

Bundle BCU Mental Health Legislation Compliance and Capacity Committee 6 February 2025

Agenda attachments

Agenda - 2025-02-06 BCU Mental Health Legislation Compliance and Capacity
Committee Agenda - V3.0

- 1 PRELIMINARY MATTERS
 - 1.1 MH25.01 - Welcome and Apologies
Chair
 - 1.2 10:00 - MH25.02 - Declarations of Interest relating the the agenda
Chair
 - 1.3 10:05 - MH25.03 - Unconfirmed Minutes of the Mental Health Legislation Committee - 7
November 2024
Chair
MH25.03 - Minutes from MHL Committee 07.11.24 V0.02 Unconfirmed (Public)gsw
 - 1.4 10:10 - MH25.04 - Matters Arising & Table of Actions
Chair
MH25.04 - Summary Action Log MHL Committee (Updated 29.01.25) Publicgsw
- 2 FOR ASSURANCE
 - 2.1 10:15 - MH25.05 - Mental Health Act Assurance Report
Deputy Director for Legal Services
MH25.05a - MHLC - MHA Assurance Report - Cover Paper - Feb 2025
MH25.05b - MHLC - MHA Assurance Report - Feb 2025
 - 2.2 10:30 - MH25.06 - Mental Capacity Assurance Report
Director of Safeguarding and Public Protection
MH25.06 - Mental Capacity Assurance Report - MHLC DoLS and MCA Update Report
Q3 06.02.25 V3.00
 - 2.3 10:45 - MH25.07 - HIW Assurance Report
Deputy Director for Legal Services
MH25.07 - MHLC - HIW Assurance Report - January 2025 v2
MH25.07 - Appendix A- HIW Inspection Report-Heddfan Unit 21-23 October 2024
 - 2.4 11:00 - MH25.08 - Associate Hospital Managers Update Report
Associate Hospital Managers
MH25.08 - MHLC - MHA Associate Hospital Manager Report - Feb 2025
 - 2.5 11:15 - MH25.09 - Report from the Power of Discharge
Associate Hospital Managers
MH25.09 - MHLC - PoD Group Chair's Assurance Report - Feb 2025
 - 2.6 11:25 - MH25.10 - MH Bill 2025
Deputy Director for Legal Services
MH25.10 - MHLC - Draft MHA Bill - Feb 2025
 - 2.7 11:35 - MH25.11 - Advocacy Services across North Wales
MHLD Representative to present.
MH25.11 - 2024 01 07 MHL Committee Advocacy paper V7 (002)
- 3 FOR INFORMATION
 - 3.1 11:50 - MH25.12 - Cycle of Business
Head of Corporate Affairs
 - 3.2 11:55 - MH25.13 - Forward Workplan
Head of Corporate Affairs
- 4 CLOSING BUSINESS

- 4.1 MH25.14 - Agree Items for referral to Board / other Committees
Chair
- 4.2 MH25.15 - Agree items for Chairs Assurance Report
Chair
- 4.3 MH25.16 - Review of Meeting Effectiveness
Chair
- 4.4 MH25.17 - Date of Next Meeting - 8 May 2025
Chair



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Agenda

BCU Mental Health Legislation Compliance and Capacity Committee

Date 06/02/2025
Time 10:00 - 12:00
Location Boardroom, Carlton Court, St Asaph LL17 0JG
Chair Gareth Williams

1 PRELIMINARY MATTERS

1.1 MH25.01 - Welcome and Apologies

Chair

1.2 MH25.02 - Declarations of Interest relating the the agenda

10:00

Chair

1.3 MH25.03 - Unconfirmed Minutes of the Mental Health Legislation Committee - 7 November 2024

10:05

Chair

1.4 MH25.04 - Matters Arising & Table of Actions

10:10

Chair

2 FOR ASSURANCE

2.1 MH25.05 - Mental Health Act Assurance Report

10:15

Deputy Director for Legal Services

2.2 MH25.06 - Mental Capacity Assurance Report

10:30

Director of Safeguarding and Public Protection

2.3 MH25.07 - HIW Assurance Report

10:45

Deputy Director for Legal Services

2.4 MH25.08 - Associate Hospital Managers Update Report

11:00

Associate Hospital Managers

2.5 MH25.09 - Report from the Power of Discharge

11:15

Associate Hospital Managers

2.6 MH25.10 - MH Bill 2025

11:25

Deputy Director for Legal Services

2.7 **MH25.11 - Advocacy Services across North Wales**
11:35 MHLD Representative to present.

3 **FOR INFORMATION**

3.1 **MH25.12 - Cycle of Business**
11:50 Head of Corporate Affairs

3.2 **MH25.13 - Forward Workplan**
11:55 Head of Corporate Affairs

4 **CLOSING BUSINESS**

4.1 **MH25.14 - Agree Items for referral to Board / other Committees**
Chair

4.2 **MH25.15 - Agree items for Chairs Assurance Report**
Chair

4.3 **MH25.16 - Review of Meeting Effectiveness**
Chair

4.4 **MH25.17 - Date of Next Meeting - 8 May 2025**
Chair

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Mental Health Legislation Committee
held in Public on 7 November 2024
in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	Title
Gareth Williams	Health Board Vice Chair (Chair of Mental Health Legislation Committee)
Rhian Watcyn Jones	Independent Member
In Attendance	
Teresa Owen	Executive Director of AHPs and Health Science
Alberto Salmoiraghi	Medical Director, Mental Health & Learning Disabilities (MHLD)
Mandy Jones	Deputy Director of Nursing
Michelle Denwood	Director of Safeguarding & Public Protection
Dr. Prashant Bhat	Consultant Child Psychiatrist, North Wales Adolescent Service
Chris Walker	Head of Safeguarding Adults
Matthew Joyes	Deputy Director for Legal Services
Phil Williams	Associate Hospital Manager
Jenny Gilmore	Associate Hospital Manager
Committee Support	
Philippa Peake-Jones	Head of Corporate Affairs

Agenda Item
PRELIMINARY MATTERS
MH24/29 Welcome and Apologies
Apologies were received for Dyfed Jones, Angela Wood, Louise Bell, Ffion Johnstone and Wendy Lappin.
MH24/30 Declarations of Interest
Jenny Gilmore declared an interest in the Mental Capacity Assurance Report as Chair of the Advocacy Service in North Wales.
MH24/31 Unconfirmed Minutes of the Meeting held 01.08.24
It was resolved that the Committee: <ul style="list-style-type: none"> • AGREED that the minutes of the meeting held on 01.08.24 were a true and accurate record subject to the following amendments: • Correct spelling of Jenny Gilmore • Correct job title for Chris Walker as Head of Safeguarding Adults • Amend wording on MH24.20.2 to read 'Mental Health Act compliance should be included' rather than 'could'



- Bank, Locum and Interim Staff to be referred to as Bank, Locum and Honorary Staff.

MH24/32 Matters Arising & Action Log

Mental Health Act Assurance Report

- In relation to Action MH24.20.10 it was noted that Chief Inspector Luke Hughes of the North Wales Police had been invited to join the meeting, he was unavailable on this occasion but will plan to join a future meeting. An informal meeting has taken place with the Chair to discuss S135/S136 and it was confirmed that operational colleagues within North Wales Police are not currently adhering to making contact first before conveying patients and this is being addressed. Discussion also took place in relation to Right Care, Right Place (RCRP) and a verbal update will be provided as part of the meeting. It was confirmed that the Interim Director of MHL D is also in regular contact in relation to the crisis work and this provided assurance to the Committee. The Chair referred to the query around the deadline for informing patients held under the MH Act of their rights stating that this had been raised with other Vice Chairs and Ros Alstead, Independent Advisor with agreement that 30 days was too long. It was agreed that the policy would be reviewed taking into consideration next of kin.
- In relation to Action MH24.9.10 regarding patients being able to communicate in their language of choice, it was agreed that this would be referred to the Quality, Safety and Experience Committee (QSE). The Deputy Director of Nursing also agreed to raise this at the Patient Carer Experience Group.

Actions:

- **MH24/32.1** Deputy Director of Legal Services to review the Policy for Information to Patients (S132/33 Mental Health Act) and provide an update at the next meeting.
- **MH24/32.1** Translation services to be referred to the QSE Committee to ensure patients are being provided with the opportunity to communicate in the language of choice.

FOR ASSURANCE

MH24/33 Mental Health Act Assurance Report

Members received the report and the Deputy Director of Legal Services highlighted:

- There are currently staffing issues within the Mental Health Act Legal Team and gaps in specific areas caused by sickness and bereavement which is also affecting local offices. This is a challenging position and the team have been reprioritised to provide support however this has caused issues with the level of auditing and reporting the team are able to complete and report.
- This has also resulted in reduced support to Clinicians in terms of prompting the review of sections, processing paperwork and supporting hearings and tribunals. The consequence of this has resulted in cases where sections have lapsed and unlawful detentions. It was noted that there have not been any clinical risks incurred as a result of this but there have been legal risks incurred.



- The specific staffing issues are being addressed with the Executive Director of AHPs and Health Science and the Director of Corporate Governance to ensure critical posts are filled on an interim basis.
- In terms of the fundamental and rectifiable errors included in the report, it was noted that there had been seven lapsed sections and two invalid sections during the quarter. This may be a result of the current staffing issues resulting in the information not being picked up in a timely manner. The reasons for the invalid sections have been highlighted and these are being addressed.
- It was noted that some information is missing from the report which is due to both technical and staffing issues.
- There has been an issue with transfers of patients from England where legislation allows clinicians to use electronic signatures: a memo is being sent out to staff to confirm we are unable to accept electronic signatures as we require a manual signature in Wales.

In discussing the report, the Committee:

- Noted the impact that the staffing issue is having on the team and also the Associate Hospital Managers.
- Highlighted that issues have been raised by Clinicians: it was noted that feedback around the current challenges has been provided and mitigating factors have been suggested such as Clinicians actively monitoring Section expiry dates during ward rounds.
- Suggested contact with local offices would be helpful to allow teams to raise specific queries and gain advice and technical specialist views to provide support. It was noted that there is a current agreement with a law firm for the team to access advice and it was agreed that this would be picked up outside of the meeting.
- Acknowledged the importance of the work completed by the Mental Health Act team and suggested the need to address succession planning to ensure the safety of patients and the Health Board.
- Queried whether systems and processes are in place at ward level to support any future issues with staff absence. It was noted that there are issues with staff cover across sites due to patient records being paper based however the team are working to ensure cover is provided to inpatient facilities seven days a week to address urgent issues.
- Referred to section 5 of the report and suggested the information should be based on movement rather than trends, it was agreed that this would be reviewed and the IT team are currently working on a revised system to extract the data which will be included in a future report.
- Highlighted the issue of Section 135-136 detentions for under 18s and confirmed that this information is being scrutinised by the Safeguarding Forum to provide additional assurance for the Committee.
- Noted the need to be aware of what the data is telling us and how this translates into what is happening at ward level. It was suggested that a form of benchmarking with other Health Boards would be valuable.
- Queried the number of out of area placements as this has previously been highlighted as a concern. It was noted that the current figure is 26, these placements are being addressed and actioned as part of the acute care pathway discussions and the issue has also been escalated to the Chief Executive in terms of



performance. Going forward there is a need to look at issues with flow, the number of placements available locally, housing and discussions with partners. Work is also taking place to try and identify a step-down facility which may help to reduce the number of out of area placements required.

- Highlighted an issue in relation to 136 assessments being completed in ED and the impact this has on capacity in ED and also on the psychiatric liaison team and the need to be aware of patients being managed by the correct service.

Action:

- **MH24/33.1** Deputy Director of Legal Services to address providing support for staff from local offices and external suppliers to gain advice on specific issues.

It was resolved that the Committee

- **NOTED** the report and appendices.

MH24/34 Mental Capacity Assurance Report

Members received the report and the Director of Safeguarding & Public Protection highlighted:

- The report refers to BCU wide information and is based on frontline staff in terms of capacity and restrictions.
- The liberty protection safeguards have not been implemented on a national basis and Welsh Government recognise the clear challenges with the current position in relation to deprivation of liberty and the Mental Capacity Act.
- To move forward, work is taking place on a national basis to assist all Health Boards and organisations who hold accountability for the implementation of the legislation.
- The key areas that will be reviewed include updating the Deprivation of Liberty Safeguards (DoLS) paperwork, developing training requirements and streamlining DoLS processes.
- The key areas being addressed have also been highlighted in the internal audit and the team are embedded in moving forward with this piece of work. There will be a need to interrogate the data to identify areas for improvement.
- In relation to table 1 of the report, it was emphasised that this is a nationally recognised tool used to identify our position and this is also benchmarked on a national basis.
- Reference was made to the DoLS backlog confirming a figure of 56, it was noted that this figure can fluctuate depending on the number of applications. Some of the cases are complex and require discussion and engagement with families, advocates and patients.
- The addition of Welsh Government monies has allowed the team to reduce the figure down from a backlog of 115 applications to the current figure and this is being monitored closely on a monthly basis.
- Reference was made to the Independent Mental Capacity Advocate (IMCA) service and the commission of Conwy and Denbighshire Mental Health Advocacy Service (CADHMAS) for the provision of IMCA Services across North Wales which is a contractual arrangement.
- It was suggested that CADHMAS are invited to attend a future meeting of the Committee.



- All DoLS applications that are submitted are quality assured by the team with a target of 100% accuracy.
- In terms of training, moving forward nationally this will be mandated and will provide bespoke training in required areas such as documentation.
- Three cases were highlighted as going through the Court of Protection and there is engagement with the relevant teams to ensure there are no delays to implementation or learning.
- The red action in the action log related to mandatory training for Bank, Locum, and Honorary Staff to include MCA Level 1 and Level 2 (where applicable). It was suggested that this is included on the Committee action log to monitor progress.

In discussing the report, the Committee:

- Requested further information in relation to the best interest assessors as well as the mental capacity advocates and relevant person representative services. It was agreed that this information would be included in a future paper.
- Received confirmation that there are currently six best interest assessor employed full time, five have recently been seconded to attend the best interest assessor course at Manchester University who are not yet qualified and an additional five individuals are employed within the organisation in various roles who are qualified though not employed for this purpose and are undertaking assessments in order to address the backlog.
- Queried whether the comprehensive review of risks associated with DoLS and the Mental Capacity Act has commenced. It was confirmed that this is being reported into the Executive Group.

Actions:

- **MH24/34.1** Monitor progress against action 3.0 relating to mandatory training for Bank, Locum, and Honorary Staff as part of the actin log.
- **MH24/34.2** Provide an update on the Court of Protection cases at a future meeting.
- **MH24/34.3** Invite representative(s) of CADHMAS to attend a future meeting.
- **MH24/34.4** Include additional information relating to best interest assessors, mental capacity advocates and relevant person representative services in a future paper.

It was resolved that the Committee:

- **ACCEPTED** the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Report and the identified activity for the period of Q2 2024-25.
- **RECEIVED** the DoLS and MCA Audit Action Plan and recorded progress.

MH24/35 Health Inspectorate Wales (HIW) Assurance Report

Members received the report and the Deputy Director of Legal Services highlighted:

- There are currently no open actions related to the Mental Health Act or MCA from previous inspections.
- There was an unannounced inspection of the Heddfan Unit in October and no immediate issues were raised around Mental Health legislation.

It was resolved that the Committee:

- **NOTED** the report.



MH24/36 Associate Hospital Managers Update Report

Members received the report and the Deputy Director of Legal Services highlighted:

- The report includes a summary of activity of hospital manager panels and the agreed outcomes.
- In terms of the hearing standard, the current figures is just under 90% and exception reports have been included for those that have not been completed in a timely manner.

In discussing the report, the Committee:

- Queried the term 'regrading to informal', it was noted this term is used for patients formerly under a section who are now being treated as voluntary patients rather than under section.
- Noted with concern that two panels had been cancelled due to a delay in receiving reports from Clinicians. It was confirmed that this is being discussed as to whether hearings are cancelled if the information is not received within a timely manner.
- Acknowledged the current recruitment campaign for AHMs and the need for this to be communicated out more widely to encourage applicants.

It was resolved that the Committee:

- **NOTED** the report.

MH24/37 Report from the Power of Discharge Group

It was resolved that the Committee:

- **NOTED** the report.

FOR INFORMATION

MH24/38 Cycle of Business

It was resolved that the Committee:

- **NOTED** the document.

It was agreed that the following items would come back to future Committee meetings:

- Invite the Chief Inspector of the North Wales Police to attend a future meeting.
- An update on the implementation of the Right Care, Right Place (RCRP) and the Medical Director for MHLD provided a verbal update on the progress to date to the Committee.
- Invite Conwy and Denbighshire Mental Health Advocacy Service (CADHMAS) to attend a future meeting.
- A report on the Court of Protection cases.
- A report on the introduction of the new Mental Health Bill announced by the UK Government.

CLOSING BUSINESS

MH24/38 Agree Items for referral to Board / other Committees



It was resolved that the following would be referred:

- Translation services to the QSE Committee to ensure patients are being provided with the opportunity to communicate in the language of choice.

MH24.39 Agree Items for Chairs Assurance Report

It was resolved that the following would be referred to in the Chairs Assurance Report:

- Issues with staff capacity
- The ongoing issues with DoLS at a national level
- The valuable work completed by the Associate Hospital Managers

MH24/40 Review of Meeting Effectiveness

In discussing the item, the Committee:

- Agreed there had been good discussion around the agenda items.

MH24/41 Date of Next Meeting

The next meeting will be held on 6th February 2025.

Mental Health Legislation Committee Action Log

Updated 29.01.25

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH24/32.1	07/11/24	Matters Arising and Action Log Deputy Director of Legal Services to review the Policy for Information to Patients (S132/33 Mental Health Act) and provide an update at the next meeting.	Matt Joyes	Feb 25	
2	MH24/32.1	07/11/24	Matters Arising and Action Log Translation services to be referred to the QSE Committee to ensure patients are being provided with the opportunity to communicate in the language of choice.	Philippa Peake-Jones	Feb 25	
3	MH24/33.1	07/11/24	Mental Health Act Assurance Report Deputy Director of Legal Services to address providing support for staff from local offices and external suppliers to gain advice on specific issues.	Matt Joyes	Feb 25	
4	MH24/34.1	07/11/24	Mental Capacity Assurance Report Monitor progress against action 3.0 relating to mandatory training for Bank, Locum, and Honorary Staff as part of the action log.	Philippa Peake-Jones	Feb 25	
5	MH24/34.2	07/11/24	Mental Capacity Assurance Report Provide an update on the Court of Protection cases at a future meeting.	Matt Joyes Michelle Denwood	Feb 25	



6	MH24/34.3	07/11/24	Mental Capacity Assurance Report Invite a member of CADHMAS to attend a future meeting.	Philippa Peake-Jones	Feb 25	
7	MH24/34.4	07/11/24	Mental Capacity Assurance Report Include additional information relating to best interest assessors, mental capacity advocates and relevant person representative services in a future paper.	Michelle Denwood	Feb 25	
8	MH24.13.1	02/05/24	Report from the Power of Discharge (Associate Managers) Group Iain Wilkie and Teresa Owen to pick up with the Local Authorities on capacity issues around Approved Mental Health Practitioners.	Iain Wilkie Teresa Owen	Feb 25	Remain Open This will be picked up in the next round of meetings with Local Authorities.

