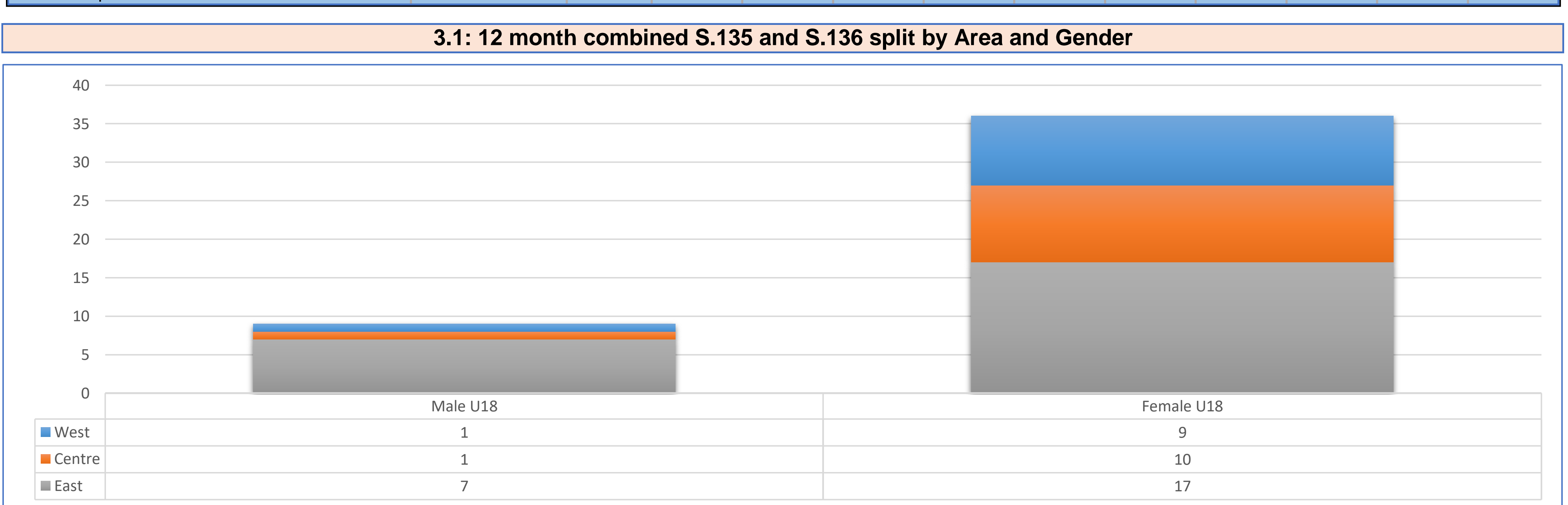


	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	2	0	1	1	2	0	0	2	0	1	0	2
Centre	0	0	5	1	1	0	3	0	0	0	0	1
East	6	1	1	0	4	3	0	1	1	1	2	5
BCUHB Total	8	1	7	2	7	3	3	3	1	2	2	8

2.2: Section 136 Outcomes twelve month trend up to and including Dec_22

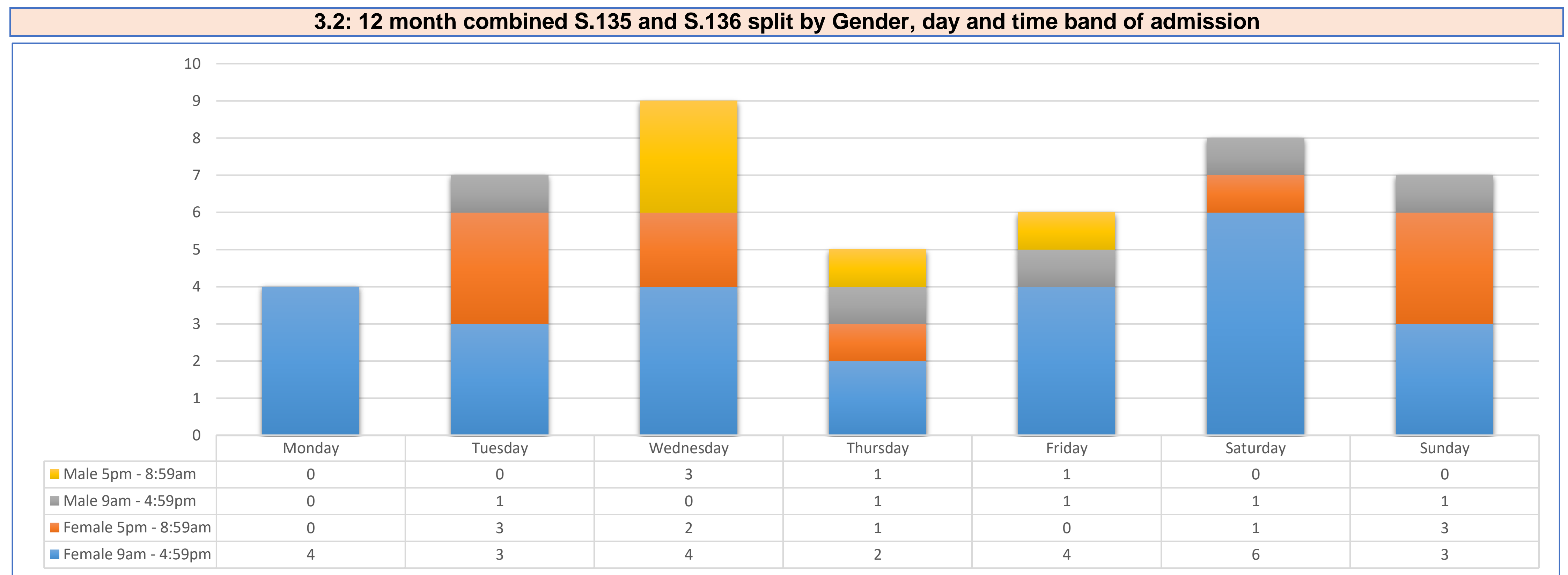
Outcome of 136 detention	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
Discharged - No Mental Disorder	1	1	0	0	0	1	0	0	0	1	0	2
Discharged - Referred to Services	0	0	0	0	0	0	0	0	0	1	1	0
Discharged - Follow up service	5	0	6	2	7	2	2	1	0	0	0	2
Admitted	2	0	1	0	0	0	1	1	0	0	1	4
Section Lapsed	0	0	0	0	0	0	0	1	1	0	0	0

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



	Male U18	Female U18
West	1	9
Centre	1	10
East	7	17

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	3	1	1	0	0
Male 9am - 4:59pm	0	1	0	1	1	1	1
Female 5pm - 8:59am	0	3	2	1	0	1	3
Female 9am - 4:59pm	4	3	4	2	4	6	3

4: 1st Place of Safety 12 month trend up to and including Dec_22

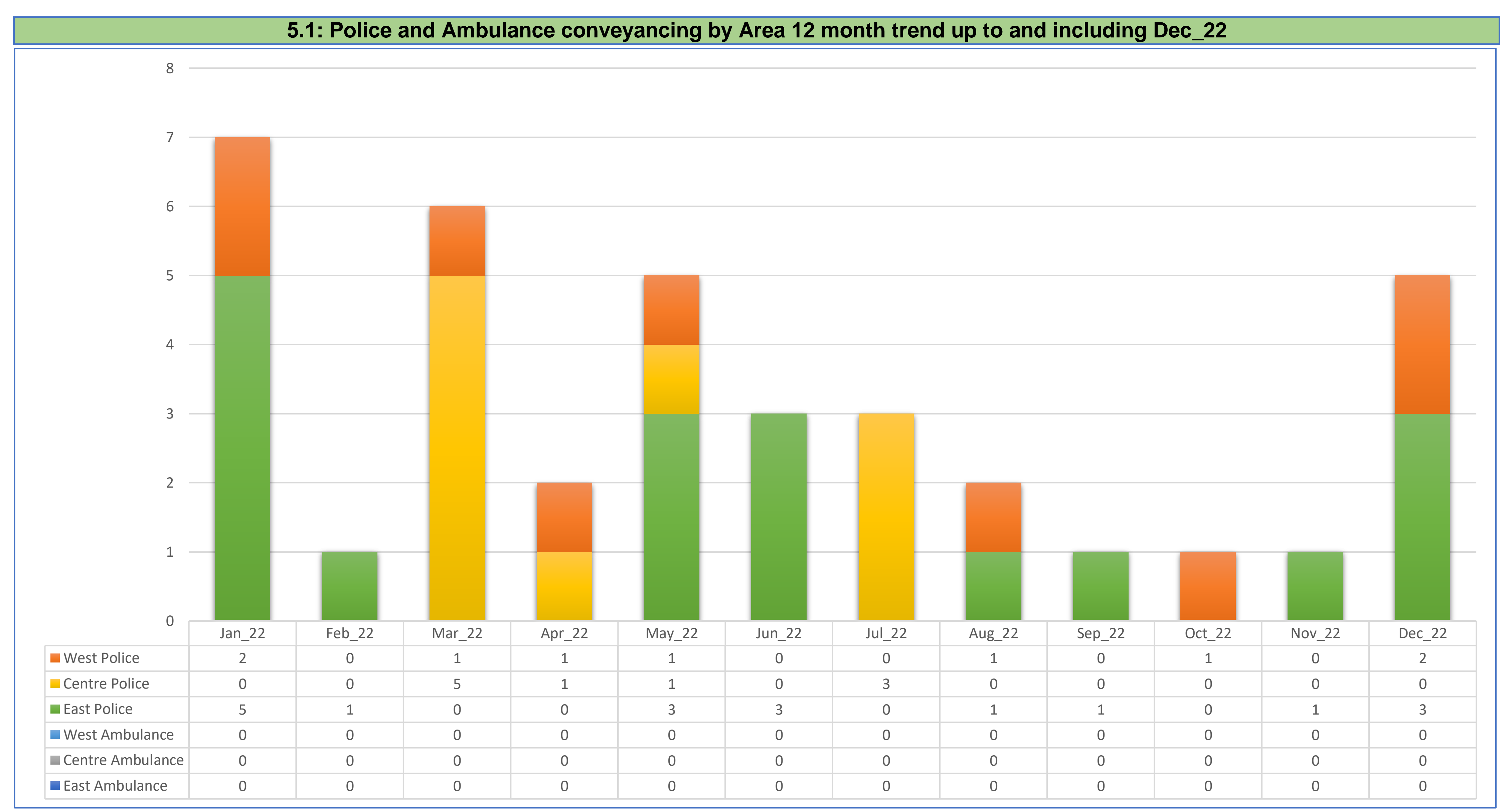
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
A&E	5	0	5	1	2	0	0	2	0	1	1	2
Ward	0	0	0	0	1	0	0	0	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	3	1	2	1	4	3	3	1	1	1	1	5
Hospital	0	0	0	0	0	0	0	0	0	0	0	1
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	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West	1	0	1	0	1	0	0	1	0	1	0	0
Centre	0	0	3	1	0	0	0	0	0	0	0	0
East	4	0	1	0	1	0	0	1	0	0	1	2

5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Dec_22



	Jan_22	Feb_22	Mar_22	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22
West Police	2	0	1	1	1	0	0	1	0	1	0	2
Centre Police	0	0	5	1	1	0	3	0	0	0	0	0
East Police	5	1	0	0	3	3	0	1	1	0	1	3
West Ambulance	0	0	0	0	0	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 Dec_22

7.1: Consultations and Outcomes for Dec_22

OFFICER CONSULTATION?

Yes | No | Not recorded

1 | 3 | 4

Outcome based on whether consultation was sought

Not Recorded: 1
No: 2 | 1 | 1
Yes: 1 | 2

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

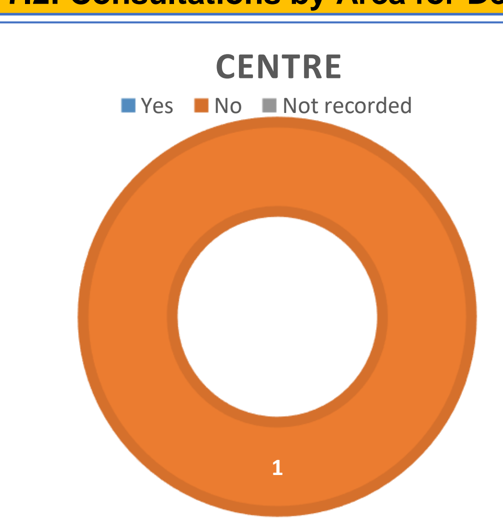
Discharged - No Mental Disorder | Discharged - Referred to Services | Discharged - Follow up service | Admitted | Section Lapsed

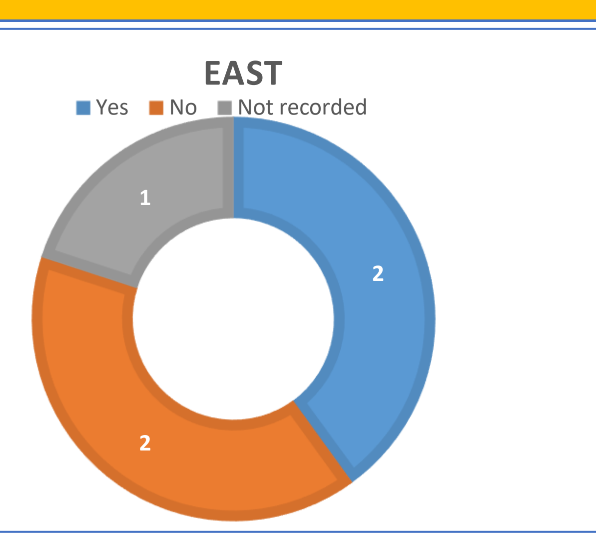
7.2: Consultations by Area for Dec_22

WEST

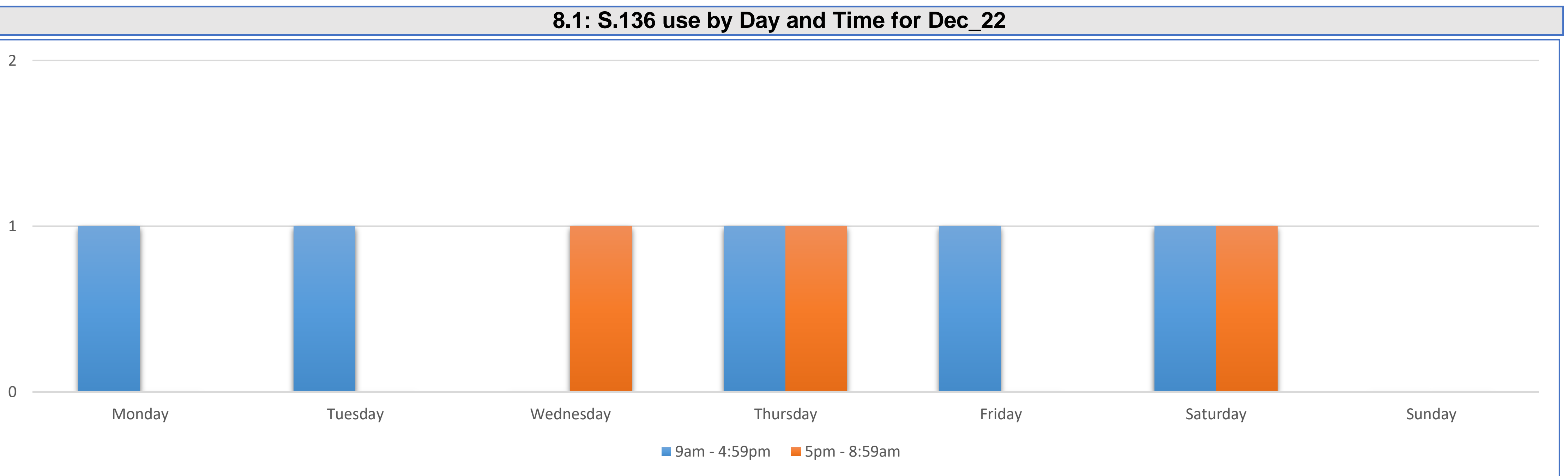
Yes | No | Not recorded

1 | 1

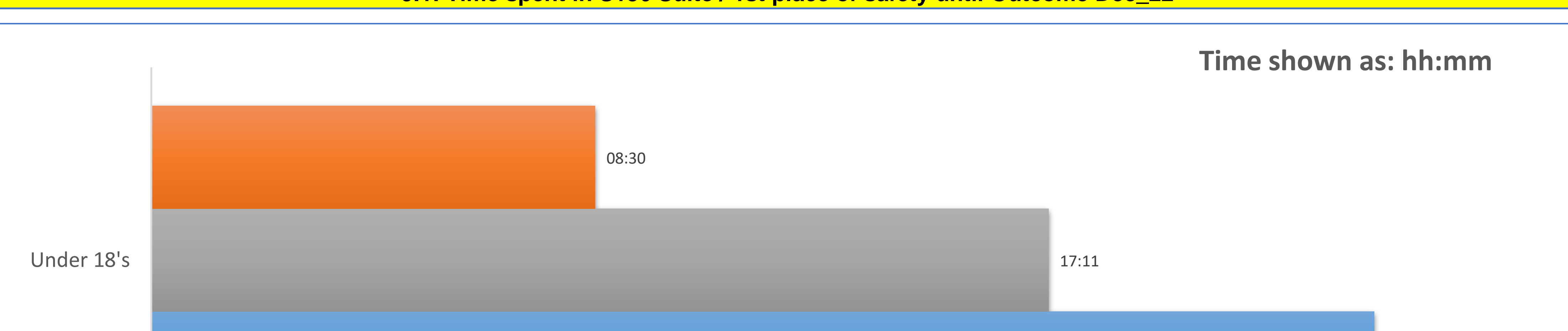
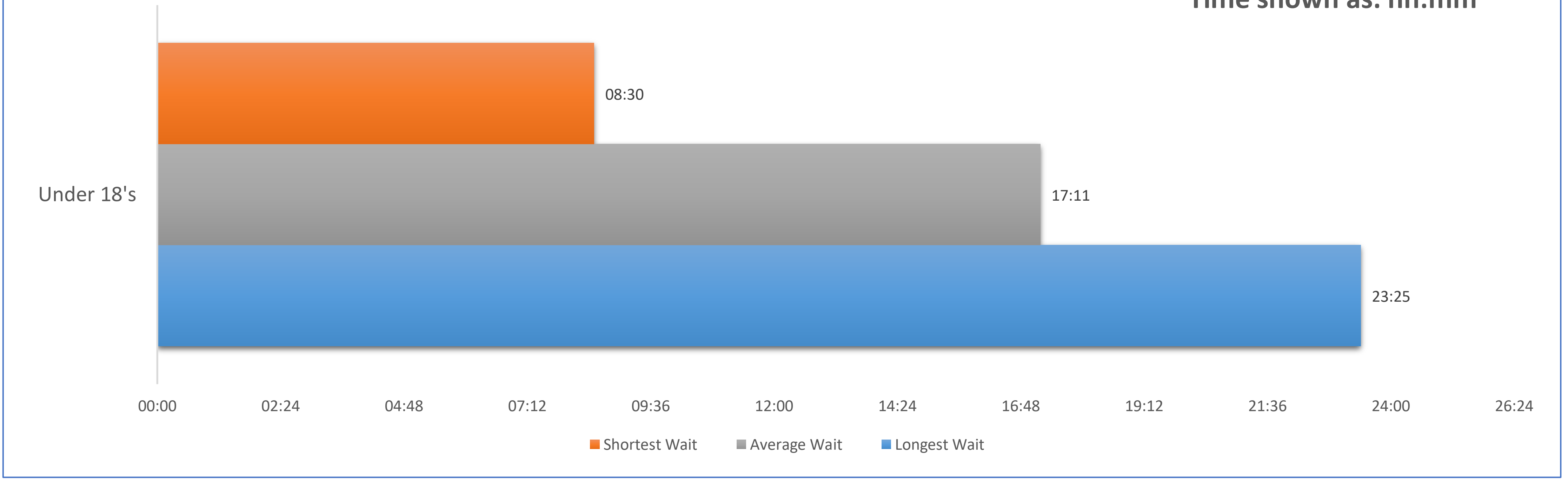




8.1: S.136 use by Day and Time for Dec_22

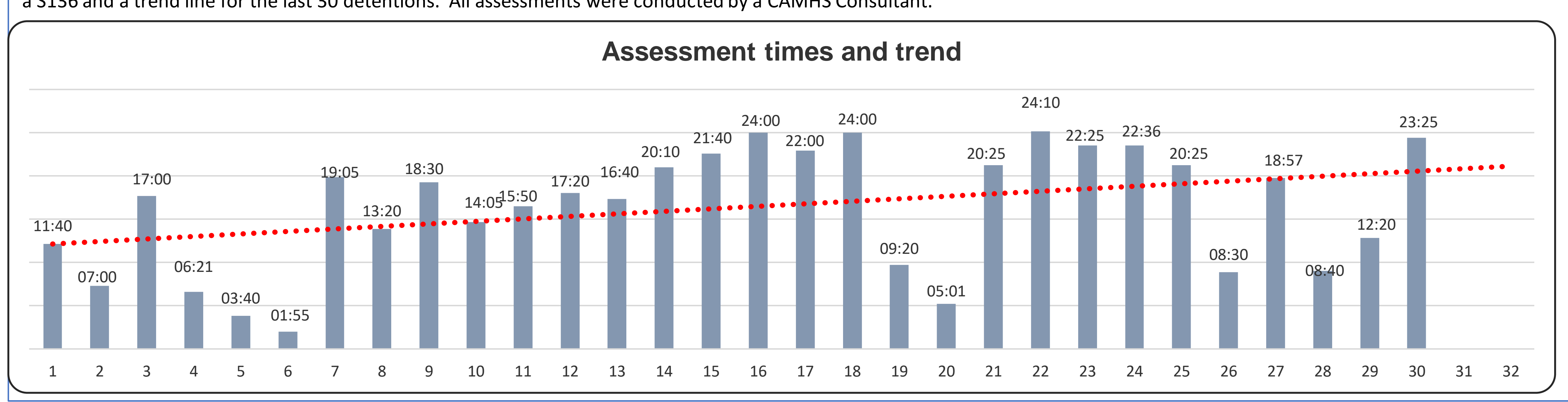


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Dec_22

10.1: Narrative for Dec_22

There were 15 detentions recorded this month for nine young persons. Multiple detentions are recorded due to transfers between units and regradings. A total of eight detentions under section 136, three under section 2 and two under section 3 were enacted this month. 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 S136 detentions in December
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
23 - 22:25	15:30	18:00	OOH
24 - 22:36	17:30	17:40	OOA
25 - 20:25	15:12	16:50	within hours
26 - 08:30	01:35	02:00	OOA
27 - 18:57	21:40	21:40	OOA
28 - 08:40	04:20	04:20	OOA
29 - 12:20	22:40	01:40	OOA
30 - 23:25	14:00	14:20	within hours

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Corporate Risk Register Report</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Mental Health Act Capacity and Compliance Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">The purpose of this standing agenda item is to highlight and to note the progress on the management of the Corporate Risk Register and the new escalated. The scheduled Risk Management Group meeting which was due to be held on the 6th December 2022 was cancelled and in accordance with good governance the Health Board Leadership Team have approved the Risk Management Group papers and recommendations.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to:

Review and discuss the report.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Nick Lyons, Executive Medical Director</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Phil Meakin, Associate Director of Governance</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">Individual risks detail the related links to Strategic Objectives.</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="3">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.</td></tr>
<tr><td colspan="2">Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</td><td colspan="3">No</td></tr>
</table>

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Individual risks detail the related links to the Board Assurance Framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group were scheduled to meet on the 6th December 2022 to scrutinise the risks. Following the cancellation of the Group the Health Board Leadership Team have approved the papers, recommendations and proposals.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â’r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Individual risks detail the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf:

Next Steps:
The Risk Management Group will be meeting on the 10th February 2023; therefore, an updated position of the risks will be presented during the next Mental Health Act Capacity and Compliance Committee.

Rhestr o Atodiadau:

List of Appendices:

Appendix 1 - Mental Health Act Capacity and Compliance Committee Corporate Risk Register Report.

Appendix 2 – Newly Escalated Risks.

Appendix 3 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score.

Appendix 4 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels.

Mental Health Act Capacity and Compliance Committee
10th February 2023
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 Corporate Risk Register(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 were due to meet on the 6th December 2022, following the cancellation of the meeting, and, in accordance with good governance, the Health Board Leadership Team were requested to review and approve the Risk Management Group papers, recommendations and proposals in relation to the updating of the risks on the Corporate Risk Register. As the Risk Management Group meeting was cancelled no "deep dive" into a Corporate Risk was undertaken, this will be carried out at the next Risk Management Group which is scheduled for the 10th February 2023.

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting which is scheduled for the 10th February 2023.

2.2 Following the discussion and support at the Risk Management Group during August 2022, risk CRR20-06 is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' (CRR22-32) has been developed, and was approved for inclusion on the Corporate Risk Register at the October 2022 Risk Management Group. A second of the three proposed revised risks has further been developed and included on the Corporate Risk Register following approval from the Health Board Leadership Team 'Risk of Lack of access to clinical and other patient data' (CRR23-33). Work remains ongoing to develop the 3rd revised risk 'Risk of poor clinical recording of patient information', which will include the transfer over of open actions from the current CRR20-06 and result in the closure and archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'.

2.3 The following risks have been incorporated onto the Health Board's risk register and following Executive approval have been included onto the Corporate Risk Register (Appendix 2).

- CRR23-34 – There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.
- CRR23-35 – Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.

2.4 The following risks have been incorporated onto the Health Board's risk register and following Executive approval work is ongoing to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model.
- CRR23-36 - Cost of Living Impact on Staff and Patients.
- CRR23-37 - Targeted Intervention.
- CRR23-38 - Workforce.
- CRR23-39 - Patient Flow - Impact on Access and Quality of Care

It is not anticipated that any of the risks will fall under the remit of the Mental Health Act Capacity and Compliance Committee.

2.5 The following risks were also considered by the Risk Management Group related to Vascular Services.

2.5.1 CRR22-25 – Risk of failure to provide full vascular services due to lack of available consultant workforce. – This risk was approved for escalation during the October 2022 Risk Management Group meeting. Following positive developments there is a proposal to de-escalate this risk to be managed at Tier 2 level as part of the December Risks Management Group paper recommendations. As this is a proposal for a de-escalation of a CRR Risk this proposal will be formally confirmed at the Quality, Safety and Experience (QSE) Committee in March 2023. The QSE Committee will be provided with the appropriate information to support the review.

2.5.2 CRR22-26 – Risk of significant patient harm as a consequence of sustainability of the acute vascular service. - This risk has been approved for escalation during the October 2022 Risk Management Group meeting and following positive developments there is a proposal to de-escalate this risk to be managed at Tier 2 level as part of the December 2022 Risk Management Group paper recommendations. As this is a proposal for a de-escalation of a CRR Risk this proposal will be formally confirmed at the QSE Committee in March 2023. The QSE Committee will be provided with the appropriate information to support the review.

2.5.3 Furthermore, in relation to the above two risks a new risk will be developed that encompasses a broader consideration of risk related to the Vascular services.

2.6 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)	29	0	5	1
Tier 2 (9-12)	319	97	36	100
Tier 3 (1-8)	218	52	43	89

2.7 Training for MHLD Update

The Regional Risk Manager for West and Head of Governance for MHLD has historically had regular meetings to discuss risk management, risk registers and training in risk management. Recent organisational changes within the Division has led to a handover of the risk role to a new Interim Head of Governance MHLD.
An initial meeting has taken place to discuss plans for a targeted training initiative and the establishment of a Divisional Risk Management Group.
Training is now been planned for February 2023 and will initially, be targeted at Divisional Directors and Heads of Operations.