ACTIONS PROPOSED FOR CLOSURE

Closed Actions (as agreed at meeting on)

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status



Teitl adroddiad:	Mental Health Act (MHA) Assurance Report		
Report title:			
Adrodd i:	Mental Health Legislation Committee		
Report to:			
Dyddiad y Cyfarfod:	06 February 2025		
Date of Meeting:			
Crynodeb Gweithredol: Executive Summary:	<p>The Mental Health Act Assurance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during October to December 2024.</p> <p>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.</p> <p>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.</p> <p>Lapsed sections are reported as 'exceptions' throughout the report, and invalid detentions recorded as 'fundamentally defective'. Any lapses or fundamentally defective sections are Datix reported and investigated.</p> <p>A monthly report is submitted to the Deputy Director for Legal Services and the Medical Director for Mental Health and Learning Disability Services to ensure that the MHA is monitored with the exceptions highlighted including any mitigation and learning that has occurred.</p> <p>Appendices are included to support the report.</p>		
Argymhellion: Recommendations:	The Committee is asked to note the report.		
Arweinydd Gweithredol: Executive Lead:	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance		
Awdur yr Adroddiad: Report Author:	Matthew Joyes, Deputy Director for Legal Services		
Pwrpas yr adroddiad: Purpose of report:	<p>I'w Nodi <i>For Noting</i></p> <input type="checkbox"/>	<p>I Benderfynu arno <i>For Decision</i></p> <input type="checkbox"/>	<p>Am sicrwydd <i>For Assurance</i></p> <input checked="" type="checkbox"/>

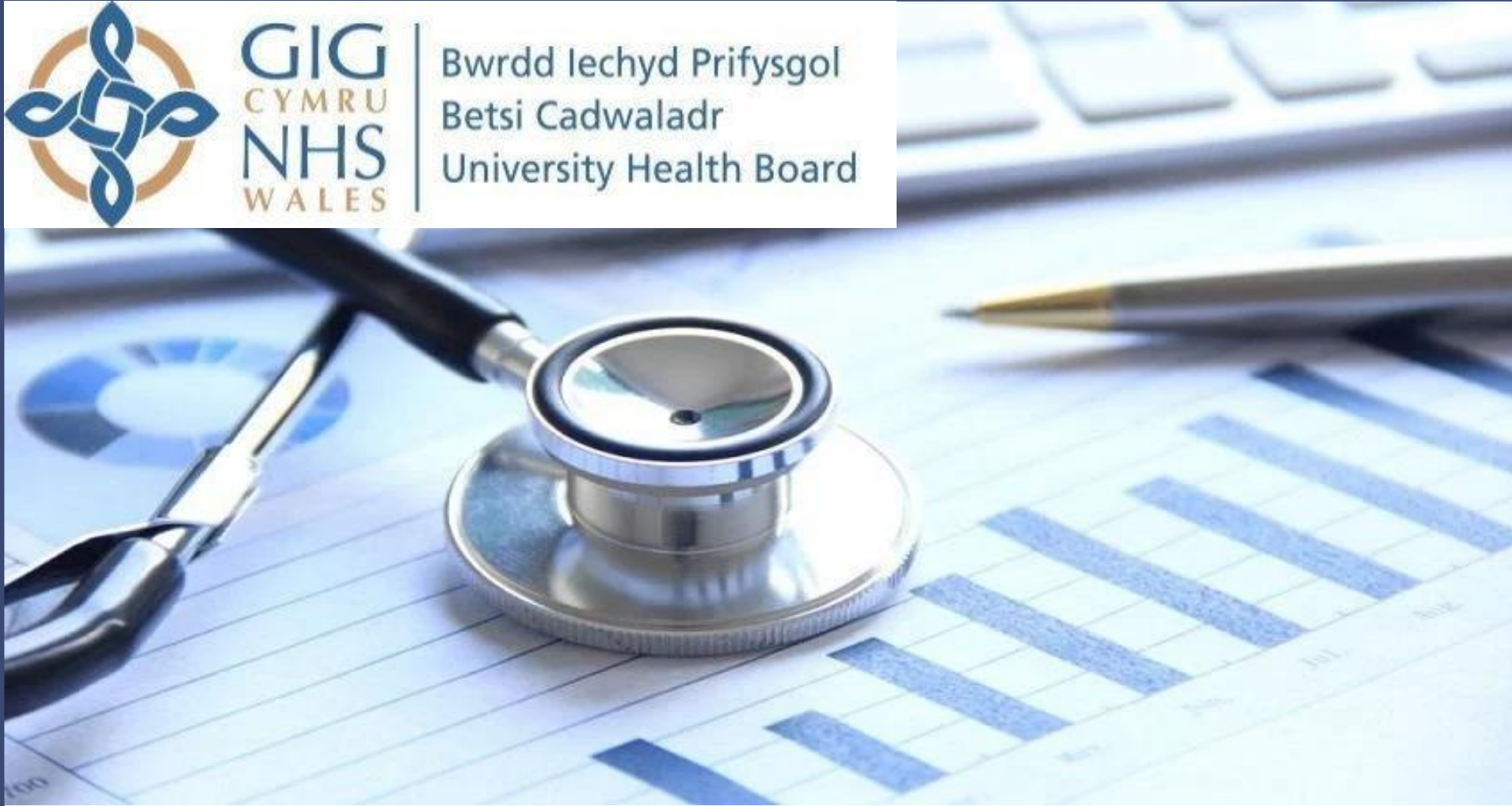
Lefel sicrwydd: Assurance level:	Arwyddocaol Significant <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol Acceptable <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol Partial <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
<p>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:</p> <p><i>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:</i></p>				
<p>Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided. Subject to capacity being restored to the team, the aim would be to include this in the next report.</p>				
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning			
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:	<p>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.</p> <p>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. These are reported as exceptions within the report.</p>			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqlA been identified as necessary and undertaken?	The use of the Mental Health Act sections apply to all persons and 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)	Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided.			

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 <i>Financial implications as a result of implementing the recommendations</i>	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i>	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i>	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services. A monthly report is produced and the data submitted monthly to Dr Alberto Salmoiraghi, Medical Director for Mental Health & Learning Disability Services and Matthew Joyes, Deputy Director for Legal Services. Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.
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 N/A	
Rhestr o Atodiadau: List of Appendices: MHA Assurance Report	



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The Mental Health Act 1983 (MHA) provides for the assessment and treatment of people with a mental disorder and sets out the rights that they have. Under this law, a person can be admitted, detained and treated in hospital for a mental disorder without their consent. The MHA also provides more limited community-based powers, community treatment orders and guardianship.

In 2007 the Act was amended to ensure that service users are receiving the treatment they need and to provide professionals with a clearer framework.

The MHA Code of Practice is issued under section 118 of the Mental Health Act 1983 by the Welsh Ministers and after being laid before the Senedd. The Code provides the principles and guidance on how the MHA should be applied in practice. The Code is Statutory Guidance and persons are required to have regard to the Code in carrying out their functions under the MHA.

Connections between the Mental Health Act 1983 and other legislation, in particular the Mental Health (Wales) Measure 2010, are detailed in the Code.

The “Hospital Managers” (i.e. the Health Board) retain the ultimate responsibility for the execution of all duties or acts carried out by staff in relation to the MHA including ensuring that the grounds for detaining service users are valid and legal.

Executive Summary:

During the previous quarter, the Mental Health Act (MHA) Team has continued to experience unprecedented absences resulting in significant capacity challenges at both a managerial level and in the West Office. The MHA Team and Legal Services Department have worked above and beyond usual working to provide cross-cover and additional capacity has been explored; however, attempts at mitigation failed due to the specialist and unique nature of the work and as a result a number of reports/meetings/audits remain suspended and there remains a significant risk to the proper administration of the MHA. This issue has highlighted the lack of resilience in the team in that there is no deputy manager position to provide both management cover and cross-office cover.

The team have sought to focus on critical tasks; however, despite all interventions, the level of work continued to outstrip capacity. In terms of the impact, this can be summarised as:

- Delays in Sections being renewed;
- Delays in Hospital Manager Review Panels being arranged;
- Delays in Mental Health Tribunals being arranged;
- Delays in service user rights being confirmed;
- Standing down of compliance audits and reports;
- Standing down of Associate Hospital Manager training and appraisals;
- Reduction in monitoring reports being produced, including to the Mental Health Law Committee;
- Reduced legal support to clinical staff in relation to MHA legal advice;
- Delays or reduced quality national data returns to Welsh Government with some returns unable to be provided.

Because of these pressures, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided. Subject to capacity being restored to the team, the aim would be to include this in the next report. Additionally, national data returns such as the "S136 Report" and "KP90" report are delayed.

The MHA Team and Legal Services Department will continue to explore all options. A risk is logged on the risk register and a paper was submitted to the Executive Team.

It is important to note that these challenges have not impacted upon the care and treatment provided to patients by the clinical teams.

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 their health and safety or for the protection of others for them 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). The nurses who can use this power are those registered in either Sub-Part 1 or 2 of the register maintained under article 5 of the Nursing and Midwifery Order 2001 whose registration includes an entry indicating that the nurse's field of practice is either mental health nursing or learning disabilities nursing.

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 for 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

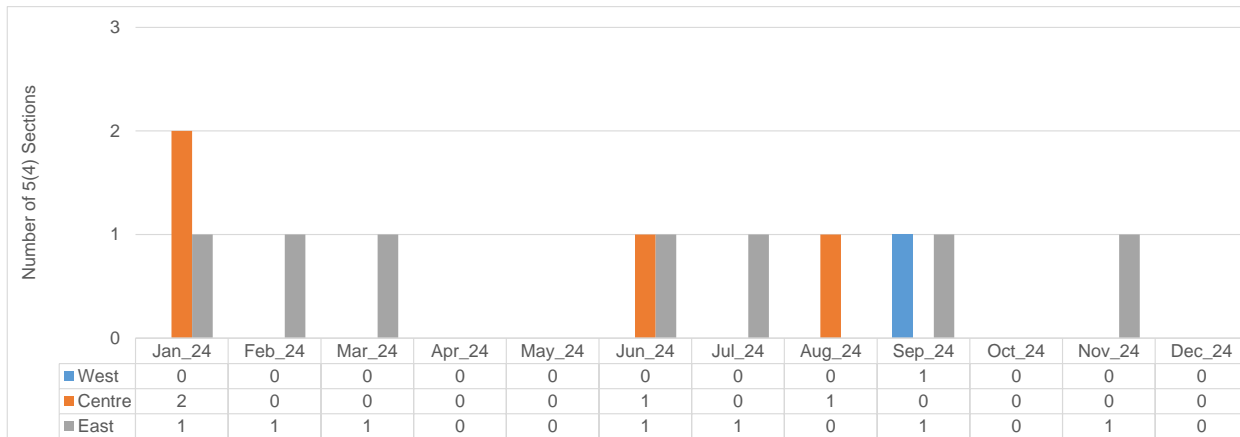
Section 62: Emergency Treatment of a detained patient regardless of section status

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 2024	November 2024	Monthly Trend	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
Section 5: Application in respect of patients already in hospital	0	1	↓	1	4	↓	3	1	East	1
								2	Centre	0
								2	West	0



A Section 5(4) will be used if a qualified nurse of the prescribed class (mental health or learning disability trained) 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 nurse feels this is in the best interest of the patient.

There were no exceptions to report in the period under review.

LAPSES

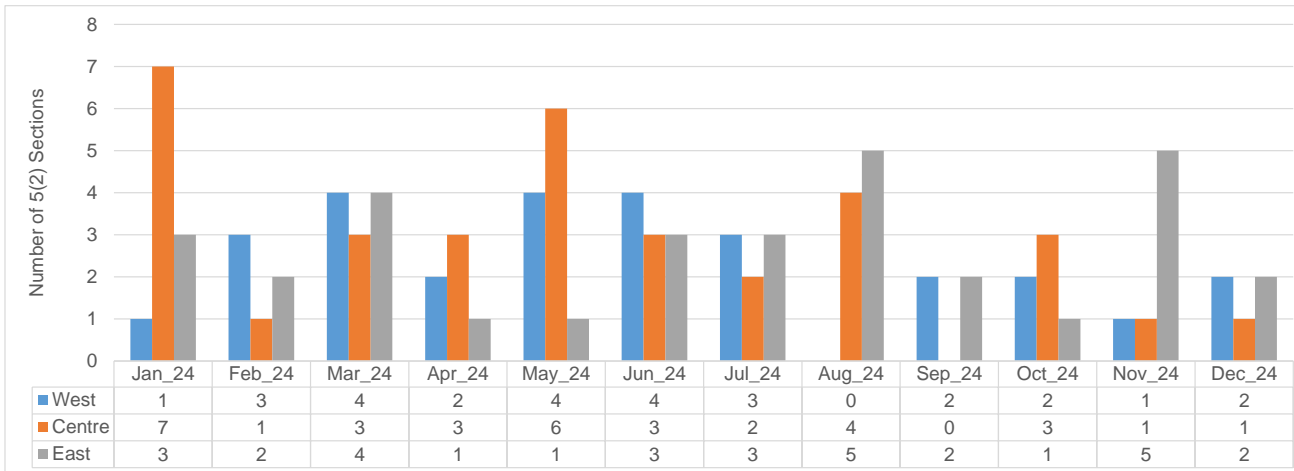
No exceptions to report.

WEST		
The data above does	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome

EAST		
Month	Duration (hh:mm)	Outcome
Nov_24	04:35	Section 5(2)

Section 5(2) - BCUHB	December 2024	November 2024	Monthly Trend	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
Section 5: Application in respect of patients already in hospital	5	7	↓	18	21	↓	24	1 East 2 Centre 2 West	8 5 5

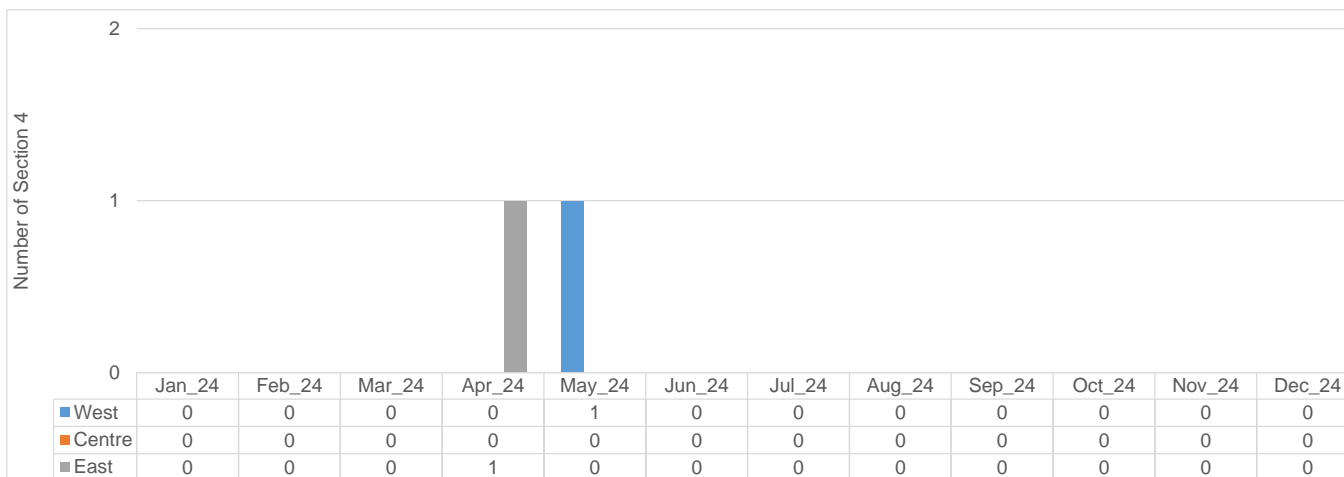


Section 5(2) Outcomes			
	Oct 2024	Nov 2024	Dec 2024
Section 2:	3	1	2
Section 3:	2	3	3
Informal:	1	1	0
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	0	2	0
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards.

There were no exceptions to report in the period under review.

Section 4 - BCUHB	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter	Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	0	0	➔	0	0	➔	1	1 Centre	0
								1 East	0
								1 West	0



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

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

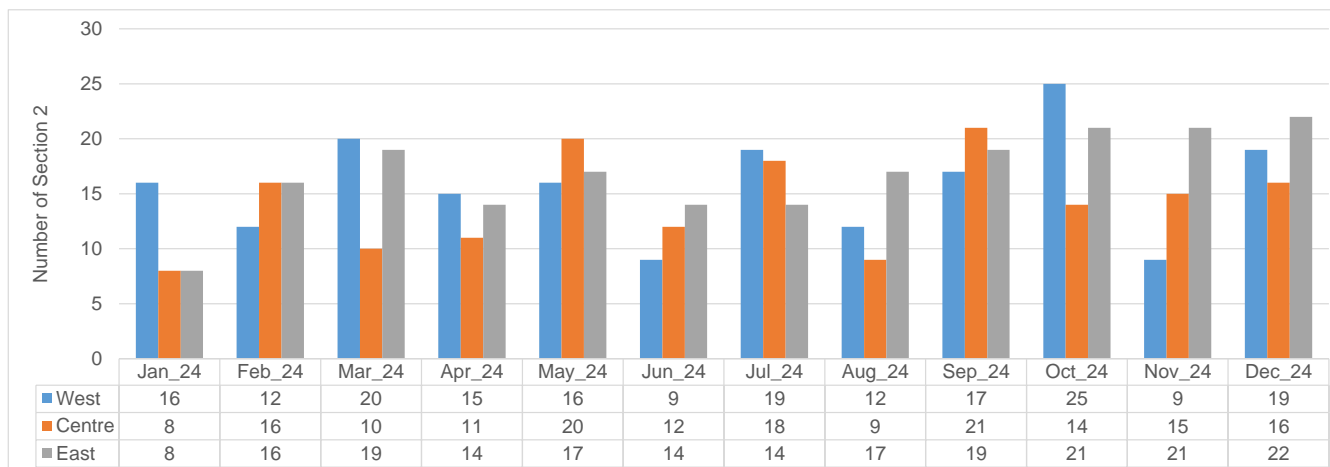
There are no exceptions to report.

WEST		
Month	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome

EAST		
Month	Duration (hh:mm)	Outcome

Section 2 - BCUHB	December 2024	November 2024	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 2: Admission for assessment	57	45	↑	162	146	↑	140	1 East	64
								2 West	53
								3 Centre	45



* data is as at position and is subject to change

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.

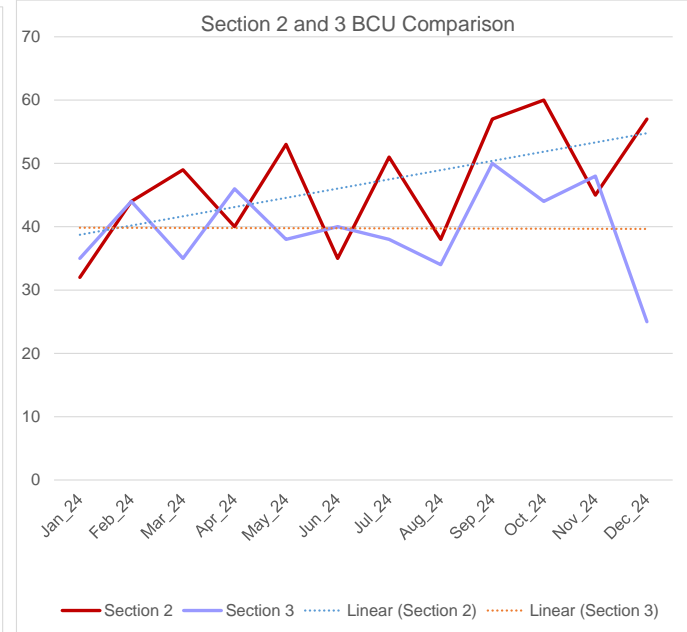
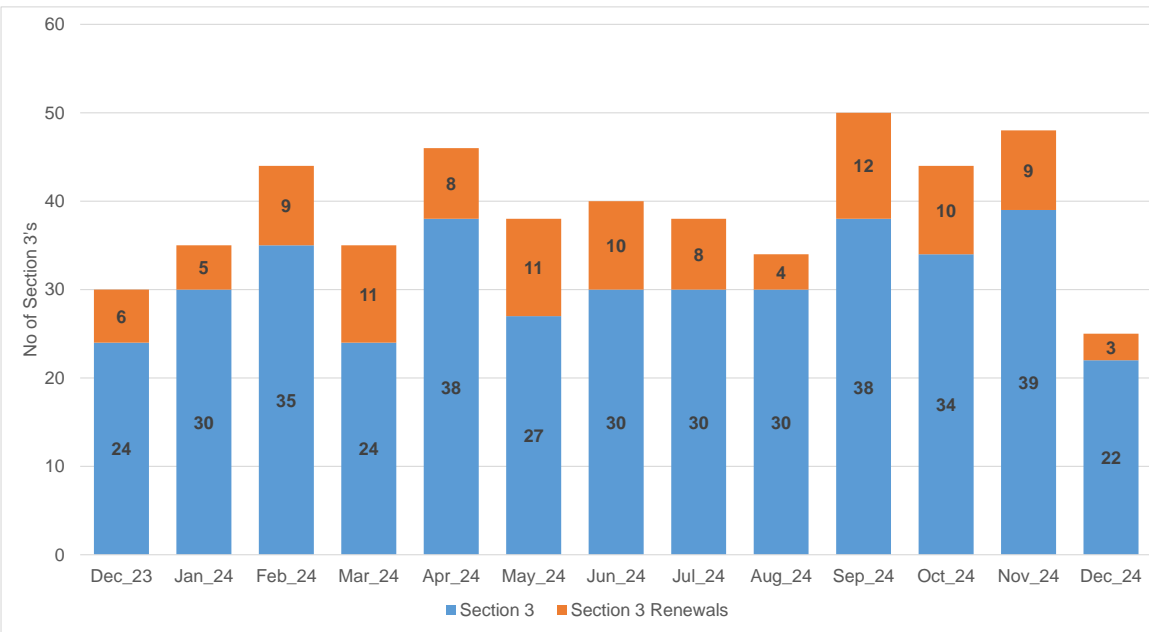
EXCEPTIONS:

There are no exceptions noted this period however, for noting: the use of Section 2 is slightly higher this quarter than previous and indicates an increasing trend.

Section 2 Outcomes

Unable to provide data

Section 3 - BCUHB	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter	Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	25	48	↓	117	122	↓	119	1 West	44
								2 Centre	41
								3 East	32

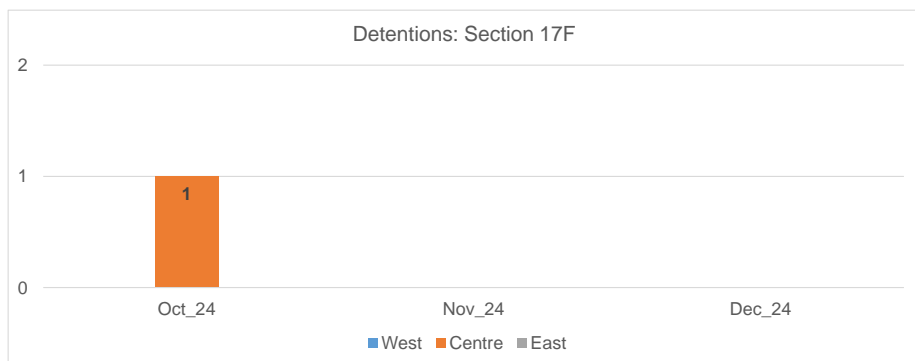
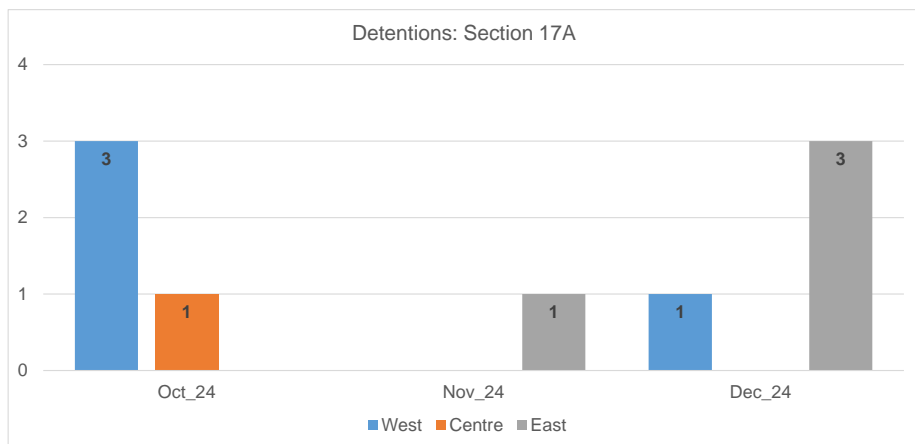


* data is as at position and is subject to change

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.

There are no exceptions to report this period.

Section 17 A-F - BCUHB	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter	Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	4	1	↑	11	19	↓	16	1 East	4
								1 West	4
								3 Centre	3



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.

Fundamental and Rectifiable Errors	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter	Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	10	14	↓	76	80	↓	107	1 Centre	33
								2 West	5
								3 East	2



Rectifiable Errors

Rectifiable errors were previously reported on a quarterly basis and benchmarked with the other health boards throughout Wales. Due to capacity to produce this report Cardiff and Vale have discontinued the report. The last report received covered April - June 2023. Discussions are underway with a proposal that the NHS Wales Executive may facilitate this report going forward.

Errors will be calculated due to missing data within documents such as middle names missing parts of an address or an obvious slip of the pen such as dating 2023 rather than 2024.

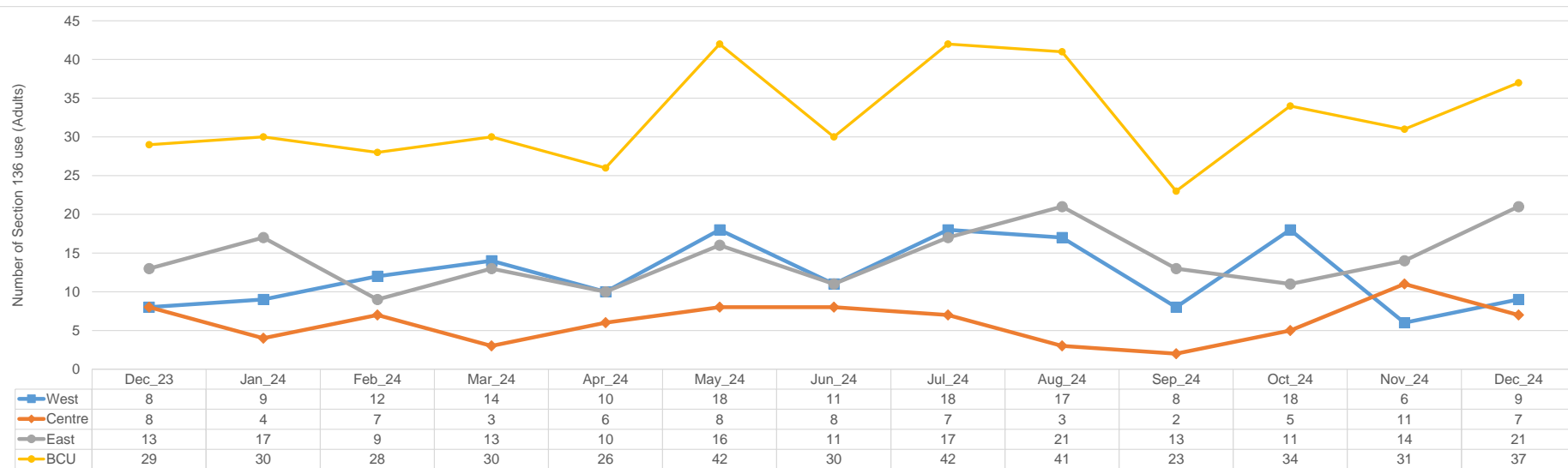
It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

It is expected that the number of Fundamental and Rectifiable Errors will see a significant increase due to the acute staffing challenges in the MHA Team (see Executive Summary).

The data in this report does not fully reflect the West position due to these pressures affecting data input.

Due to the need to manage workloads dynamically, some errors recorded for Central may relate to paperwork processed at that office relating to other units.

Section 135 - 136	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	37	31	↑	102	106	↓	99	1 East 2 West 3 Centre	46 33 23



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

Section 136	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	37	31	↑	102	106	↓	99	1 East	46
								2 West	33
								3 Centre	23

Section 136 Outcomes

Unable to provide data

Section 136 - Known to Service

Unable to provide data

Of those discharged, how many were discharged as having no mental health disorder

Unable to provide data

Section 136: Detentions over 4 hours

Unable to provide data

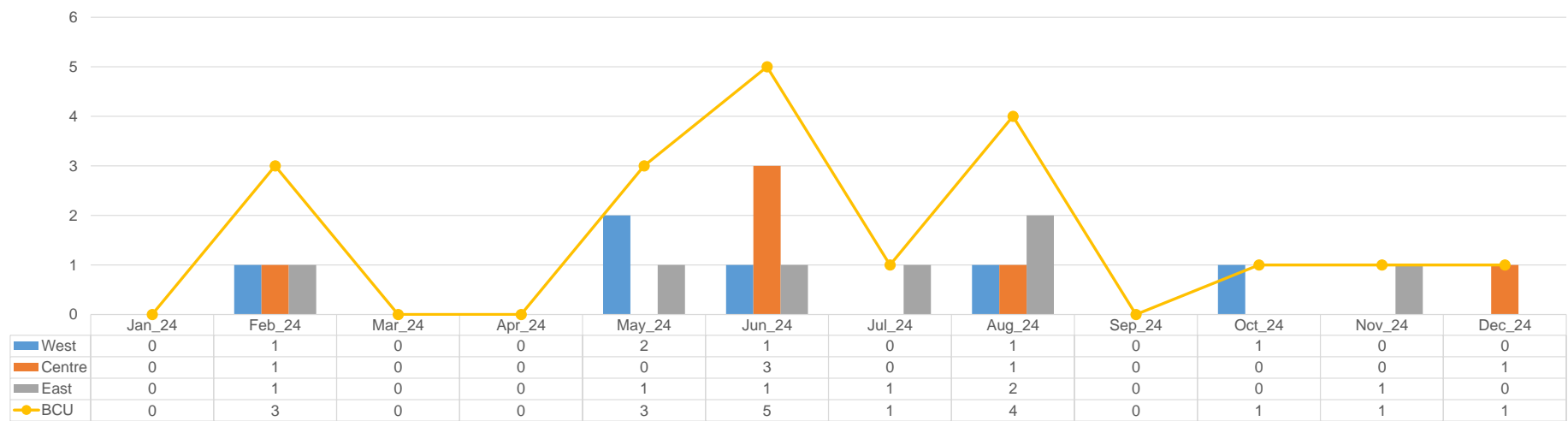
Whilst the Health Board notes detentions that may last over four hours in some instances this may be unavoidable due to the requirement for medical needs to be met prior to an assessment, or in some circumstances risks may be greater if discharge occurs out of hours.

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%.

The Criminal Justice Liaison Service actively assists the police by providing advice and information to signpost people in crisis to other avenues rather than the police using the S136 power if this is an appropriate option.

Section 135 - 136 (Under 18)	December 2024	November 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter	Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	1	1	➔	3	5	↓	5	1 Centre 1 East 1 West	1 1 1

Under 18s Section 136 Detentions



The tables below shows the ages of young persons assessed and the outcomes for the year period April 24 - March 25.

Under 18 Assessments	
AGE	Number of Assessments
11 and 12	
13	
14	
15	2
16	2
17	4

Outcome of Assessments	
Outcome	Number
Returned Home	4
Returned to Care Facility	3
Admission to childrens ward	
Admission to Adult ward / S136 suite	1
Admission NWAS / CAMHS	
Admission OOA	
Other (Friends, Hotel, B&B)	

Unable to provide data - Section 136 Under 18 Detailed Data

Unable to provide data - Forensic sections

Total Transfers for the Quarter

	Oct 2024	Nov 2024	Dec 2024
Internal Transfers	8	13	17
External Transfers (Total)	17	19	11
External Transfers (In)	10	13	8
External Transfers (Out)	7	6	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. A transfer due to step down/up needs will include transfer to PICU or rehab wards, adult to older persons, MSU to rehab.

External Transfers

This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England may include complex cases requiring specialist service or may require an out of area bed if the Health Board cannot facilitate admission at the time. Those repatriated are returning to their home area or transferring in for specialised care.

Patients detained in Independent Hospitals (in Wales and outside of Wales)

There are a number of persons who will be detained in independent hospitals that are offering services required. These people are monitored by the Continuing Healthcare Service and Team to ensure that they are in the correct placement for their needs.

Unable to provide data - Transfers detailed data

Unable to provide data - Section 62

Unable to provide data - Hospital Manager Reviews and Tribunals

Teitl adroddiad: <i>Report title:</i>	Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q3 2024-25 Update			
Adrodd i: <i>Report to:</i>	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 06 February 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	This report provides the Quarter 3 update on the provision of DoLS and MCA activity within the Health Board.			
Argymhellion: <i>Recommendations:</i>	<p>The Board is asked to:</p> <p>Accept the DoLS and MCA Report and the identified activity for the period of Q3 2024-25</p> <p>Receive the DoLS and MCA Audit Action Plan and recorded progress.</p>			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: <i>Report Author:</i>	Michelle Denwood, Director of Safeguarding and Public Protection Hayley Lloyd, DoLS and MCA Regional Team Manager Mat Phillips, Safeguarding Adults/Adults with Dementia Lead Chris Walker, Head of Safeguarding Adults, DoLS and MCA			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
<p>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:</p> <p><i>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:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	N/A			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	Mental Capacity Act (MCA 2005)			

<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	N/A
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	N/A
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)</i></p>	The risk is identified below
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	No financial implications
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	No workforce implications
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>This quarterly report is submitted directly to the Committee.</p> <p>Deprivation of Liberty Safeguards is held within the portfolio of the Executive Director of Nursing and Midwifery and this update has been reviewed by Angela Wood, Executive Director of Nursing and Midwifery.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	N/A (see Risk below)
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	N/A
<p>Camau Nesaf: Gweithredu argymhellion</p> <p><i>Next Steps:</i> <i>Implementation of recommendations</i></p>	
<p>Rhestr o Atodiadau: <i>List of Appendices:</i></p> <p>Appendix 1: DoLS and MCA Audit Action Plan Appendix 2: The Role of a Best Interest Assessor</p>	

Cyflwyniad / Cefndir Introduction / Background

The activity recorded within the report provides oversight and organisational assurance in relation to the Health Board's statutory duty under The Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA 2005) for the period of Q3 2024-25. The activity includes key actions to ensure that DoLS and the MCA as part of the wider Safeguarding and Public Protection agenda remains paramount to service delivery across the Health Board.

DoLS 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. The functions of the Safeguarding and DoLS Team include the legal responsibility of Supervisory Body, which must provide scrutiny and independence.

Corff yr adroddiad Body of report

Legislation Update

The implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) remains on hold by UK Government. There is no further legislative update.

Welsh Government (WG) additional recurring funding remains available and we continue to work towards strengthening the current DoLS system, implementing elements of the LPS where possible. Promoting MCA awareness and delivering MCA training whilst addressing the DoLS backlog (legal term for applications awaiting authorisation) remains our focus as per WG directive.

The MCA/DoLS National Workforce Group continues to meet enabling stakeholders to jointly consider issues of local concern that may have a wider or national relevance and provide a forum for joint working on national projects. The task of the group is to implement aspects of the LPS in order to improve the DoLS system making a more streamline approach.

Current Health Board Position (Q3)

In collaboration with other Health Boards, the National Workforce Group continues to hold quarterly meetings. The action plan remains focused on addressing the following points:

1. DoLS paperwork – Develop National DoLS Forms to update and simplify the forms incorporating the necessary information only to ensure continued working within the Law.
2. MCA Training – Explore and develop National Training Standards and training packages.
3. DoLS Process – Explore areas for improvement and the implementation of a potential new DoLS work stream.

Update on each action.

- **Action 1:** The Health Board continues to lead the paperwork subgroup and has developed a DoLS Form 1 (DoLS Application Form). This form has been internally reviewed and approved by the National MCA/DoLS Group. A pilot of the Form 1 should begin in Q4 pending WG approval, failing this it will be Q1 25-26. The goal is to enhance compliance with MCA/DoLS documentation by streamlining the forms, thereby reducing the statutory paperwork and repetition.

- **Action 2:** This is a key activity for the Health Board, with progress on MCA training compliance achieved during 2023-24. National training programmes have been developed to offer a standardised approach to MCA awareness and understanding. These programmes will equip staff with the necessary skills to confidentially support patients and uphold their rights under the legislation.
- **Action 3:** This relates to the DoLS Backlog. As of the 23/01/2025 the DoLS Backlog for the Health Board stands at 71. The current backlog is higher than Q2 but significantly lower prior to the intervention and financial support from the Welsh Government [WG]. The increase is in-line with previous recording and is due to the limited number of assessments completed during December (due to staff annual leave) and an unprecedented increase in DoLS applications submitted by Managing Authorities. It is important to note, applications received can differ significantly from month to month and the backlog will fluctuate.