3 Budgetary / Financial Implications

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

4 Risk Management

4.5 See the details of individual risks in Appendix 1.

5 Equality and Diversity Implications

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

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

Appendix 1 – Mental Health Act Capacity and Compliance Committee Corporate Risk Register Report.

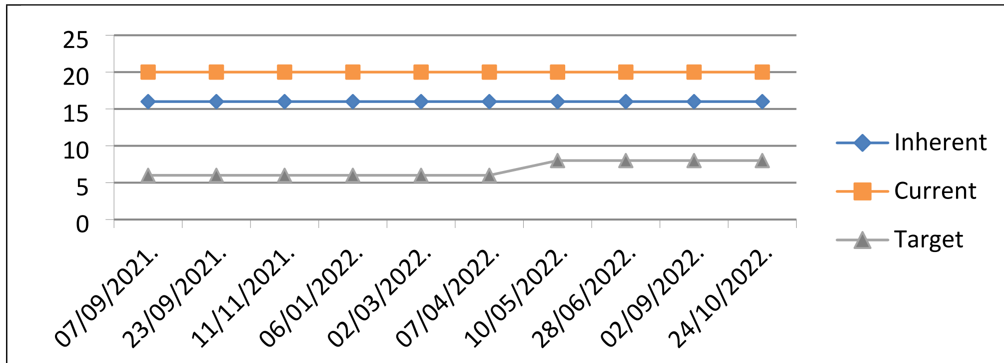
<table>
<tr><td rowspan="4">CRR21-14</td><td>Director Lead: Executive Director of Nursing and Midwifery.</td><td>Date Opened: 20 August 2021</td></tr>
<tr><td>Assuring Committee: Mental Health and Capacity Compliance Committee</td><td>Date Last Reviewed: 24 October 2022</td></tr>
<tr><td rowspan="2">Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.</td><td>Date of Committee Review: 04 November 2022</td></tr>
<tr><td>Target Risk Date: 31 October 2023</td></tr>
<tr><td colspan="3">There is a risk that the increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

This may be caused by the increased number of patients who are refusing admission or who have a 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.

The amendments to the Mental Capacity Act, resulting in new legislation and the required preparation by the Welsh Government for the implementation of the Liberty Protection Safeguads (LPS) requires engagement at a National, Regional and Local level which has resulted in the divertion of resources.

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 an increase in financial cost, poor patient experience and reputational damage for BCUHB.</td></tr>
</table>



	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 July 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 are 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. 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 non recurring 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.	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 Board Workshop. 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.

8. Liberty Protection Safeguards (LPS) Implementation group is in place to inform the organisation of LPS and to commence the preparation for the receipt of COP and future implementation of LPS across the organisation reporting to the Mental Health Capacity and Compliance Committee [MHCCC] Committee. 9. Welsh Government non recurring monies are identified to strengthen training and implementation of LPS for 16/17 year olds. 10. Heads of Safeguarding Strategic Objectives are cross referenced and include actions from the identified Safeguarding Risks ensuring triangulation and governance. These risks are monitored following the Safeguarding Governance Framework. 11. Welsh Government non recurring monies have supported the development of training materials for MCA, and the appreciation and understanding of capacity, which has included the reiteration of the safeguarding Team and the contact details.	6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government. 7. A Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the safeguarding team, which is reported to the MHCCC (Mental Health Capacity Compliance Committee). 8. The MCA awareness materials were disseminated from 14th November – Safeguarding Week.

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 BCUHB Business Case has been approved as part of the Integrated Medium Term Plan (IMTP) 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. The business case has been delayed presentation to the Board Workshop due to challenges. (The next available date is Feb 2023) To support additional activity WG non recurring monies has supported the implementation of additional roles and activities. 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.
6. New Liberty Protection Safeguards Code of Practice is proposing that the commissioning arrangements of Independent Mental Capacity Advocates will be the responsibility of Health Boards on behalf of both health and local authorities. At present there is a lack of commissioned service in place and new arrangements require establishments in terms of governance arrangements and quality monitoring. Confirmed with WG and meeting arranged with the 6 local authorities.
7. Sudden rise in the number of DoLS assessment resulting in a backlog. We are, currently using non recurring Welsh Government monies to support current post holders to work additional hours, weekends and evenings (we are unable to recruit to specialist posts).
8. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting, this was identified in a Court of Protection DoLS case and it is noted that this is not unique to BCUHB. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance. Immediate safeguards are in place and work is taking place alongside the Risk Team who has developed a SoP.
9. There are local and national staffing challenges with regard to the recruitment of MCA and DoLS (BIA) specialist staff. This has been recognised by Welsh Government. There are currently no Best Interest Assessor courses available to train staff as a result of the delayed authorisation of the Legal Framework. We are supporting flexible working arrangements, the immediate recruitment to vacancies and current post holders (BIAs) are working enhanced hours to deliver out of hours support. From November/December a 7 day MCA and DoLS advisory service using WG non recurring monies will be in place.
10. During Q2 2022-23 there has been an increase in the number of DoLS applications submitted by the Managing Authority 74% of all applications required amendments to the application prior to authorisation. A rolling audit activity with immediate escalation is in place.
11. The team and service is experiencing a combined sickness and vacancy position of 30%. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.
12. The development and ratification of strategic activities are delayed and some are outside of the original timescales. Risk assessments against each activity are in place to identify the risk and priority of the activity. Specific activities are highlighted to reporting Committees/Groups to obtain agreement if timescales require amendment or escalation.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in Controls reviewed to ensure relevance with current risk position. 3. Welsh Government monies identified to strengthen training and implementation of LPS for 16/17 year olds. 4. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance in relation to identified community settings. 5. Action ID's 18117 and 21213 – Actions remain delayed. The Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The Workforce advice is to be obtained prior to submission to the Board Workshop. 6. Action ID 20957 – Action delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023. 7. Action ID 23066 – Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action (ID 24305) for the monitoring of Mental Capacity Act [MCA] training has resulted from the closure of this action as BCUHB continue to evidence low compliance with MCA mandatory training data. 8. Action ID 23505 – BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG guidelines and national legislation. 9. Identification of new action - Using WG non recurring monies, current safeguarding team members are undertaking additional 'out of hours' (7 day service) DoLS assessments in-line with WG guidance and approval. This is monitored weekly to prevent staff 'burn out' and to support their health and wellbeing. This is funded via non recurring WG monies. 10. Identification of new action - Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients within the community. National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services to support the development of a Standard Operating Procedure is underway. Training Data is under review relating to key services, with the objective to develop a bespoke training provision and evidence improved identification of service users who require a legal deprivation to be in place. 11. Identification of new action - Embed regular audits to monitor and implement actions to improve the current quality of DoLS applications. This will ensure that the documentation meets the requirements of the legal framework and BCUHB's legal duties in line with the Deprivation of Liberty Safeguards legislation.

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

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	BCUHB IMTP resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. The delay in the draft LPS Code of Practice has resulted in challenges to identify posts and evidence the required resource specific to LPS for the BCUHB safeguarding Business Case. Progress update WG has released non recurring monies (based upon a business case model) to support the preparation for	Delay

					LPS. This is to focus upon the implementation and awareness of the MCA and reduce the DoLS backlog. The Corporate Safeguarding IMTP has been agreed and we were informed in January 2022 that safeguarding is on the reserve list. Work is taking place to agree the current Safeguarding Budget with Finance. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. Workforce advice has been obtained prior to submission to the Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve	

					monies for this financial year 2022-2023 Non recurring WG funding has been utilised to support out of hours BIA assessments and enhanced roles and responsibilities of existing staff – recruitment to specialist roles remains to be a challenge.	
	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. October 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023.	Delay
	21213	Utilise the agreed BCUHB IMTP funding application to support the	Michelle Denwood, Director of	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the	Delay

		increased activity within Safeguarding.	Safeguarding and Public Protection		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. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice is to be obtained prior to submission to Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve monies for this financial year 2022-2023	

	23066	Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.	Michelle Denwood, Director of Safeguarding and Public Protection	30/11/2022	Action Closed 24/10/2022. 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. October 2022 progress update - Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action for the monitoring of MCA training has resulted from the closure of this action as BCU continue to evidence low compliance with MCA mandatory training data.	Completed

	23505	Establish commissioning and governance arrangements for IMCAS as directed by the LPS code of practice. In line with WG guidelines ensure that there is suitable provision of IMCA services across the geographical area.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	The appointment of Independent Mental Capacity Advocates and delegated resource will ensure patients voice and choice will be heard and will be part of the legal considerations given to a patients Deprivation of Liberty. Additional IMCA's will support the LPS process and provide patietns with an independent voice under the legal framework. Working with the six LA's provides assurance that all interested agencies are aware and engaged in the process. October 2022 progress update - BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG guidelines and national legislation.	On track

	23506	Establishment of operational groups to support the implementation of LPS within clinical and operational service delivery.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	To ensure that the service and function is embedded in front line practice. This will reduce unlawful detention and comply with the Code of Practice.	On track
	24304	Implementation of a task and finish group for Court of Protection DoLS within key community settings to ensure internal engagement to establish clear lines of accountabilities, escalation and governance.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	This will reduce the likelihood of unlawful detention relating to the directions of the court.	On track
	24305	Improve the implementation and understanding of the Mental Capacity Act (MCA) and improve MCA Mandatory training compliance.	Michelle Denwood, Director of Safeguarding and Public Protection	30/10/2023	Improve understanding and unlawful detention of service users. Update Position Training resource and a variety of materials are to be disseminated throughout the	On track

					organisation during Safeguarding Week 14th Nov. Enhanced Training Audit activities are to be identified.	
	TBC	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding to engage in the development of a SoP to support to manage the complex process of Community DoLS and for the identification of patients who may be eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors and Commissioned Service Providers National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with	On Track

					Commissioning Services has commenced.	
	TBC	Develop, implement and trial a 7 Day Out of Hours MCA and DoLS advisory service utilising WG funding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Utilise WG funding to ensure out of hours MCA and DoLS compliance amongst frontline services. Undertake audits of applications and BIA activity/performance within the trial period. Review the trial 7 day service to determine the long term requirements of services.	On track
	TBC	Embed regular documentation audits into practice to provide assurance that there is no delay in the quality or completion of DoLS applications.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Updating current audit activity will ensure that the submitted DoLS and MCA documentation meets the requirements of the legal framework in line with the Deprivation of Liberty Safeguards legislation. An improvement in the documentation submitted will reduce the time taken to process applications, reduce the time taken by front line	

					staff having to amend or revisit documentation, and ultimately speed up the process of authorisation which will ensure compliance with the legal framework.	

Appendix 2 – Newly Escalated Risks

<table>
<tr><td rowspan="4">CRR23-34</td><td>Director Lead: Executive Director of Public Health</td><td>Date Opened: 28 June 2017</td></tr>
<tr><td>Assuring Committee: Partnerships, People and Population Health Committee</td><td>Date Last Reviewed: 31 October 2022</td></tr>
<tr><td rowspan="2">Risk: There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.</td><td>Date of Committee Review: New Risk</td></tr>
<tr><td>Target Risk Date: 31 March 2024</td></tr>
<tr><td colspan="3">There is a risk that residents in North Wales may be unable to quit smoking.
This may be caused by their current smoking behaviours including use of vapes and illicit tobacco, income levels, living in socio-economically deprived areas, have a mental health condition or disability, or are from ethnic backgrounds and/or from the LGBTQ+ community.
This may result in lack of confidence and/or capacity to engage with Help Me Quit Services.
This may result in premature mortality and disease including cancers, respiratory diseases and cardio vascular disease, including strokes, heart attacks and dementia.
This may impact on the Board's ability to achieve its national performance target.
This will impact on the Board's ability to comply with the Smoke Free Regulations 2020.</td></tr>
</table>

<table>
<tr><td rowspan="6">To be populated following approval</td><td></td><td>Impact</td><td>Likelihood</td><td>Score</td></tr>
<tr><td>Inherent Risk Rating</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td>Current Risk Rating</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td>Target Risk Score</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td>Risk Appetite</td><td colspan="2">low level</td><td>1-8</td></tr>
<tr><td>Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board</td><td colspan="3">New Risk</td></tr>
</table>

Controls in place	Assurances
1. Continuation of the HMQ for Baby Service with additional investment from Prevention and Early Years funding to support the development and pilot of an Incentivisation Scheme in one area. 2. Continuation of the HMQ in Hospital Service with additional investment from WG Prevention and Early Years funding to support the further development of this service in line with NHS Performance Framework 22-23 to support both staff and patients. 3. Investment from the WG Prevention and Early Years funding to provide support for patients with mental health conditions to support introduction of Smoke Free Regulations. 4. Pharmacy Level 3 Services supported by Prevention and Early Years funding. 6. Insight work to understand barriers identified by priority groups in accessing HMQ Services. 7. HMQ Communications Plan to include a focus on promotion of new service developments and informed by engagement with priority groups with targeted social media to encourage take up of Services. 8. Nicotine Replacement Therapy for staff insight report. 9. BCUHB's Smoke Free Regulations response to include support for staff, patient documentation, no smoking policy, signage, mental health services provision, compliance support and interface with Local Authorities. 10. Business Case for Hospital Compliance Officers (Smoke Free Environment Officers). 11. 'No Ifs No Butts' campaign with partners across the region. 12. De-normalisation actions with partners across the region.	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements.

2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success.
3. Provision currently through National funding, with funding identified for 2 years, cost pressures for the health board if the national funding were withdrawn.
4. Services are not based onsite at all main hospitals.
5. There are difficulties attracting to vacant posts due to fixed term nature - funding is not recurrent.

Progress since last submission
A small BCUHB group has been established to update the policy in line with smoke free legislation relating to mental health and to complete an updated and more comprehensive EQIA alongside this policy. Occupational health are currently leading this supported by BCUHB colleagues. It is anticipated that this work will be completed by end November, following this the reports will then be submitted to relevant BCUHB groups/committees for information.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	22820	Communication - social media HMQ	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit	On track

	22823	HMQ Services Strengthening the Service	Mrs Gwyneth Page, Public Health Assurance & Development Manager	30/12/2022	Encourage smokers to access services and quit	On track
	22824	Communication - Partnership Plan	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit	On track
	22825	HMQ Services - Accommodation of staff	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/12/2022	Encourage smokers to access services and quit	On track
	24229	Maternity incentive pilot	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	This will encourage people to attempt quit, accept support and stay quit. Reduction in pregnant smokers in line with priorities in the tobacco control action plan.	On track
	24230	Primary Care Project (EAST Managed Practices)	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Engaging with smokers through local GP practice to encourage interaction with service and quit attempts.	On track

<table>
<tr><td rowspan="3">CRR23-35</td><td>Director Lead: Executive Director of Finance and Performance</td><td>Date Opened: 19.11.2018</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 02.11.2022</td></tr>
<tr><td>Risk: Electrical and Mechanical Infrastructure on the Wrexham Maelor Site</td><td>Date of Committee Review: New Risk
Target Risk Date: 31.03.2027</td></tr>
<tr><td colspan="3">There is a risk of system failure in regard to the Infrastructure on the Wrexham Maelor site which is becoming increasingly obselete due to age and condition.
The impact could result in an immediate and unplanned loss of clinical services.</td></tr>
</table>

<table>
<tr><td rowspan="6">To be populated following approval</td><td></td><td>Impact</td><td>Likelihood</td><td>Score</td></tr>
<tr><td>Inherent Risk Rating</td><td>4</td><td>5</td><td>20</td></tr>
<tr><td>Current Risk Rating</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Target Risk Score</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Risk Appetite</td><td colspan="2">Select low, moderate or high level</td><td>1-8</td></tr>
<tr><td>Movement in Current Risk Rating Since last presented to the Board in – New Risk</td><td colspan="3">New Risk</td></tr>
</table>

<table>
<tr><th>Controls in place</th><th>Assurances</th></tr>
<tr><td>1. On Call Estates Officers and site shift staff available to attend in the case of a failure or outage. Specialist Electrical and Mechanical Engineering Contractors on-call to attend site
2. Specialist Imprest stock held in stores.
3. Bi monthly meeting of Business Continuity Team which includes representation of all stakeholders impacted by this risk.
4. The BCU Planning Team (Chaired by the Hospital Director) have developed a Business Continuity Plan for essential mitigation of electrical infrastructure</td><td>1. Risk discussed at Estates Divisional meeting - Bi-monthly. Discussed at the East Site and IHC Risk Management Groups.
2. Authorised engineers (auditors) that assess compliance with current HTMS.</td></tr>
</table>

associated site risks and also includes those services which would be affected and need to relocate.	

Gaps in Controls/mitigations
Redevelopment Programme planning although recommenced is not finalised.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use resources (key enabler)	BAF21-13 BAF21-17

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	21570	Business Continuity Planning	Mr Rod Taylor, Director Of Estates	01.04.2022	The aim of this approach is to provide Corporate assurance that a sequence of progressive management actions are in place to mitigate and react to site developments in order to provide near continuous support to YMW based services.	Completed

	21488	Internal Gateway Review -YWM PBC	Mr Rod Taylor, Director Of Estates	31.03.2023	This approach will provide assurance review to confirm if sufficient resource has been made available and how the risk will be managed until all issues are resolved.	Completed
	21571	YWM Continuity Programme Phase One	Mr Rod Taylor, Director Of Estates	31.03.2024	This will provide clarity on the deliverables, timelines and identify any unresourced areas.	On track
	23751	YWM Redevelopment Programme	Mr Ian Donnelly, Ihcd Operations East	31.03.2024	This will provide assurance that all elements of the PBC have been implemented and associated risk will therefore have been effectively managed and reduced.	On track
	24340	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace full sections of cable between substations in their entirety therefore reducing the amount of joints and as such improving resilience. In order to mitigate the risks the following replacements are proposed with 11kv rated armoured cable:	On track
	24341	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	To provide the level of resilience security and switching control required it is proposed that a new substation is constructed which can accommodate a 6-panel distribution panel, this is also to accommodate a separate switchgear from the DNO which	On track

					will controlled by the Health Board.	
	24342	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	It is proposed that to provide greater resilience for this element that the substation is fitted with 2 No. ring main units and 2 No. 1,000 KVA transformers replacing the currently defective equipment.	On track
	24343	Phase 1 Continuity Scope of Works - Heating Systems in EMS Part of YWM Site	Mr Rod Taylor, Director Of Estates	31.03.2024	The risks with the heating systems will be mitigated by: Retaining pipework where there is a 2-pipe system and replacing areas served by 1 pipe systems – to increase the efficiency of the system. Installing separate heating systems for each of the outbuildings connected to the central boiler house, such that each building is self-sufficient – removing a single point of failure to the outbuildings. Installation of injection circuit stations at the head of each department – to provide greater control and aid commissioning. Installation of above ground distribution pipework – to allow maintenance and reduce any down times. Installation of instantaneous point of use water heaters to hand basins and sinks - removing the	On track

					single point of failure to the outbuildings.	
	24344	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	The installation of 9 new area valve service units and new distribution pipework at a high level both externally and within the buildings for ease of access. NIST (Non-interchangeable screw threads) Lockable Line Valves will be provided where applicable so to minimise disruption to the Hospital should any future works to the system be necessary. The pipe run design has been sized at 35mm diameter to provide capacity for the system to work in pandemic conditions.	On track
	24345	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new vacuum plant to plant rooms 1.4 and 8a with associated pipework to run in areas which allow for ease of maintenance. This also allows for N+1 resilience and an overall capacity of 6,505L/min.	On track
	24346	Phase 1 Continuity Scope of Works - Medical Gas Supplies	Mr Rod Taylor,	31.03.2024	Installation of new multiplex medical air plant complete with safety valves and integral	On track

		and Distribution Pipework (MGPS) (Workstream 3)	Director Of Estates		controls. To service the increased capacity required of 6,800L/min and providing N+1 resilience.	
	24347	Phase 1 Continuity Scope of Works - Fire Detection Upgrade L1 and Fire Alarm Panels	Mr Rod Taylor, Director Of Estates	31.03.2024	The renewal of previously installed panels, including loop isolators which have become obsolete and the installation of a new separate network. A new network loop will be installed across the whole site excluding the residential facilities located within the north site.	On track
	24348	Phase 1 Continuity Scope of Works - Nurse Call including Emergency and Panic Alarms	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace the Nurse call and Panic Alarms to all wards within the YMW site.	On track
	24349	Phase 1 Continuity Scope of Works - Heating Calorifiers and Roofing Works	Mr Rod Taylor, Director Of Estates	31.03.2026	To improve obsolete systems associated with Hot Water generation and distribution by upgrading existing Hot Water Calorifiers. Roofing refurbishment will take place to EMS Flat Roof areas and valleys.	On track
	24350	Phase 1 Continuity Scope of Works - Critical Ventilation Systems	Mr Rod Taylor, Director Of Estates	31.03.2027	Critical Ventilation Systems and plant replacement for Theatres 1 to 8 including upgrading the Main Kitchen Ventilation system.	On track

Appendix 3 - 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	16
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			
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		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
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.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	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
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

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
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
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce.	This risk may be able to be de-escalated. Will be discussed at March QSE		
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	This risk may be able to be de-escalated. Will be discussed at March QSE		
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		
CRR22-32 (Formally CRR20-06)	Retention and Storage of Patient Records	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-33 (Formally CRR20-06)	Risk of Lack of access to clinical and other patient data	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-34	There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	Executive Director of Public Health	Partnerships, People and Population Health	15
CRR23-35	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.	Executive Director of Finance	Quality, Safety and Experience	16

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.

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.

Teitl adroddiad: *Report title:*	Criminal Justice Liaison update report			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee (MHCACC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 10 February 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides data around activity of the Criminal Justice Liaison service.			
Argymhellion: ***Recommendations:***	The Board is asked to note the report. Particular attention is paid toward the levle of S136 use. This report evidences low numbers of pre-consultation by officers. Of the 299 S136 used in the past six months, CJLS have been consulted with for 122 potential S136 whilst this is an increase of 34 and a promising sign that consultation maybe increasing following on from previous reports, it evendences just 27.8% of the total number of S136 in this last six month period. Of those 122 consultations there has been a documented diversion of 39. This data is further broken down by geographical area within the report. This report also addesses the bespoke clinics held across the region. Of the 165 available assessment slots past reporting period, 88 of these where not attended. This equates to just over 53% non-attendance, hence discussion needed with senior probation management.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health			
Awdur yr Adroddiad: ***Report Author:***	Ruth Joyce, Criminal Justice Liaison Service Manager, Mental Health & Learning Disabilities			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***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:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Mental health and learning disability division
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	EQIA completed
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	None identified
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Current national issues around recruitment. The team have one whole time vacancy. There is an existing member of staff that is having a trail period as per redeployment policy
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Growth of service may impact in team establishment figures which may need review.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Ordinarily Divisional QSE Due to change in meeting dates the paper was not listed on cyle of business at divisional QSE
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	N/A

Reason for submission of report to confidential board (where relevant)	
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** • Appendix 1 - Criminal Justice Liaison Service (CJLS) Quarter 3&4 Report July-Dec 2022	

Mental Health Capacity and Compliance Meeting – 10/02/2023

Appendix 1 - Criminal Justice Liaison Service (CJLS) Quarter 3&4 Report July-Dec 2022

Background.

Background (CJLS) has been operational since January 2019. The service covers a 9-5 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 has accessed services along with psych liaison records and liaison.

Performance:

During this previous 2022 Quarter 3 and Quarter 4 CJLS have documented involvement with 711 calls/events received in FCC which is consistent with previous reporting. Data from North Wales Police states that within the previous Q3 and Q4 the force control center (FCC) received 29,769 emergency calls and 55,615 non-emergency calls. 101 and 999 calls showed overall a slight increase reporting period.

Month	999	101
July 2022	10,780	19,244
Aug 2022	10,677	19,902
Sept 2022	8,312	16,469
Totals	29,769	55,615

Unfortunately data for quarter 4 was not available due to staff movement and transfer of email systems. Therefore it is not possible to work out exact percentage on term of involvement. However when looking at previous figures this usually equates to approx. 1.2% of emergency calls. Whilst this may seem a small number, as mentioned in previous reporting, often complex calls can take a large portion of a single practitioner's shift and events dealt with as per police priority to preserve life and a large proportion of the 101 are slow time crime or not directly crime/incident related.

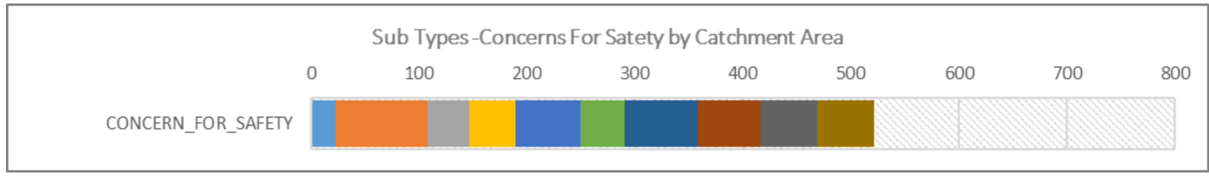
CJLS continue to explore areas of demand within strategic Public Protection of Vulnerable Persons Unit (PVPU) and within the health board. This work could be further enhanced upon on an operational level by the potential mental health act meeting in planning by the Interim director of nursing.

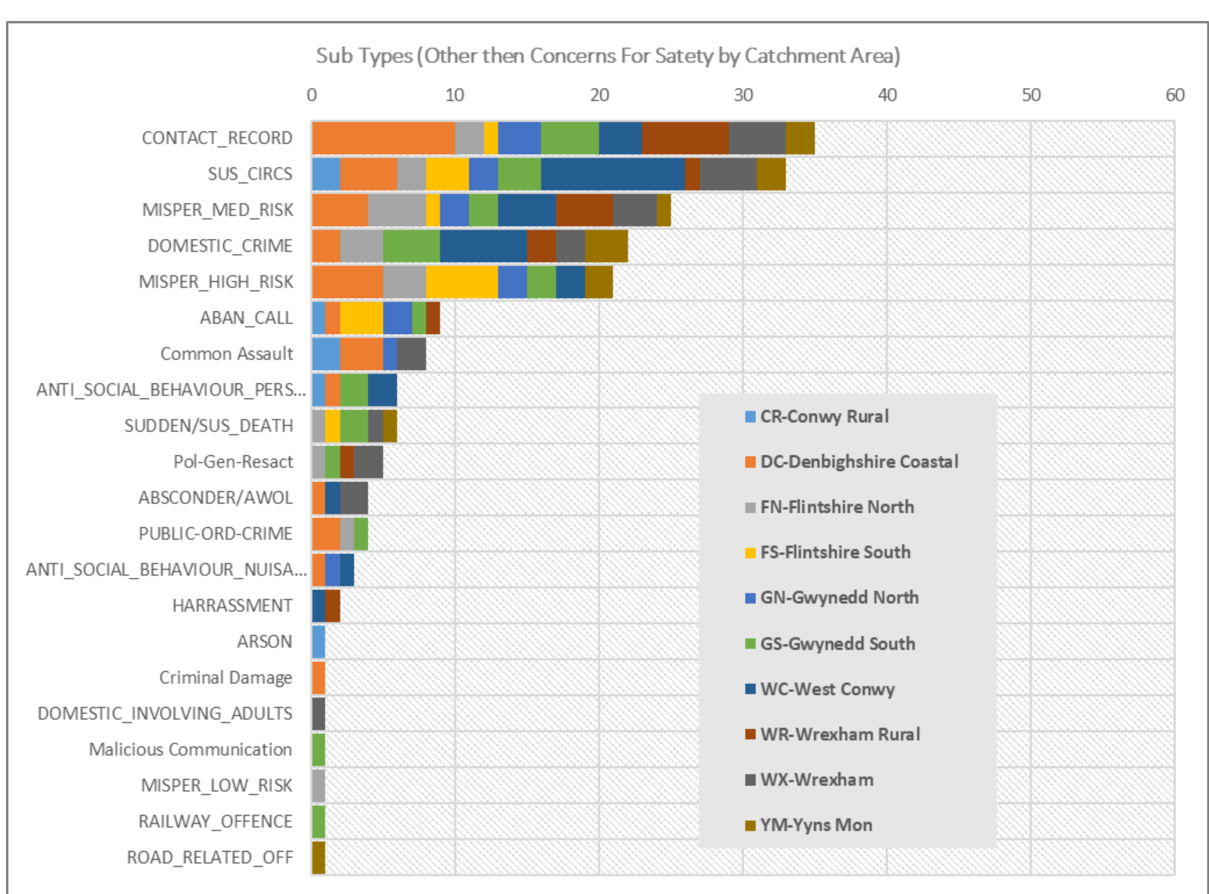
CJLS continue to have an active part in the completion of complex case reviews where the team are able to facilitate multi-agency meetings alongside police colleagues for individuals who regularly use the emergency services and experience mental health crisis or increased demand to agencies. During the past month CJLS have also been involved with local Anti-social behavior tasking groups across the region.