Utilising additional WG funding, we have been able to continue to offer Secondment opportunities to strengthen the current DoLS/MCA system. The WG monitors these activities to track performance and improvements, supporting the implementation of this legislation and enhancing patient care.

Performance and Activity

The annual trend for DoLS applications continues to be an upward trajectory within the Health Board. This is in line with the National picture. During Q3 2024-25 a total of 573 DoLS applications were submitted, this is a 11.0% increase in comparison to last year's figure. Although the increase places pressure on the service it also continues to demonstrate learning and compliance with the statutory legislation.

We are currently reporting an average of a five-week delay between receipt of a DoLS application and the subsequent standard authorisation (known as the Backlog). This position is not unique and other Health Boards and Local Authorities (LA) are in a similar if not worse off position. WG recognises the demand on the Health Board and the continued financial support offered has enabled additional work to be undertaken by the Best Interest Assessors (BIA's) and Section 12(2) Doctors during evenings and weekends resulting in a reduction in authorisation times.

As previously reported the internal Audit of the MCA/DoLS Team was completed in April 2024-25, which included a thorough review of processes for managing DoLS activities within the Health Board. This review covered procedures, staff training and the monitoring and escalation of cases. The overall outcome indicated Assurance and Limited Assurance, with progress noted in the following key areas:

- **Action 1:** To review current BCUHB training policies and procedures with service leads for Bank, Locum and Honorary staff to ascertain current agreements in place in relation to the completion of MCA training prior to and during employment:

After engaging with the relevant services, the scope has been expanded to include agency staffing and any newly onboarded agency staff members. Through collaboration with commissioning services and agencies, we have successfully developed and amended the Training Procedure. It has been confirmed that all mandatory training for Bank, Locum, and Honorary staff will now include MCA Level 1 and Level 2 (where applicable) and this requirement has been extended to agency staff and any newly employed agency staff members. Training compliance is monitored monthly, and any instances of low compliance will be escalated through the IHC/Safeguarding Forums. Training data will be provided monthly to the respective services, monitored according to the Safeguarding Governance and Reporting Framework (SGPG, QDG, QSE), and reported through the newly established Quality Performance Reviews.

- **Action 2:** The Supervisory Body (DoLS Team) to continue addressing quality issues with relevant areas and continue to review capacity of BIAs and Mental Health Assessors (Section 12(2) Approved Doctor) to ensure Standard Authorisations are granted within the legal timeframe.

As per the DoLS/MCA legislation, timescales for the completion of a DoLS assessment are clearly recorded. Once allocated for assessment the statutory framework is followed. The wider concern remains the volume of applications that are received and the continued upward trajectory. This is a national issue recorded by the Welsh and UK Government.

There has already been a significant improvement in reducing the DoLS Backlog due to the additional work by the MCA/DoLS Team. Further support / Q&A Sessions have been held across West, Central and East areas focusing on the quality of the paperwork. The Supervisory Body (DoLS/MCA Team) continues to link directly with wards to request necessary amendments ensuring documentation is satisfactory.

The Data Analyst within the Safeguarding & Public Protection Team has developed a Power BI dashboard to capture key performance data related to compliance of applications within timescales and other relevant data. Monthly reports are generated to identify areas needing improvement. The Supervisory Body, BIA's and the MCA training lead link directly with the areas of low compliance to provide targeted intervention, advice and support if required. Issues, concerns, and best practices are reported into SGPG, Safeguarding Forums and the Mental Health Legislative Committee for assurance and oversight. The dashboard also includes DoLS data and best interest assessments. The December DoLS monthly report indicates an improvement of the quality of paperwork for December 2024. Regular monthly reporting is now in place and this action can be closed. Issues, concerns and best practices are reported into the Mental Health Legislative Committee for oversight and assurance.

Five Health Board staff members have completed the BIA qualification course in Q3 and are expected to qualify in Q4. Supervision is in place for all staff. The capacity to complete additional assessments and train BIA's is established. This action will be monitored through quarterly SGPG and Mental Health Legislative Committee reporting.

- **Action 3:** Managing Authorities (Hospital Wards) to ensure that the applications are completed appropriately and returned in a timely manner.

This action directly addresses the inaccuracies with DoLS documentation by front line practitioners. Improving the quality of information and reducing the inaccuracies is a key target for the Health Board and additional support is already in place. Support and Q&A sessions have been conducted across all DGH's, receiving positive feedback. While the errors are mostly minor, improving is necessary to ensure good governance, compliance with legislation and to mitigate potential challenges in the Court of Protection (CoP). Every application is quality assured and audited upon receipt by the MCA/DoLS Team, with feedback on the quality of the paperwork provided within 24 hours.

Support / Q&A sessions have been held across West, Central and East areas focusing on the quality of paperwork. The Supervisory Body (DoLS Team) continues to link directly with wards to request necessary amendments, ensuring documentation is satisfactory. The DoLS data and best interest assessments are included in the data dashboard. The December 2024 DoLS monthly report shows improvement in the quality of the paperwork.



Any issues related to DoLS paperwork and low compliance with training data is reported through the IHC/MHLD Safeguarding Forums, the Mental Health Legislative Committee and the Safeguarding Governance and Performance Group. The MCA training lead offers additional bespoke training, advice and support to areas with high non-compliance.

The digitalisation of MCA and DoLS documentation is being led by the Welsh Government.

The review of MCA and DoLS paperwork is complete. Minor amendments to training programmes are pending approval at the Safeguarding and Public Protection Senior Leads Meeting and the Safeguarding Performance and Governance Group. Daily calls and visits to high referral areas are completed. An additional MCA training package has been developed and will need approval following the governance process. Best interest assessors visit the wards several times a week, providing advice and support. The MCA training lead maintains daily contact and visits the DGH's multiple times a week offering additional bespoke MCA training sessions to areas of low compliance. The Supervisory Body continues to work directly with the wards to address any issues.

Welsh Government (WG) Monies

WG confirmed that all additional funding will be made permanent in line with a bidding process and until an agreement is reached with regard to how the funding is shared with Health Boards and LA's. To meet the expectations of the funding we will continue to offer developmental opportunities for trained staff within the team to support the strategic and operational management of DoLS and the MCA.

Following further conversations between WG and the Health Board a decision on the amount of funding for Independent Mental Capacity Advocate (IMCA) services is pending an agreement with regard to the commissioning of IMCA and the additional funding of RPR services. There will be no financial implications for the Health Board.

Independent Mental Capacity Advocate (IMCA)

The Health Board hold geographical responsibility for the provision of an IMCA service across North Wales. IMCA services enable the Health Board and Local Authorities (LA) to meet the statutory requirement of the offer of advocacy services to service users across North Wales.

In Line with Welsh Government (WG) guidance additional funds, as referenced earlier in the paper, have been made available for the provision and strengthening of IMCA and Relevant Person Representative (RPR) services in North Wales. This is permanent funding secured by the Health Board via a WG bidding process.

The Health Board currently commission Conwy and Denbighshire Mental Health Advocacy Service (CADHMAS) for the provision of IMCA Services across North Wales.

The funding awarded by WG is done so with strict spending guidelines. This proposal meets those guidelines and will support IMCA provision for Health Boards and the LA's. WG have agreed that funding designated by them for the use of strengthening IMCA service in North Wales will be equally distributed amongst the Health Board and the LA's using a calculation tool to determine the amount each respective organisation receives.

The provision of IMCA and RPR services is a statutory obligation introduced under the Mental Capacity Act 2005 (MCA) to ensure individuals are provided with a legal independent safeguard. The provision is also a directive made by WG in preparation for the proposed new UK Government legislation known as the Liberty Protection Safeguards (LPS).

Quarterly review meetings for the provision of North Wales independent mental capacity advocacy are held. There appears to be an improvement in awareness and knowledge around the IMCA service, with a recent review identifying a slight increase in referrals received. Moving forward, a key action is to raise awareness throughout the Health Board to ensure vulnerable adults receive the necessary advocacy. Staff have been identified to focus on visiting hospitals and delivering of training. The MCA training lead has established good working relationship and collaborates with the IMCA service.

WG are due to agree future arrangements for IMCA funding. IMCA funding and RPR funding may be split to allow each respective agency the opportunity to fund their own RPR services. However, IMCA commissioning will remain the responsibility of the Health Board.

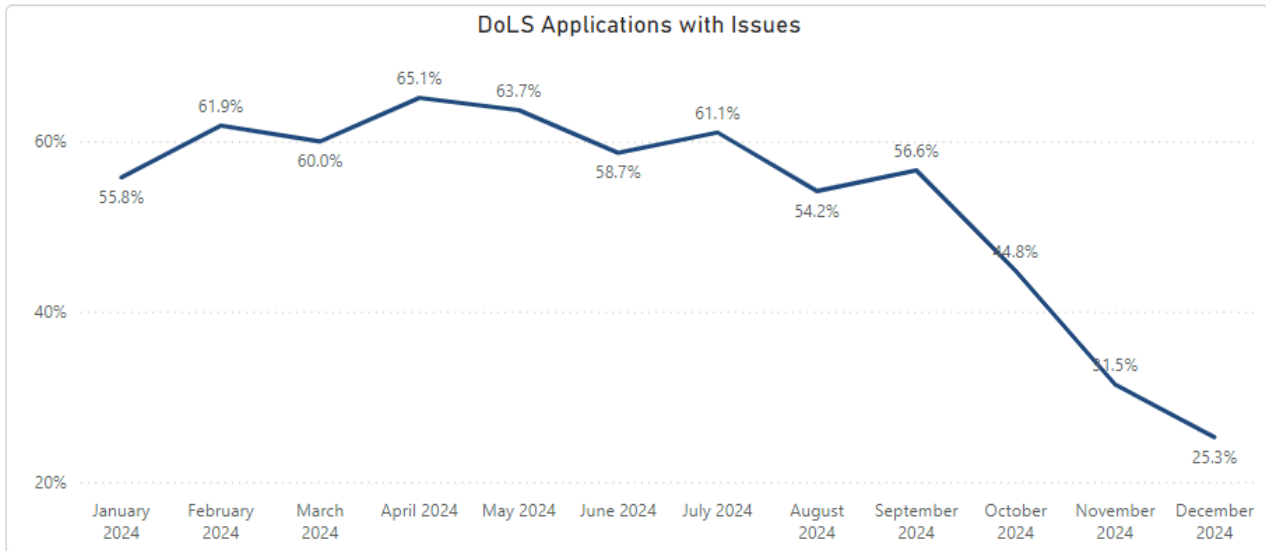
Strategic Implications Assessment and Analysis

MCA and DoLS activities and objectives are aligned to the agreed strategic objectives identified within the Safeguarding and Public Protection Governance and Reporting activity to support performance and obtain assurance against compliance with legislation and statutory guidance.

DoLS Documentation Audit

The independent audit undertaken by the Health Board Audit Team in Q3 2024-25 included 573 DoLS applications. The submitted DoLS paperwork, on a whole, is of high quality but continues to demonstrate minor errors. However, these errors are identified by the Supervisory Body (DoLS Team) on the immediate receipt of the application and are returned to the Managing Authority to be amended. The paperwork is then returned by the Managing Authority within the legislative framework timescale and does not result in a delay in the authorisation of the DoLS. This also supports immediate operational reflection and learning to improve quality. Table 1 below demonstrates a real improvement in the quality of the paperwork in Q3. This is credited to the DoLS/MCA Team and all Health Board services who submit DoLS applications.

Table 1:



Analysis

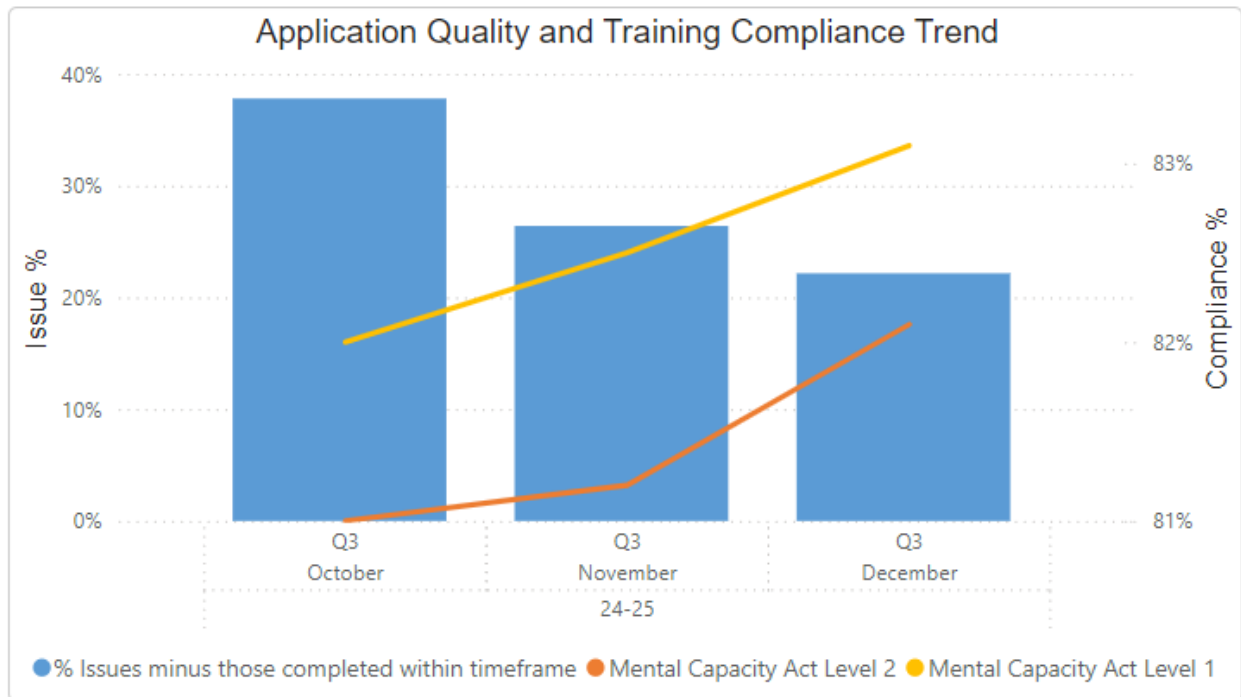
Of the 195 applications that recorded issues during Q3 all of them were rectified within the legislatively approved timeframe. The majority of the issues from the applications continue to be minor with minimal amendments required. During December, 25.3% of the applications received were noted to have issues with them. This is a decrease when compared to last month when 31.5% of the applications recorded issues. Errors have reduced by over 50% over the last Quarter.

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

- No inclusion of the Mental Capacity Assessment Form. The findings from the audit reported that the Managing Authority (Hospital Ward) had completed the Form but had not included it as part of the initial set of paperwork.
- Mental Capacity Assessments were 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 are resolved immediately by the Managing Authority.
- The DoLS application documentation was not completed correctly. It was reported that it was not signed or was not dated correctly. Issues were resolved quickly and we plan to include enhanced monitoring of timescales.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority should provide current medical information.

Table 2 below shows the trend between the quality of the DoLS applications and MCA Level 1 and Level 2 training compliance. There is a clear improvement in compliance with Level 1 and Level 2 MCA training and a significant reduction to the errors in DoLS paperwork.

Table 2: Q3 2024-25



Training

The Health Board have recorded an improvement in MCA training compliance (see Table 3 below) in 2024-25.

Table 3:

Compliance by Health Economy December 2024

Grouped Org L4	Staff	MCA Level 1	MCA Level 2	Average	Modules below 85%
Corporate Services	12932	75.6%	73.0%	74.3%	2
Health Community Centre (HCCX)	5476	87.3%	88.0%	87.6%	
Health Community East (HCEX)	5613	88.3%	87.9%	88.1%	
Health Community West (HCWX)	4465	87.7%	87.6%	87.7%	
Integrated Clinical Delivery - Primary Care (ICDP)	619	86.8%	88.9%	87.8%	
Integrated Clinical Delivery - Regional Care (ICDR)	1640	82.9%	83.8%	83.4%	2
Mental Health & LDS (MX00)	2195	91.0%	91.2%	91.1%	
Midwifery and Womens Services (WXXX)	846	88.2%	88.2%	88.2%	
Total	33786	83.1%	82.1%	82.6%	2

The MCA Training Lead provides additional MCA training tailored specifically to the needs of each ward. A Level 3 MCA and DoLS training package is also available monthly and delivered face to face. An additional bespoke training package is available to wards with high referral rates. All qualified staff members Band 5 and above, are encouraged to undertake the Level 3 training. An MCA level 1 booklet is used for non-clinical staff to aid compliance and a work booklet for MCA Level 2 to aid staff to meet the mandatory training compliance is also being developed. The Training packages are now being led by Welsh Government National Group.

Competency	Q2 2024-25	Q3 2024-25	Trend
Mental Capacity Act Level 1	81.5%	83.1%	↑
Mental Capacity Act Level 2	80.5%	82.1%	↑

Q3 2024-25 has already seen an overall improvement in MCA training compliance. There are a number of individual Divisions and Services that have a compliance rate above the organisational target of 85%.

Analysis

Training compliance and understanding of DoLS and MCA are key targets. The approach ensures that all areas or departments with reduced compliance receive extra training and support. The MCA training lead is visible across the Managing Authorities (hospital wards) offering support and advice and attending relevant meetings to encourage employees to complete their training. A revised virtual training program is also available and remains in place to promote training. MCA training is included within the mandatory Adult Level 2 Safeguarding module to utilise all available opportunities.

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 can fluctuate. 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)

The Standard Operating Procedure (SOP) for 16–17-year-olds within the CoP DoL process to reflect the legislative policy and to ensure good practice is now approved and available on BetsiNet. This includes the application of the MCA for 16–17-year-olds. Implementation and application will be monitored.

**Goblygiadau Cyllidebol / Ariannol
*Budgetary / Financial Implications***

There are no financial implications for this report.

**Rheoli Risg
Risk Management**

Risk CRR 24-03. There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients. Following review at the Health Board Risk Management Group and the Formal Executive Group in Q1 the current risk score is recorded as 12 however, the Chief Executive Officer has requested that the risk associated to DoLS and the MCA are reported into the Executive Group.

Following the new Risk Management Training the Safeguarding, DoLS and MCA Team were commended for their management of the risk. A comprehensive review of the risks associated with DoLS and the MCA has taken place in Q3. As a result, the team are in the process of updating/amending DoLS/MCA related risks and will present them at the Office of the Nurse Director’s Risk Management meeting for approval.

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.

**Goblygiadau Cydraddoldeb ac Amrywiaeth
*Equality and Diversity Implications***

N/A

Appendix 1 Betsi Cadwaladr University Local Health Board (BCUHB) Mental Capacity Act and DoLS MHLIC Action Plan 2024-2025

Corporate Safeguarding MCA/DoLS Team (previously completed actions have been removed)
RAG Rating- Red ■ Out of Time Frame. Amber ■ Within Timeframe. Green ■ Completed.

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	Welsh Government funding, actions and objectives.	<ul style="list-style-type: none"> • Fund additional Best Interest Assessments to reduce the DoLS Backlog. • Embed MCA training across BCUHB. • Prepare for the implementation of LPS. • Improve MCA training compliance for Locum and temporary staff. 	CW HL	<p><u>Q3 2024-25 Update:</u> This action will be ongoing until March 2025 following confirmation from WG that funding is available for 2024-25.</p> <p>Additional BIA assessments continue out of hours. The MCA training compliance has improved significantly throughout the Health Board. The MCA Lead continues to provide targeted sessions for areas of low compliance and our temporary staffing establishment within the Health Board.</p> <p>All mandatory training for Bank, Locum, and Honorary staff will now include MCA Level 1 and Level 2 (where applicable), and this requirement has been extended to agency staff and any newly employed agency staff members.</p>	31.03.2025 On Track	Amber

2.0	DoLS Internal Audit Actions and Objectives	<ul style="list-style-type: none"> Improve MCA Level 1 and 2 compliance for Bank Locum and Honorary staff: Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate. 	CW HL	<p><u>Q3 2024-25 Update:</u> All mandatory training for Bank, Locum, and Honorary staff will now include MCA Level 1 and Level 2 (where applicable), and this requirement has been extended to agency staff and any newly employed agency staff members. Training compliance will be monitored through Safeguarding Forums.</p> <p>Revised MCA Level 1 and 2 programs are currently being updated on a National level.</p>	30/09/2024	Green
3.0	DoLS Internal Audit Actions and Objectives	<ul style="list-style-type: none"> DoLS Authorisations: Address quality issues with relevant areas and review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor) to improve the authorisation process ensuring Standard Authorisations are completed within the 2-week timeframe 	CW HL	<p><u>Q3 2024-25 Update:</u> The data analyst has developed a Power BI dashboard to capture key performance data related to compliance of applications within timescales and other relevant data. Monthly reports are generated to identify areas needing improvement.</p> <p>Five Health Board staff members began the BIA qualification course in Q3 and are expected to qualify in Q4.</p> <p>The December DoLS monthly report indicates an improvement of the quality of paperwork for December 2024.</p>	31/03/2025 On Track	Amber



4.0	DoLS Internal Audit Actions and Objectives	<ul style="list-style-type: none">DoLS Documentation: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body will communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain, this will be escalated as appropriate.	CW HL	<p><u>Q3 2024-25 Update:</u> Support / Q&A sessions have been held across the Health Board focusing on the quality of paperwork. The Supervisory Body (DoLS Team) continues to link directly with wards, requesting necessary amendments, ensuring documentation is satisfactory. The December 2024 DoLS monthly report shows improvement in the quality of the paperwork.</p> <p>Best interest assessors continue to be present on the wards on a regular basis providing advice and support. The MCA training lead maintains daily contact and visits the DGH's multiple times a week offering additional bespoke MCA training sessions to areas of low compliance.</p> <p>The Supervisory Body continues to work directly with the wards to address any issues on a daily basis. The DoLS Form 1 (Application Form) has been produced and approved by the National group. A pilot of the form will commence in Q4 and the Health Board are leading on the digitalisation of the documentation.</p>	31/03/2025	Green
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Appendix 2 The role of the Best Interest Assessor [BIA]

The Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 as an amendment to the Mental Capacity Act (MCA) 2005 to provide legal protection for vulnerable people who are, or may become, deprived of their liberty in a hospital or care home. The Best Interest Assessor (BIA) role is specific to the requirements of this DoLS framework and is set out in Law.

The role of the BIA is to carry out a specific function under the DoLS legal framework and is guided by the ethical values of social care and health professionals, promoting a person-centred and rights-focused approach to protect people. BIA practice draws on a wide range of practice skills and knowledge and is specific to DoLS. The BIA assesses the individual, gathers the necessary information, consults with relevant people and makes decisions and recommendations based on these assessments. The role should have a clear start and end, which unlike health and social care case work, will not adopt an ongoing role and must ensure independence and maintain clear boundaries to the ongoing care and treatment planning.

There are six assessments which have to take place before a DoLS Standard Authorisation (SA) can be granted. The BIA is required to carry out the age assessment, no refusals assessment, mental capacity assessment and best interest assessment. A suitably qualified doctor is required to complete the mental health and eligibility assessment respectively.

The BIA has a range of duties and responsibilities that they must adhere to under DoLS. They are:

- Evidence and confirm the individual is aged 18 years or over.
- Establish whether the SA would conflict with other existing authority for decision-making (for example; is there an advanced decision or a Lasting Power of Attorney).
- Determine whether the individual lacks capacity to make decisions about their accommodation for care and treatment.
- Complete a best interest's assessment to establish whether a deprivation of liberty is occurring and whether it is in the best interest of the individual to be deprived of their liberty in order to prevent harm.
- The BIA must also evidence whether the deprivation of liberty is a proportionate response to the likelihood of the individual suffering harm and the seriousness of that harm.
- Consult with the individual, family, friends and other professionals involved in their care to gather a comprehensive view of the individual's situation and needs.
- Explore whether there are any less restrictive options available to meet the individual's needs.
- Review the SA to ensure the deprivation of liberty remains appropriate and the individuals' rights continue to be upheld.
- Recommend who is appropriate to be the Relevant Persons Representative (RPR) – Someone to advocate on behalf of the individual and raise a challenge to the SA if the individual is objecting.
- Recommend the length of the SA and also recommend whether any conditions should be attached to the SA that the Managing Authority (Wards and Care Homes) must address.

The BIA plays a crucial role in the DoLS process and is responsible for ensuring that any deprivation of liberty is in the best interests of the individual and is necessary and proportionate and whether the proposed care plan is the least restrictive option available. The BIA is accountable for the assessments and must provide written reports which are clear, concise and informative, based on analysis of complex evidence allowing the Supervisory Body (SB) to then make an informed decision about authorising the deprivation of liberty.



Teitl adroddiad: <i>Report title:</i>	Healthcare Inspectorate Wales (HIW) Assurance Report			
Adrodd i: <i>Report to:</i>	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	06/02/2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>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 Quality Health and Care Standards 2023 and the Mental Health Act.</p> <p>This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.</p>			
Argymhellion: <i>Recommendations:</i>	The Committee is asked to note the report			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: <i>Report Author:</i>	Erika Dennis, Quality Lead Manager Clare Jones, Quality Assurance Manager			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <input type="checkbox"/>	<p>I Benderfynu arno <i>For Decision</i></p> <input type="checkbox"/>	<p>Am sicrwydd <i>For Assurance</i></p> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <input checked="" type="checkbox"/> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <input type="checkbox"/> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <input type="checkbox"/> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <input type="checkbox"/> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
<p>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:</p> <p><i>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:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>		<p>Objective 4 - Improving quality, outcomes and experience</p> <p>Objective 5 - Establishing an effective environment for learning</p>		

<p>Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:</p>	<p>The Health Board's 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.</p> <p>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.</p>
<p>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?</p>	<p>This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.</p>
<p>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?</p>	<p>Naddo N</p>
<p>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)</p>	<p>N/A</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations</p>	<p>Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act) require no financial consideration at present.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith Workforce implications as a result of implementing the recommendations</p>	<p>N/A</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori Feedback, response, and follow up summary following consultation</p>	<p>This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: (or links to the Corporate Risk Register)</p>	<p>N/A</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) Reason for submission of report to confidential board (where relevant)</p>	<p>N/A</p>

Camau Nesaf:
Gweithredu argymhellion
Next Steps:
Implementation of recommendations

N/A

Rhestr o Atodiadau:
List of Appendices:
Appendix A- HIW Inspection Report-Heddfan Unit 21-23 October 2024

New inspections, publications and updates relating to the Mental Health Act

Healthcare Inspectorate Wales (HIW)

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

The Health Boards Quality Assurance and Regulation Team track and monitor HIW Improvement / Action Plans via the Health Boards Audit Management and Tracking System (AMaT), as with other quality regulatory activity.

Reporting on progress with service improvement actions is based on the most up to date position on the AMaT system. This may not always fully reflect the progress of the service.

Inspections

1 Unannounced Visit: Gwanwyn and Hydref Wards, Heddfan Unit

Inspection Date: 21st to the 23rd October 2024

Publication Date: 23rd January 2025

Responsible Director: – Iain Wilkie, Director of MHL D.

HIW Recommendation (1)

The health board must ensure that the MHA legal status of patients is recorded within their Medicine Administration Record (MAR) charts to provide clear guidance to staff.

Service Improvement Actions

Action Reference MD12/1

MHL D Clinical Director to communicate importance of medical staff filling in MHA legal status on MAR charts.

Progress Status

MD12/1: Overdue (pending evidence to confirm completion of action).

HIW Recommendation (2)

The health board must implement robust governance oversight to ensure unnecessary or duplicate documentation is removed from patient MHA records, to avoid confusion for staff.

Service Improvement Actions

Action Reference MD21/1

Ensure duplicate and outdated documentation is removed from files.

Action Reference MD21/2

Local audit to be undertaken aligned to Good Record Keeping, outcome brought through weekly managers meeting for discussion and support.

Progress Status

MS21/2: In Progress (awaiting progress update)

MD21/2: Overdue (awaiting progress update)

HIW Recommendation (3)

The health board must ensure patient Section 17 leave forms are fully completed and signed as appropriate.

Service Improvement Actions

Action Reference MD22/1

Clinical Director to remind medical staff of their responsibility and accountability.

Action Reference MD22/2

To discuss Section 17 Leave form completion in the consultant forums.

Action Reference MD22/3

Audit to be carried out to ensure compliance

Progress Status

MD22/1: Overdue (pending evidence to confirm completion of action)

MD22/2: Overdue (for discussion at the next local consultant meeting)

MD22/3: In Progress (awaiting progress update)

Hospital Inspection Report (Unannounced)

Hydref and Gwanwyn Wards,
Heddfan Psychiatric Unit, Betsi
Cadwaladr University Health Board

Inspection date: 21, 22 and 23 October 2024

Publication date: 23 January 2025



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

Copies of all reports, when published, will be available on our [website](#) or by contacting us:

In writing:

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Website: www.hiw.org.uk

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.

We are:

- Independent - we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.



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1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our [website](#).

Healthcare Inspectorate Wales (HIW) completed an unannounced inspection of Heddfan Psychiatric Unit within Betsi Cadwaladr University Health Board on 21, 22 and 23 October 2024. The following hospital wards were reviewed during this inspection:

- Gwanwyn - 13 bed mental health ward for older adults with an organic illness
- Hydref - 13 bed mental health ward for older adults with a functional illness.

Our team for the inspection comprised of two HIW healthcare inspectors, three clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of two questionnaires were completed by carers and three were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Throughout our inspection, we witnessed staff treating patients with respect and kindness and supporting them in a dignified and sensitive way. However, we found that some improvements were required to maintain the dignified and respectful care of patients. These included including installing privacy screening within ensuite patient bathrooms and ensuring patient bedroom observation panels were kept closed when staff were not undertaking observations.

We found the patients on both wards were provided with a suitable programme of therapeutic activities to support their health, wellbeing and rehabilitation. Patients had access to their own ensuite bedrooms and the communal areas of the wards. However, staff told us that the communal garden on Gwanwyn Ward was unsuitable and that the ward staffing was not always sufficient to accommodate patient access to the outside areas of the ward.

The wards' communal areas provided a pleasant and suitably decorated therapeutic patient environment but the patient bedrooms on Gwanwyn were sparsely decorated and not personalised to the patients. In addition, there was limited information for patients and their families displayed throughout the ward to help patients and their families understand their environment and care.

This is what we recommend the service can improve:

- Review the environmental issues within the Gwanwyn Ward communal garden and provide equitable access for patients to use the garden to support their physical and mental wellbeing
- Install suitable privacy screening within all patient ensuite bathrooms, to ensure their privacy and dignity is protected
- Ensure patient bedrooms provide a suitable, therapeutic environment of care for the relevant patient group
- Ensure patients are provided with relevant, up-to-date and accessible information to support their care.

This is what the service did well[]

- The wards had processes in place to help promote and maintain the physical health of patients

- Staff were passionate about their roles and were enthusiastic about how they supported and cared for the patients
- Staff showed respect for upholding patient rights and individual patient preferences

Delivery of Safe and Effective Care

Overall summary:

The wards had policies, processes and procedures in place to support the management of risk. Staff confirmed there was a governance structure in place in terms of activities and meetings to discuss incidents, findings and issues related to patient care. However, some improvements were required to maintain the safety of patients, staff and visitors, including ensuring sufficient personal safety alarms were available for all staff, and that the hospitals established audit processes were completed within set timescales. We also noted that a fire door on Hydref Ward was damaged and required repair, which was resolved during the inspection.

We found robust procedures in place for the safe management of medicines and Mental Health Act (MHA) monitoring, though some improvements were required in respect of the completion and filing of ward-based MHA records. We reviewed patient Care and Treatment Plans (CTPs) and found a good standard of record keeping which reflected the needs and risks of the patients. Each ward had an appointed Infection, Prevention and Control (IPC) lead and the wards were clean, tidy and uncluttered throughout the inspection. However, some improvements were required to ensure that staff cleaning checklists were fully completed and that the wards' laundry arrangements supported effective IPC.

We found staff were providing safe and effective patient care under challenging circumstances, with due consideration for the needs of the patient groups. Hydref Ward was a designated ward for older adults with a functional illness but was also providing care for adult patients, and patients with organic mental illnesses. Staff told us that this arrangement placed significant pressure on them in relation to providing person-centred patient care for patients with mixed needs.

The health board had informally approved an increase in the number of staff on duty to meet patient needs. However, there was a high reliance on bank and agency staff to meet the increased staff establishment and fill vacant shifts. In addition, we identified that only one registered nurse would be working with a team of healthcare support workers during the night shifts. Action must be taken to formally review the ward staffing establishment and implement measures to ensure shifts are appropriately filled with the right skill mix of staff, to maintain the safety of staff and patients.

We were told that the patients on the wards had no access to clinical psychology support because the clinical psychologist post had been vacant for the previous two years. Therefore, we were not assured that patients were receiving a comprehensive assessment of their condition and that clinical decisions relating to patient care and treatment were being determined through a full multi-disciplinary approach.

During our previous inspection of the wards in 2022, we found improvements were required in relation to the poor quality and preparation of the food served to patients. During this inspection, we again found that robust improvements were required in respect of this issue.

This is what we recommend the service can improve:

- Ensure sufficient personal safety alarms are available for all staff and that alarms are identifiable, monitored and accounted for
- Ensure the wards' established audit processes and documentation are fully completed within set timescales
- Review the wards' laundry arrangements to ensure they support effective IPC
- Ensure all patients are cared for in an environment which supports their diagnosis, presentation and clinical needs
- Review the current provision of psychology support for the patients on the wards, to support the safe and effective provision of psychological interventions
- Review of the quality, variety, preparation and provision of patient food, to ensure it consistently meets patient needs and dietary requirements.

Immediate assurances: | |

During the inspection we reviewed staff training records, staffing rotas, and incident forms for Hydref and Gwanwyn wards. Incidents of patient restraint were being recorded on the Datix electronic reporting system and within Restrictive Physical Intervention (RPI) records. Our review of Datix incidents and RPI records during the last six months identified that some staff had participated in physical restraints who had not completed the RPI training. Therefore, we were not assured that staff and patient safety was being maintained during incidents of physical restraint.

In addition, we found that Datix and RPI records did not clearly capture all details of the restraint incidents, and the actions performed by each staff member during the incident. Therefore, we were not assured that appropriate records were being captured for each incident, to identify shared learning opportunities and support accurate governance oversight and monitoring.

Details of the concerns for patient's safety and the immediate improvements and remedial actions required are provided in [Appendix B](#).

This is what the service did well:

- Staff had a good knowledge of safeguarding procedures and reporting arrangements
- Photographs of the patients were attached to their medication records, which we identified as good practice
- Staff demonstrated good knowledge of MHA processes. Additional MHA audit activities were being considered to identify opportunities for shared learning and drive quality improvement
- Both wards were supported by an associate physician who supported and contributed to the care and treatment of the patients.

Quality of Management and Leadership

Overall summary:

Established governance arrangements were in place to provide oversight of clinical and operational issues. We found suitable arrangements in place for senior staff to monitor compliance with mandatory training and noted that overall mandatory training compliance rates were high on the wards.

We found a strong teamwork ethos and staff were dedicated to delivering a high standard of patient care. Staff told us that there had been improvements in staff culture and morale since our previous inspection, creating a more stable and supportive working environment. However, some staff felt that senior managers were not visible and that communication between management and ward staff was ineffective.

We saw evidence of high staff compliance with annual appraisals but were told that the formal clinical supervisions process was not always conducted within set timescales. We did not see evidence that staff meetings took place on a regular basis on Gwanwyn Ward.

Our staff engagement highlighted a general feeling that there were not enough staff to meet fluctuating demands on the wards and to maintain patient and staff safety. The health board must reflect on the feedback provided by staff throughout this report and consider what action must be taken so improvements can be made.

Processes were in place to record and investigate patient concerns and complaints. However, there was no process in place to routinely capture patient nor family/carer feedback on Gwanwyn Ward.

This is what we recommend the service can improve: []

- Maintain regular meetings for staff engagement, to discuss issues, share learning and encourage staff feedback
- Ensure staff have access to regular formal clinical supervision to support their learning and development
- Capture patient and family/carer feedback, to influence improvement with the patient experience and drive improvement.

This is what the service did well:

- We witnessed staff working well together during the inspection
- Good compliance with mandatory training
- Staff were receptive to our views, findings and recommendations.

3. What we found

Quality of Patient Experience

Patient feedback

We invited patients, family and carers to complete a HIW questionnaires to obtain their views on the service provided on the wards. We received two family/carer questionnaires. The sample size was therefore too small to draw any conclusion on themes or trends within the wards.

For those who responded, the feedback on the standard of care and treatment provided was positive. They rated the care and service as 'very good' and told us they were able to visit as often as they wished. They confirmed that staff treated patients with respect and kindness, and that patients were provided with care and treatment when they needed it. They also felt welcomed and safe during their visits and agreed that staff were polite to them and encouraged their involvement to care for the patient.

Person-centred

Health promotion

There were processes in place to help promote and maintain the physical and mental health needs of patients. We reviewed five patient records and found that patients received appropriate physical assessments on admission, and a regular review of their plan and progress was made. We found that long term patient health conditions were appropriately monitored, and staff demonstrated a good understanding of the patients in their care.

All patients had individual ensuite bedrooms and they could also access the communal areas of the wards throughout the day. Both wards provided a range of self-directed patient activities including DVDs, games, puzzles and books. Each ward had a dedicated activities coordinator to support the provision of therapeutic patient activities, and we witnessed activities being undertaken with patients throughout the inspection. We found the patients on both wards were provided with a programme of suitable therapeutic activities to support their health, wellbeing and rehabilitation.