Calls/Events- Overall:

The data below shows a breakdown of all the sub types of calls as categorised on police systems. This reports data highlights highest percentage of calls/events dealt with by CJLS as those classified as 'concern for safety'. This accounts for over 500 of the 711 events entered onto SharePoint within this reporting period. 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 calls to FCC.



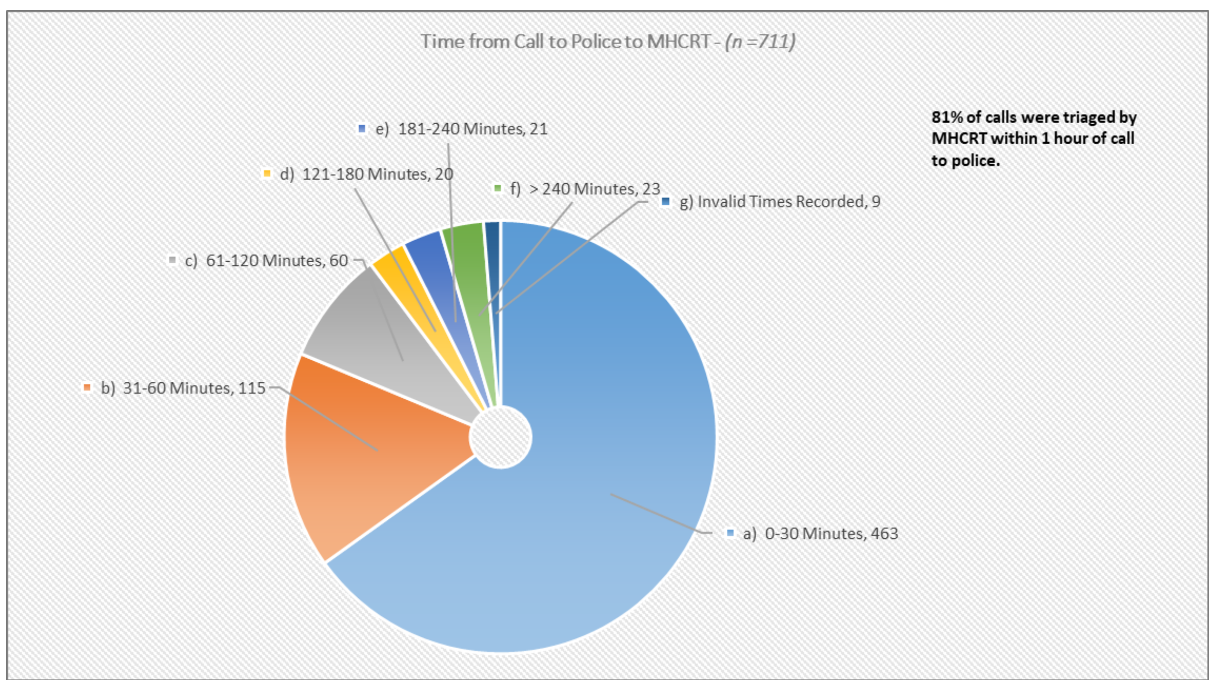


Calls/Events- Timeline:

For information: 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 as these are immediate or urgent response events.

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 consistent with previous reporting. Approximately 60% of calls receiving intervention within 30 minutes of the call being received by North Wales Police call handlers and 79% of all calls/events requiring CJLS intervention being supported within 60 minutes.



S136 suite usage:

The chart below shows that CJLS have been consulted with for 122 potential S136 within the last two quarters, this is an increase of 34 and a promising sign that consultation maybe increasing following on from previous reported increase Q1 and Q2.

Of those 122 consultations there has been a documented diversion of 39. This data is further broken down by geographical area on the graph.

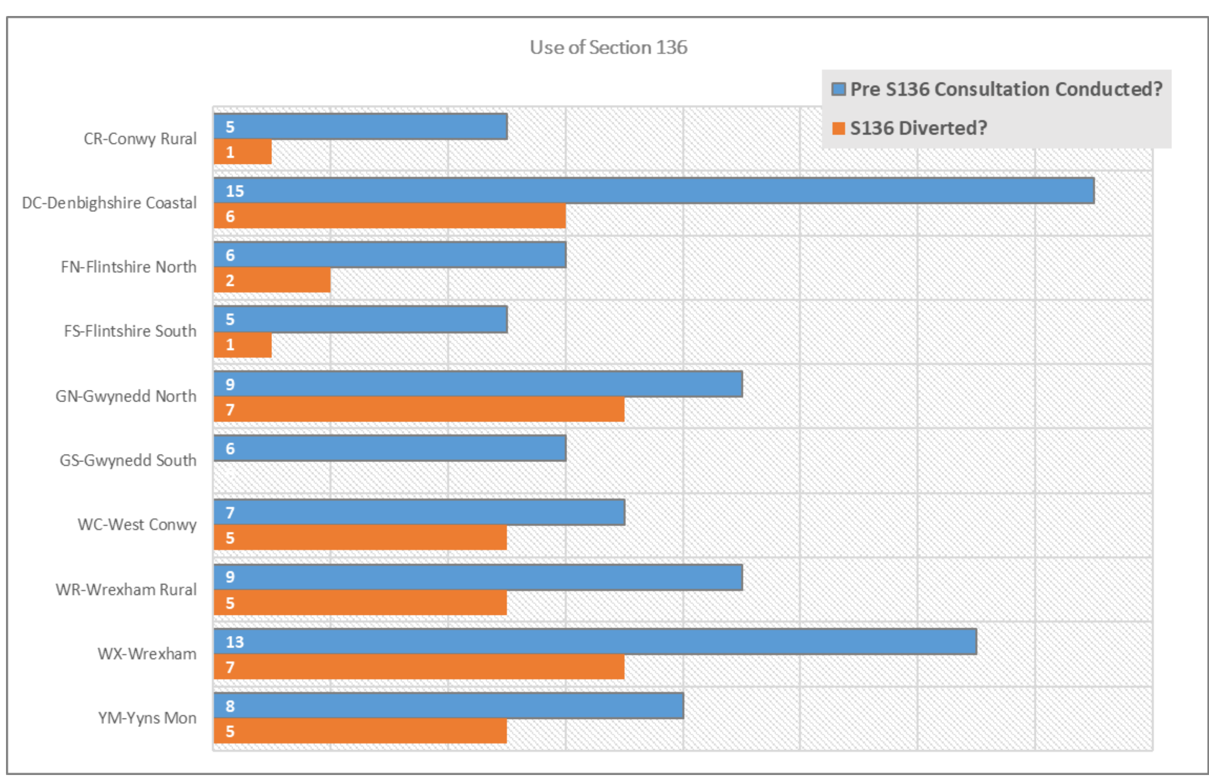
Mental health act office data notes an overall number of S136 uses as 299 implemented in the past two quarters. Therefore showing that CJLS have been involved in 27.8% of the total number of S136 in this last six month period. This is an area that continues to need addressing.

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 include

utilising officer feedback and experience from individuals who have experienced use of S136 or contact with North Wales Police during crisis or distress.

CJLS have attended regional police stations within this reporting period and have more planned. This will enable the team to meet officers and promote the control room service while keeping consultation and communication at the forefront of decision process around use of S136. The team are also actively involved with the Policing Education Qualifications Framework (PEQF) where CJLS have opportunity to educate new officers in regard to basic mental health awareness, increase knowledge in regard to the team and push discussions around use of consultation.



Costings for S136:

Accurate costing continue to be a complex area and the costings given are using ‘rough’ data around basic provision during S136 intervention.

North wales police routinely provide costings based on Mental Health Act office data, this only takes into account the time period from application of S136 by the police officer, therefore this does not include administration time, such as completion of forms/CID16 or populating event chronology post incident. This does not include time pre S136 with person in distress. Total for this quarter is £33,734

MONTH	Avg Cost per detention	Total cost	Avg transfer time to 136 suite
Jul-22	£326	£16,309	02.32hrs
Aug-22	£199	£11,176	01.33hrs
Sep-22	£111	£6,249	00.52hrs
Oct-22	£152	£6,551	01.11HRS
Nov-22	£160	£6,598	01.15HRS
Dec-22	£216	£11,487	01.41HRS

	Total:	£58,370

Chart below shows average costings based on the hourly average 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 monthly figures. This is an estimated cost that does not include attendance from Section 12(2) doctor and Approved Mental Health Professional as the attendance time scale for these professionals is different for every assessment and therefore difficult to gain an average. Important to note again this a conservative estimate.

	BCUHB (Band 6 and Band 3)			
Month	**Avg cost per detention**	**Number of detentions**	**Avg time per detention**	**Total cost per month**
Jul-22	£285.57	50	9hrs 38	£14,278.50
Aug-22	£425.75	56	12hrs 36	£23,842.00
Sep-22	£353.20	56	11hrs 55	£19,779.20
Oct-22	£305.00	43	9hrs 57	£13,115.00
Nov-22	£255.51	41	8hrs 31	£10,475.91
Dec-22	£270.54	53	9hrs	£14,338.62
				£95,829.25

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

CJLS Diverts saving				
Month	**Avg cost per detention**	**Number of diversions**	**Avg time per detention**	**Potential health saving**
Jul-22	£247.62	3	9hrs 38	£742.86
Aug-22	£425.75	6	12hrs 36	£2,554.50
Sep-22	£353.20	6	11hrs 55	£2,119.20
Oct-22	£305.00	9	9hrs 57	£2,745.00
Nov-22	£255.51	4	8hrs 31	£1,022.04
Dec-22	£270.54	6	9hrs	£1,623.24
			Total:	£10,806.84

Court and community attendance

CJLS have adapted to meet demand in the three local magistrates courts to attend where demand dictates at overnight remand courts. All areas are now rostered for CJLS cover in the custody and court where staffing allows.

Probation clinics are held in five areas as listed below, along with occasional bespoke clinic within approved premises. The team have offered 165 assessment appointments during this reporting period.

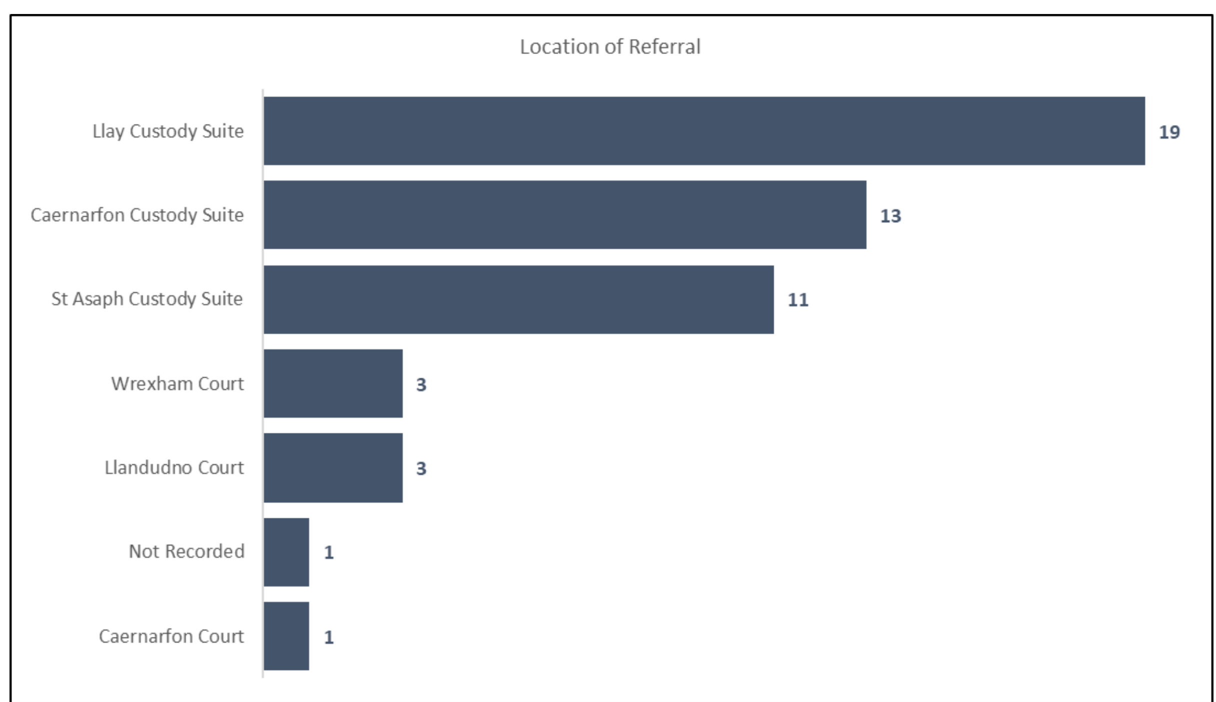
Referral rates are shown per below:

There continues to be a high level of non-attended appointments, CJLS will be attending Probation team meeting regularly to share this data which is also shared with senior probation staff and reviewed in February 2022. Of the 165 available assessment slots over past two quarters, 88 of these where not attended. This equates to just over 53% non-attendance, hence discussion needed with senior probation management.

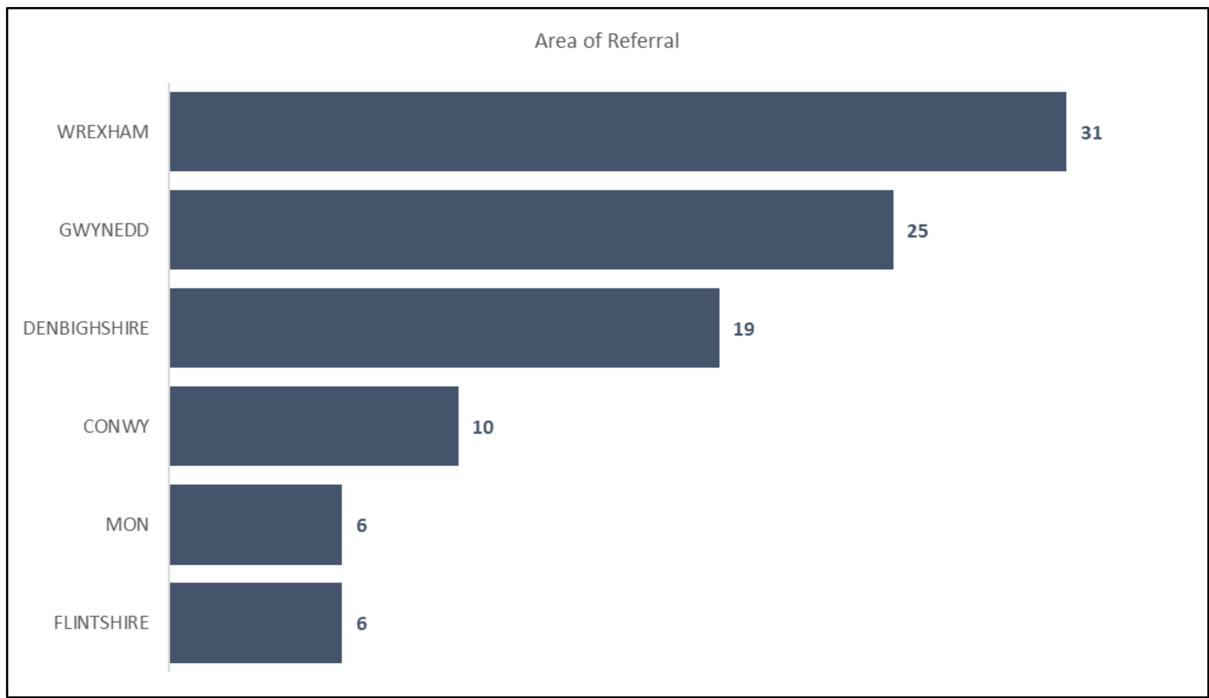
DATE		BOOKED IN	DNA
July			
	TOTALS	29	18
August			
	TOTALS	49	28
September			
	TOTALS	23	15
October			
	TOTALS	24	13
November			
	TOTALS	24	10
December			
	TOTALS	16	4

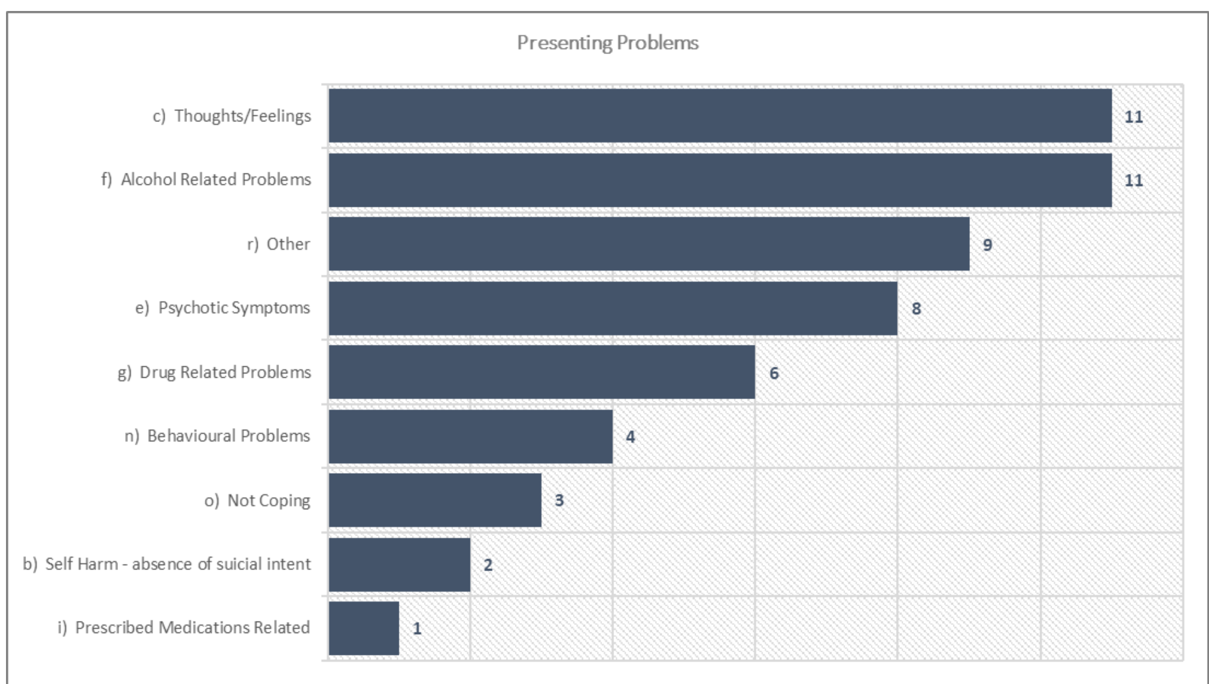
Community referrals and Probation clinics:

The graphs below evidence that referrals' source and geographical area data remains similar to previous reports with the largest area of referral being National Probation service. These referrals are accepted from all areas of offender management including approved premises and have remained consistent at 25 referrals.



CJLS continue to work in collaboration with Checkpoint, a Police and Crime Commission project that is now being developed under the Prevent Hub for North Wales police. CJSL will be in a position to offer Checkpoint service users assessment and onward referral where needed.

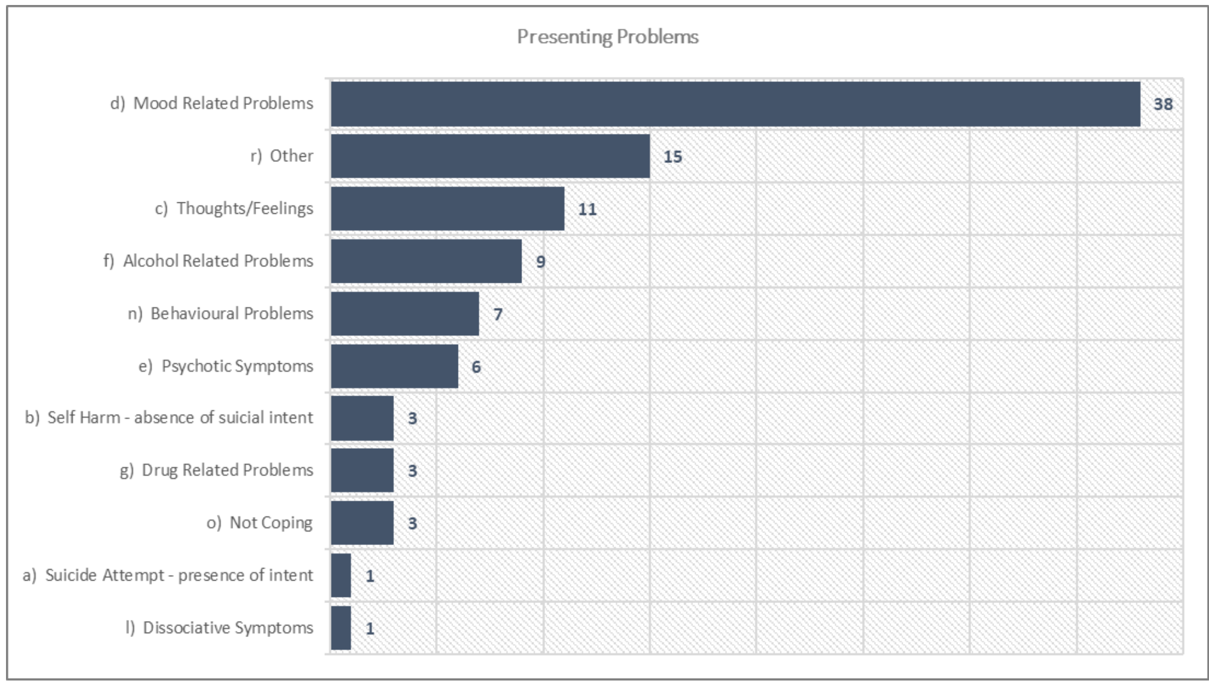




As can be seen from the graph above, the presenting problems remain very similar to all previous reports with very similar themes.

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 recently engaged with the Women's centre in Central area and will be utilising this relationship to refer females for continuing support and utilising premises where gender specific needs are prevalent.



<u>Activity for coming months:</u>

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 create activity for the next 6-12 months and there has been specific liaison in regard to 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. Therefore along with the development and growth of unscheduled care within CAMHS opportunities around co-working and liaison will be improved.

Involvement in crisis care planning and multi-agency reviews has proved a very positive area of work and the team are cited on many crisis/safety plans that enable the practitioners to liaise effectively with officers dealing with the young person. These plan often include information on how to approach and interact along with a comprehensive list of agencies/individuals who will be able to support.

The S135/136 monitoring group has been re-established 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. This group meets bi-monthly.

As previously mentioned, a continuing are 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 of CJLS amongst key staff groups. This will allow focus on areas with limited knowledge or use of CJLS to have input to improve this. One way of ensuring a positive message is to share the feedback from previous interaction and from the training that CJLS provide to share the poor conversion rate to detention under the act or admission, therefore proving many of these assessments could managed without exercising S136 power.

CJLS will also continue to consider service reconfiguration over the next quarters as the team has had movement within the team and joined by a new team member very recently. This are remains a focus for the service to ensure the service can develop and utilise experience of the team to continue to evidence best practice.

This will in turn allow for service management to focus on strategic development of the service whilst ensuring representation at crucial strategic and operational committees or forums to share the performance data, acknowledge and mitigate potential service risk.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Report on Physical Restrictive Intervention September 2022 - December 2022 MHLD Division, CAHMS and Health Board</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Mental Health Capacity and Compliance Committee (MHCACC)</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">This paper updates the MHACCC on monitoring arrangements for Physical Restrictive Intervention (RPI), referred to in this paper as restraint. The paper sets out themes and trends in restraint practice, how restraint is recorded and reported and associated assurance.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Board is asked to Note the activity and assurance on restraint between September 2022 and December 2022.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Bethan Young, Positive Intervention Clinical Support Service Lead</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="4">
<table><tr><td>I'w Nodi
For Noting
☒</td><td>I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr></table>
</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">• Priorities within "A Healthier Wales: long term plan for health and social care"
• North Wales Learning Disabilities Strategy
• Alignment with the BCUHB Integrated Medium Long-term Plan
• Supports delivery against Targeted</td></tr>
</table>

	Intervention requirements • Aligned with the Divisional Clinical Strategy/Clinical Effectiveness • Supports integration agenda and aligns with BCUHB Operating Model • Linkages with delivery of the Digital Strategy • Covid-19 response and recovery • Strengthen our wellbeing focus • Recovering access to timely planned care pathways • Improved unscheduled care pathways • BCU Estates Strategy • People Stronger Together Strategy
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health and Safety Executive Mental Health Act Mental Capacity Act Deprivation of Liberty Safeguards Mental Health Act 1983 Code of Practice for Wales 2016 Welsh Government Reducing Restrictive Practices Framework 2021
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	EQIA has not been undertaken for this paper and not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	SEIA has not been undertaken for this paper, not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There are no new risks associated with this paper.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	The reporting of restraints has been via the Positive Steps – Reducing Restrictive Practice Group and the MHLD Division Quality Safety Experience group

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	As requested by MHCACC

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Positive Steps – Reducing Restrictive Practice Group to include representation from IHC Director of Nursing
BAME patient characteristics to be collected in relation to patient restraints for analysis and future reporting
Continued training of the staff to reach satisfactory compliance
Next reporting cycle will include data relating to restraint practice in Learning Disability
To ensure timely ratification process for the recently updated Policy on Restraint

Rhestr o Atodiadau:
List of Appendices:

- Appendix 1 - Report on Physical Restrictive Intervention September 2022 - December 2022 MHLD Division, CAHMS and Health Board
- Appendix 2 - Terms of reference Positive steps - Reducing Restrictive Practice Group
- Appendix 3 – PICSS Team feedback

Mental Health Capacity and Compliance Committee:

Appendix 1 - **Report on Physical Restrictive Intervention September 2022 - December 2022 MHLD Division, CAHMS and Health Board**

Date - 10th February 2023

1. Introduction/Background

The Mental Health Capacity and Compliance Committee (MHCACC) have requested an update on the monitoring arrangements for restraint. This report is to capture the themes, trends and reporting of restraint practice within the ,ental Health and learning Disability (MHLD) Division but also includes restraint practice for CAHMS services and the Health Board.

2. Body of report

This report sets out the range of activity relating to restraint on mental health wards across the Division, CAHMS services and the wider Health Board.

The information and data within this report has been gathered through the following sources:

- Positive Interventions Clinical Support Service (PICCS) database from September 2022 - December 2022
- DATIX
- PICSS service training data base
- Restraint surveillance
- Communication and support provided to individual areas
- BCUHB Health Board Positive Steps - Reducing Restrictive Practices group

Background

The PICSS team provide surveillance for all incidents of restraint which are discussed in the monthly Positive Steps - Reducing Restrictive Practices group and the monthly MHLD Division Quality Safety Experience group. The PICCS team also provide training on the All Wales Passport Module D- Restrictive Physical Intervention and Module C- Breakaway, both of which are competency based.

It is important to recognise that staff often have a difficult role in challenging circumstances, when visiting clinical areas the PICSS team have witnessed some excellent care and support to patients. Good practice and preventative interventions have resulted in the reduction of the use or the need to use restraint, this is acknowledged and shared.

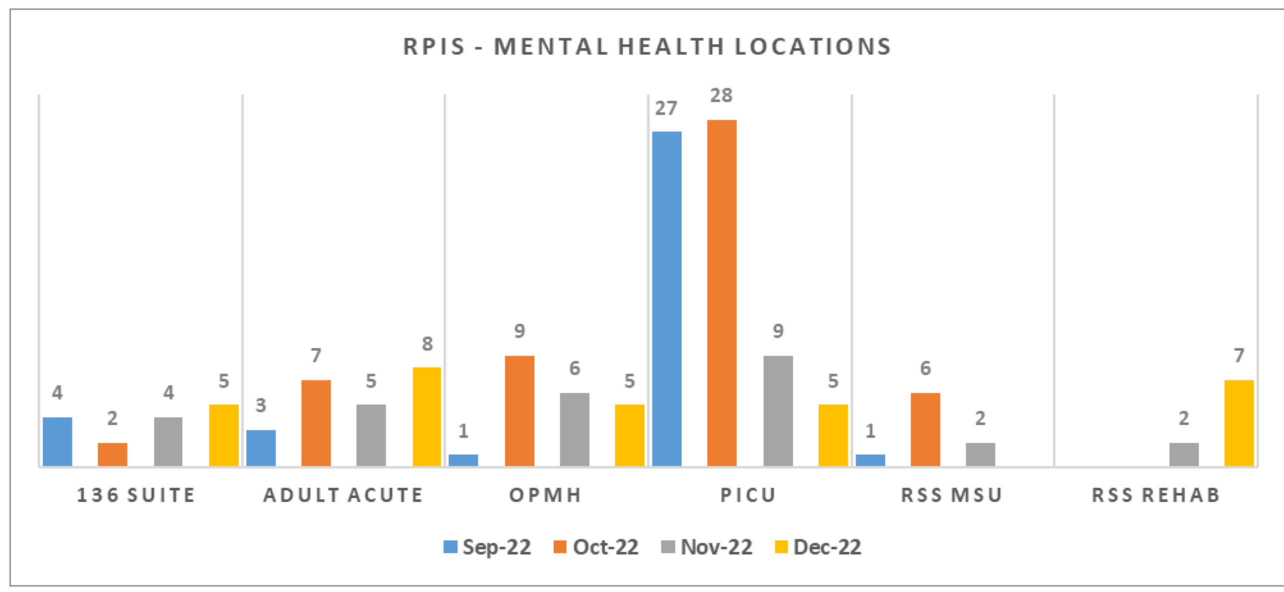
Restraint activity

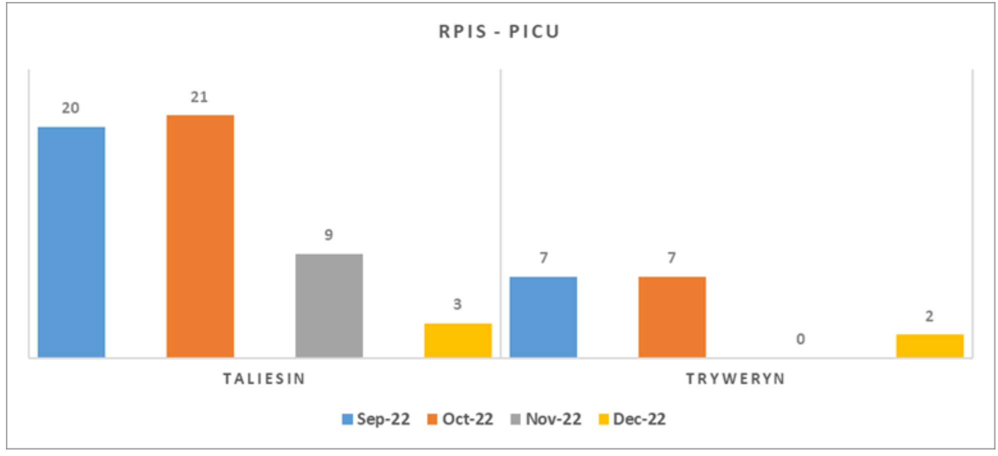
This section of the report will update on themes and trends on restraint activity via the specialty pathways in the MHLD Division.

Psychiatric Intensive Care Units (PICU)

The data demonstrates that the highest number of restraints occurred on Taliesin ward, Hergest Unit. In September 2022 four patients accounted for the majority of these restraints. The reasons reported were to prevent a patient from engaging in deliberate self-harm, aggressive behaviour and to administer intra muscular medication (rapid tranquilisation). In October 2022, three patients accounted for the majority of restraints with the reason being to prevent a patient from engaging in deliberate self-harm. The PICSS team attended Taliesin ward twice weekly during this period to review the patient's positive behavioural plans, support staff by providing de-brief sessions and to assist in the management of behaviours which challenge.

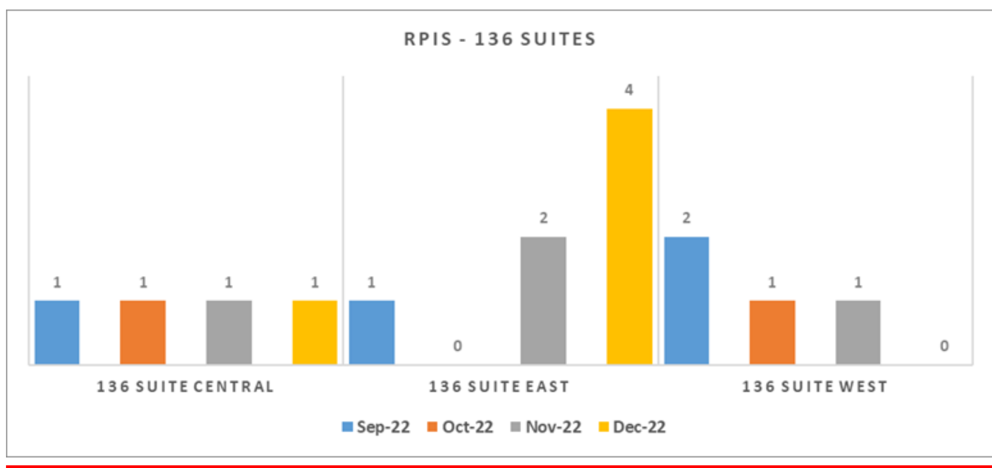
On Tryweryn ward, Heddfan Unit there were no individual patients who accounted for the majority of restraints however, the main reason recorded was aggression. The PICSS team supported the ward by assisting with the patients positive behavioural support plans.





Section 136 suites

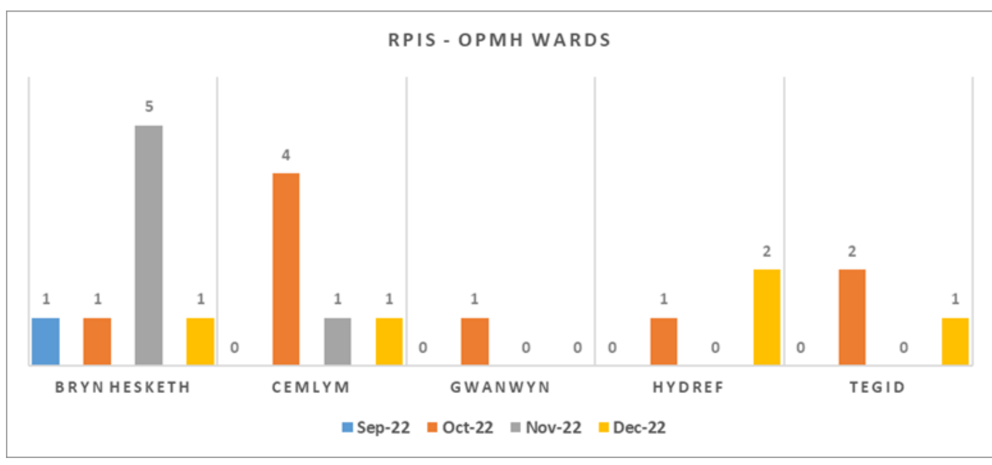
The highest number of restraints occurred in Heddfan (East). In December 2022 all four restraints were in relation to a 13 year old young person who was engaging in deliberate self-harm. On three occasions the young person required intra muscular medication (rapid tranquilisation) and was placed in the prone position to assist in the management behaviours which challenge.



Older adults

The highest proportion of restraints occurred in Bryn Hesketh and Cemlyn wards.

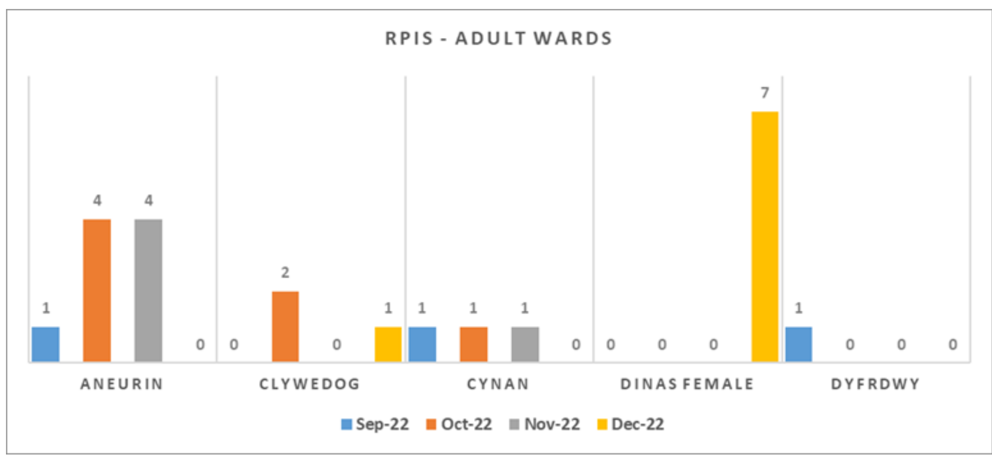
The restraints were in relation to two individuals who were displaying aggressive behaviour towards staff and the other patients. The PICSS team spent time on both wards to review the Positive behavioural support plans, offer staff support and to assist in the management of the patients behaviours which challenge. Additional RPI update courses were put in place and facilitated on the ward to increase training compliance.



Acute care

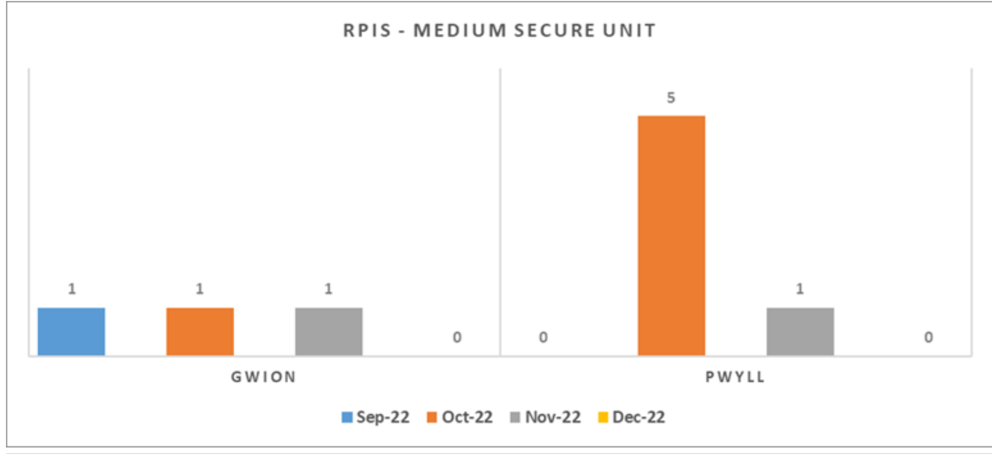
On Aneurin ward there were four patients who were displaying a variety of behaviours which challenge, including engaging in deliberate self-harm, aggression and attempting to abscond from the ward. On Dinas female ward one patient accounted for all seven restraints. The patient was attempting to engage in deliberate self-harm

by ligaturing. The PICSS team were involved in numerous MDT meetings for both areas, helped develop more robust positive behaviour support plans and attended the wards to provide clinical support to both teams.



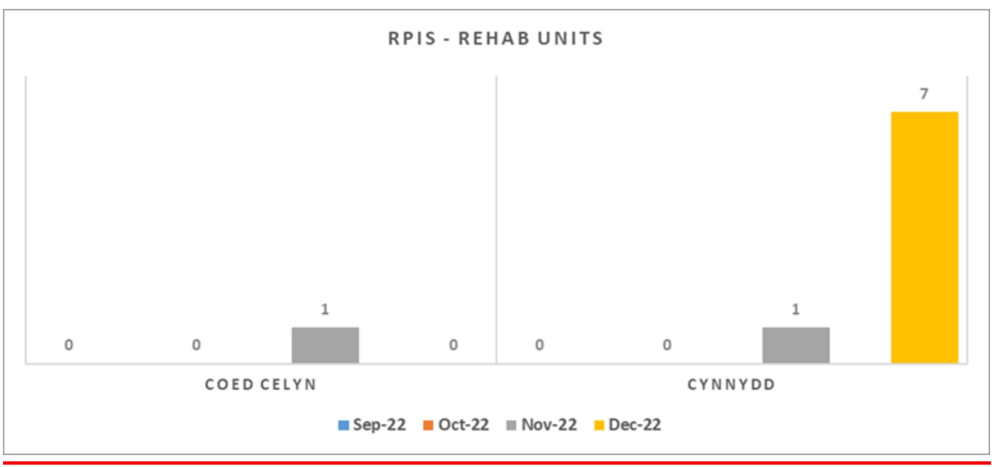
Secure services

The highest number of restraints were on Pwyll ward (assessment ward) and were all for the same patient to prevent from engaging in deliberate self-harm. The PICSS team attended the ward to offer support with patients positive behavioural support plan and to support the staff in the management of self-harming behaviours.



Rehabilitation services

All of the restraints which occurred on Cynnydd ward were in relation to the same individual. The reason for this intervention was to prevent the patient from engaging in deliberate self-harm. The PICSS team attended an MDT for this patient and also went to the ward to offer some practical support in the management of his behaviours which challenge.



Position of the restraint and time of the restraint

The prone position (face down) is classed as a high risk position. The majority of prone restraints occurred on Taliesin ward, PICU Hergest. In the majority of cases the patient was placing themselves in this position so that they could engage in deliberate self-harm (biting arms). The PICSS team reminded staff of the risks associated with placing patients in the prone position. The PICSS team discuss risks associated with prone during the training provided by the team.

RPIs by Restraint Position

	Prone	Multiple positions including prone	Positions considered to be lower risk	*Not recorded*	Grand Total
136 Suite	0	1	7	*7*	15
Adult	0	2	11	*10*	23
OPMH	0	1	10	*10*	21
PICU	5	13	41	*10*	69
RSS MSU	0	1	2	*6*	9
RSS Rehab	1	0	1	*7*	9
CAHMS	0	0	7	*4*	11
DGH	0	0	1	*3*	4
DGH ED	0	0	0	*2*	2
Grand Total	6	18	80	*59*	163

Overall, restraints are recorded as lasting between 1-3 minutes (within NICE guidelines). Where prolonged restraints have taken place (10 minutes +) the PICSS team contact the ward to request additional narratives to help understand why this was the case.

RPIs by Duration

	<1 minute	1-3 minutes	4-10 minutes	>10 minutes	*Not recorded*	Grand Total
136 Suite	2	2	2	2	*7*	15
Adult	1	7	2	2	*11*	23
OPMH	3	5	1	1	*11*	21
PICU	11	31	12	4	*11*	69
RSS MSU	2	0	1	0	*6*	9
RSS Rehab	1	0	1	0	*7*	9
CAHMS	3	3	1	0	*4*	11
DGH	0	0	1	0	*3*	4
DGH ED	0	0	0	0	*2*	2
Grand Total	23	48	21	9	*62*	163

Reason for restraint

The highest reasons recorded for restraint is self-harm and patient aggression. In areas where the PICSS team have supported teams due to high incident numbers there has been a reduction in physical interventions. Appendix 2 provides examples of this feedback. Other factors are considered in the reduction of incidents for example ward acuity, admissions and discharges and also the transfer of patients between one unit and another.

	Self harm	Aggression	Assault	Medication	Aggitation	*Other/not recorded*	Total
136 Suite	4	5	1	0	0	*5*	15
Adult	7	3	3	2	1	*7*	23
OPMH	0	10	0	1	3	*7*	21
PICU	30	15	7	5	2	*10*	69
RSS MSU	3	2	2	0	0	*2*	9
RSS Rehab	3	4	1	0	0	*1*	9
CAHMS	3	3	0	1	0	*4*	11
DGH	0	2	0	1	0	*1*	4
DGH ED	0	2	0	0	0	*0*	2
Grand Total	50	46	14	10	6	*37*	163

Seclusion data

There are two seclusion rooms within the MHLD Division (Hergest Unit & Ty Llewellyn, Medium Secure Unit). Of the seclusion episodes in Ty Llewellyn, the patient was not restrained prior to entering seclusion (patient walks in themselves). The PICSS team attend the Medium Secure Unit monthly to provide support sessions for staff. Additional training for the team will include more scenario based training to enhance staff skills in the management of these challenging behaviours.

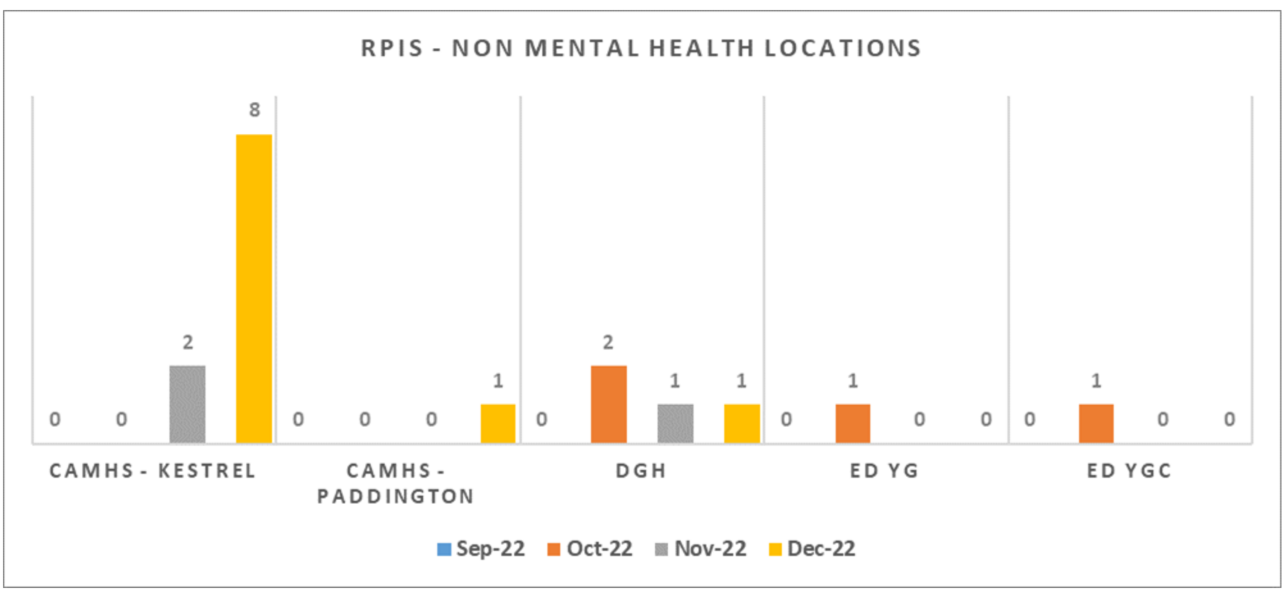
Use of Seclusion Rooms

	Sep-22	Oct-22	Nov-22	Dec-22
Ty Llywelyn	No data received	3	3	3
Hergest Unit	3	No data received	0	0

Use of seclusion not recorded on DATIX

Restraints recorded in other areas

Since October 2022, the PICSS team have been gathering data on restraints for CAMHS and other Health Board settings. The highest number of restraints recorded is within CAHMS services. In December 2022 6 of the restraints were to manage the same young person who was displaying aggressive and self-harming behaviours. The PICSS team have attended the unit, offered support in the management of these behaviours and assistance with the positive behavioural support plans and staff support.



Restraints that occurred in other areas of the Health Board were carried out by security staff. One of the restraints in October 2022 were a patient suffered a cardiac arrest (Wrexham) is subject to a review process.

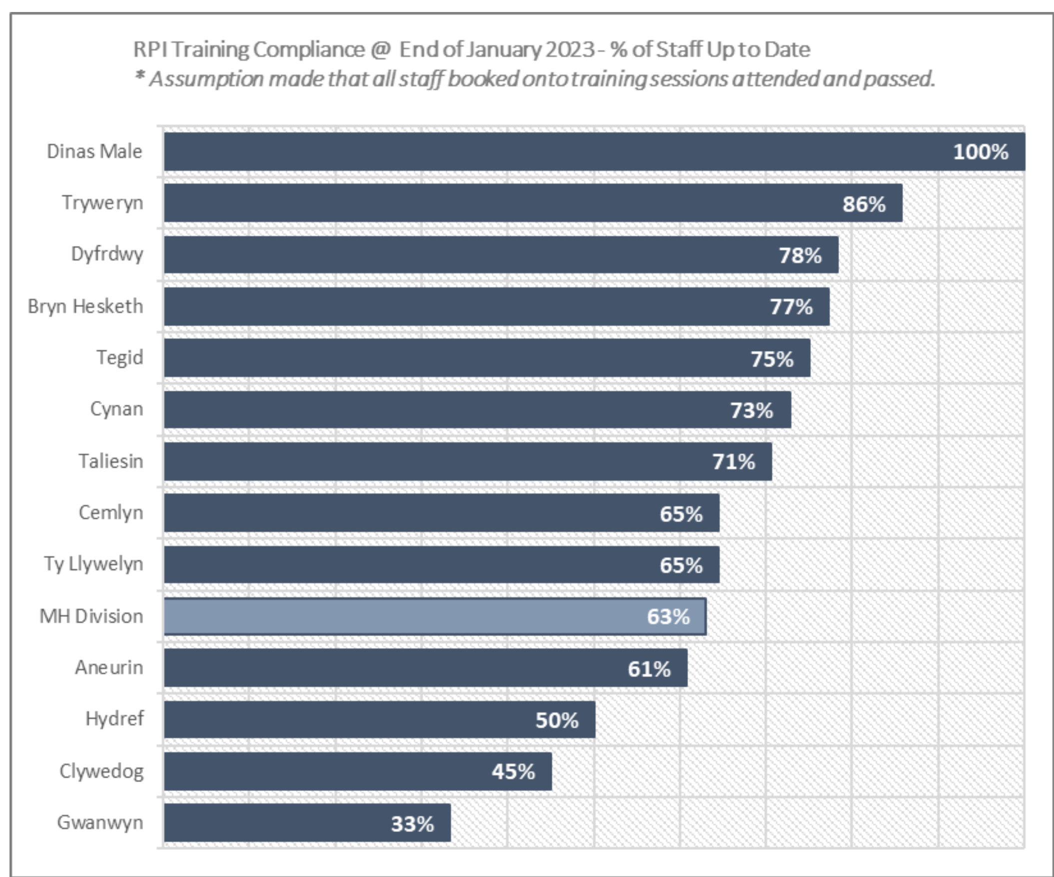
Environmental factors

It is important to consider that each mental health unit is very different in terms of the physical environment and the way in which patients are managed. For example, the Heddfan Unit have spacious wards with single rooms available for patients. Other examples of the estate are limited, for example the Ablett Unit which has narrow corridors and makes observation a challenge. The Hergest Unit for example have wards with multi-occupancy bays. Environmental factors will be discussed at the monthly Positive Steps- Reducing Restrictive Practice Group to look at implementing

the 'Safe Wards' model into all of our inpatient areas to enhance the patient experience.

Training to date

The MHLD Division remain in a recovery position post Covid. Training has been reviewed and reduced from two day updates to one day updates where possible for example in older person wards. The training team has also been temporarily increased to add more capacity.



Training trajectories for MHLD Division indicate compliance at 63% by the end of January 2023, 72% by the end of February 2023 and 84% by the end of March 2023. The Division will be looking to accelerate training compliance sooner if possible. Breakaway training is required for all Rehabilitation units (standalone units) and lone working community staff. Based on the information there is around 550 staff to train. From April 2023 the PICSS team will be facilitating all Restrictive Physical Intervention training for CAHMS staff, subject to a business case.

Moving forward

The MHLD Division has recently commenced the process for accreditation with the Restraint Reduction Network. This will provide a form of assurance for the MHLD Division and BCUHB that we are meeting restraint reduction training standards.

The Positive Steps - Restraint Reduction Group is now established and Terms of Reference agreed. This new governance group will support assurance on:

1. Monitoring on all restraints across the Health Board
2. Reporting on themes and trends for mental health and learning disability
3. Staff Training compliance
4. Collection of data on patients and protected characteristics subject to the Mental Health Act, Mental Capacity Act and informal patients
5. Adherence to current procedural guidelines/ Policy update
6. Patient experience story
7. HIW action plan and Ablett external review plan
8. Security and CAHMS update
9. Blanket restrictions throughout the Division

The MHLD0047 Physical Restraint Policy has been approved through the MHLD Policy and Procedure group and this policy will now proceed to the next stage of ratification. A common theme throughout the policy is around restraint reduction and how effective leadership, data collection and analysis, preventative tools, patient experiences and post incident support are imperative in achieving this.

Future reporting will include data on BAME characteristics and any association with restraint.

Positive Steps – Restraint Reduction Group will consider how feasible to record the number of positive behavioural support plans in place and to showcase examples of best practice.

3. Budgetary / Financial Implications

There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Director of Nursing.

4. Risk Management

Restrictive practices are subject to DATIX and review by the MHLD Division.

5. Equality and Diversity Implications

Terms of Reference and Operating Arrangements

BCUHB Health Board
Positive Steps- Reducing Restrictive Practice Group

INTRODUCTION

In line with the Mental Health and Learning Disability (MH&LD)/ Health Board Governance Structure, MH&LD, Health and Safety and CAHMS Management Teams shall nominate a group known as the Reducing Restrictive Practice Group. The focus of the group is the timely scrutiny of behaviour management and restrictive practices within the Mental Health/ Learning Disability and wider Health Board.

To give an overview of incidents from across the Health Board, analysing data and agreeing actions.

This group has now been established.

PURPOSE

The purpose of the Reducing Restrictive Practice Group is:

1. To provide the correct Governance to the Health Board through monthly meetings to analyse and review the use of physical restraint within the Health Board.
2. To provide and enhance surveillance throughout the Health Board.
3. Analysing statistical themes and actions required
4. To create stronger links within the Health Board and Health and Safety in relation to restraint reduction and agree actions to reduce restrictive practice.
5. To provide a platform to monitor and survey incidents of Physical intervention within the Health Board.
6. To discuss incident data throughout the Health Board looking at how many restraints have occurred in different areas and to ensure the correct monitoring and governance is in place for these incidents.
7. To discuss training issues – BCU MH physical intervention training and other training relating to the prevention and management of behaviours which challenge.
8. To discuss training compliance and training trajectories within the Health Board.

9. SLT's to provide assurances that patients have a PBS plan in place and where possible have been co-produced with the patient. This is to evidence that the Health Board is working in a proactive way to reduce incidents of Physical Intervention.