There were secure outside garden areas for patients on both wards, including three outside spaces on Gwanwyn Ward. However, we were told that the patients on Gwanwyn Ward had limited access to the main garden area, as the ground

surface was unsuitable and posed a falls risk during wet weather. In addition, we were told that staffing was not always sufficient to accommodate patient access to the outside areas on Gwanwyn Ward.

The health board must review the environmental issues within the Gwanwyn Ward communal garden and provide equitable access for patients to use the garden, to support their physical and mental wellbeing.

Dignified and respectful care

Staff treated patients with dignity and respect and displayed a caring and understanding attitude to patients. They communicated with patients using appropriate and effective language. The staff we spoke with were passionate about their roles and were enthusiastic about how they supported and cared for the patients. During the inspection, we witnessed staff respecting the privacy of patients by knocking their bedroom door before entering.

Each patient bedroom had ensuite shower facilities, which helped to maintain their privacy and dignity. However, there were no shower screens or curtains fitted in the ensuite bathrooms on Gwanwyn Ward. Staff advised that the curtains were repeatedly damaged by patients and were not replaced. We identified that this arrangement could compromise patient privacy and dignity during their stay.

The health board must undertake measures to install suitable privacy screening within all patient ensuite bathrooms, to ensure their privacy and dignity is protected.

All patient bedroom doors had an observation panel, which allowed staff to undertake therapeutic observations without opening the door and disturbing the patient. We were told that patients could close them from inside their rooms if required, but staff routinely left the panels in the 'open' position between observations. This posed a risk that patients could be seen in their bedrooms by staff, patients and visitors.

The health board must ensure patient bedroom observation panels are kept closed when staff are not undertaking observations.

The wards' communal areas provided a pleasant and suitably decorated therapeutic environment for patients, in keeping with their needs. Patients on Hydref Ward could store their possessions and personalise their bedrooms, subject to individual risk assessment. We were told that Hydref patients were provided with an electronic wrist band, which afforded them access to their individual rooms and communal patient areas as appropriate.

However, we viewed three patient bedrooms on Gwanwyn Ward and found they were sparsely decorated and not personalised to the patients. We discussed this with staff, who confirmed that the patients were unable to lock or personalise their rooms, due to their individual risk assessments.

The health board should explore ways to ensure that the Gwanwyn Ward patient bedrooms provide a suitable, therapeutic environment of care for the relevant patient group.

During the inspection we noted that most patients on Gwanwyn Ward were male. However, all but one member of staff working on the ward were female. We identified that this arrangement could potentially pose difficulties in providing dignified and respectful patient care.

The health board should ensure senior staff consider individual patient needs when rostering shifts to staff, to maintain an appropriate gender balance.

Patient information

Both wards provided helpful pictorial information boards to identify the staff for patient and visitor awareness. However, we observed that the Gwanwyn board was located outside the ward entrance, where it could not be seen by patients. In addition, staff confirmed that the information provided on the board was out of date.

We found a range of suitable and relevant patient information was displayed on Hydref Ward to help patients and their families understand their care. However, we noted a general absence of any relevant patient information displayed throughout Gwanwyn Ward, which included:

- No information regarding advocacy services
- No information regarding the role of HIW and how patients can contact HIW
- No Mental Health Act information
- No information on how to raise a concern or complaint
- No list of available and appropriate legal representatives for detained patients
- No pictorial board identifying the ward's staff members for patient and family/carer awareness.

The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.

Individualised care

We reviewed the Care and Treatment Plans (CTPs) of five patients. These were person-centred and each patient had an individualised programme of care that reflected their needs and risks. The CTPs also outlined areas where patients were involved in making decisions about their care. More findings on the CTPs can be found in the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

We found that the patients on both wards were supported to make their own decisions about how to care for themselves wherever possible, promoting their independence and quality of life. Patients had appropriate access to walking aids, and we witnessed staff supporting patients to use them during the inspection.

Staff respected patient personal choices about how they wished to be supported. We saw evidence that patients could make their own food and clothing choices and observed staff assisting patients to eat and drink, where necessary. Patients were supported to carry out everyday tasks, including laundry and attending to personal hygiene. Most staff members who completed a questionnaire felt that patients were informed and involved in decisions about their care.

Patients could spend time away from other patients in their bedrooms, and there were separate rooms available for patients to use according to their needs and wishes. The wards had suitable visiting rooms where patients could see their families in private.

Timely

Timely care

Staff provided timely and effective patient care in accordance with clinical need. Established meeting processes were in place to support the timely care of patients, including twice-daily safety huddle meetings to establish staffing and bed occupancy levels and discuss patient care requirements. We attended an Acute Care Management meeting and saw that staff demonstrated a good level of understanding of the individuals they were caring for, and that discussions focused on what was best for the patient.

Regular multidisciplinary team (MDT) meetings were also in place to share and discuss the care of patients in a timely manner. We were told that any issues were raised and discussed during clinical governance meetings, where concerns and incidents were routinely discussed to identify trends and opportunities for wider service and organisational learning.

There were various additional meetings and processes to support the timely and effective care of patients. These included a weekly falls meeting as well as monthly Quality, Safety and Experience meetings.

Equitable

Communication and language

The wards used electronic patient record keeping to document and communicate patient care in a timely manner. Staff could also participate in online meetings, conduct audit processes and share other information electronically.

We were told that some patients had access to their own personal electronic devices, subject to individual risk assessment. Communal iPads were also available for patient use, and we witnessed staff supporting patients to use them during the inspection. Patients could also use the ward telephones to keep in touch with family/carers as required.

Staff showed understanding of the importance of speaking with patients in their preferred language. We were told that patient language preferences were identified on admission and translation services were utilised to support them if required. We were provided with a recent example of how staff had effectively used translation services to meet the needs of a non-English speaking patient during their stay.

We found plentiful information displayed and provided to patients in Welsh. We were told that some ward staff were Welsh speakers, and that additional Welsh speaking staff could be allocated to the wards if required.

Rights and equality

We reviewed the records of three patients who were detained under the Mental Health Act. The documentation was compliant with relevant legislation and followed guidance of the 2016 Mental Health Act Code of Practice for Wales (the Code). All patients had access to a mental health advocate who provided information and support to patients with any issues they may have regarding their care. Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

We found satisfactory arrangements in place to promote and protect patient rights. Staff compliance with mandatory training for Equality, Diversity and Human Rights was high at 97% on Gwanwyn Ward and 94% on Hydref Ward. Policies were also in place to help ensure everyone had equitable access to the same opportunities and fair treatment.

During our staff discussions, they demonstrated suitable regard for upholding patient rights and individual patient preferences. Regular meetings were held to review and discuss practices to minimise the restrictions on patients, based on individual patient risks. Patient care was consistently provided in accordance with the patient age group and their needs. The Care and Treatment Plans also evidenced that the social, cultural and spiritual needs of patients had been considered.

Reasonable adjustments were in place to ensure equitable access to, and use of services. The wards were accessible to wheelchair users, and other specialist equipment was available for patient use if required.

Delivery of Safe and Effective Care

Safe

Risk management

There were established policies, processes and audits in place to support the management of risk, which enabled staff to provide safe and clinically effective care. We considered the processes in place to manage risks to help maintain the health and safety of patients, staff and visitors, and found the following suitable measures in place:

- The wards were accessible to all, including those with mobility difficulties
- The ward environments were clean, tidy and well-maintained throughout
- The ward entrances were secured at all times throughout the inspection to prevent unauthorised access or egress
- The patient bedrooms were suitably alarmed to alert staff when patients rose from their beds. We were told that additional personal alarms could be provided to patients if appropriate
- Ligature cutters were appropriately stored for use in the event of a self-harm emergency, and staff knew where to find them
- A programme of monthly and annual ligature point risk assessments was being undertaken, which detailed the actions taken to mitigate and reduce the risk of ligature on the wards
- There were regular audits of emergency resuscitation equipment; staff had documented when these had occurred to ensure that the equipment was present and in date.

We did, however, find some issues that required immediate attention to maintain the safety of patients, staff and visitors.

We were told that staff carried personal safety alarms to use in the event of an emergency, and that there was a documentary sign in/out process for the alarms. However, during the inspection not all staff were carrying personal safety alarms, and we witnessed two staff members on Gwanwyn Ward sharing a single alarm between them.

On reviewing the alarm sign in/out documentation, we found many occasions where the alarms were not signed as returned, including ten separate instances during October 2024. Staff told us it was difficult to keep track of the alarms as they were not clearly identifiable to a particular ward and were sometimes taken to other wards, passed between staff members, or taken home by staff. In

addition, we were told that the two wards shared a single alarm charger, which posed difficulties in ensuring the alarms were sufficiently charged.

We discussed these issues with senior staff who confirmed that there were insufficient personal alarms available for all staff. We highlighted our concerns regarding the potential risk to staff and patient safety, if staff were unable to call for assistance in the event of an emergency.

Prior to the conclusion of our inspection, senior staff ordered an additional 10 alarms and two chargers for the wards. To ensure staff and patient safety was protected in the meantime, spare alarms were immediately obtained from other wards in the hospital. Senior staff confirmed that personal safety alarms were added as a standing agenda for discussion during daily safety huddle meetings, to ensure sufficient alarms were available for all staff.

The health board must:

- **Ensure sufficient personal safety alarms are available for all staff**
- **Implement a robust system of governance oversight and audit to ensure personal safety alarms are identifiable, monitored and accounted for.**

During our tour of Hydref Ward, the emergency fire door near to the sluice room was damaged and did not open properly, requiring significant force to open. This posed a risk to staff, patient and visitor safety, in the event of a fire emergency. We highlighted our concerns to staff and the door was suitably repaired during the inspection.

The hospital had established processes and audits in place to support patient care and safety. Whilst we found that the hospital's audit processes were generally well-completed, we noted that the monthly Matron's Audit was last completed in June 2024.

The health board must ensure that the hospital's established audit processes are fully completed within set timescales, to ensure the safety of patients, staff and visitors.

Infection, prevention and control and decontamination

We considered the patient environment, clinical areas and the wider hospital, and found they were clean, tidy and uncluttered throughout. The wards were in a very good state of repair and decoration, with appropriate furniture, fixtures and fittings in place for the patient group. We witnessed nursing and housekeeping staff cleaning the wards regularly throughout the inspection.

Suitable IPC policies, procedures, staff training and governance arrangements were in place to maintain staff, patient and visitor safety. The wards had appointed IPC leads, and staff compliance with mandatory IPC training was high at 100% on Gwanwyn Ward and 97% on Hydref Ward. The staff we spoke with during the inspection demonstrated a good understanding of their role and responsibility in upholding IPC.

All staff who completed a questionnaire provided positive feedback about the IPC arrangements in place. They confirmed that an effective infection control policy and effective cleaning schedules were in place. They agreed that appropriate PPE was supplied and used, and that the environment allowed for effective infection control. However, during the inspection we identified some IPC/environmental issues which posed a potential risk to staff, patient and visitor safety:

- A bench in the Hydref Ward communal corridor was damaged in several places, preventing effective IPC
- The staff toilet tap on Hydref Ward could not be fully closed and was leaking continuously
- The wards' laundry facilities were located off the wards, with only a tumble dryer provided on each ward. This meant that ward staff had to transport soiled patient laundry off the wards to be washed, which posed a potential IPC risk
- Whilst we found the wards to be suitably clean throughout the inspection, we noted several gaps in the nurses' daily cleaning checklists on both wards.

The health board must:

- **Repair or replace all damaged or faulty furniture, fixtures and fittings to ensure staff, patient and visitor safety**
- **Review the wards' laundry arrangements to ensure they support effective IPC**
- **Ensure the wards' cleaning schedules are fully completed.**

Safeguarding of children and adults

We found appropriate safeguarding measures in place to protect vulnerable adults, and staff could access the health board's safeguarding policy and Wales safeguarding procedures via the intranet. Our staff discussions highlighted a good knowledge and understanding of the safeguarding procedures and reporting arrangements.

We were told that safeguarding incidents and concerns were recorded on the Datix electronic incident reporting system and were monitored by the senior management team. In addition, safeguarding concerns were regularly reviewed to

help identify any themes and lessons learned. We found high staff compliance with mandatory training for safeguarding adults and children on both wards.

Medicines management

Relevant policies were in place and were accessible to staff, such as medicines management and rapid tranquillisation.

We reviewed the wards' clinic arrangements and found robust procedures in place for the safe management of medicines. All prescribed medications were securely stored in the medication fridges and in locked cupboards as appropriate. We saw evidence of regular temperature checks of the medication fridges to monitor that medication was being stored at the correct temperature. The records evidenced that medication stock was accounted for when administered, and that stock checks were being undertaken as required. We found appropriate internal auditing systems in place to support the safe administration of medication, with strong pharmacy involvement.

We reviewed patient Medication Administration Records (MAR charts) and found they were maintained to a good standard. The charts were consistently signed and dated when medication was prescribed and administered, and a reason was recorded when medication was not administered. We noted that photographs of the patients were attached to their medication records, which we identified as an example of good practice. Patient consent to treatment certificates were appropriately completed and stored alongside their MAR charts. However, we saw examples where the current MHA legal status for patients was not always recorded in the MAR charts we reviewed. This posed a potential risk of medication being administered to patients in error.

The health board must ensure that the MHA legal status of patients is recorded within their MAR charts to provide clear guidance to staff.

We observed safe and appropriate prescribing of medications in accordance with patient needs. Regular medication reviews were completed to ensure patient medications remained appropriate. We were told that patients or their family/carers were involved in decisions about their medications wherever possible. Patient medications were routinely discussed during ward round meetings, during which any updates or changes to their medication were recorded. Easy read information was available to support patients in understanding their medication.

Staff we spoke with during the inspection demonstrated appropriate knowledge and understanding of medications management procedures. We found good systems in place to ensure medication errors were appropriately recorded,

investigated and supervised, and that any learning opportunities were shared with all staff.

Effective

Effective care

Staff used the Datix system for recording, managing and monitoring incidents. There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that themes and trends could be monitored and analysed. Staff confirmed that debriefs took place following incidents, and that relevant learning was shared with staff verbally and electronically.

During the inspection, we found the staff numbers to care for the patients generally met the wards' minimum staffing establishment. Staff told us that the health board had introduced the 'HealthRoster SafeCare' programme to ensure safe staffing levels were continuously met. We were told that the health board had reviewed the staffing establishment of the wards and had increased the staffing template ahead of a formal establishment agreement taking place. However, staff told us that this situation created difficulties for them when arranging cover for vacant shifts to meet the increased establishment. Some staff we spoke with during the inspection felt that the increased establishment was still insufficient, due to the level of patient acuity and care requirements on the wards.

The health board must formally review the staff establishment on Hydref and Gwanwyn wards, to ensure the staffing levels are appropriate to safely support and manage the needs of patients.

We noted a reliance on bank and agency staff to fill vacant shifts on the wards. Some staff felt the use of agency staff often added pressure on substantive staff, as they were required to support them in addition to their own responsibilities. We were told that some agency staff were not always suitably skilled to work on the wards, as they were unfamiliar with the ward environments and the patient groups. Staff told us that the process for booking agency staff did not permit them to specifically request agency staff who were familiar with the wards and patient groups.

The health board must:

- **Review the existing temporary staff booking process for bank and agency staff, and ensure staff are suitably skilled to care for relevant patient groups**

- Aim for consistency and continuity of care when using temporary staff, such as 'block-booking' staff who are familiar with the environment and patient groups
- Ensure attention is given to the skill mix and proportion of temporary staff rostered, to maintain patient and staff safety.

During the inspection, we found that during the night shifts only one registered nurse would be working with a team of healthcare support workers. This meant that the registered nurse working the night shift could not take a break without leaving the ward without nursing cover. We identified that this potentially impacted on staff wellbeing and patient safety. We highlighted our concerns with this arrangement to staff.

The health board must ensure there is an appropriate number of registered nursing staff on duty to support staff wellbeing and maintain patient safety.

The staff we spoke with on both wards told us that the shared staff room was not fit for purpose, being too small to allow them to take their breaks in comfort. We were told that some staff sat in their own vehicles to take their breaks without disturbance. The staff we spoke with felt their working practices would be improved by the provision of a separate break room for the staff on both wards.

The health board should consider the staffroom environment and ensure it is suitable for staff to take their breaks in comfort, to support their wellbeing.

At the time of our inspection, both wards were experiencing high levels of patient acuity. We found staff were providing safe and effective patient care under challenging circumstances, with due consideration for the needs of the patient groups. Hydref Ward was a designated ward for older adults with a functional illness, but we noted that the ward was also providing care for adult patients and patients with organic mental illnesses. Staff told us that the mix of patients placed significant pressures on them in relation to providing safe and effective patient care.

We discussed this issue with senior staff, who felt that some adult patients were suitably placed on the ward due to their level of frailty but confirmed that at least one patient was unsuitably placed on the ward. We identified that this arrangement posed a potential risk to staff and patient safety and presented challenges in providing person-centred patient care for patients with mixed needs.

The health board must make every effort to ensure patients are cared for in an environment which supports their diagnosis, presentation and clinical needs.

Where this is not possible, mitigations must be implemented to maintain staff and patient safety.

We observed staff responding to patient needs in a timely manner and managing patient risks through therapeutic observation and engagement. We found that observation levels for individual patients were regularly reviewed for appropriateness and safety. Staff confirmed that patients were observed more frequently if their behaviour required closer monitoring. This was consistent with our findings on reviewing patient observation records, which were completed contemporaneously as appropriate.

During our discussions with staff, they showed understanding of the restrictive practices available to them, including appropriate preventative measures that can reduce the need for restrictive responses to challenging behaviour. We observed staff engaging with patients appropriately and providing reassurance and support throughout the inspection. We saw evidence of restrictive practices being used as a last resort in accordance with individual patient needs, with thorough monitoring around therapeutic effect and risk.

During the inspection we reviewed staff training records, staffing rotas, and incident forms for Hydref and Gwanwyn wards. Staff compliance with Restrictive Physical Intervention (RPI) training on Gwanwyn and Hydref Wards was 91% and 76% respectively. Incidents of patient restraint were recorded on the Datix system and within Restrictive Physical Intervention (RPI) records. Our review of Datix incidents and RPI records during the last six months identified that some staff had participated in physical restraints who had not completed the RPI training. We viewed four RPI incidents involving untrained staff members on Hydref Ward. Therefore, we were not assured that staff and patient safety was being maintained during incidents of physical restraint.

In addition, we found that Datix and RPI records did not clearly capture all details of the restraint incident and the actions performed by each staff member during the incident. The time of the incident was not recorded in two reports we reviewed, and other examples found three RPI records were incorrectly recorded as two duplicate incidents within Datix, rather than being recorded individually. Therefore, we were not assured that appropriate records were captured for each incident, to identify shared learning opportunities and support accurate governance oversight and monitoring.

Our concerns regarding these issues were dealt with under our immediate assurance process. Further information on the improvements we identified, and the actions taken by the health board, are provided in [Appendix B](#).