10. To promote the use of positive interventions and restraint reduction practices being guided by current legislation in Wales. Ensuring that areas who are using physical interventions are doing so in line with Welsh Government Reducing Restrictive Practices guidance.

11. To assist in supporting staff by looking at opportunities for effective discussions which may reflect their experiences of incidents through supervision facilitated by the wards. In addition, to signpost additional support services, ensuring that staff are informed and are accessing all relevant support mechanisms throughout the Division and the BCUHB as a whole.

12. To respond to questions and queries relating to behaviour management issues that staff may have put to the group.

13. To ensure that the basic principles of restraint reduction are embedded into practice, these being:

- Leadership- Each ward has a mission philosophy and guiding values which promote the avoidance of restraint
- Performance measurement- to determine the effectiveness of the local restraint reduction strategies in place
- Learning and development- Ensure staff working in your area have attended the PICSS PBS training/ 5 day RPI training/ 2 day RPI update training, ensuring that staff have the key competencies to support the view that restraint is only to be used as a last resort to manage the risks that are associated with behaviours which challenge
- Communication and customer focus- ensure that the group involves patients/ advocacy in the restraint reduction plan
- Continuous improvement- Post incident support and learning is embedded into organisational culture

14. To ensure the accurate recording of incidents on the Datix system and ensure that review of each incident by the group is accurately recorded on the system.

15. Fulfil assurance and governance arrangements within the Health Board

16. Ensure robust scrutiny and challenge for items tabled at the meetings.

17. Provide expertise and advice for behavioural management support matters within MH&LD.

DELEGATED POWERS AND AUTHORITY

The group will, in respect of its provision of advice to the MH/LD Service Quality delivery group

- Monitor and review the restraint reduction policy which has been developed for the Health Board
- Consider the relevance of new evidence based practice for the Health Board and the implications of changes practices.

To achieve this, the group will be designed to ensure that:

- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.
- There is an ethos of continuous quality improvement.
- There is good team working, collaboration and partnership working.
- Risks are actively identified and robustly management and mitigated.
- Decisions are based upon valid, accurate, complete and timely data and information.

Authority

The group is authorised by the MH&LD division to provide assurance that Restraint reduction strategies are being monitored within the Division.

Sub-Groups

The group may establish task and finish groups to carry out on its behalf specific aspects business aligned to this group.

MEMBERSHIP

Chair Director of Nursing MH/LD

Vice Chair PICSS Lead

Members Director of Nursing
Assistant Director of Nursing
PICSS lead
PICSS manager
Heads of Nursing
Health and Safety- BCUHB
Senior CAHMS services Representative
Director of Nursing- DGH

Member Appointments

Appointed Members shall hold office of the group for a timeframe that reflects the annual nomination by MH&LD Senior Management Team. Tenure of appointments will be staggered to ensure business continuity. A member may resign, or be removed by SMT or MH/LD Service Quality delivery group .

Support to Group Members

The Secretariat, on behalf of the group Chair shall:

- Maintain a register of attendance at meetings
- Formally minute meetings, with allocated actions that will be collated into a summary action plan.
- Draft minutes will be available and circulated, no later than one week following a meeting then checked and approved at the subsequent meeting.

MEETINGS

Quorum

At least the Chair/Vice Chair plus a member of staff representing each SLT must be present to ensure the quorum of the Group. Written feedback with apologies for non-attendance would enable a quorum.

Frequency of Meetings

Meetings shall be held no less than weekly and otherwise, as the Chair of group deems necessary.

Meetings to be held face to face or via MS Teams meeting at least once every week.

Attendance

Where a member cannot attend a meeting, a deputy or written report must be provided. The Chair will initiate action in the event that a member fails to attend, or sends a report or representative to attend three consecutive meetings.

REPORTING AND ASSURANCE ARRANGEMENTS

The minutes of the meeting will be formally recorded and approved by the Chair or Vice Chair. The Chair to ensure appropriate escalation arrangements are in place to alert the Health Board of any urgent/critical matter that may affect the operation and reputation of BCUHB.

The group to act as a forum to answer related queries asked by the division – and to act upon them.

Minutes approved by chair.

Information from this meeting will report to MH division quality group and also Health Board Quality Executive Delivery Group

Report as required to Mental Health Act Committee Group.

RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

The group relationship with the Board and its Committees/Groups is via Mental Health and Learning Disability QSE. An exception report will be produced and submitted to MH/LD Service Quality delivery group

APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

There are no standing orders to Committee Business applicable to group.

REVIEW

These Terms of Reference and Operating Arrangements shall be reviewed by the group annually.

CHAIR'S ACTION ON URGENT MATTERS

- Chair's action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Date Terms of Reference Approved:

Signed :…………………………………………………………(Chair)

Date:

Mental Health Capacity and Compliance Committee – 10.02.2023

Appendix 3: PICSS feedback

- **Head of Nursing West**
  Since my return to post as HON we have developed closer working links with the team. The team is incredibly supportive and reactive to support the service in the West. The west are working very hard to reduce the number of incidences and with support from recommendation from the team the female ward has seen immense benefit to the reduction of incidences since adopting the principles of safe wards and increase in patient activity.
  A weekly meeting has been set up to review the incidences in week, this will further evolve with support from the team and psychology to consider any learning and strategies that may have been effective to reduce incidences.
  Working together we will also be looking to strengthen patient feedback both during and post admission
  It is valued also how reactive the team have been to support the mandatory training compliance with the trajectory of achieving 100% compliance by June 2023.

- **Head of Nursing Central**
  I have had a think about the role of the PICCS team for Ablett, BHU patients and staff.
  The overwhelming reports are positive especially in relation to the development of behavioural support plans. This aspect is a relatively new development for our older person's wards but something that has been greatly appreciated.
  As you know, Tegid ward has faced some unusual challenges over the last 12 months. There was a degree of anxiety for staff in regards to the concept of restraint for a patient subject to court of protection. Whilst it is acknowledged that some errors were made in regards to this care episode, the support afforded by your team ensured that those mistakes were translated into a learning experience.
  More broadly, all managers note that the RPI team are approachable and accessible and your input is valued.

- **Matron HDU Ysbyty Gwynedd**
  I am very pleased to give feedback to your fantastic team.
  As you know 2022 was an incredibly challenging year in critical care. Never before have staff been subject to such intimidation, abuse and physical assaults. At a time when we were struggling to identify sources of support you and your team were just excellent. The physical techniques you taught the team proved invaluable and gave staff the confidence they needed to continue working under such difficult circumstances. More than that though, the team really benefitted from the informal de-brief type discussions with your colleagues. This sort of behaviour is so alien to us in critical care and staff were unsure of their rights. Your team were great reinforcing that behaviours were not OK and that staff should call the police etc.
  Very many thanks for all the support

<table>
<tr><td>Teitl adroddiad:
Report title:</td><td colspan="4">Management of Court of Protection Cases within the Health Board</td></tr>
<tr><td>Adrodd i:
Report to:</td><td colspan="4">MHCC Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:
Date of Meeting:</td><td colspan="4">10/02/2023</td></tr>
<tr><td>Crynodeb Gweithredol:
Executive Summary:</td><td colspan="4">This report has been produced to provide the Committee with assurance as to the management of Court of Protection (CoP) cases within the Health Board.</td></tr>
<tr><td>Argymhellion:
Recommendations:</td><td colspan="4">The Committee is asked to note the report.</td></tr>
<tr><td>Arweinydd Gweithredol:
Executive Lead:</td><td colspan="4">Angela Wood, Executive Director of Nursing and Midwifery</td></tr>
<tr><td>Awdur yr Adroddiad:
Report Author:</td><td colspan="4">Matthew Joyes, Deputy Director of Quality</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:
Assurance level:</td><td>Arwyddocaol
Significant
☐
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:
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:</td></tr>
<tr><td colspan="5">N/A</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:
Link to Strategic Objective(s):</td><td colspan="3">Quality</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:
Regulatory and legal implications:</td><td colspan="3">N/A</td></tr>
<tr><td colspan="2">Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?
In accordance with WP7 has an EqIA been identified as necessary and undertaken?</td><td colspan="3">N/A</td></tr>
<tr><td colspan="2">Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?
In accordance with WP68, has an SEIA identified as necessary been undertaken?</td><td colspan="3">N/A</td></tr>
<tr><td colspan="2">Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</td><td colspan="3">BAF21-10 - Listening and Learning</td></tr>
</table>

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Court of Protection Report	

Management of Court of Protection Cases within the Health Board

1. This report has been produced to provide the Committee with assurance on the management of Court of Protection (CoP) cases, arising in both the community and acute settings.

2. The Court of Protection was established under the terms of the Mental Capacity Act 2005, which came into force on 1 October 2007. It is a specialist court which makes specific decisions or appoints other people known as deputies to make decisions on behalf of people who lack the capacity to do so for themselves. The Court of Protection can:

   - decide whether a person 'has capacity' (is able) to make a particular decision for themselves
   - make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make these decisions
   - appoint a deputy to make ongoing decisions for people lacking capacity to make those decisions
   - decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid
   - remove deputies or attorneys who fail to carry out their duties
   - hear cases concerning objections to register an LPA or EPA.

   Cases are heard by Circuit, District and High Court Judges, at the central registry in Holborn, and at courts throughout England and Wales. Hearings are normally in public, but the court retains the power to sit in private.

3. CoP cases move at pace and require prompt attention by the Health Board in order to ensure that the best interests of a patient are met. These patients are vulnerable. In most cases, they are either already under a Deprivation of Liberty Safeguards (DoLS) or have been sectioned under the Mental Health Act and are being considered to move to a DoLS.

4. The following measures have been implemented to address issues in the process:

   - Legal management of all new CoP cases are now undertaken by the newly formed Legal Services Team (who came into effect from August 2022).

- The Legal Services Team act as a central point of contact to ensure oversight of all CoP cases from a legal perspective, ensuring legal support is in place and Court orders are complied with.

- NHS Wales Legal and Risk Services (LARS) are notifying the Legal Services Team with any updates for historical or ongoing cases to ensure that support can be provided as necessary.

- All new referrals to LARS or requests for advice, for both acute and community settings, are be made via the Legal Services Team.

- All cases are now logged on Datix to ensure robust monitoring and to aid with reporting.

- The Legal Services Team is working with senior clinicians in the Mental Health and Learning Disabilities Division (MHLD) to develop relationships and provide support as required.

- A Learning Event is being organised in conjunction with LARS and the Assistant Director of Nursing (MHLD). Anonymised past cases will be used as learning points together with a general overview of legislation and process. Due to unexpected staff absence, this has been delayed.

- A clear policy and procedure document is in development. Due to unexpected staff absence, this has been delayed and is now due for the next meeting of the Committee.

5. There are no individual cases that require escalation to the Committee. The new governance process has ensured all cases have been appropriately managed.

6. There are no budgetary implications associated with this report. However, the increasing costs attached to Court of Protection cases, and the devolved nature of costs to divisions, is an area for future improvement in control.

7. A risk relating to Court of Protection oversight and compliance is on the risk register (ref: 4596, score 12). This will be reviewed once the Deputy Director of Quality considers the new arrangements are sufficiently embedded and sustained.

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Mental Health Act Section 17 Policy</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Mental Health Capacity and Compliance Committee (MHCACC)</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">Extant policies are required to be reviewed at regular periods, the attached MHLD 0044 Section 17 Leave of Absence Policy has been in situ for a number of years and has progressed through review and require sign off to be uploaded to the health boards policy page to ensure staff are working to an up to date document. The policy has been merged with the Ty llywelyn Section 17 leave policy as requested at the last MHCCC. The merged areas and changes are highlighted in red for ease of locating. The new document has been out for consultation and has been ratified by the MHLD Policy Sub Group and viewed by Matthew Joyes for approval as chairs action.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The committee is asked to approve the Policy.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Wendy Lappin, Mental Health Act Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

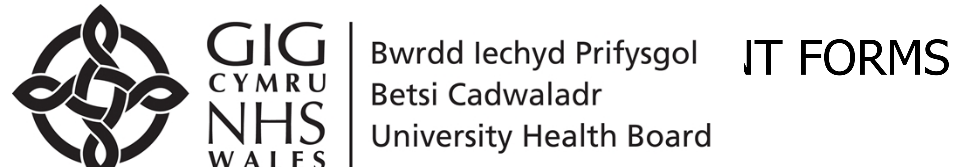
Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:</td><td colspan="3">Quality</td></tr>
</table>

Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	All policies relating to patient care should be written with the Code of Practice for Wales in mind and take into consideration the Mental Health Act, Human Rights Act and the Mental Capacity Act. Within the Code of Practice for Wales 2016 it states: "It is essential that compliance with the legal requirements of the Mental Health Act 1983 (the Act) and the Mental Health Act Code of Practice for Wales (the Code) are monitored. Local health boards (LHB) and local authorities (LA) should have agreed governance processes for ensuring the appropriate policies and procedures in place are regularly reviewed" (CoPW A1.1).
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	The policy has undergone an Impact Assessment attached which has also been reviewed and updated.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	*Following discussion with MH&LD Senior Management Team, the Office of the Board Secretary and the Equality Team, the assessment is that a SEIA in not required. The Policies submitted to the Committee for approval involve the application by the Health Board of UK legislation. The legislation is highly prescriptive and not open to interpretation. The strategic or 'policy' decisions as to the content and application of the legislation are made at a national level by the UK Government (the Mental Health Act is not devolved). Therefore, the request for the Committee to approve the policies has been assessed as 'not strategic'. The Mental Health Act is currently under review following the final report of the Independent Review of the Mental Health Act 1983 (December 2018) and a consultation 'reforming the Mental Health Act', ran from the 13/01/20 to the 21/04/21. A collective response was submitted by the Health Board 21/04/2021. The Impact assessment for the review is available for information here: Reforming the Mental Health Act: impact assessment (publishing.service.gov.uk).*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	N/A

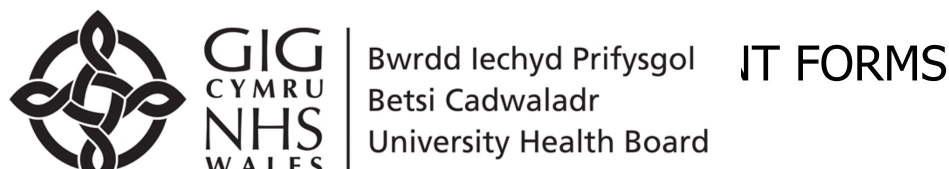
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The policy has been reviewed and approved via the relevant groups / individuals as indicated on the documentation. All relevant feedback and comments from consultation and from within the groups have been addressed and recorded for audit purposes.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 - MHLD 0044 Section 17 Leave of Absence Policy Appendix 2 – EQIA MHLD 0044	



Mental Health Capacity and Compliance Committee - Mental Health Act Section 17 Policy
10th February 2023
Appendix 1 - MHLD 0044 Section 17 Leave of Absence Policy

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	MHLD 0044 Section 17 Leave of Absence Policy
Date form completed:	October 2018 Reviewed June 2022 and December 2022



Mental Health Capacity and Compliance Committee - Mental Health Act Section 17 Policy
10th February 2023
Appendix 1 - MHLD 0044 Section 17 Leave of Absence Policy

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- A policy, protocol, guideline or other written control document;
- A strategy or other planning document e.g. your annual operating plan;
- Any change to the way we deliver services e.g. a service review;
- A decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or a disability as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ *How does your policy / proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?*
- ✓ *What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce / remove these?*

- ✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / proposal? Can these barriers be reduced or removed?*
- ✓ *Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.*
- ✓ *How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?*

Part A **Form 1: Preparation**

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	MHLD 0044 Section 17 Leave of Absence Policy.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983. The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016. The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	Mental Health and Learning Disabilities Division Policy/Procedure Sub Group. Mental Health and Learning Disabilities Division Senior Leadership Team Quality and Safety Experience Group.
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Mental Health Act 1983 (as amended 2007) Mental Health Act Code of Practice for Wales (Revised 2016) MHLD AC008 Missing absconding Patient Policy Welsh Language Act 2016 MAPPA Guidance (Updated November 2022) MHLD 0061 Ty Llywelyn Medium Secure Unit Security Procedure MHLD 0041 Policy for the use of handcuffs (specific to Ty Llywelyn Medium Secure Unit) MM01 BCUHB Medicines Policy Social Services and Well-being (Wales) Act 2014

Part A **Form 1: Preparation**

		Wales Safeguarding procedures (2019) SA01 Adult at Risk Procedure SCH01 Safeguarding Supervision Procedure
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Service Users, Employees and workers, Registered Nursing Staff, Responsible Clinicians, Approved Clinicians, Mental Health Act Administrators and Assistants, and other professionals working within mental health services.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Training for employees / workers who may be involved in the care of detained patients. Communication to employees / workers Workflow chart. Cooperation of employees / workers Time constraints
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This policy ensures that any person working within mental health, forensic and acute hospital services has an understanding of Section 17 Leave. It allows for people working within mental health and acute hospital services to be aware of their responsibilities and avenues to follow to ensure that Section 17 leave is used appropriately.

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? i.e. Will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A **Form 2: Record of potential Impacts - protected characteristics and other groups**

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	√			√	This policy relates to all persons of any age who will be detained under the MHA that will have access to Section 17 leave. As North Wales has a large demographic of older persons it is highly likely that the detained patients could be suffering from dementia. Older person may be more likely to have a sensory impairment or a physical impairment which may lead to a lack of understanding of section 17 leave	Staff are aware of how to access translation services which are available for sign language, braille and languages.
Disability (think about different types of impairment and health conditions:- i.e. physical,	√			√	Mental Health Illness can affect anyone and it is acknowledged that people with learning impairments may require additional support to understand their detention. Persons who are detained under the MHA will often initially be in a state of crisis and not fully understand the information given to them or why they require permission to leave the unit. Sensory and physical impairments can apply	Discrimination is eliminated by everyone being treated in accordance with the current legislation. Provisions have been considered for specialised services such as sign language and

Part A **Form 2: Record of potential Impacts - protected characteristics and other groups**

mental health, sensory loss, Cancer, HIV)					at all ages and may render understanding and communication difficult.	assistance by learning disability staff. Staff will explain to the patient their rights under section 17 leave and leaflets are not simply handed over with the expectation of the patient to understand.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		√			We do not consider there are any impact for persons who are undergoing gender reassignment.	
Pregnancy and maternity		√			Having considered potential impacts none have been identified considerations will be given to pregnant women and nursing mothers under workforce policies.	Leave would be risk assessed prior to permission being granted.
Race (include different ethnic minorities, Gypsies and Travellers)	√			√	We are aware that people from BAME backgrounds can be more likely to have a Mental illness. If someone meets the criteria for detention race would not affect the decision. This policy applies to all who meet the criteria. There is	Discrimination will be eliminated through the understanding of cultural values and communication needs will be met by where possible providing

Consider how refugees and asylum-seekers may be affected.					evidence that BAME populations are disproportionately more likely to be detained.	information and leaflets in alternative languages. Translators are also available as required.
Religion, belief and non-belief		√			We do not consider there are any impact for persons due to their belief or non-belief.	
Sex (men and women)		√			We do not consider there are any impact due to a person's sex.	
Sexual orientation (Lesbian, Gay and Bisexual)		√			We do not consider there are any impact due to a person's sexual orientation.	
Marriage and civil Partnership (Marital status)		√			We do not consider there are any impacts due the marital status.	
Low-income households		√			No impact on this policy.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	**No**	**(+ve)**	**(-ve)**			
	√				The powers under the MHA do not violate human rights because the procedural safeguards established under convention case law do not apply to emergency situations. The proposed policy promotes human rights in ensuring that all patients are detained lawfully and receive	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

					appropriate care in accordance with their needs and have access to section 17 leave if this is deemed appropriate.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	√			√	The Welsh Language Standards are to be adhered to in Wales this involves ensuring that it is clarified at the outset as to what language a patient wishes to communicate in.	Once someone is detained under a section they must be explained their rights and information given to them with confirmation they have understood. Within the explanation of rights form this now details if the information has been given in the patients preferred language and will be reported on.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Treating the Welsh language no less favourably than the English language	√			√	Information for the patients are available in both English and Welsh. When it is explained to a patient the reason for the section and the use this should be done in Welsh if this is the patients first language.	Forms are also in English and Welsh for staff to choose which they wish to complete. The Section 17 leaflet within the policy is translated to Welsh.

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Engagement has been via the Health Boards consultation page of the intranet and distribution to appropriate groups. The document was distributed to the MHLD divisional staff, Local Authority safeguarding and the Welsh Language Department. This enabled care coordinators / safeguarding to consider the impact on those with protected characteristics and discuss if necessary.	
Have any themes emerged? Describe them here.	It was noted that escorting staff may not always be nursing staff.	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	The policy has been amended to reflect that there could be a number of escorts from different professions. (Therapy staff, psychological staff)	

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	MHLD 0044 Section 17 Leave of Absence Policy

2. Brief Aims and Objectives: (Copy from Form 1)	A patient currently liable to be detained in a hospital or specified hospital unit can only leave that hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act 1983. The policy aims to provide staff with sufficient guidance in order to ensure effective compliance with providing leave to detained patients in accordance with the Mental health Act and the Code of Practice for Wales 2016. The policy is required to ensure that staff are aware of their responsibilities for granting leave under the Act, aware of their responsibilities for documenting leave of absence and managing the risks that may be associated with this and to ensure that staff are aware of the procedures to follow when a patient is absent without leave (AWOL)

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes X	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No X

Part B Form 5: Summary of Key Findings and Actions

<table>
<tr><td colspan="2">3c. Is your policy or proposal of high significance?

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?</td><td>Yes</td><td>No X</td></tr>
<tr><td rowspan="2">4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?</td><td>Yes</td><td colspan="2">No X</td></tr>
<tr><td colspan="3">Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?

This policy will ensure that the law is complied with under the MHA and the provision of ensuring appropriate use of section 17 and that the correct procedures are followed.

It is felt this policy has a positive effect on all as it ensures those who have access to section 17 leave will be escorted, monitored and information recorded, an audit structure ensures the granting and recording of section 17 leave is recorded adequately.

Article 5 is considered in ensuring the patient is not deprived of their liberty .

Although potential negative impacts have been identified these have been mitigated against.</td></tr>
<tr><td rowspan="2">5. If you answered ‘no’ above, are there any issues to be addressed e.g. reducing any identified minor negative impact?</td><td>Yes X</td><td colspan="2"></td></tr>
<tr><td colspan="3">Record Details:</td></tr>
</table>

Part B Form 5: Summary of Key Findings and Actions

<table>
<tr><td></td><td colspan="2">Negative impacts have been identified under Age, Disability, and Race but these have been mitigated within the document.</td></tr>
<tr><td rowspan="5">6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?</td><td>Yes x</td><td>No</td></tr>
<tr><td>How is it being monitored?</td><td>Section 17 forms are forwarded to the Mental Health Act office. Records of all periods of leave will be documented in the patient's care notes. Compliance will be monitored as an integral part of the divisional clinical governance systems by the Clinical Operational Managers and reported through the QSE groups.</td></tr>
<tr><td>Who is responsible?</td><td>Clinical Operational Managers.</td></tr>
<tr><td>What information is being used?</td><td>Each area is to establish audit processes to ensure documentation is completed in line with the policy and leaves are being carried out accordingly identifying the number of leaves and escorts used and types of leave granted.</td></tr>
<tr><td>When will the EqIA be reviewed? (Usually the same date the policy is reviewed)</td><td>3 years from re-approval.</td></tr>
</table>

Part B Form 5: Summary of Key Findings and Actions

7. Where will your policy or proposal be forwarded for approval?	MHLD Policy/Procedure Implementation Group MHLD Senior Leadership Team Quality, Safety and Experience Group. MHCCC

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Wendy Lappin	Mental Health Act Manager
	Sean Gallagher	Interim Head of Nursing, RSS, LD, SMS
	Simon Allen	Clinical Operational Manager Forensic and Rehab
Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	These are already in place as described in mitigating actions		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	These are already in place as described in mitigating actions		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?

Version 4 review MHLD 0044

Mental Health Capacity and Compliance Committee
10th February 2023
Appendix 2 - EQIA MHLD 0044

Mental Health & Learning Disabilities Section 17 Leave of Absence Policy

Author & Title	Wendy Lappin, Mental Health Act Legislation Manager Simon Allen, Clinical Operational Manager Forensic and Rehab
Responsible Dept / Director:	Matthew Joyes, Associate Director of Quality, Quality Directorate.
Type of Document	Policy
Approved by:	MHLD Policy/Procedure Group – 24/01/2023 Matthew Joyes Associate Director of Quality – 26/01/2023 Mental Health Capacity Compliance Committee -
Date approved:	
Date activated (live):	
Documents to be read alongside this document:	MHLD AC008 – Missing Absconding Person Policy Code of Practice for Wales (revised 2016) Mental Health Act 1983 (as amended 2007) MAPPA Guidance (Updated November 2022) MHLD 0061 Ty Llywelyn Medium Secure Unit Security Procedure MHLD 0041 Policy for the use of handcuffs (specific to Ty Llywelyn Medium Secure Unit) MM01 BCUHB Medicines Policy Social Services and Well-being (Wales) Act 2014 Wales Safeguarding procedures (2019) SA01 Adult at Risk Procedure SCH01 Safeguarding Supervision Procedure Ty Llywelyn Court Guidelines Ty Llywelyn Security Escort Guidelines
Date of next review:	Maximum 3 years
Date EqIA completed / reviewed:	August 2018 reviewed June 2022
First operational:	3 November 2008

Previously reviewed:	August 2018				
Changes made yes/no:	Yes				
Details of changes since last review	Updated information section 7 regarding restricted patients medical appointments, Annexes added. Case law regarding longer periods of leave acknowledged. Absence without leave (S18) includes reference to the Ministry of Justice. Inclusion of legacy policy MHLD 0025 – Ty Llywelyn Section 17 and Therapeutic Leave Policy relating to Patients detained under the MHA 1983(2007) Ty Llywelyn radio guidelines added as an appendix. Medication references and Safeguarding added.				

PROPRIETARY INFORMATION
This document contains proprietary information belonging to the Betsi Cadwaladr University Health Board. Do not produce all or any part of this document without written permission from the BCUHB.

Contents Page

Contents

1. Introduction and Policy Statement 5
2. Purpose of the Document 5
3. Scope 5
4. Aims and Objectives 6
5. Roles and Responsibilities 6
   5.1 Responsible Clinician 6
   5.2 Nurse in Charge 7
   5.3 Escorting staff 8
   5.4 Ty Llywelyn Multidisciplinary Team and Allied Agencies 8
6. Inpatient Mental Health Units Procedure 9
(not inclusive of Ty Llywelyn) 9
7. Inpatient Mental Health Units Short Term Leave 10
(Not inclusive of Ty Llywelyn) 10
8. Inpatient Mental Health Units Longer periods of Leave 10
(Not inclusive of Ty Llywelyn) 10
9. Inpatient Mental Health Units Custodial Leave 11
(Not inclusive of Ty Llywelyn) 11
10. Restricted Patients 11
11. Ty Llywelyn Section 17 and Therapeutic Leave Procedure 12
   11.1 Additional Requirements for Unescorted Community Leave 13
   11.2 Additional Requirements for Section 17 Leave 13
12. Ty Llywelyn Types of Leave 14
   12.1 Off Ward Leave (Internal and Garden) 14
   12.2 Grounds Leave (Bryn Y Neuadd Hospital Site) 15
   12.3 Therapeutic Community Leave 16
   12.4 Court Attendance 16
   12.5 Emergency Leave 16
   12.6 Special Leave 17
13. Medication 17
14. Recording of Leave 18
15. Conditions of leave 18
16. Care and Treatment whilst on leave 19
   16.1 Physical Disorder 19
17. Extension of Section 17 Leave 20
18. Rescinding of Section 17 Leave 20
19. Absence without leave (AWOL) (S18) 20
20. Information to relevant individuals 21
21. Monitoring, Escalation and Implementation Arrangements 21
22. Reference to Legislation 22

Appendix 1 - Procedure 23
Appendix 2 – S17 Leave form 24
Atodiad 2 - Ffurflen absenoldeb S17 25
Appendix 3 - Ty Llywelyn Section 17 Leave – Nurse in Charge Guidelines 26
Appendix 4 – Ty Llywelyn External Leave (Section 17) Patient Description...27
Appendix 5 – Checklist for Signing Section 17 Leave...................28
Appendix 6 – Information Leaflet...29
Appendix 7 – Ministry of Justice Annexes 31
Appendix 8 – Ty Llywelyn two way radio guidelines/protocol......33

1. Introduction and Policy Statement

A patient currently liable to be detained in a Hospital or specified Hospital Unit can only leave that Hospital lawfully – even for a very short period – by being given leave of absence under Section 17 of the Mental Health Act.

Section 17 of the Act requires the Responsible Clinician to authorise personally any leave from Hospital of a patient detained under the Act.

Section 17 applies to patients who are detained under Part 2 of the Mental Health Act namely Sections 2, 3, 37 and 47 of the Act. It does not apply for patients detained under sections 4, 5(2), 5(4), 135 or 136.

Part 3 of the Mental Health Act covers patients on Restriction Orders (i.e. Section 37/41, 47/49 and 48/49) the Responsible Clinician **must** first seek the agreement of the Ministry of Justice before granting leave under Section 17.

The Responsible Clinician is also not able to grant leave of absence to patients detained under Section 35, 36 or 38 of the Act. For Sections 35 and 36 the remanding court must be in agreement with the leave, the Responsible Clinician would need to request in writing, permission from the court prior to the leave being granted. For Section 38 no leave can be granted the court must be made aware in instances of emergency treatment.

Well thought out leave, which serves a definable purpose and is carefully and sensitively executed, has an important part to play treating and rehabilitating restricted patients. It also provides valuable information to help clinical teams and the Ministry of Justice in managing the patient in hospital and to all parties when considering discharge into the community. (Ministry of Justice 2012)

Informal patients are not subject to Section 17 leave under the Mental Health Act. A patient who is not detained has the right to leave, other than those patients subject to authorisation under the Deprivation of Liberty Safeguards (DoLS). However, patients may be asked by staff to inform them when they want to leave the ward. In the case of children, safeguarding needs and the opinion of the person with parental responsibility should be taken into account.

Staff within this document refers to those persons working/employed for Betsi Cadwaladr University Health Board and will include permanent and temporary (agency) workers.

2. Purpose of the Document

The purpose of this policy is to ensure that leave arrangements under Section 17 comply with the Mental Health Act provisions.

The policy informs hospital staff how to manage and record Section 17 leave.

3. Scope

This policy is concerned with inpatients who are detained under the Mental Health Act 2007 within the facilities managed by Betsi Cadwaladr University Health Board.

This Policy standardises the authorisation of Grounds and Community Leave and ensures that related decisions are justified and carefully documented making clear the responsibilities of the various members of the Multidisciplinary Team and partner agencies.

The Policy covers specific additional responsibilities and leave requirements for Ty Llywelyn Medium Secure Unit.

The policy is concerned with Section 17 leave only. (17A or Supervised Community Treatment is addressed within a separate policy).

4. Aims and Objectives

This policy provides guidance on the use of leave of absence and the procedure that must be followed when granting Section 17 leave.

In understanding the policy, reference should be made not only to Section 17 of the Act but also to its Code of Practice (For Wales 2016), Chapter 27, Leave of Absence, and the Ministry of Justice Guidance 2012.

5. Roles and Responsibilities

The responsibilities of the Responsible Clinician and other professional staff involved with the patient's care remain the same whilst the patient is on leave, although it is exercised in a different way. The duty to provide after-care under Section 117 Aftercare provisions applies to patients who are on leave of absence, provided they qualify.

All staff involved in the management of a patient have a professional responsibility to make known to the Nurse in Charge, any observations or concerns related to the patient which could bring in to question the appropriateness of allowing leave to proceed. Such observations or concerns should be recorded in the patient's clinical notes and included in future risk management planning. As a partner agency there is a duty to report any observations or concerns that involve an adult or child at risk or criminal activity via the approved pathways under the Social Services and Well-being (Wales) Act 2014, Wales Safeguarding procedures (2019), SA01 Adult at Risk Procedure and SCH01 Safeguarding Supervision procedure.

Ward Managers and the Nurse in Charge are responsible for the implementation of the policy.

Additional responsibilities in regards to restricted patients and Ty Llywelyn Medium Secure Unit is covered in section 10.

5.1 Responsible Clinician

Only the patient's Responsible Clinician can grant leave of absence to a patient detained under the Act. Responsible Clinicians cannot delegate the decision to grant leave of absence to anyone else. In the absence of the usual Responsible Clinician, e.g. if they are on leave, permission can be granted only by the Approved Clinician who is, for the time being, acting as the patient's Responsible Clinician as a nominated deputy.

The nominated deputy should only be granting permission for necessary leave that cannot be deferred and should make decisions in consultation with the other Multidisciplinary Team members who have a sound knowledge of the patient.

The Responsible Clinician's authority that leave can be granted to a patient should be recorded on a Section 17 Leave Form (Appendix 2), written, signed and dated by the Responsible Clinician. Written authorisation from the Ministry of Justice must accompany the Section 17 documentation and stored in the ward Section 17 file for restricted patients.

Responsible Clinicians may grant leave for specific occasions or for specific or indefinite periods of time. They may make leave subject to any conditions which they consider necessary in the interests of the patient or for the protection of other people.

The Responsible Clinician can authorise the Nurse in Charge of the ward to curtail leave at his or her discretion. In practice, this is likely to be leave granted for specific occasions or specific periods.

When a patient is transferred or a change of Responsible Clinician is made the new Responsible Clinician **MUST** review any previously granted leave and either agree for continuation by completing a new Section 17 leave form or recording that this has been revoked.

5.2 Nurse in Charge

The Nurse in Charge, before allowing any patient leave will ascertain whether or not there have been any changes in the patient's mental state, potential risk to the patient or others, or general circumstances that could raise doubts about the propriety of allowing leave. In reaching this decision, the Nurse in Charge should take particular account of other team members' views and the written entries in the clinical records that have been noted within the previous 48 hours. If the Nurse in Charge has concerns as to whether leave should be facilitated, leave should be withheld until the matter can be reviewed with the patient's Responsible Clinician and/or the Clinical Team.

The Nurse in Charge when allowing leave must ensure that an up to date Section 17, Ministry of Justice authorisation (if required) and a care plan are in place and that all associated documentation is completed appropriately and is readily available for the period of leave. This includes destination, duration with time of return, escort details, patient description (clothing) and patient's financial status.

The Nurse in Charge prior to facilitating the leave must ensure that the unit staffing establishment is not compromised and there are sufficient numbers to provide escorting staff and response staff in case of emergency during the leave.

Ty Llywelyn Nurse in Charge section 17 leave guidelines should be followed by Ty Llywelyn staff (Appendix 3).

The Nurse in Charge has the authority to curtail leave. Leave should only be curtailed where, in the opinion of the Nurse in Charge of the ward, there is a marked

deterioration in the mental state of the patient. Where the nurse considers it necessary to curtail leave, a record must be made in the patient's case notes and the Responsible Clinician must be informed at the earliest opportunity.

5.3 Escorting staff

Staff who are responsible for escorting patients may be nursing, therapy, psychology and assistants whilst using Section 17 leave if applicable.

For the Medium Secure Unit escorting staff must be employed by Betsi Cadwaladr University Health Board and have received Ty Llywelyn security training. Staff should have an awareness of Ty Llywelyn policies and guidelines and have an up to date knowledge of the patient group including risk profile.

Designated escorts cannot include family members, carers, students or advocates for those patients detained within the Medium Secure Unit, although they may accompany the patient on allocated leave if approved by clinical team, staff must ensure they are fully aware of the security protocols related to patient leave in these instances.

Prior to leave the escorting staff should familiarise themselves with the conditions of the Section 17 leave and ensure appropriate Ministry of Justice permission is granted if required.

Following the leave the escorting staff are responsible for communication in relation to how the leave went and documentation appertaining to the leave process. If at any time the escorting staff are concerned for safety whilst on leave they can end the leave and return to the unit.

5.4 Ty Llywelyn Multidisciplinary Team and Allied Agencies

In order to ensure a consistent and effective response in the event of an untoward incident / situation during a period of therapeutic leave, leave must be routinely facilitated during office hours Monday to Friday unless agreed and appropriately planned by the Multidisciplinary Team.

To ensure all up to date intelligence and information is available to the Multidisciplinary Team when applying for and authorising leave, liaison with North Wales Police should be considered. This will be for consultation only and North Wales Police will not be involved in clinical decision making. Where appropriate the respect, feelings and fears of victims and others who may have been effected by a patients previous offences will also be taken into account by the clinical team with a record of this highlighted in the clinical notes.

Monthly meetings between North Wales Police Protection of Vulnerable Peoples Unit and Ty Llywelyn Head of Operations and or Ward Managers are undertaken providing up to date risk information relating to patients leave. North Wales Police will also hold patients' description forms for all MAPPA (Multi Agency Public Protection Agency) nominal and or restricted patients within Ty Llywelyn to assist and support therapeutic leave contingency plans. Consent to share information will be sought for unrestricted patients prior to any leave being granted.

All leave decisions should routinely be made, recorded and reviewed at the clinical team meetings, however there will be occasions when decisions are made outside of these meeting and must only be done so by a quorum of 3 Multidisciplinary Team members which must include the Responsible Clinician.

Prior to facilitating any authorised leave the clinical team must ensure a robust care plan is formulated and approved by the Multidisciplinary Team. This will include the aims, planned benefits, escort arrangements, assessment criteria and contingency planning. The leave plan should also be outcome focused, commensurate with the individual patients overall treatment plan.

6. Inpatient Mental Health Units Procedure
(not inclusive of Ty Llywelyn)

The procedure flowchart should be consulted (Appendix 1).

The Responsible Clinician should ensure that when considering and planning leave the criteria identified within the Code of Practice paragraph 27.7 should be adhered to.

Leave of absence granted for specified occasions may include:

- Outpatient appointments
- Therapy sessions
- Attendance at weddings/funerals
- Shopping expeditions
- Home leave

Leave of absence granted for specified periods may include:

- Overnight leave at home
- Weekend leave
- Weeks leave

The Section 17 leave form (Appendix 2) must be completed and the dates of the leave specified, to include leave details, duration, frequency and number of escorts if required. The determination of the number of escorts will be by the Responsible Clinician following discussion with the Multidisciplinary Team to include the consideration of risks identified in risk assessments.

NOTE: Leave with relatives is regarded as UNESCORTED Leave unless this is specified as custodial leave (please see section 9).

The form must be signed and dated by the Responsible Clinician or the covering Responsible Clinician.

On return from leave whether escorted or unescorted the nursing staff must complete a mental state examination and feedback in relation to the leave any further information from family may also be ascertained.

7. Inpatient Mental Health Units Short Term Leave
(Not inclusive of Ty Llywelyn)

The Responsible Clinician may decide to authorise short-term leave, managed by other staff. If the patient is subject to restrictions the authority of the Secretary of State for Justice will also be required. As an example, the patient may be given leave for a shopping trip of two hours every week, with the decision on which particular two hours left to the discretion of the responsible nursing staff. The parameters within which this discretion may be exercised should be clearly set out by the Responsible Clinician to ensure the terms of the leave prescribed, cannot be interpreted differently by the staff managing the leave of absence.

8. Inpatient Mental Health Units Longer periods of Leave
(Not inclusive of Ty Llywelyn)

Leave may be used to assess a patient's suitability for discharge from detention. The patient should be fully involved in the decision to grant leave and should be able to demonstrate that they will be able to cope outside of the hospital.

When considering whether to grant leave for more than seven consecutive days, or extending leave so that the total period is more than seven consecutive days, Responsible Clinicians should also consider whether the patient should go on to a Community Treatment Order (CTO) instead. This does not apply to restricted patients, or, in practice, to patients detained for assessment under Section 2 of the Act as they are not eligible to be placed on a CTO. (CoPW 27.8)

The option of using a CTO does not mean the Responsible Clinician cannot use longer-term leave if that is the more suitable option, but they will need to be able to show both options have been considered. Decisions should be fully documented in the patient's notes. CoPW 27.9)

Long term Section 17 leave cannot be used if the patient is not required to need any medical treatment within a hospital, 'medical treatment' includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care (but see also subsection (4) below); …

> (4) Any reference in this Act to medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. (Upper Tribunal case no: HMW/1727/2020 [2021] UKUT 53 (AAC) DB v Betsi Cadawaldr University Health Board)

Subject to patient consent, there should be detailed consultation with appropriate relatives and friends, including, where appropriate, independent advocacy and community services.

Where relatives/friends are to be involved in the patient's care, but the patient does not agree that they should be consulted, leave should not be granted.

It is essential carers, especially where the patient is residing with them while on leave, and professionals who support the patient while on leave should know who to

contact if they feel consideration should be given to return of the patient before their leave is due to end.

9. Inpatient Mental Health Units Custodial Leave
(Not inclusive of Ty Llywelyn)

Under the Mental Health Act a Responsible Clinician may direct that a patient remains 'in custody' while on leave of absence. Patients may be kept in the custody of any officer on the staff of the hospital or any person authorised in writing by the Hospital Managers.

Custodial Leave may be used in circumstances to allow patients to participate in escorted trips or to have compassionate home leave.

The code of practice 27.25 states while it may often be appropriate to authorise leave subject to the condition a patient is accompanied by a friend or relative, responsible clinicians should only specify that the patient is to be in the legal 'custody' of a friend or relative if it is appropriate for that person to be legally responsible and that the person understands and accepts the responsibilities of being the patient's legal custodian. In the case of children, it may be appropriate for the person with parental responsibility to be the legal custodian. Otherwise leave with friends or relatives is classed as unescorted.

If custodial leave is to be used the Section 17 leave form must be countersigned by a suitable person to sign on behalf of the Hospital Managers as specified under the MHLD Mental Health Act Scheme of Delegation.

10. Restricted Patients

Where the courts of the Secretary of State have decided that a restricted patient is to be detained in a particular unit of a hospital, that patient will require the Secretary of State's permission to have leave of absence, to go to any other part of that hospital as well as outside the hospital. (CoPW 27,35)

Following Multi-Disciplinary Team agreement and completion of risk assessments, the Responsible Clinician must apply to the Ministry of Justice for Escorted and/or Unescorted leave with the completion of leave request form available from Request leave for restricted patients - GOV.UK (www.gov.uk) Responsible Clinicians should submit any additional information they consider would assist in reaching a decision.

Written authorisation from the Ministry of Justice must accompany the Section 17 documentation and be stored in the patient's notes.

The Responsible Clinician should notify the Ministry of Justice if they need to suspend the leave of any restricted patients. Consideration will then be given as to whether to revoke or rescind the leave or allow the leave to continue.

All Responsible Clinicians at any hospital have general consent to exercise their power to grant leave for medical treatment. The terms differ, depending on the type of patient (whether the patient is a transferred prisoner or whether they have been diverted to hospital for treatment by way of a hospital order). The precise terms are set out in the attached annexes. (Appendix 7). If the Responsible Clinician wishes to

deviate from these criteria, they should contact the Mental Health Casework Section at the Ministry of Justice and seek written approval to do so, explaining why the change is sought and considered to be appropriate.

It is accepted that there will be times of acute medical emergency where the patient requires emergency treatment. In these situations, the Responsible Clinician may use their discretion, having due regard to the emergency or urgency being presented and the management of any risks, to have the patient taken to hospital.

The Secretary of State (through the Ministry of Justice Casework Section) should be informed as soon as practicable that the patient has been taken to hospital, what risk management arrangements are in place, be kept informed of developments and notified when the patient has been returned to the secure hospital. (CoPW 27.37).

11. Ty Llywelyn Section 17 and Therapeutic Leave Procedure

The use of handcuffs as per the policy (MHLD 0041) may be required when undertaking leave dependent on the patients' legal status and risk.

The escorting staff must carry a hospital radio and/or a mobile phone whilst off the ward and remain in contact as per Ty Llywelyn Radio guidelines (Appendix 8).

A Care Plan must be in place for any Section 17 Leave. It should cover issues related to destination, length of absence, frequency, escorting arrangements, purpose of leave, arrangements to monitor and review leave, risk assessment, victim issues, the need for special conditions and a contingency plan. It should be written by the Named Nurse and countersigned by the Responsible Clinician in consultation with the Multi-Disciplinary Team members.

A patient's leave status should be reviewed minimally at fortnightly clinical team meetings.

It is important that escorting staff should, in every case, be aware of not only the current mental state of the patient/s but their history, risk indicators and risk management plans.

The taking of an authorised leave will ultimately depend on the Nurse in Charge of the ward. It is the responsibility of the Nurse in Charge to authorise leave. They can also withhold the use of leave should the mental state of the patient deteriorate, or for any other appropriate reason or justifiable concern.

A timed entry must be made in the patients electronic clinical notes indicating that a mental state examination has been carried out and risk presentation has been considered prior to any leave taking place.

Leave should be documented in the nursing offices white board indicating – the destination, time leaving the ward, expected time of return and a full clothing description should be recorded on the leave form (Appendix 4).

Any concerns raised during leave process the Nurse In Charge has the authority to suspend further leave until the matter is reviewed by the Multi-Disciplinary Team at the next available clinical team meeting.

It is the responsibility of the Nurse in Charge to ensure that no leave is agreed or facilitated if the weather is severely inclement.

The ward nursing team must ensure all patients proceeding on leave must have an up-to-date photograph on their clinical record and completed patients missing persons form. Where a patient is unwilling to co-operate with this process, leave should be withheld.

Following all periods of Section 17 leave the escorting staff should complete the leave evaluation note on the patient electronic notes system.

11.1 Additional Requirements for Unescorted Community Leave

Any Unescorted Ground or Community Leave may, after discussion by the Multi-Disciplinary Team, be categorised by the authorising Responsible Clinician as 'shadowed' (i.e. observed / followed at a discreet distance by staff). Where it is deemed appropriate, the Responsible Clinician should fully and clearly specify the circumstances and arrangements for such shadowing on the Section 17 authorisation form.

11.2 Additional Requirements for Section 17 Leave

If the leave is suspended for a period of more than 48 hours due to breach of hospital policy or deterioration of mental state, a line must be drawn through the authorisation on the Section 17 leave form and a record of the suspension made in the clinical records, staff must ensure that care plans are also amended accordingly. Reinstatement of any suspended leave must be agreed with the patient's Responsible Clinician following discussion by the Multi-Disciplinary Team.

Where a patient has been granted Unescorted Community Leave accompanied by parents, relatives, or other appropriate persons this must be recorded on the Leave form and fully care planned and risk assessed to ensure that they are suitable and appropriate to accompany the patient. Ward staff would escort the patient to meet with his visitors in the unit reception area and reiterate the conditions relating to the leave.

Staff are reminded that restricted patients under part 3 of the Mental Health Act cannot be granted any Section 17 Leave without the permission of the Ministry of Justice. It is imperative that medical staff examine all leave authorisations most carefully, as the wording of these may vary from case to case. (Further detailed Ministry of Justice guidance on procedures for seeking leave authorisation is available from the Mental Health Act Department).

Any proposed leave beyond the boundaries of England and Wales (i.e. Scotland, Channel Isles, Isle of Man, or abroad) will require Responsible Clinician and Multi-Disciplinary Team approval following authorisation from the Ministry of Justice.

All proposed leave involving air or sea travel must be notified beforehand to Betsi Cadwaladr University Health Board Legal Department for Travel Insurance purposes.

On completion of Section 17 leave patients may be subject to a random pat down search immediately on return to the ward. Other searches may be stipulated by the RC following Multi-Disciplinary Team discussion.

Patient must only have a maximum of £20.00 when utilising community leave unless agreed by staff team and care planned accordingly.

12. Ty Llywelyn Types of Leave

There are six categories of Leave:

12.1 Off Ward Leave (Internal and Garden)

This refers to leave from the ward but within the secure perimeters of Ty Llywelyn Medium Secure Unit. It includes leave to gardens, session rooms, gym/sports area as well as the central core. All internal off ward leaves will be escorted by staff.

Off Ward Leave within Ty Llywelyn must be authorised by the Multi-Disciplinary Team initially at pre admission meeting and authorised by the Nurse in Charge.

Number of escorts required for internal and garden leave must be determined by the Nurse in Charge unless specified following a risk assessment by the Multi-Disciplinary Team.

Authorisation must be sought from the Nurse in Charge prior to any Off Ward Leave. All Off Ward Leave must be recorded on the office whiteboard by the Security Nurse, indicating purpose, location and times of leave.

Garden access is normally permitted between the hours of 07:30 and 19:30. During the short winter days, leave should not extend beyond dusk. The garden area and perimeter must be checked twice daily by the allocated nurse in accordance with the Ty Llywelyn Perimeter Checklist. The escorting nurse must check the garden, its perimeter and any gates to ensure there are no potential hazards or breaches in perimeter security prior to any access.

Session rooms including sports area should be checked prior to use in accordance with the Security Procedure (MHLD 0061). The escorting member of staff should ensure there are no potential hazards or risks to security prior to any patient access.

At least one member of staff should be identified as escort (i.e. a member of staff who has completed security induction).

During garden access, the identified escort must remain in the garden area, in a position where they can view the whole garden, the door into / out of the building and the patient/s.

The escorting nurse is to complete a headcount of patients prior to leaving the ward and again on their return.

The identified escort must remain vigilant at all times, monitor movement of patients and their behaviour, presentation and interactions whilst off the ward and or in the garden area.

When accessing session / therapy rooms the escorting staff should remain in the room with the patient / group or outside (in line of sight) when stipulated by care team.

In the event of an incident, staff must summon assistance using the radio and or personal alarm. The patients should be escorted back to the ward or into the building from the garden.

12.2 Grounds Leave (Bryn Y Neuadd Hospital Site)

This refers to leave outside of the secure perimeter of the Medium Secure Unit, but is within the boundaries of Bryn Y Neuadd Hospital Site.

This may be **Escorted** or **Unescorted** and must be designated as one or the other on the Section 17 Leave form (Appendix 2).

Where a patient is subject to a Restriction Order under the Mental Health Act 1983 permission for leave away from the secure perimeters of the hospital requires written authorisation by the Ministry of Justice. Such authorisation will be requested by the Responsible Clinician as and when appropriate.

Grounds Leave must be discussed and agreed by the Multi-Disciplinary Team, and clearly documented by the Responsible Clinician on a Section 17 Leave authorisation form.

Where Group Leave is authorised, the staff-to-patient ratio should be clearly stated. Where 'line of sight' monitoring / shadowing is authorised, requirements must be clearly detailed, such as monitoring communication. The frequency and duration of leave should also be clearly document.

Grounds leave will not commence before 09.30hrs and will not, during summer months, extend beyond 19:00 hrs. During the short winter days, leave should not extend beyond dusk.

Prior to the patient going out on leave, the escorting staff in conjunction with the Nurse in Charge will ensure appropriate documentation is completed, this includes destination, duration with time of return, escorts, patient description (clothing) and patients financial status. (Patient Description Form - Appendix 4).

Identified escorts will have completed security induction training and have a comprehensive awareness of the patient and relevant care plans.

The identified escort(s) must remain vigilant at all times, monitor patient's behaviour, presentation and interactions throughout. During leave the escorting staff will walk

with the patient. It is important not to allow the patient to walk ahead or behind the escorting staff.

In the event of an incident, staff must summon assistance and maintain contact using the radio and or mobile phone. The patients should be escorted back to the unit / ward and a detailed account of the incident should be documented as required.

12.3 Therapeutic Community Leave

Community Leave refers to any leave outside of the perimeter of the Bryn Y Neuadd Hospital site. It includes the local village and wider community leave and leave outside of the locality as stipulated in the Section 17. It may be **Escorted** or **Unescorted.**

Where a patient is subject to a Restriction Order under the Mental Health Act 1983 permission for leave away from the secure perimeters of the hospital requires to be authorised by the Ministry of Justice. Such authorisation will be requested by the Responsible Clinician as and when appropriate.

Section 17 Leave must be discussed and agreed by the Multi-Disciplinary Team and clearly documented by the Responsible Clinician on a Section 17 Leave authorisation form. The locality / venue(s) authorised should be clearly recorded.

Documentation should include a full risk assessment and stipulate escort requirements, including number, qualification and gender of staff. Additional risk management strategies must also be included. Where group leave is authorised, staff-to-patient ratio should be clearly stated. Where 'shadowing' or 'line of sight' monitoring is authorised, requirements must be clearly detailed.

Section 17 Leave may be a one off or standing / recurrent arrangement. This should be clearly documented. Where a standing arrangement is in place, leave must be reviewed at regular intervals no greater than 3 months. The frequency and duration of leave should also be clearly documented. Where 'one off' leave is authorised, any specific dates or times should be recorded. A standing arrangement will still require a risk assessment prior to each leave taking place.

Where overnight leave is authorised, the address of the accommodation and contact details should be documented within the care plan.

All leave destinations and circumstances will be risk assessed prior to authorisation and included in individual care plan.

12.4 Court Attendance

If court appearance is required then the patient will have a court attendance care plan in place including contingency risk management plans in line with Ty Llywelyn Court Attendance Guidelines.

12.5 Emergency Leave

This refers to leave contingency plan only granted for medical emergencies.

All patients leave care plan must include emergency contingency plan as required taking into account any legal restrictions that may be in place including geographical areas and victims.

In the event that a patient requires urgent medical treatment for a physical disorder or injury, and the situation is such that the Responsible Clinician has been unable to complete the paperwork to authorise the leave of absence, or to give verbal authorisation of leave, then the Nurse in Charge should contact the Ward Manager/Clinical Site Manager within Office Hours or the Bronze On Call Manager and all Medical Staff to inform them of the situation. This should not prevent the patient from receiving the necessary treatment, since leave may be granted retrospectively in emergency situations. It is the responsibility of all staff involved to ensure this is done in a timely manner. Patients subject to Ministry of justice or court restrictions, in need of urgent treatment, and the situation is such that Ministry of Justice or court permission has not been obtained, this should also not prevent the patient from receiving the necessary treatment. Staff must inform them at the earliest opportunity.

Section 35/36/38 patients are only allowed emergency medical leave. They should be given special consideration although the Ministry Of Justice is not involved in their management. If necessary the Responsible Clinician can consult the relevant court. All involved should remember that these patients are essentially remand prisoners.

12.6 Special Leave

Special Leave may be requested for circumstances such as compassionate visits to close family members and/or attendance at the funeral of family. Special leave may also be required to provide non-emergency medical treatment. For Restricted patients, following discussion and agreement at the Multi-Disciplinary Team meeting, the Responsible Clinician can grant medical leave if this is covered by the guidance detailed in the Ministry of Justice Annex's (Appendix 7). Appropriate risk documentation and Care Plans must be in place.

All proposed special leave must have a contingency plan in place agreed by the Multi-Disciplinary Team and if felt appropriate this may be shared with North Wales Police.

13. Medication

Medication arrangements should be made as part of the planning to ensure supply and safe administration of medication.

Short term leave medication should be planned in advanced and ordered from the hospital pharmacy. The leave medication can be dispensed from the All Wales inpatient mental health chart using the leave section, and a photocopy will be retained in the pharmacy. Controlled drugs must be prescribed on an outpatient prescription and sent to pharmacy with the drug chart where the original copy will be retained in pharmacy. Medication dispensed and labelled by pharmacy for leave can be supplied to cover the period of time until the patient returns to hospital. Nurses must not dispense medication from ward stock to facilitate supply of leave medication as this is a contravention of Regulations under the Medicines Act. If

medication is required out of hours the emergency duty pharmacist must be contacted for advice.