During the inspection, we were told that the patients had no access to clinical psychology support because the clinical psychologist post had been vacant for the previous two years. Therefore, we were not assured that patients were receiving a comprehensive psychological assessment, and that clinical decisions relating to their care and treatment were being determined through a full multidisciplinary approach.

The health board must review the current provision of psychology support for the patients on the wards, to support the assessment of patients' psychological needs and the safe and effective provision of psychological interventions.

Nutrition and hydration

Our patient records review found that patients nutritional and hydration needs were appropriately assessed, recorded and addressed, and they were provided with diets in accordance with their individual needs. Patients also had access to specialist dietetic services if needed, and where applicable, they were supported by the Speech and Language Therapy (SALT) team. However, we found that the quality and preparation of the food served to patients required improvement, which was consistent with our findings during our previous inspection of the wards in in 2022.

The food was pre-cooked in the main hospital and sent to the ward on heated trolleys to be served to patients. We were told there was little variety in the food provided, and patients were not involved in creating the menus. We observed food being served to the patients during the inspection and found it to be unappealing and unappetising.

Staff we spoke with expressed concern regarding the poor quality and variety of the patient food. They told us that the menus rotated weekly but were repetitive and had not been changed in many years. They told us that on occasions, they and family/carers were supplementing the patients' diets by providing additional food themselves. We were also told of occasions when the patient food had not arrived from the main hospital, yet no replacement was provided. We witnessed an example on Gwanwyn Ward, where the hot food was delivered but the patient finger foods were not, limiting choice and suitability for some patients.

The wards had set mealtimes and patients were not provided with a hot meal outside of these times if they had missed their meal. Staff felt this arrangement did not meet the needs of the individual patients being cared for on the wards. In addition, some preferred patient foods which were previously provided were no longer served, including cooked breakfasts and suppers.

The health board must undertake a review of the quality, variety, preparation and provision of patient food at the hospital, to ensure that it consistently meets the patient needs and dietary requirements.

Patient records

We found patient records were generally well-organised on both wards and were easy to navigate through clearly marked sections. Patient records were maintained both electronically and in paper files. The paper records were securely stored on the wards, and the electronic system was password protected to prevent unauthorised access. Clinical details were recorded contemporaneously and comprehensively, which provided a detailed overview of the patients and their care.

During the inspection staff told us the paper records system presented difficulties for them in respect of document completion, volume and storage. They felt that their working practices would be improved with a fully electronic health record system. This issue was also identified during our previous inspection of the wards in 2022.

The health board should review the current paper health record system with a view to implementing a fully electronic health record system in the hospital.

Mental Health Act monitoring []

We reviewed the statutory detention documents of three patients on the wards and discussed the monitoring and audit arrangements with staff. We were assured that the health board's responsibilities under the MHA were being upheld. All records reviewed were compliant with the MHA and Code of Practice. Clear reasons were documented to evidence the decisions made in relation to patient care and detention.

The hospital had a dedicated Mental Health Act (MHA) administrator who provided ongoing support to staff. The MHA department files were generally well organised, easy to navigate and contained detailed and relevant information. However, on reviewing the ward-based MHA documentation, we saw instances where statutory documents were unnecessarily retained or duplicated within the files. We also found expired patient section 17 leave forms within the files, which had not been removed as appropriate. We identified that these issues could cause confusion for staff when reviewing patient records.

The health board must implement robust governance oversight to ensure unnecessary or duplicate documentation is removed from patient MHA records, to avoid confusion for staff.

Patient leave was suitably risk assessed and the forms outlined the conditions and outcomes of the leave for each patient. However, we saw an example where one patient Section 17 leave form was undated and contained missing staff and patient signatures. The form was also not completed to indicate who should be provided with a copy.

The health board must ensure patient Section 17 leave forms are fully completed and signed as appropriate.

There were good processes in place to support patient rights, and we found patients were well-supported to access advocacy services. The wards' Patient Status at a Glance boards provided clear and comprehensive information to staff in relation to the patients' MHA status and associated data, which we identified as an example of good practice.

During our discussions with staff, they demonstrated good knowledge of MHA processes. We were told that additional audit activities were being considered in relation to Section 62 of the MHA in order to identify opportunities for shared learning and drive quality improvement. We identified this as an example of good practice.

Monitoring the Mental Health (Wales) Measure 2010: care planning and provision

Alongside our review of statutory detention documents, we considered the application of the Mental Health (Wales) Measure 2010 (the Measure). We reviewed five patient Care and Treatment Plans (CTPs) and found a good standard of clinical record keeping which reflected the needs and risks of the patients. The CTPs were aligned to the domains of the Measure and provided a comprehensive account of the patients' presentation and the interventions being offered. The records were regularly reviewed, well organised and easy to navigate.

We saw appropriate arrangements in place to meet the physical and mental health needs of patients. To support patient care plans, there was an extensive range of assessments to determine the provision of patient care, along with risk assessments which set out the identified risks and how to mitigate and manage them. We saw evidence that patients at risk of falls or pressure sores were suitably risk assessed and monitored. Weekly falls review group meetings took place to identify areas of concern and points of learning from falls incidents, to prevent reoccurrence.

All patients had an individualised and person-centred CTP which reflected their needs and risks. We saw that patients, family and carers had been involved in the development of their CTPs wherever possible. Regular MDT reviews were being

undertaken to conduct a more formal review of patient care, which included the involvement of family/carers, external agencies and community professionals as appropriate. We found evidence of discharge and aftercare planning within the patient records, with multiagency discussions being held regarding appropriate future placements.

It was positive to note that both wards were supported by an associate physician who supported and contributed to the care and treatment of the patients. We identified this as an example of good practice.

Quality of Management and Leadership

Staff feedback.

We engaged with staff throughout the inspection and received three responses to our staff questionnaire. The response rate was too small to draw robust conclusions on themes or trends within the wards.

The three responses to the questionnaire were generally mixed. Two recommended the hospital as a place to work and told us they were satisfied with the quality of care they gave to patients. In addition, they agreed that patient care was the health board's top priority. However, most were not content with the health board's efforts to keep staff and patients safe and stated they would not be happy with the standard of care provided for their friends or family.

All respondents agreed that their job was not detrimental to their health, and that their current working pattern allowed for a good work-life balance. All agreed that they were aware of the Occupational Health support available to them and most agreed that the health board takes positive action on staff health and wellbeing. However, most felt they were unable to meet the conflicting demands on their time at work.

Staff were asked to provide comments or suggestions for improvement, and commented:

“Staff are put at risk as higher management won't allow the ward manager to do the job (they) are employed to do.”

“...management regarding staffing levels and patients' wellbeing.”

The health board may wish to reflect on this aspect of staff feedback and consider whether any improvements can be made.

Leadership

Governance and leadership

We observed strong team working on the wards and found staff were dedicated to delivering a high standard of patient care. We were told of recent changes to the ward's staffing and leadership structure, which provided a more stable and supportive working environment for staff. Staff told us that morale had increased since our previous inspection in 2022. Many staff spoke positively of the

improvements implemented by the new ward manager on Hydref Ward, and we were told that the manager of Gwanwyn Ward was caring and supportive.

Most staff who completed our questionnaire confirmed that their immediate manager asked for their opinion before making decisions that affect their work. However, most felt that their immediate manager could not be counted on to help them with a difficult task at work, and that their immediate manager did not give them clear feedback on their work.

Some staff we spoke with during the inspection told us that the support provided to them by the senior leadership team (SLT) had improved since our previous inspection. We were told that monthly SLT drop-in sessions had been introduced to ensure that the SLT was more visible and accessible for all staff.

However, some staff whom we spoke with during the inspection and all who completed our questionnaire felt there was little SLT visibility and involvement on the wards, and that communication between senior management and staff was ineffective. Just one survey respondent felt that senior managers were committed to patient care.

The health board must reflect on this aspect of staff feedback and consider whether improvements in relation to senior management visibility and communication could be made.

Workforce

Skilled and enabled workforce

We found the staffing levels were appropriate to maintain patient safety within the wards at the time of our inspection. However, some staff told us they felt there were not enough staff to meet fluctuating staff needs and increased patient demand on the wards. We noted a reliance on bank or agency staff to meet the wards' increased staffing establishment and to respond to changes in patient acuity, as outlined previously in this report.

We found suitable processes in place to monitor staff compliance with mandatory training. Overall mandatory training compliance rates were generally high across most areas on both wards. All staff who completed our questionnaire felt they had received appropriate training to undertake their role. However, improvements were required for Fit Test PPE Mask training courses on Hydref ward, and also for Basic Life Support training, which was currently at 75% compliance.

The health board must implement measures to ensure all outstanding staff training is completed and that staff are supported to attend the training.

We were told that development opportunities were available to staff, which were discussed during their annual appraisals. It is noteworthy that 94% of staff on Gwanwyn Ward and 97% on Hydref Ward had received an annual appraisal. We were told that a formal clinical supervision process was also in place for all staff, but it was not always conducted within set timescales, due to the conflicting demands of the wards.

The health board must ensure that staff have access to regular formal clinical supervision to support their learning and development.

Culture

People engagement, feedback and learning

An established process was in place where patients could escalate concerns via the NHS Wales 'Putting Things Right' (PTR) process. Senior staff confirmed that formal complaints were recorded on the Datix system and were monitored by senior managers throughout the investigation. Staff told us that they aimed to resolve complaints immediately wherever possible, and share learning from incidents appropriately. We were told that patients and family/carers could raise concerns at any time, and that any verbal feedback was recorded within patient records and discussed during staff meetings.

During the inspection we found there was no dedicated process in place to routinely capture patient nor family/carer feedback on Gwanwyn Ward. We found a suitable monthly patient meeting process in place on Hydref Ward. However, the paper patient and visitor feedback forms were located outside the ward's main entrance, where patients could not readily access them. There were no processes or information boards displayed on the wards to inform patients and family/carers of actions taken as a result of their feedback.

The health board must:

- **Consider ways to formally and routinely capture patient and family/carer feedback on Gwanwyn Ward, to enhance patient care and drive quality improvement**
- **Ensure patients can access feedback forms wherever possible**
- **Implement processes to routinely inform patients and family/carers of actions taken as a result of their feedback.**

Our engagement with staff identified that they knew and understood the Duty of Candour requirements, and that the health board encouraged them to report errors, near misses or incidents. Two respondents to our staff questionnaire felt

secure to raise concerns about patient care or other issues. However, none felt confident that the health board would address their concerns. In addition, one strongly felt that when errors, near misses or incidents were reported, no action was taken by the health board to ensure that they do not happen again.

We were told that there were various support systems available following incidents if required. These included Occupational Health, Human Resources and a self-referral counselling service. However, two staff responding to the questionnaire disagreed that the health board treated staff who are involved in an error, near miss or incident fairly. Most felt that they were not given feedback about changes made in response to reported errors, near misses and incidents.

The health should reflect on the staff feedback relating to incident reporting, to ensure staff are fully supported and provided with feedback following an incident.

Staff told us that the wards held regular staff meetings to share updates, concerns and feedback, and strengthen staff working relationships. However, we found the ward staff meetings did not always take place on a regular basis on Gwanwyn Ward.

The health board must ensure ward staff meetings are conducted on a regular basis to facilitate staff engagement, discuss ward issues and share feedback following concerns or incidents.

We found that several health board policies or procedures were past their review dates during our inspection. These included:

- Procedure for NHS Staff to Raise Concerns - Review date June 2024
- Seclusion and Long Term Segregation - Review date September 2023
- Business Continuity Plan - Review date September 2024.

The health board must ensure key policies and procedures are reviewed and updated in a timely manner to ensure staff are supported in their roles.

Information

Information governance and digital technology

Patient records and data were being maintained in line with General Data Protection Regulation (GDPR) legislation. All information recorded on the hospital's electronic records system was password protected. Paper records were securely stored. Information was accessible to all relevant staff and there were established processes to share information with partner agencies in safe and

secure way. Staff compliance with mandatory information governance training was high at 92% on Gwanwyn Ward and 97% on Hydref Ward.

Learning, improvement and research

Quality improvement activities

It was evident through our discussions with senior staff that the health board was continuously reviewing the provision of the service on the wards. Ward staff spoke positively of their involvement in a wider health board quality improvement project focussing on patient falls, to identify areas of improvement, share learning and to reduce falls. We were told that the ward staff upheld the standards of the health board's ward accreditation programme, which seeks to improve the standard and quality of patient care via a process of continuous performance assessment and improvement.

During our staff discussions we were apprised of regular audit activities and meetings to discuss findings, incidents and other issues related to patient care. There were processes in place to ensure incidents or issues were identified, investigated, escalated, and monitored to prevent reoccurrence.

Staff were receptive and responsive to our findings and recommendations throughout the inspection. Some improvements we identified were rectified during the inspection and we later received assurances from the health board on how the immediate assurance issues identified have been or will be addressed.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

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

As a result of the findings from this inspection the service should:

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

The improvement plan, once agreed, will be published on HIW's [website](#).

Appendix A - Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
During our tour of Hydref Ward, we saw that the emergency fire door located near to the ward’s sluice room was damaged and did not open properly, requiring significant force to open.	This issue posed a potential risk to staff, patient and visitor safety. as they may be unable to exit the ward in the event of an emergency.	We highlighted our concerns to staff.	The door was suitably repaired during the inspection.

Appendix B - Immediate improvement plan

Service: Hydref and Gwanwyn Wards, Heddfan Psychiatric Unit

Date of inspection: 21-23 October 2024

Findings

During the inspection we reviewed staff training records, staffing rotas, and incident forms for Hydref and Gwanwyn wards. Staff compliance with Restrictive Physical Intervention (RPI) training on Gwanwyn and Hydref Wards was 91% and 76% respectively.

Incidents of patient restraint were being recorded on the Datix electronic reporting system and within Restrictive Physical Intervention (RPI) records. Our review of Datix incidents and RPI records during the last six months identified that some staff had participated in physical restraints who had not completed any RPI training. We viewed four RPI incidents involving untrained staff members on Hydref Ward. Therefore, we are not assured that staff and patient safety is maintained during incidents of physical restraint.

In addition, we found that Datix and RPI records did not clearly capture all details of the restraint incident and the actions performed by each staff member during the incident. The time of the incident was not recorded in two reports we reviewed, and other examples found three RPI records were incorrectly recorded as two duplicate incidents within Datix, rather than being recorded individually. Therefore, we were not assured that appropriate records are captured for each incident, to identify shared learning opportunities and support accurate governance oversight and monitoring.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
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1.	The health board must ensure that all staff on Hydref and Gwanwyn wards are compliant with their RPI training to ensure patient and staff safety is maintained.	Delivery of safe and effective care	<p>Ward training compliance is monitored to achieve 85% and above, with booking of training in place to achieve this compliance.</p> <p>Hydref have 76% training compliance with 6 x staff have training dates in November 2024; 1 x staff is due to return from maternity imminently and will be given a date as part of return; 5 x staff are medically exempt.</p> <p>Gwanwyn have 91% training compliance with 1 x staff member will repeat training in the next 2 months. Dates have been arranged for the remaining 6 staff.</p>	Head of Operations and Service Delivery, East	December 2024
2.	The health board must implement measures to ensure there are sufficiently trained staff members to manage incidences of restraint on both wards, until all staff have received their training.	Delivery of safe and effective care	<p>The Health Board has issued a written control memo to remind teams to ensure arrangements are in place for all staff trained in RPI clearly identified per shift.</p> <p>For the Heddfan Unit, this is reported 2 x daily through the safety huddles.</p>	<p>MH&LD Assistant Director of Nursing</p> <p>Head of Operations and Service Delivery, East</p>	<p>Completed</p> <p>Completed</p>

		<p>Daily reminders take place to ensure untrained staff do not engage in RPI. 2 x daily reminders though safety huddle. Monitored weekly through OLM. Assurance has also been received that the arrangements noted for the Heddfan Unit are similar if not the same in other MHLD Division mental health units.</p> <p>For Learning Disability services, the number of staff trained in RPI discussed in both inpatient and SLT safety huddles with reminders as required on untrained RPI staff not engaging in RPI.</p>	<p>Assistant Director of Nursing</p> <p>Head of Operations and Service Delivery, Learning Disability</p>	<p>Completed</p> <p>Completed</p>
3.	The health board must ensure restraint incidents are appropriately recorded and provide a full description of the incident, including the actions of staff involved, to support effective governance, oversight and ongoing monitoring.	<p>Delivery of safe and effective care</p> <p>The Health Board has issued a written control memo to remind teams to ensure DATIX and RPI records clearly capture all details of the restraint incident and actions performed by each staff member.</p> <p>For the Heddfan Unit, recording takes place through the Datix systems with the completion of CR1 on every</p>	<p>MH&LD Assistant Director of Nursing</p> <p>Head of Operations and Service Delivery, East</p>	<p>Completed</p> <p>Completed</p>

		<p>occasion of RPI. Datix are reviewed weekly through ICOP meetings.</p> <p>Assurance has also been received that the arrangements noted for the Heddfan Unit are similar if not the same in other MHLD Division mental health units.</p> <p>For Learning Disability, as above but in addition, reviewed in the weekly behavioural meeting chaired by the LD restraint lead.</p>	<p>MHLD Assistant Director of Nursing</p> <p>Head of Operations and Service Delivery, Learning Disability</p>	<p>Completed</p> <p>Completed</p>
4.	The health board must ensure that our findings in relation to restraint training compliance and incident recording are not systemic across other areas of the organisation.	<p>Delivery of safe and effective care</p> <p>MHLD Division PICCS team continues to provide RPI training and monitors the quality of DATIX & CRI completion.</p> <p>Restraint training compliance reported and monitored monthly into MH&LD Service Quality Delivery Group. Action taken to progress any areas below 85% compliance by each Senior Leadership Team.</p> <p>To further strengthen governance, introduce two new reporting metrics; %</p>	<p>Positive Interventions Lead</p> <p>MH&LD Assistant Director of Nursing</p>	<p>Completed</p> <p>Completed</p> <p>December 2024</p>

		<p>of staff trained who undertook the RPI and % of completed DATIX accompanied by a fully completed CRI form. Report to be monitored monthly via Quality Delivery Group.</p> <p>Identify shared learning opportunities during monitor and review of incidents to ensure staff and patient safety is maintained during incidents of physical restraint, including the creation of a “7 minute briefing” where applicable.</p>	<p>Positive Interventions Lead</p> <p>Positive Interventions Lead</p>	<p>December 2024</p>
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The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): Iain Wilkie

Job role: Director of Mental Health

Date: 31st October 2024

Appendix C - Improvement plan

Service: Hydref and Gwanwyn Wards, Heddfan Psychiatric Unit

Date of inspection: 21-23 October 2024

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

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1. We were told that the patients on Gwanwyn Ward had limited access to the main garden area and that the ward staffing was not always sufficient to accommodate patient access to the outside areas on Gwanwyn Ward.	The health board must review the environmental issues within the Gwanwyn communal garden and provide equitable access for patients to use the garden to support their physical and mental wellbeing.	Health promotion	<p>Patients access communal garden with staff supervision and support, with risk assessments undertaken as required. Patients also have access to another garden area on the ward.</p> <p>Undertake Tri Partite Environmental Risk Assessment, scheduled for 15.01.25.</p>	<p>OPMHU Inpatient Service Manager</p> <p>OPMHU Inpatient Service Manager</p>	<p>Completed</p> <p>15.01.2025</p>