14. Recording of Leave

The granting of leave and the conditions attached to it, should be clearly recorded in the patient's case notes. The prescribed leave should be recorded on the Section 17 leave form (Appendix 2) be duly signed by the patient and forwarded immediately to the Mental Health Act Office.

All expired Section 17 leave authorisation forms should be clearly marked as no longer valid.

Copies of the authorisation of leave form should be given to the patient, any appropriate relatives or friend and any professionals in the community who may need to be informed.

The outcome of leave, whether or not it went well, benefits achieved and particular problems encountered or concerns raised should be recorded in the patient's case notes to inform future decision-making.

The leave will be updated and recorded on any relevant IT Patient Information Systems as used within the Health Board.

Within Ty Llywelyn documentation should include a full Risk Assessment and stipulate escort requirements, including number, qualification and gender of staff. Additional risk management strategies must be included e.g leave care plan, and risk formulation. Staff should ensure all escorting contingencies are identified in the leave care plan taking into account all security requirements. (Leave authorisation checklist – Appendix 5)

15. Conditions of leave

The Responsible Clinician, Ministry of Justice or a Court can attach any conditions that are considered appropriate: for example,

- Exclusions from any geographical area
- The use of mechanical restraints
- That the patient resides at a particular address during the time they are on leave
- That the patient remains in the custody of any officer on the staff of the Hospital or of any person authorised in writing by the Hospital Managers for the duration of the leave

.

Patients, who are sent for assessment to other hospitals, should be recorded under the provisions of section 17 leave. E.g Appointment/treatment at Whiston Hospital.

Patients on section 17 leave from one hospital to a second hospital remain liable to be detained in the first hospital.

> ***EG***: *a patient is placed in Tan Y Castell from Ablett for a short time under S17 leave, the current Responsible Clinician will remain the*

Responsible Clinician for the patient as the patient has not been transferred under Section 19 of the Act.

Section 17 leave is not required to allow a patient to be transferred from one hospital to another, transfers should be enacted under Section 19 of the Act.

***EG**: A patient is within the Hergest Unit and needs to go to the Ablett Unit, this is a transfer of care and a transfer should be facilitated under Section 19 of the Act by completion of the internal transfer documentation.*

16. Care and Treatment whilst on leave

The responsibility held by the Responsible Clinician and the nursing staff remain the same whilst the patient is on Section 17 leave.

Where it is necessary to administer treatment to a patient who is on Section 17 leave but the patient is not consenting under Part 4 of the Act, the Responsible Clinician should decide if it would be in the best interests of the patient's health or safety or for the protection of other persons for their Section 17 leave to be rescinded.

However the refusal of treatment may not on its own be sufficient grounds for such an action and a decision should take into consideration the guiding principles in (chapter 1 Code of Practice for Wales 2016), including the least restrictive care and treatment option and maximisation of independence should be given.

16.1 Physical Disorder

Occasionally, patients detained under the provisions of the Mental Health Act will be transferred under Section 17 to local Acute Hospital for the purpose of treating their physical disorders.

Section 17 leave is not required if the patient is detained within a psychiatric unit considered part of that hospital site, eg Heddfan to Wrexham Maelor. Section 17 leave will be required for offsite treatment, eg Hergest to Ysbyty Glan Clwyd.

However the Responsible Clinician will be responsible for ensuring that the staff of the receiving Acute Hospital understand the specific implications and requirements of the Section of the Mental Health Act under which the patient is detained and of the implications of Section 17 leave.

Patients from Ty Llywelyn Medium Secure Unit requiring admission for physical treatments will have staff from the unit escorting them at all times.

When staff are not required the explanation to the acute hospital staff must include the following:

- That detention under the Mental Health Act provides no authority to proceed with most physical treatments without the patient's valid consent.
- That the responsibility for the patient's mental health treatment remains with the Responsible Clinician and that the patient continues to be detained by the Hospital Managers of the Psychiatric Service.

- The receiving Hospital should be provided with information which will allow them speedy access to psychiatric advice and support.
- A full explanation of any risk assessments undertaken and their outcome. A risk assessment which shows any risk of absconding or the possibility of self-harm or harm to others should result in a robust assessment of whether psychiatric nursing support should be provided for the duration of the patient's stay.
- Following conclusion of the physical treatment the patient should not be discharged but returned to the care of the Psychiatric Service.

17. Extension of Section 17 Leave

Section 17 leave can be extended without the patient returning to hospital. This can only be authorised by the Responsible Clinician.

18. Rescinding of Section 17 Leave

The Responsible Clinician can rescind the leave of absence under Section 17 where it is considered necessary in the interests of the patient's health or safety or for the protection of other people.

The Responsible Clinician must carefully consider the reasons for rescinding Section 17 leave and the effect it may have on the patient's care and treatment.

If rescinding the Section 17 leave is considered necessary, the Responsible Clinician must record in writing the reasons for doing so and for this record to be included in the patient's case notes. The patient must be informed of the reasons.

The current Section 17 leave form must be struck through and cancelled clearly being evident, a copy must be forwarded to the Mental Health Act Office.

The nurse in charge has the discretion to end the leave if it is felt necessary, the reasons must be communicated to the Responsible Clinician and documented in the patient's case notes.

Leave may be revoked at any time should staff have clinical concerns in relation to the patient's health and wellbeing and or in order to ensure public protection. In the case of restricted patients and where leave is suspended the Ministry of Justice should be informed at the earliest opportunity.

The reasons for leave cancellation should be fully explained to the patient and recorded in the clinical notes.

19. Absence without leave (AWOL) (S18)

Where detained patients on Section 17 leave in the community are absent without leave, the duty nurse should be informed immediately who will contact the Responsible Clinician.

The Responsible Clinician will decide whether the patient should be returned to Hospital and agree with the duty nurse who should be informed and how the patient should be returned, e.g. by involving the Police or the Ambulance Service.

The Police may need to be immediately informed if there is a risk to self or others whilst absent without leave. There may also be the need for an adult/child at risk report to be completed to gain appropriate multidisciplinary support and response to those deemed at risk.

The procedures identified in the MHLD AC008 Missing Absconding Persons Policy should be followed.

The Ministry of Justice must be informed immediately if a restricted patient is AWOL and informed on their return.

All patients will have contingency plans in place prior to any leave being undertaken including actions and level of risk posed to themselves and others. For those patients detained within Ty Llywelyn this information is shared with North Wales Police, protection of vulnerable peoples unit at monthly meetings to inform appropriate level of response required.

The appendices within the MHLD AC008 Missing Absconding Person Policy **MUST** be adhered to.

20. Information to relevant individuals

The information leaflet (Appendix 6) will be provided to the patient, carer, family member or any other relevant person as necessary once Section 17 leave has been agreed. The contact details will be completed by the nursing staff prior to the leaflet being distributed.

A copy of the Section 17 leave form will be provided to the patient, carer, family member or any other relevant person as necessary and in line with General Data Protection Regulations (GDPR).

21. Monitoring, Escalation and Implementation Arrangements

Ward Managers will be made aware of the policy and will be responsible for ensuring that all staff follow the procedures when leave is granted.

Mental Health Act Administration staff will continue to deliver regular training updates to staff within BCUHB to ensure staff are compliant with leave of absence for detained patients.

Records of all periods of leave will be documented in the patient's case notes. Compliance with this policy will be monitored as an integral part of the divisional clinical governance systems and audited by the Clinical Site Managers and reported through the Quality and Safety Experience Groups.

Each area is to establish audit processes to ensure documentation is completed in line with the policy and leaves are being carried out accordingly identifying the number of leaves and escorts used and types of leave granted.

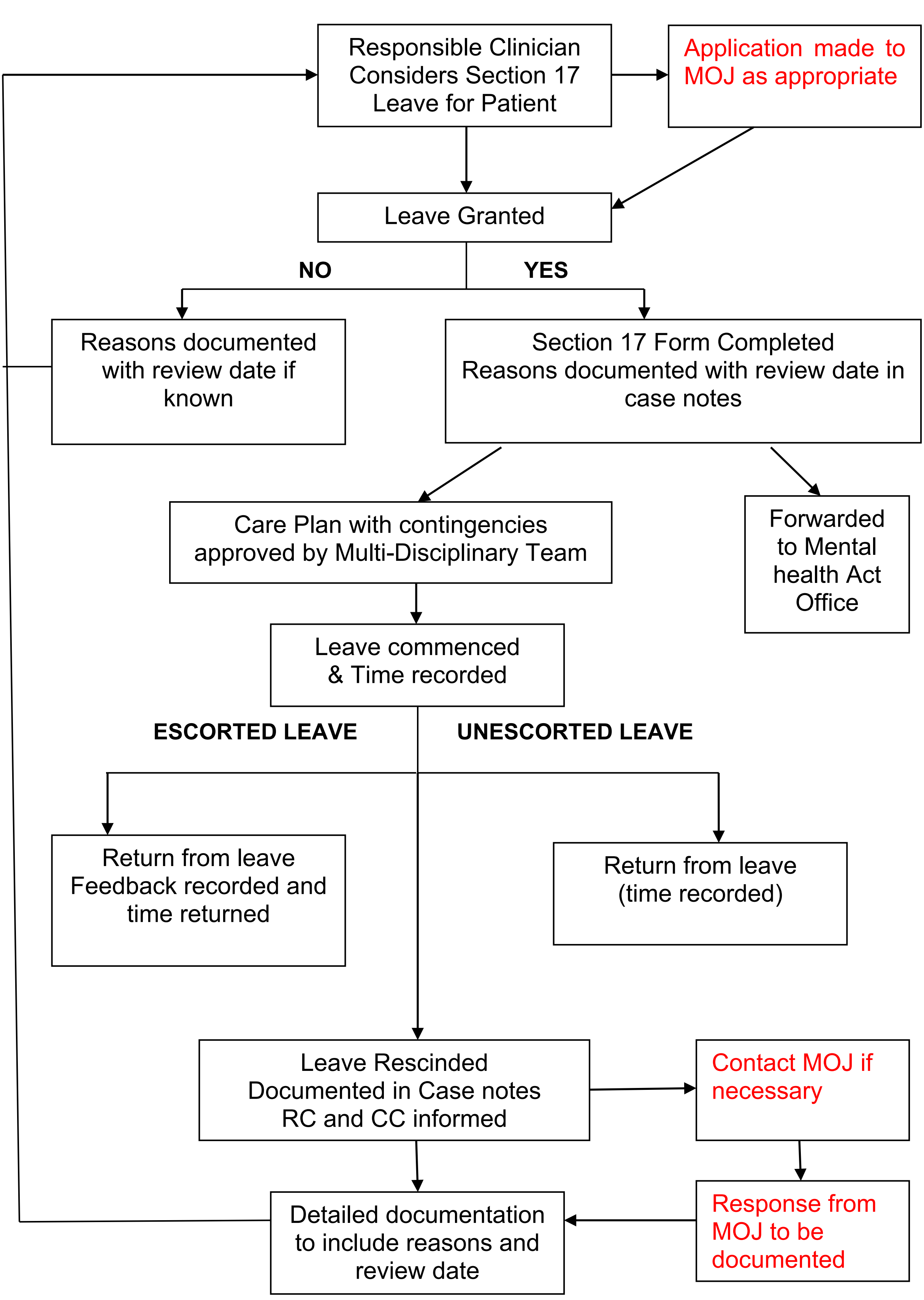
22. Reference to Legislation

Department of Health and Welsh Office, Mental Health Act revised Code of Practice for Wales 2016 ISBN 978-1-4734-7176-4

Jones R., 2022 Mental Health Act Manual 25th Edition. London: Sweet and Maxwell

Upper Tribunal case no: HMW/1727/2020 [2021] UKUT 53 (AAC) DB v Betsi Cadawaldr University Health Board

Appendix 1 - Procedure



Appendix 2 – S17 Leave form

PATIENT'S LEAVE OF ABSENCE
SECTION 17–MENTAL HEALTH ACT 1983

From: Dr ________________________
Responsible Clinician

Unit/Ward: ______________________

Section: _____________

AFFIX ID LABEL HERE

Section 17 Leave of absence CANNOT be granted to patients detained under S36, S37/41, S47/49, S48/49 unless the appropriate written permission has been obtained from either the Court or Ministry of Justice.

S37/41 Has authorisation for proposed leave been received from Ministry of Justice? YES / NO (please delete as appropriate)
If leave is for more than 7 consecutive days has a CTO been considered? YES / NO (please delete as appropriate)
Please document reasons in notes.

NB: LEAVE WITH RELATIVES IS REGARDED AS UNESCORTED LEAVE UNLESS CUSTODIAL AND AGREED BY HOSPITAL MANAGERS
Custodial leave: Yes/No Signed on behalf of Hospital Managers: Signature:_______________________ Date: _______________

	LEAVE DETAILS	DURATION	FREQUENCY	ESCORTS
Within Hospital Perimeter				
Specified Location				
Unlimited Area/Specific Trips				
Overnight Leave				

This arrangement is authorised from __________________ (date) to ______________________ (date)

Other conditions:

- **Leave will only be allowed at the discretion of the Nurse in Charge of the ward at the time leave is to be taken.**
- **Patient may be subject to random drug or alcohol screening following leaves and/or pat down search upon return to the ward.**

Signature – RC ________________________________ Date ___________________________

To be completed by the patient: **I understand the terms and conditions of the above leave and that leave will only be allowed at the discretion of nursing staff.**

Signature – PATIENT ____________________________ Date ____________________________

Witness – NURSE _____________________ ___________________(print and sign) Date ____________________________

Copy to (please tick): Patient: ☐ GP: ☐ Keyworker: ☐ Relative/Friend (if appropriate): ☐ Other _________________: ☐

Feedback regarding leave has been documented for the period above: YES / NO (please delete as appropriate)

Atodiad 2 - Ffurflen absenoldeb S17

ABSENOLDEB CLAF
ADRAN 17 - DEDDF IECHYD MEDDWL 1983

Gan : Dr______________________________
Clinigydd Cyfrifol

AFFIX ID LABEL HERE

Uned / Ward: ________________________

Adran: ______________

Ni ellir caniatau absenoldeb Adran 17 i gleifion sy'n cael eu cadw dan S36, S37/41, S47/49, S48/49 oni bai bod y caniatad ysgrifenedig priodol wedi'i gael gan un ai y Llys neu'r Weinyddiaeth Gyfiawnder.

S37 / 41 A gafwyd caniatâd ar gyfer absenoldeb arfaethedig gan y Weinyddiaeth Gyfiawnder? DO / NADDO (dileer fel sy'n briodol)
Os yw absenoldeb am fwy na 7 diwrnod yn olynol a oes CTO wedi cael ei ystyried? DO / NADDO (dileer fel sy'n briodol). Cofnodwch y rhesymau yn y nodiadau.

DS: MAE ABSENOLDEB GYDA PERTHNASAU YN CAEL EI YSTYRIED FEL ABSENOLDEB HEB GWMNI ONI BAI EI FOD YN WARCHODOL NEU WEDI'I GYTUNO ARNO GAN REOLWYR YR YSBYTY.
Absenoldeb gwarchodol: Ia / Na Llofnodwyd ar ran Rheolwyr yr Ysbyty: Llofnod:__________________Dyddiad: _______________

	MANYLION YR ABSENOLDEB	HYD	AMLDER	HEBRYNGWYR
O fewn perimedr yr ysbyty				
Lleoliad penodol				
Ardal annherfynol / teithiau penodol				
Absenoldeb dros nos				

Cymeradwywyd y trefniant hwn o__________________ (date) i ______________________ (date)
Amodau eraill:

- **Caniateir absenoldeb yn ôl cyfarwyddyd y Nyrs Mewn Gofal y ward ar amser y cymerir yr absenoldeb.**
- **Efallai y bydd cleifion yn cael prawf sgrinio cyffuriau neu alcohol yn dilyn absenoldebau a/neu archwiliad wrth ddychwelyd i'r ward**

Llofnod - RC ______________________________________ Dyddiad ____________________

I'w gwblhau gan y claf: Rwy'n deall amodau a thelerau'r absenoldeb uchod a bydd absenoldeb yn cael ei ganiatáu ar ddisgresiwn y staff nyrsio yn unig.
Llofnod – CLAF ____________________________ Dyddiad ____________________________

Tyst – NYRS ______________________ ____________________(printiwch a llofnodwch) Dyddiad _____________________________

Copi i (ticiwch): Claf: ☐ Meddyg Teulu: ☐ Gweithiwr allweddol: ☐ Perthynas/ffrind (os yw'n briodol): ☐ Arall __________________: ☐

Mae adborth ar gyfer absenoldeb wedi'i gofnodi ar gyfer y cyfnod uchod: DO / NADDO (dileer fel sy'n briodol)

Appendix 3 - Ty Llywelyn Section 17 Leave – Nurse in Charge Guidelines

Emergency	Planned – one off and recurrent	Care Plan
In cases of medical emergency, NIC to contact Ward managers / modern matron and patients RC to inform them of situation.	Has formal care plan specific to leave been agreed by the MDT and signed by the patient	Plan should include: destination, length of absence, frequency, escorting arrangements, purpose of leave, arrangements to review and monitor leave, risk assessment, the need for special conditions and a contingency plan.
↓	↓	
Leave Care plan and risk assessment to include contingency arrangements in place. Consideration to high risk / profile and media sensitive patients.	Is there a in date signed section 17 document in place (R.C & Pt) Alongside the MOJ leave approval letter.	
↓	↓	
Nurse in Charge to contact destination i.e: emergency dept to arrange and formalise visit, taking into account waiting times and risk management.	Nurse in Charge to assess pt mental state prior to authorising leave and document on Paragon.	
↓	↓	
Nurse in Charge to ensure Ministry of Justice is contacted regarding emergency leave. MOJ: 02070354848	Nurse in Charge to complete patient leave form, incl:description / clothing, escorts, destination, times, how much money patient has, ensure regular contact maintained with escorts.	
↓	↓	
Nurse in Charge to complete patient leave form, incl:description / clothing, escorts, destination, times etc.	NIC to ensure escorting staff document leave outcome on their return to the ward.	
↓		
Nurse in Charge to maintain contact with escort party throughout time away from the unit.		

Appendix 4 – Ty Llywelyn External Leave (Section 17) Patient Description

Date	Destination & Escort(s)	E/L	U/L	Time Out	Time Due Back In	Time In	Number and Gender of Escorts	Description	Items Taken Out	Items Taken Back	Staff Sign Out	Staff Sign In

Appendix 5 – Checklist for Signing Section 17 Leave

1	**Check MOJ / Court Approval Paperwork and indicate correct on S17 leave form**	
2	**Check Multi-Disciplinary Team Care Plan for Proposed Leave – Reference must be made in this plan to date of CTM discussion and decision**	
3	**Ensure all escorting contingencies are identified in the Multi-Disciplinary Team Leave Care Plan, taking into account all security requirements.**	
4	**Check Part B Risk Formulation and Part C**	
5	**Check Dates on Section 17 Leave Form**	
6	**Section 17 Leave Signed**	
7	**Mental State Examination has taken place prior to leave**	

Appendix 6 – Information Leaflet

TAFLEN WYBODAETH DEDDF IECHYD MEDDWL, 1983 CYFNOD O'R YSBYTY DAN ADRAN 17

MENTAL HEALTH ACT, 1983 SECTION 17 LEAVE INFORMATION LEAFLET

Beth yw cyfnod o'r ysbyty dan Adran 17?
Mae Adran 17 yn gyfnod o'r ysbyty wedi'i drefnu sy'n rhan bwysig i baratoi'r defnyddiwr gwasanaeth ar gyfer cael ei ryddhau o'r ysbyty yn y pendraw. Bydd yn galluogi'r tîm gofal i ganfod sut mae'r defnyddiwr gwasanaeth yn datblygu, ac mae hefyd yn caniatáu ffordd o gadw mewn cysylltiad â ffrindiau a theulu, a mynychu pethau y tu allan i'r ysbyty.

Pryd y caniateir cyfnod o'r ysbyty dan Adran 17?
Bydd hyn yn wahanol ym mhob achos. Bydd yn ddibynnol ar nifer o wahanol bethau er enghraifft; effeithiau salwch ac amgylchiadau a'r manteision a'r risgiau y bydd yr absenoldeb yn eu cael a chadw'r ysbyty oddi tano.

Pwy sy'n gallu awdurdodi cyfnod o'r ysbyty?
Dim ond y meddyg sy'n gyfrifol am ofal y defnyddwyr gwasanaeth (a elwir yn y Clinigydd Cyfrifol neu RC) sy'n gallu awdurdodi cyfnod o'r ysbyty. Y meddyg ymgynghorol yw hwn fel arfer, ond gall fod yn feddyg arall os yw'r RC arferol i ffwrdd o'r gwaith. Bydd angen awdurdodiad cyfyngedig gan y Weinyddiaeth Gyfiawnder neu Lys cyn i'r RC ganiatáu gadael.

Am ba mor hir y gellir caniatáu Adran 17?
Gellir ei roi am gyfnod penodol neu amhenodol. Pan fo cyfnod o'r ysbyty am fwy na 7 niwrnod yn cael ei roi, bydd y RC yn ystyried a fydd Gorchymyn Triniaeth Cymuned yn fwy addas.

I ble y gellir caniatáu Adran 17?
Bydd y RC yn cwblhau manylion y cyfnod o'r ysbyty yn ysgrifenedig megis y dyddiadau a'r amseroedd, ac unrhyw amodau sy'n berthnasol. Dylid trafod hyn â'r defnyddiwr gwasanaeth, y tîm gofal a'r teulu / gofalwyr. Dylid rhoi copi o'r ffurflen cyfnod o'r ysbyty Adran 17 i'r defnyddiwr gwasanaeth ac

What is Section 17 leave?
Section 17 is planned leave from hospital which is an important part in preparing the service user for eventual discharge from hospital. It will enable the care team from finding out how well the service user is progressing and it also allows means of keeping in touch with friends and family and attending to things outside of hospital.

When is Section 17 leave granted?
This will be different in each case. It will be dependent on a number of different things for example; the effects of illness and circumstances and the benefits and risks the leave will have and the hospital detention is under.

Who can authorise leave?
Only the doctor in charge of the service users care (known as the Responsible Clinician or RC) can authorise leave. This is usually the consultant but may be another doctor if the usual RC is away. Restricted detentions will require authorisation from the Ministry of Justice or a Court prior to the RC granting leave.

How long can Section 17 be granted for?
It can be given for a specific or indefinite period. Where leave is given for more than 7 days the RC will consider if a Community Treatment Order will be more appropriate.

Where can Section 17 be granted to?
The RC will complete the details of the leave in writing such as the dates and times and any conditions that apply. This should be discussed with the service user, the care team and family / carers. A copy of the Section 17 leave form should be given to the service user and any other people who need

unrhyw unigolyn arall sydd angen gwybod am y cyfnod o'r ysbyty, er enghraifft perthynas agosaf.

A ellir atal Adran 17?
Efallai y bydd y RC wedi gadael cyfarwyddiadau i'r nyrs, na ddylid caniatáu cyfnod o'r ysbyty os yw'r defnyddiwr gwasanaeth yn sâl iawn, a bod risg os yw'r cyfnod o'r ysbyty yn cael ei ganiatáu. Bydd y RC wedi trafod y math hwn o sefyllfa pan fydd yn caniatáu'r cyfnod o'r ysbyty.
Amod o'r cyfnod o'r ysbyty yw bod y defnyddiwr gwasanaeth yn cael ei hebrwng gan aelod o staff, ac efallai y bydd oedi achlysurol i ddarparu nyrs sy'n hebrwng. Ni ddylai hyn ddigwydd yn aml iawn, ac mae'n well ei osgoi drwy gynllunio ymlaen llaw gyda'ch nyrs benodol.

A ellir ymestyn y cyfnod o'r ysbyty heb ddychwelyd i'r ysbyty?
Gellir, er hynny dim ond y RC all wneud hyn.

Pan rydych ar gyfnod o'r ysbyty dan Adran 17
Dylai defnyddwyr gwasanaeth bob amser geisio bod yn ôl ar y ward ar yr amser a gytunwyd arno, ac a nodwyd ar y ffurflen cyfnod o'r ysbyty dan Adran 17.
Gellir rhoi'r gorau i absenoldeb wedi'i hebrwng os yw'r hebryngwr yn y cwestiwn.
Os nad yw rhywun yn dychwelyd i'r ward, mae'r Ddeddf Iechyd Meddwl yn datgan bod yn rhaid i staff ysbyty ddod â'r unigolyn yn ôl i'r ysbyty, gyda chymorth eraill os oes angen.

Gwybodaeth i ofalwyr a pherthnasau
Dylai gofalwyr, perthnasau ac unigolion eraill yn y gymuned sydd angen gwybod am y cyfnod o'r ysbyty gael copi o'r awdurdodiad. Os yw'r cyfnod o'r ysbyty dan Adran 17 yn amlinellu bod yn rhaid i'r defnyddiwr gwasanaeth fod yng ngwarchodaeth gyfreithiol ffrind neu berthynas, bydd angen i'r unigolyn hwnnw ddeall y cyfrifoldeb a'i dderbyn.

Manylion cyswllt:
Cydlynydd Gofal:....................................

Ward...

Tîm Crisis..

Gwasanaeth IMHA.......................

to know about the leave for example the nearest relative.

Can Section 17 be withheld?
The RC may have left instructions for the nurse that leave should not be given if the service user is particularly unwell and that there is a risk if the leave were to go ahead. The RC will have discussed this kind of situation when granting the leave.
It a condition of the leave is that that the service user is to be escorted by a staff member there may be an occasional delay in providing a nurse escort. This should not happen very often and is best avoided by planning ahead with your named nurse.

Can leave be extended without returning to hospital?
Yes however only the RC can do this.

Whilst out on Section 17 leave
Service users should always try to be back on the ward at the time agreed and stated on the Section 17 leave form.
Escorted leave can be stopped if the escort is concerned.
If someone does not return to the ward the Mental Health Act provides that hospital staff must bring that person back to hospital with the help of others if necessary.

Information for carers and relatives
Carers, relatives and other people in the community who need to know about the leave should be given a copy of the authorisation. If the Section 17 leave specifies that the service user is to be in the legal custody of a friend or relative that person will need to both understand and accept the responsibility.

Contact details:
Care Coordinator:……………………………..

Ward………………………………………….....

Crisis Team ……………………………………

IMHA Service …..……………………………

Appendix 7 – Ministry of Justice Annexes

Annex B

Terms of medical leave for all hospitals, other than high secure, for patients detained under sections 45A, 47/49, 48/49:

Medical Leave

In accordance with section 41(3)(c) of the Mental Health Act 1983 ("the 1983 Act"), the Secretary of State consents to the exercise of the power in section 17 of the 1983 Act to grant a leave of absence for the purposes of attending medical appointments subject to the following conditions:

a) Emergencies

In the case of emergency medical leave the priority is to deal with the physical health crisis. Responsible Clinicians may apply appropriate security arrangements at their discretion. Responsible Clinicians are asked to seek to ensure the usual security arrangements as set out in b) are in place, but the Secretary of State recognises that this will not always be possible or appropriate in an emergency situation.

There is no need to inform the Secretary of State of the emergency medical leave immediately, but an email to the MHCS team as soon as practicable is requested. Where appropriate, the Responsible Clinician should also inform the local Police. If the admission to general hospital develops into overnight leave, the arrangements at c) should be put into place and the Secretary of State should be informed.

b) Routine Day Appointments

In the case of routine appointments, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- They must travel in a secure vehicle with a separate driver (in addition to the 2 escorting staff)
- Handcuffs must be carried and are to be worn as necessary
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following the appointments
- If any concerns arise, leave must be immediately suspended

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

c) Overnight Medical Leave

In the case of overnight medical leave appointments for one or more nights, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The Responsible Clinician must inform the Secretary of State in writing in advance of the overnight leave setting out the reason for the overnight stay and the expected length of time such leave will take
- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- They must travel in a secure vehicle with a separate driver (in addition to the 2 escorting staff)
- Handcuffs must carried and are to be worn as necessary
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following discharge from general hospital
- If any concerns arise, leave must be immediately suspended, or security arrangements increased to protect the public

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

This consent for medical leave at b) and c) applies only to situations where there is a medical need for the treatment/appointment outside the secure hospital site. The Secretary of State does not generally consider that cosmetic surgery, tattoo removal, or similar treatments by choice are essential. Where the RC is of the view that such an appointment is essential, you must seek authority for such an appointment from the Secretary of State by application.

In all cases an appropriate risk assessment should be carried out by the care team in advance of any medical appointment and consideration should be given as to whether it is necessary to impose further security measures based on the level of risk identified

If there are incidents of the leave being misused or evidence of behaviours which pose a risk to the public or patient, the Responsible Clinician must suspend the leave.

The Secretary of State's consent is given on the understanding that the granting of section 17 leave involves no undue risk to the patient or to others and that there is a medical need for the treatment/appointment outside the secure hospital site.

The local police should be contacted at once and the Mental Health Casework Section should be informed by telephone, with a follow up written report from the responsible clinician, if the patient fails to return to hospital from leave by the agreed time.

Annex C

Terms of medical leave for all hospitals, other than high secure, for patients detained under sections 37/41 hospital orders (or equivalent):

Medical Leave

In accordance with section 41(3)(c) of the Mental Health Act 1983 ("the 1983 Act"), the Secretary of State consents to the exercise of the power in section 17 of the 1983 Act to grant a leave of absence for the purposes of attending medical appointments subject to the following conditions:

a) Emergencies

In the case of emergency medical leave the priority is to deal with the physical health crisis. Responsible Clinicians may apply appropriate security arrangements at their discretion. Responsible Clinicians are asked to seek to ensure the usual security arrangements as set out in b) are in place, but the Secretary of State recognises that this will not always be possible or appropriate in an emergency situation.

There is no need to inform the Secretary of State of the emergency medical leave immediately, but an email to the MHCS team as soon as practicable is requested. Where appropriate, the Responsible Clinician should also inform the local Police. If the admission to general hospital develops into overnight leave, the arrangements at c) should be put into place and the Secretary of State should be informed.

b) Routine Day Appointments

In the case of routine appointments, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- Use of handcuffs is at the Responsible Clinician's discretion
- Use of secure transport is at the Responsible Clinician's discretion
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following the appointments
- If any concerns arise, leave must be immediately suspended

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

c) Overnight Medical Leave

In the case of overnight medical leave appointments for one or more nights, Responsible Clinicians have authority to grant leave at their discretion according to the following conditions:

- The Responsible Clinician must inform the Secretary of State in writing in advance of the overnight leave setting out the reason for the overnight stay and the expected length of time such leave will take
- The patient must be escorted by a **minimum** of two (2) members of staff at all times
- Use of handcuffs is at the Responsible Clinician's discretion
- Use of secure transport is at the Responsible Clinician's discretion
- A check on victim location should be made in order to prevent possible inadvertent contact (through the Victim Liaison Officer if there is one)
- The patient must be returned to hospital immediately following discharge from general hospital
- If any concerns arise, leave must be immediately suspended, or security arrangements increased to protect the public

Any request to deviate from these conditions must be agreed in writing by the Secretary of State.

Details of the treatment and appointments taken should be recorded in the Annual Statutory Report.

This consent for medical leave at b) and c) applies only to situations where there is a medical need for the treatment/appointment outside the secure hospital site. The Secretary of State does not generally consider that cosmetic surgery, tattoo removal, or similar treatments by choice are essential. Where the RC is of the view that such an appointment is essential, you must seek authority for such an appointment from the Secretary of State by application.

In all cases an appropriate risk assessment should be carried out by the care team in advance of any medical appointment and consideration should be given as to whether it is necessary to impose further security measures based on the level of risk identified

If there are incidents of the leave being misused or evidence of behaviours which pose a risk to the public or patient, the Responsible Clinician must suspend the leave.

The Secretary of State's consent is given on the understanding that the granting of section 17 leave involves no undue risk to the patient or to others and that there is a medical need for the treatment/appointment outside the secure hospital site.

The local police should be contacted at once and the Mental Health Casework Section should be informed by telephone, with a follow up written report from the responsible clinician, if the patient fails to return to hospital from leave by the agreed time.

Appendix 8 – Ty Llywelyn two way radio guidelines/protocol

Ty Llywelyn

Two Way Radio Guidelines / Protocol

Simon Allen (Clinical Operations Manager)
North Wales Forensic Psychiatric Service
Betsi Cadwaladr University Health Board

Ty Llywelyn

RADIO USER GUIDELINES

All three wards will have 6 radios and chargers:

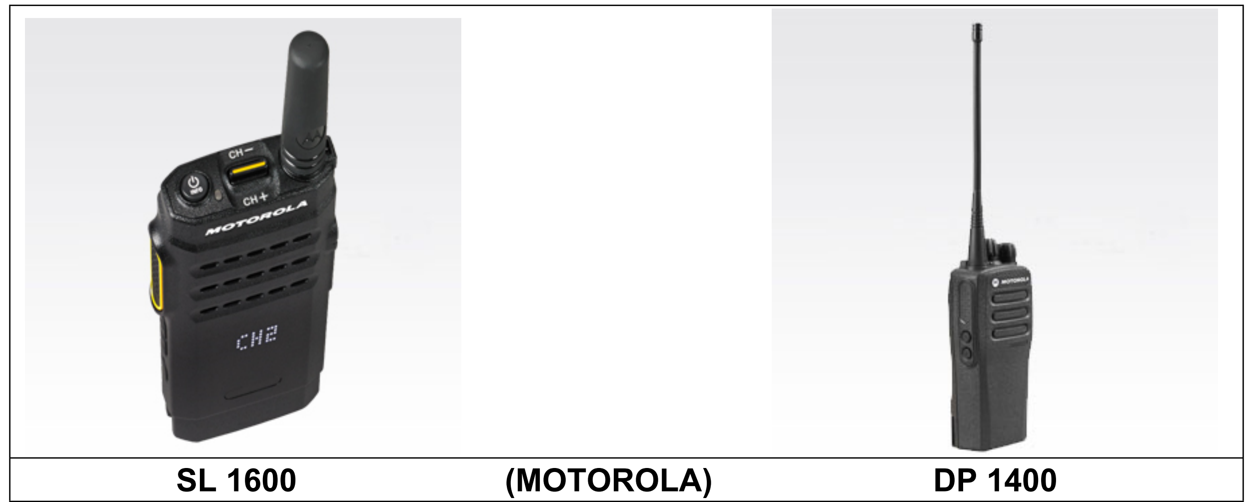
Radio	Amount	Purpose	Channel
Motorola SL 1600	**5**	**Regular communication, therapeutic leaves and emergency communication eg Untoward Incidents, AWOLs and searches.**	**ONE**
Motorola DP 1400	**1**	**Fire Radio**	**TWO**
Motorola SL 1600		**Learning Disability Services and Shared Contact**	**THREE**

Staff must ensure that radios are used at all time when undertaking escorted leave within the MSU, hospital grounds and local village. Staff must adhere to the guidelines as continued communication is vital to ensure the safety of all parties.

Security Nurses must ensure that Radios are fully charged at all times and when allocated to an individual, kept on their person at all times when in Ty Llywelyn.

Radios will also be allocated on a daily basis to the Response Nurses, Nurse in Charge, Ward Manager, Matron and escorting staff as required.

To assist in maintaining a safe environment for all and the safety and welfare of staff and patients when on leave, radio allocation to key staff members is essential. This will enhance communication between ward and senior staff along with the response nurses to enable immediate comms and ensure that responses to any untoward incident and or increased acuity is appropriate and timely.



SL 1600	(MOTOROLA)	DP 1400

USING THE RADIO

- Press to Talk (PPT), ie, keying the radio transmission button.
- Ideally Press PPT button for 1 second prior to using radio to allow for clearer transmissions, release PPT immediately after transmitting any message to allow for others to transmit response.
- Radio checks carried out at the beginning of each shift and before leaving ward for leaves.
- Radios are put on charging cradles whilst not in use and battery strength checked before using.
- Ensure correct frequency/channel is selected:

  Channel 1 – Escort / Communication Channel

  Channel 2 – Fire radio channel

  Channel 3 – Learning Disability

Fire Radio checks to be carried out with Reception at the beginning of each shift.

When utilising radios for leave, escorting staff and response staff must ensure checks are carried out as per guidelines.

VOICE PROCEDURE

- Voice procedure is designed to provide **SECURE**, **ACCURATE** and **DISCIPLINED** usage when speaking on the radio.

SECURITY

- Think before you speak
- Use correct procedure
- Be brief.

ACCURACY

- The necessity for clear speech over radio conversations
- Use adequate and regular pauses
- Speak slower than usual conversation
- Speak directly into the microphone
- The voice should be pitched at a consistent level

DISCIPLINE

Radio discipline is the responsibility of every user and should adhere to the following:

- Listen before you speak
- Use correct voice procedure
- Answer all calls promptly
- Keep the airways free of unnecessary talk
- Be brief and to the point
- No swearing or inappropriate language

PHRASE	MEANING
Affirmative	Normally used when a question is asked and the reply is YES
Disregard	This transmission has been made in error – ignore
Figures	Numbers to follow
Go ahead	Ready to receive your message
I spell	Next word will be spelt out using the phonetic alphabet
I say again	I am repeating the transmission or portion requested
Negative	Normally used when a question is asked and the reply is NO
Out	End of transmission, no answer is required or expected
Over	Invitation to transmit
Roger	Message was received and understood
Roger so far	Confirm parts of long message before continuing with rest of message
Say again	Repeat all of your last transmission
Standby	Wait for a short period and I will get back to you
Wait over	Wait for a short period and I will get back to you
Wait out	The waiting period is longer than “wait over” and I will call you as soon as possible

All words spelt over a radio system should be spelt phonetically to avoid confusion.

PHONETIC ALPHABET

A	Alpha	**N**	November
B	Bravo	**O**	Oscar
C	Charlie	**P**	Papa
D	Delta	**Q**	Quebec
E	Echo	**R**	Romeo
F	Foxtrot	**S**	Sierra
G	Golf	**T**	Tango
H	Hotel	**U**	Uniform
I	India	**V**	Victor
J	Juliet	**W**	Whiskey
K	Kilo	**X**	X-ray
L	Lima	**Y**	Yankee
M	Mike	**Z**	Zulu

RADIO CHECKS

- Escorting staff must ensure that the response nurse is in possession of a charged working radio and a check is carried out before leaving the unit.
- Response nurse must carry out regular radio checks during the period of leave (as per care plan).
- Should there be any concerns with the radios or communication breakdown then escorting staff must return to the unit immediately and response staff must make their way to the last known point of contact.
- Staff must be reminded of confidentiality and **NOT** to use patient or staff names.

INITIATING A RADIO CHECK

The call should consist of the following:

- The call sign of the station being called
- The words "**THIS IS**". The call sign of the station calling
- The words, "**RADIO CHECK**"
- The word, "**OVER**"

Examples:

- Hello Branwen Ward **This Is** Branwen mobile **Radio Check Over**
- Branwen mobile **This Is** Branwen Ward you are loud and clear **Over**
- Branwen Ward **This Is** Branwen mobile you are loud and clear also **Roger Out**

CALL SIGNS – (CS)

Who you are:	E.g., Branwen mobile
Who you are talking to:	E.g., Branwen Ward
Over:	End of that particular part of the transmission
Out:	The end of all messages (no response required from other c/s)
Roger/Understood**:**	Message received and understood

SHARED CONTACT

If additional assistance is required following contact with Ty Llywelyn response nurse, when on grounds / village leave Channel 3 can be accessed to call for assistance from Learning disability services. LD Services may also access Channel 1 to call for assistance from Ty Llywelyn if required.

Combined service searches (L.D, Forensic, Rehab) of the grounds and locality may require the use of one allocated channel, 1 or 3. Lead person from Ty Llywelyn and or L.D to coordinate this.

Radios used for escort are only to be utilised for internal leave and in the grounds of Bryn y Neuadd, Llanfairfechan local area, village and sea front

Any concerns with the radios should be reported at the earliest opportunity to Line Manager and or security lead.

****

Provider: Radio-Active Communications LTD, 6 Tower Close, Wrexham Industrial Estate, Wrexham LL13 9WB.

www.radioactivecomms.co.uk. Tel: 01978 664 242

Teitl adroddiad: ***Report title:***	Compliance with the Mental Health Act 1983 (as amended 2007) Quarterly Audit			
Adrodd i: ***Report to:***	Mental Health Capacity and Compliance Committee (MHCACC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 10 February 2023			
Crynodeb Gweithredol: ***Executive Summary:***	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 details the quarterly audit conducted in December and the progress since the audit was began in August 2021. It details comparisons of the previous audits to show if improvements have been made. 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 the audit 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, along with an audit progression for each unit since the audit began in August 2021.			
Argymhellion: ***Recommendations:***	The committee is asked to note the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health.			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☒	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***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:***				
It is evident the measures that were taken to assist some units throughout the year had a positive impact. These measures have included additional checking and support from the Mental Health Act office staff along with action plans and strengthened communication. It has also become evident that regular auditing of the files assists the units and ensures they are legally compliant for HealthCare Inspectorate Wales inspections of the Mental Health Act and Measure documentation.				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board must adhere to the statutory duties as set out in the Mental Health Act.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	This is a retrospective report on finding from quarterly audits undertaken, no EQIA is required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	An SEIA is not applicable for the audit.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	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.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no financial implications associated with undertaking the audit. Financial implications potentially would occur if a detention was invalid.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been reviewed by Matthew Joyes, Associate Director of Quality Assurance, Patient Safety and Experience. As noted within the report each area has

	been contacted to highlight changes required and assurance.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** *Appendix 1 – Compliance with the Mental Health Act Quarterly Audit 2021- 2022*	

Mental Health Capacity and Compliance Committee – 10.02.2023
APPENDIX 1

Quality Directorate / Legal Services Department

Compliance with the Mental Health Act Quarterly Audit 2021 – 2022

Audits conducted by: Mental Health Act Department Staff
Report produced by: Wendy Lappin, Mental Health Act Legislation Manager
January 2023

SUMMARY

This report combines the quarterly audit which was completed in December 2022 and progress detailed for each unit since the introduction of the audit in August 2021. This report is the 6th document produced detailing findings.

In December 2022 seven units were audited, all units showed an improvement or a maintained position in regards to standards 1, 3 and 5. Six units showed an improvement or maintained position in regards to standards 4, 6, 7 and 8.

Recent admissions throughout the audits have had an impact on standard 1 and 7 due to documents not being in the file at the time, the use of old explanation of rights forms has had an impact on standard 4.

Progress details are included for Coed Celyn, Tan Y Coed and Foelas for the quarters when they were audited, these units also contribute to the combined results progression table.

When considering the combined results, at the end of the year all standards showed an improvement with standard 3 achieving 100% closely followed by six of the standards achieving over 90% (1, 2, 5, 6 and 8).

It is evident the measures that were taken to assist some units throughout the year had a positive impact. These measures have included additional checking and support from the Mental Health Act office staff along with action plans and strengthened communication. It has also become evident that regular auditing of the files assists the units and ensures they are legally compliant for HealthCare Inspectorate Wales inspections of the Mental Health Act and Measure documentation.

Cefni, Carreg Fawr and Ty Llywelyn have all made steady improvements following the assistance of the Mental Health act office and it is clear they are now maintaining the files and their detention paperwork and responsibilities without this additional assistance.

Feedback has been given to each unit after every audit and assurance received that documents have been placed in files and new explanation of rights have been produced if required.

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

The quarterly audit will continue to be undertaken in 2023 with the Mental Health Act office staff continuing to assist in any action plans and areas where a decline is seen.

The policy MHLD 0030 Policy for Information to Patients will be shared in conjunction with this yearend audit to ensure correct documents are used.

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 audit progression tables detail the comparison to the previous audits showing an upward, downward or no change result. The shaded arrow notes the target of 100% achieved.

In December seven 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. The units not audited were due to no patients being subject to the Mental Health Act at the time.

58 files were scrutinised:

Specialism and Unit	Number of files scrutinised
Older Persons	
Cefni Hospital	13
Bryn Hesketh	11

Specialism and Unit	Number of files scrutinised
Learning Disability Villas	
Tan Y Coed	0
Foelas	0

Rehabilitation	
Tan Y Castell	4
Coed Celyn	0
Carreg Fawr	5
Forensic	
Ty Llywelyn	17

Mesen Fach	3
CAMHS	
North Wales Adolescent Service	5

1 Cefni – November Audit

No.	Standard	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**92.3%**	**7.7%**	⇧
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	**53.8%**	**46.2%**	⇧
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.	**76.9%**	**23.1%**	⇩
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**92.3%**	**7.7%**	⇧
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.	**92.3%**	**7.7%**	⇧

NOTES
There has been an improvement in the majority of the paperwork for Cefni due to assistance from the MHA department. The lack of up to date medication certificates were due to a change in ward staffing and these not being actioned following receipt. All documents were confirmed to be fully up to date following the audit.

Cefni – audit progression

No	Standard	Sept 2021 (starting Position)	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	↓ 75%	↑ 80%	↑ 81.8%	↓ 23%	↑ 92.3%
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	↓ 37.5%	↑ 100%	↓ 54.5%	↓ 30.8%	↑ 100%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**12.5%**	↑ 50%	↑ 80%	↑ 81.8%	↓ 15.4%	↑ 100%
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**25%**	↑ 50%	↑ 70%	↓ 63.6%	↓ 7.7%	↑ 53.8%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**50%**	↑ 62.5%	↑ 100%	↓ 72.7%	↓ 30.8%	↑ 100%
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	→	↓ 90%	↑ 100%	↓ 84.6%	↓ 76.9%
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	→	↓ 70%	↑ 72.7%	↓ 53.8%	↑ 92.3%
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**	↓ 87.5%	↑ 100%	→	↓ 30.8%	↑ 100%
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**37.5%**	↑ 87.5%	↑ 90%	↓ 63.6%	↓ 7.7%	↑ 92.3%

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.	**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.	**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
Bryn Hesketh continues to maintain a high standard of case notes.

Bryn Hesketh – audit progression

No	Standard	Sept 2021 (starting Position)	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
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%**		91%	60%	90%	100%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**82%**	80%	83%	100%		
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**82%**	80%	91%	100%		
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**82%**	90%	100%			
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.	**64%**	90%	58%	100%	90%	100%
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%**					

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.	**75%**	**25%**	
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. The missing CTP has been addressed.

Tan Y Castell – audit progression

No	Standard	Sept 2021 (Starting position)	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
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%**	→	→	→	→	→
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	→	→	→	→	→
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	→	→	→	→	→
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	→	→	→	→	→
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.	**100%**	→	↓ 75%	↑ 83.3%	↓ 60%	↑ 75%
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%**	→	→	→	→	→

4 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.	**100%**	**0%**	→
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**80%**	**20%**	↓
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	**80%**	**20%**	↓
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.	**60%**	**40%**	↑
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**80%**	**20%**	↓
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**80%**	**20%**	↓

NOTES
Carreg Fawr has maintained improvement in a number of areas. There are still a number of areas that require improvement. It has been confirmed that the ward manager is leading on clinical file audits to be carried out regularly with the named nurse taking responsibility for their patient's clinical files.

Carreg Fawr – audit progression

No	Standard	Sept 2021	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**80%**	50%	100%	50%	100%	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	83.3%	100%	83.3%		80%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**80%**	83.3%	100%	50%	100%	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	50%	100%	16.7%	83.3%	80%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**					
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**80%**	100%	100%			
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**60%**	83.3%	66.6%		33.3%	60%
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**					80%
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**60%**	83.3%		66.7%	100%	80%

5 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.	**100%**	**0%**	⇨
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**88.2%**	**11.8%**	⇧
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	**88.2%**	**11.8%**	⇧
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**94.1%**	**5.9%**	⇧
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.	**82.4%**	**17.6%**	⇧
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.	**82.4%**	**17.6%**	⇧

NOTES
There has been significant improvements this quarter. The unit initiated an action plan following previous audits to include in house monthly checks relating to Mental Health Act documents.

Ty Llywelyn – audit progression

No	Standard	Sept 2021 (starting position)	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**58%**	55.5%	88%	66.7%	100%	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**89%**	83%	100%		87.5%	88.2%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**84%**	77%	100%		87.5%	100%
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	94%	70.5%	60%	81.2%	88.2%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**89%**	94%		100%	93.7%	94.1%
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**95%**	100%			93.7%	100%
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**63%**	72%	82%	80%	56.2%	82.4%
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**84%**	94%	100%	86.7%	93.7%	100%
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**58%**	39%	53%	40%	37.5%	82.4%

6 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.	**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	**66.7%**	**33.3%**	⇨
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.	**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.	**66.7%**	**33.3%**	⇩

NOTES
Mesen Fach has maintained a good standard, paperwork was not included in a file due to a recent admission this was rectified on the day.

Mesen Fach – audit progression

An audit was not undertaken for Mesen Fach in September 2021

No	Standard	Nov 2021 (starting position)	Feb 2022	June 2022	Sept 2022	Dec 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**50%**	100%	50%	66.7%	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	100%			
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**25%**	80%	100%		
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**0%**	80%	75%	66.7%	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**75%**	80%	75%	100%	
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.	**75%**	60%	100%		
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**100%**		75%	100%	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**25%**	40%	50%	100%	66.7%

7 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.	**80%**	**20%**	↓
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%**	**0%**	→
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**40%**	**60%**	↓
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.	**80%**	**20%**	↓

NOTES
CAMHS has seen an improvement and a decline in some areas. Two recent admissions contributed to the lack of a Care and Treatment Plan as a Care Coordinator was yet to be appointed.

CAMHS – audit progression

An audit was not undertaken for the North Wales Adolescent Service in September 2021

No	Standard	Nov 2021 (starting position)	Feb 2022	June 2022	Sept 2022	Dec 2022
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%**				80%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**			50%	100%
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**		50%		60%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**			50%	100%
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.	**100%**	66.6%	100%	50%	40%
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%**				80%

8 Coed Celyn – audit progression

The unit was not audited in September or December 2022

No	Standard	Sept 2021 (starting position)	Nov 2021	Feb 2022	June 2022
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.	**75%**	↑ 80%	↑ 100%	→
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	↓ 50%	↑ 100%	→
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**50%**	↓ 20%	↑ 75%	↓ 50%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	↓ 80%	↑ 100%	→
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.	**100%**	↓ 80%	↓ 75%	↓ 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%**	→	↓ 75%	↑ 100%

9 Tan Y Coed – audit progression

The unit was not audited in September or December 2022

No	Standard	Nov 2021 (starting position)	Feb 2022	June 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**0%**	100%	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	50%	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**0%**	100%	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**0%**	100%	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**0%**	100%	
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.	**100%**	50%	83.3%
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%**	50%	

10 Foelas – audit progression

The unit was not audited in June, September or December 2022

No	Standard	Nov 2021 (starting position)	Feb 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**75%**	100%
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	100%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**0%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**25%**	0%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**25%**	0%
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**75%**	100%
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**75%**	100%
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**25%**	100%
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**25%**	100%

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.	**96.5%**	**3.5%**	⇧
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**93.1%**	**6.9%**	⇧
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	**79.3%**	**20.7%**	⇧
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**98.3%**	**1.7%**	⇧
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**94.8%**	**5.2%**	⇧
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**82.7%**	**17.3%**	⇧
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**98.3%**	**1.7%**	⇧
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**87.9%**	**12.1%**	⇧

Combined notes – audit progression

No	Standard	Sept 2021 (starting position)	Nov 2021	Feb 2022	June 2022	Sept 2022	Dec 2022
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**82%**	74%	93%	76.4%	80%	96.5%
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**90%**	82%	83%	84.3%	76.4%	93.1%
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**74%**	68%	90%	92.2%	74.5%	100%
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**78%**	66%	81%	64.7%	67.3%	79.3%
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**82%**	83%	95%	92.2%	78.2%	98.3%
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**96%**	98%		100%	94.5%	94.8%
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**76%**	85%	70%	80.4%	63.6%	82.7%
8.	**Mental Health Act Divider** Was there a mental health act divider in the case notes.	**94%**	93%	100%	90.2%	81.8%	98.3%
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**70.5%**	71%	76%	66.7%	60%	87.9%

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Healthcare Inspectorate Wales (HIW) Monitoring Report</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Mental Health Capacity and Compliance Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">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.

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.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Committee is asked to note the report</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Teresa Owen, Executive Director of Public Health.</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Wendy Lappin, Mental Health act Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I’w Nodi
For Noting
☒</td><td>I Benderfynu arno
For Decision
☐</td><td colspan="2">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td>Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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:</td></tr>
</table>

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal 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. 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.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by: - Mental Health & Learning Disability Service Quality Delivery Group - Matthew Joyes, Deputy Director of Quality
Cysylltiadau â risgiau BAF:	N/A

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:
Implementation of recommendations

Rhestr o Atodiadau:
Dim

List of Appendices:
Appendix 1 - Inspections

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="12">Power of Discharge Group Chairs Assurance Report</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="12">Mental Health Capacity and Compliance Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="12">Friday, 10 February 2023</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="12">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 covered the three month period October to December 2022.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="12">The committee is asked to note the report.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="12">Teresa Owen, Executive Director of Public Health</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="12">Wendy Lappin, Mental Health Act Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td colspan="4">I'w Nodi
For Noting
☒</td><td colspan="4">I Benderfynu arno
For Decision
☐</td><td colspan="4">Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td colspan="3">Arwyddocaol
Significant
☒
Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

High level of confidence/evidence in delivery of existing mechanisms/objectives</td><td colspan="3">Derbyniol
Acceptable
☐
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td colspan="3">Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td colspan="3">Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="13">Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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:</td></tr>
<tr><td colspan="5">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="8">Quality</td></tr>
<tr><td colspan="5">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="8">Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of</td></tr>
</table>

	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)
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	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.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The chairs assurance report has been approved by Matthew Joyes, Associate Director of Quality Assurance, patient Safety and Experience.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Power of Discharge Group 13/01/2023	

Mental Health Capacity and Compliance Committee - 10th February 2023

Appendix 1 - Power of Discharge Group 13/01/2023

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, due to the change of the Mental Health Act functions falling under the Legal Department of the Quality Directorate the terms of reference and the membership has been reviewed, to include the meeting being attended by the appointed Associate Hospital Managers, Associate Director of Quality, Director of Nursing MHLD, Director of MHLD and the Mental Health Act Manager.

The Power of Discharge Group meeting was held on the 13th of January 2023.

Discussions included:

- **The Associate Hospital Manager update report**.
  It was queried if the Key Performance Indicator (KPI) requirement of the report was necessary, what was it achieving? There was a difference of opinion felt in regards to this inclusion.
- **The Associate Hospital Managers Scrutiny report 2022**
  Highlights included the positive progression and improvement seen within the units, the need for more detail and parameters in relation to recently admitted patients, further clarification regarding the areas the Associate Hospital Manager scrutinise and those that the Mental Health Act office cover and reasons.

- **The MHA performance report submitted for information only**
  No comments or queries were noted.

The group felt there were no areas which required escalation and highlighting to the Mental Health Capacity and Compliance Committee