				Business case Developed by the East team to address estates issues to strengthen access. Currently progressing through Health Board Governance to be included to the Capital Estates 26/27 programme of work.	East Business Support Manager	31.12.25
2.	There were no shower screens or curtains fitted in the ensuite bathrooms on Gwanwyn Ward.	The health board must undertake measures to install suitable privacy screening within all patient ensuite bathrooms, to ensure their privacy and dignity is protected.	Dignified and respectful care	Ward Managers to ensure that shower curtains are re installed in all bathrooms. Add shower curtains to the Ward Manager's Checklist.	OPMHU Inpatient Service Manager	20.12.24 21.12.24
3.	We were told that staff routinely left the patient bedroom observation panels in the 'open' position	The health board must ensure patient bedroom observation panels are kept closed when staff are not undertaking observations.	Dignified and respectful care	A reminder circulated to all staff of the importance of ensuring observation panels are only opened during periods of observation.	OPMHU Inpatient Service Manager	20.12.24

	between patient observations.			To be monitored as part of the Ward Manager/Matron walk about.		20.12.24
4.	We viewed three patient bedrooms on Gwanwyn Ward and found they were sparsely decorated and not personalised to the patient.	The health board should explore ways to ensure that the Gwanwyn patient bedrooms provide a suitable, therapeutic environment of care for the relevant patient group.	Dignified and respectful care	Encourage families to bring appropriate personal items onto the ward upon each admission. Ward staff to consider the environment in cases where this does not take place by obtaining items on behalf of patients.	OPMHU Inpatient Service Manager	Completed 10.12.24 31.02.25
5.	The majority of the patients being cared for on Gwanwyn Ward were male. We noted that all but one member of staff working on the ward were female.	The health board should ensure senior staff consider individual patient needs when rostering shifts to staff, to maintain an appropriate gender balance.	Dignified and respectful care	Actions taken to ensure appropriate skill mix: - Sufficient staff recruited to the ward to ensure appropriate skill mix/gender balance. Consideration to skill mix/gender balance when	OPMHU Inpatient Service Manager	Completed 10.12.24

			<p>completing and locking down e-roster by ward manager will take place.</p> <p>- Ward manager will consider using staff from other wards where appropriate when gender balance not adequate, which may be due to sickness or annual leave and temporary staffing is required.</p> <p>- East SLT daily huddles and Acute Care Meetings discuss and agree if skill mix/gender balance required based on patient need and staff redeployed accordingly and support as required.</p>	<p>OPMHU Inpatient Service Manager / Safety huddle chair</p>	
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6.	We noted a general absence of any relevant patient information displayed throughout Gwanwyn Ward.	The health board must ensure patients are provided with relevant, up-to-date and accessible information to support their care.	Patient information	<p>Monitor patient information to ensure it remains relevant, up to date and accessible through the Ward Accreditation handbooks led by ward and service managers.</p> <p>Wards to ensure that they have appropriate bilingual patient leaflets available.</p> <p>Transfer patient information onto the wards into a more accessible area.</p>	OPMHU Ward Managers	<p>31.12.24</p> <p>31.12.24</p> <p>31.12.24</p>
7.	We found that not all staff were carrying personal safety alarms. Within the alarm sign in/out documentation, we found many occasions where the alarms were not signed as	<p>The health board must:</p> <p>Ensure sufficient personal safety alarms are available for all staff</p> <p>Implement a robust system of governance oversight and audit to ensure personal safety alarms are</p>	Risk management	<p>Additional patient safety alarms reordered in November 2024 with 4-6 weeks for delivery timescale.</p> <p>Implement a ward process for ensuring attack alarms are allocated daily.</p>	<p>East Business Support Manager</p> <p>OPMHU Inpatient Service Manager Completed</p>	<p>31.01.25</p> <p>Completed 22.10.24</p>

	returned, including ten separate instances during October 2024.	identifiable, monitored and accounted for.		Overseen by nurse in charge. Any deficits escalated at the daily safety huddle for immediate resolve.		
8.	The monthly Matron's Audit was last completed in June 2024.	The health board must ensure that the hospital's established audit processes are fully completed within set timescales, to ensure the safety of patients, staff and visitors.	Risk management	Complete BCU Matrons monthly audits ensuring submission for inclusion in monthly ICOP agenda for monitoring and review.	OPMHU Inpatient Service Manager	31.12.24
9.	A bench in the Hydref Ward communal corridor was damaged in several places, preventing effective IPC. The staff toilet tap on Hydref Ward could not be fully closed and was leaking continuously.	The health board must repair or replace all damaged or faulty furniture, fixtures and fittings to ensure staff, patient and visitor safety.	Infection, prevention and control and decontamination	Estates to repair damaged bench. Fix ward tap on Hydref Ward.	East Business Support Manager East Business Support Manager	31.01.25 Completed 21.10.24
10.	Staff had to transport soiled patient laundry off the wards to be	The health board must Review the wards' laundry	Infection, prevention and control and decontamination	Meet with IPC to review current laundry arrangements, to ensure effective IPC.	East Business Support Manager	31.01.25

	washed, which posed a potential IPC risk.	arrangements to ensure they support effective IPC.		Consider options appraisal following meeting to ensure effective IPC requirements for laundry.	/ OPMHU Inpatient Service Manager	
11.	We noted several gaps in the nurses' daily cleaning checklists on both wards.	The health board must Ensure the wards' cleaning schedules are fully completed.	Infection, prevention and control and decontamination	Nurse in charge to ensure daily cleaning checks are completed at the end of every shift and any gaps rectified. Audit completion of daily cleaning lists, discuss outcome at managers meeting chaired by service managers to agree actions.	OPMHU Ward managers	14.01.25 14.01.25
12.	We saw examples where the current MHA legal status for patients was not always recorded on the MAR charts we reviewed.	The health board must ensure that the MHA legal status of patients is recorded within their MAR charts to provide clear guidance to staff.	Medicines management	MHLD Clinical Director to communicate importance of medical staff filling in MHA legal status on MAR charts.	East Clinical Director	31.12.24

				Audit to be carried out to ensure compliance.	Operational OPMH Service Manager	31.03.25
13.	We were told that the health board had increased the wards' staffing establishment ahead of a formal establishment agreement taking place. However, staff told us that this situation created difficulties for them when arranging cover for vacant shifts to meet the increased establishment.	The health board must formally review the staff establishment on Hydref and Gwanywn wards, to ensure the staffing levels are appropriate to safely support and manage the needs of patients.	Effective care	Heddfan unit to continue to work to the uplifted template to meet the needs of patients. A formal MH&LD Inpatient Staffing Review has taken place.	Director of Nursing	Completed
14.	We noted a reliance on bank and agency staff to fill vacant shifts. We were told that some agency staff were not suitably skilled to work on the ward. Staff told us that the process for	The health board must: <ul style="list-style-type: none"> Review the existing temporary staff booking process for bank and agency staff, and ensure staff are suitably skilled to care for 	Effective care	Continue Health Board approval process for temporary agency staffing at twice weekly meeting. Local SLT to ensure staff are suitably	Assistant Director of Nursing OPMH Service Manager	Completed 10.12.24 Completed 10.12.24

	<p>booking agency staff did not permit them to request agency staff who were familiar with the ward and patient group.</p>	<p>relevant patient groups</p> <ul style="list-style-type: none"> • Aim for consistency and continuity of care when using temporary staff, such as ‘block-booking’ staff who are familiar with the environment and patient group • Ensure attention is given to the skill mix and proportion of temporary staff rostered, to maintain patient and staff safety. 		<p>skilled with appropriate skill mix.</p> <p>Continue with Local area induction checklists for all new staff for the ward environment, led by the duty nurse or other qualified nurse on site to support.</p> <p>Consider block booking of bank staff as required.</p> <p>Continue focus on recruitment for 3 vacant band 5 nursing substantive posts.</p>		<p>Completed 10.12.24</p> <p>31.12.24</p> <p>31.01.25</p>
15.	<p>We identified that the nurse working the night shift could not take a break without leaving the ward without nursing cover.</p>	<p>The health board must ensure there is sufficient cover for nursing staff to take breaks during their shift without leaving the ward unsupervised.</p>	<p>Effective care</p>	<p>Actions taken to ensure appropriate Registered Nurse skill mix for breaks include:</p> <p>-Where there is only 1 RMN on shift the Duty nurse will coordinate</p>	<p>OPMHU Inpatient Service Manager</p>	<p>Completed 10.12.24</p>

				<p>to enable staff nurses to take a break.</p> <p>-Duty nurse will base themselves on the ward during this break time.</p> <p>-Email communication has been sent to all Duty Nurses reminding of importance to support all staff inclusive of Registered Nurses to take breaks at night.</p> <p>-Occasion of nurses not being able to take a break will continue to be monitored and reviewed by the East Senior Leadership team</p> <p>-Full staffing review completed, awaiting Executive approval.</p>		
16.	Staff we spoke with on both wards told us	The health board should consider the staffroom	Effective care	Review current staff room to ensure it	OPMHU Inpatient	13.12.24

	that their shared staff room was not fit for purpose.	environment to ensure it is suitable for staff to take their breaks in comfort, to support their wellbeing.		remains comfortable and appropriate for staff breaks. Review Heddfan Wellness room to ensure it remains comfortable and appropriate for staff breaks. Communicate with staff to highlighting all rest areas available to take a break.	Service Manager OPMHU Inpatient Service Manager OPMHU Inpatient Service Manager	20.12.24 20.12.24
17.	Hydref Ward was a designated ward for older adults with a functional illness but the ward was also providing care for adult patients and patients with organic mental illnesses.	The health board must make every effort to ensure all patients are cared for in an environment which supports their diagnosis, presentation and clinical needs. Where this is not possible, mitigations must be implemented to maintain staff and patient safety.	Effective care	East SLT Acute Care Meeting to review of all patients to ensure an appropriate environment which supports their diagnosis, presentation and clinical needs is provided. Mitigations to maintain staff and patient	East Head of Operations	31.12.24 31.12.24

				safety completed via an MDT approach and reported through Acute Care Meeting minutes.		
18.	We were told that the patients on the wards had no access to clinical psychology support because the clinical psychologist post had been vacant for the previous two years.	The health board must review the current provision of psychology support for the patients on the wards, to support the assessment of patients' psychological needs and the safe and effective provision of psychological interventions.	Effective care	<p>Review of current psychology arrangements for older person's wards in the Heddfan unit to be reviewed. Review to commence January 2025.</p> <p>To continue to progress recruitment for outstanding psychology vacant posts for inpatient older adult services.</p> <p>In the interim, Community Older Adults Clinical Psychologists and Traumatic Stress Consultant Psychologist to</p>	BCUHB Head of Psychological Therapies and Psychology Services	31.03.25

				continue to be available for advice to inpatient staff on request.		
19.	We found robust improvements were required in relation to the quality and preparation of the food served to patients.	The health board must undertake a review of the quality, variety, preparation and provision of patient food at the hospital, to ensure that it consistently meets the patient needs and dietary requirements.	Nutrition and hydration	SLT to meet with lead caterers to discuss and agree actions required to ensure the quality of food provision, including portion sizes. To establish quarterly meetings between SLT and caterers to ensure quality of food remains in place.	OPMHU Inpatient Service Manager OPMHU Inpatient Service Manager	31.01.25 30.03.25
20.	Staff told us that their working practices would be improved with the introduction of a fully electronic health record system. This issue was also identified during our previous inspection of the wards in 2022.	The health board should review the current paper health record system with a view to implementing a fully electronic health record system in the hospital.	Patient records	Progress implementation of a fully electronic health record system, expected to be rolled out in a phased approach in late 2025. Ensure regular updates on progress of the implementation to an	Transformation Project team Transformation Project team	Expected late 2025 31.03.25

				electronic health system is provided to staff.		
21.	We saw instances where statutory documents were unnecessarily retained or duplicated within ward-based MHA files. We also found expired documents which had not been removed as appropriate.	The health board must implement robust governance oversight to ensure unnecessary or duplicate documentation is removed from patient MHA records, to avoid confusion for staff.	Mental Health Act monitoring []	Ensure duplicate and outdated documentation is removed from files. Local audit to be undertaken aligned to Good Record Keeping, outcome brought through weekly managers meeting for discussion and support.	Ward Managers OPMHU Inpatient Service Manager	Completed 06.12.24 31.01.25
22.	We saw an example where one patient section 17 leave form was undated and contained missing staff and patient signatures. The form was also not completed to indicate who should be provided with a copy.	The health board must ensure patient Section 17 leave forms are fully completed and signed as appropriate.	Mental Health Act monitoring []	Clinical Director to remind medical staff of their responsibility and accountability. To discuss Section 17 Leave form completion in the consultant forums. Audit to be carried out to ensure compliance	East Clinical Director East Clinical Director OPMHU Inpatient	20.12.24 20.12.24 31.03.25

					Service Manager	
23.	Some staff told us there was little senior management visibility and involvement on the wards and that that communication between senior management and staff was ineffective.	The health board must reflect on this aspect of staff feedback and consider whether improvements in relation to senior management visibility and communication with staff could be made.	Governance and leadership	<p>Clinical Operational Manager and Head of Operations team to visit the wards on at least a weekly basis.</p> <p>Service managers to attend ward meetings and visit the ward several times each week.</p> <p>Monthly SLT drop-in meeting held face to face and on teams and follow up with a whole areas email update, continue into 2025.</p> <p>Invite East area staff to bi-monthly learning events.</p>	<p>Head of Operations & Service Delivery / Clinical Operational Manager</p> <p>OPMHU Inpatient Service Manager</p> <p>Head of Operations & Service Delivery</p> <p>Head of Operations &</p>	<p>Completed 10.12.24</p> <p>Completed 10.12.24</p> <p>Completed 10.12.24</p> <p>Completed 10.12.24</p>

					Service Delivery	
24.	Improvements were required in respect of overall Hydref Ward staff compliance with some training courses.	The health board must implement measures to ensure all outstanding staff training is completed and that staff are supported to attend the training.	Skilled and enabled workforce []	<p>To review all training KPI's weekly through Ward Managers meeting to ensure all staff meet the expected standard.</p> <p>To report any mandatory training challenges for all training courses at the weekly managers meetings through OLM for escalation and actioned accordingly.</p>	OPMHU Inpatient Service Manager	<p>Completed 10.12.24</p> <p>Completed 10.12.24</p>
25.	We were told that a formal clinical supervision process was in place for all staff, but it was not always conducted within set timescales.	The health board must ensure that staff have access to regular formal clinical supervision to support their learning and development.	Skilled and enabled workforce []	Monitor supervision timetable through team managers meeting and operational meeting, supporting any areas not conducted within set timescales.	<p>OPMHU Ward Manager</p> <p>OPMHU Inpatient</p>	<p>Completed 10.12.24</p> <p>20.12.24</p>

				Service Manager to address any challenges with completion of Ward Managers supervision.	Service Manager	
26.	There was no dedicated process in place to routinely capture patient nor family/carer feedback on Gwanwyn Ward.	The health board must consider ways to formally and routinely capture patient and family/carer feedback on Gwanwyn Ward, to enhance patient care and drive quality improvement.	People engagement, feedback and learning	<p>Progress Ward Accreditation action plan to ensure patient/carer feedback is received.</p> <p>Establish Monthly patient/family/carer meetings.</p> <p>Ward Managers to monitor weekly CIVICA system reporting, overseen by Service Manager.</p> <p>East SLT to feedback CIVICA data to Divisional Patient Carer Experience Group</p>	<p>OPMHU Ward Managers</p> <p>OPMHU Inpatient Service Manager</p> <p>OPMHU Inpatient Service Manager</p> <p>Head of Nursing or nominated deputy</p>	<p>31.12.24</p> <p>31.12.24</p> <p>31.03.25</p> <p>31.01.25</p>

27.	The Hydref Ward patient and visitor feedback forms were located outside the ward's main entrance, where patients could not readily access them.	The health board must ensure patients can access feedback forms wherever possible.	People engagement, feedback and learning	Feedback forms to be relocated in patient ward area.	Ward Manager, monitored by OPMHU Inpatient Service Manager	13.12.24
28.	There were no processes nor information boards on the wards to routinely inform patients and family/carers of actions taken as a result of their feedback.	The health board must Implement processes to routinely inform patients and family/carers of actions taken as a result of their feedback.	People engagement, feedback and learning	Update feedback board as part of the ward accreditation handbook. Include bilingual CIVICA poster with QR code to support real time patient feedback.	OPMHU Ward Manager, supported by OPMHU Inpatient Service Manager	31.12.24 31.03.25
29.	Most staff who completed our questionnaire disagreed that the health board treated staff who are involved in an error, near miss	The health should reflect on the staff feedback relating to incident reporting, to ensure staff are fully supported and provided with feedback following an incident.	People engagement, feedback and learning	Ensure staff receive feedback as part of reporting process through the ICOP weekly meeting and directly via the DATIX system utilising a	OPMHU Ward Managers, supported by OPMHU Inpatient Service Manager	20.12.24

	or incident fairly. Most felt that they were not given feedback about changes made in response to reported errors, near misses and incidents.			<p>variety of communication methods.</p> <p>Include this as a standing agenda item on monthly team meetings.</p> <p>To encourage staff to engage with the staff surveys, including the NHS Staff Surveys, for staff to share their views, and for this to be fed through to team meetings.</p>		<p>31.01.25</p> <p>31.03.25</p>
30.	We found that ward staff meetings did not always take place on a regular basis on Gwanwyn Ward.	The health board must ensure ward staff meetings are conducted on a regular basis to facilitate staff engagement, discuss ward issues and share feedback following concerns or incidents.	People engagement, feedback and learning	<p>Put in place annual cycle of monthly ward staff meetings, share details with staff in Ward Managers' meetings.</p> <p>Circulate ward staff meeting minutes with all staff.</p>	<p>OPMHU Ward Manager</p> <p>OPMHU Ward Manager</p>	<p>31.12.24</p> <p>31.01.25</p>

				Encourage staff to contact the Ward Managers if they feel they want to raise any issues via Open Door approach.		31.01.25
31.	Several health board policies or procedures were past their review dates.	The health board must review any out-dated policies and procedures to support staff in their roles.	People engagement, feedback and learning	Provide monthly Policy report at MHLDSQDG meeting on progress with reviewing Written Control documents past their review date.	Governance Lead	31.01.25

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

Service representative:

Name (print): Carole Evanson

Job role: Interim Director of Nursing/Operations, Mental Health and Learning Disability Division

Date: 08/01/2025



Teitl adroddiad:	Mental Health Act (MHA) Associate Hospital Manager Report			
Report title:				
Adrodd i:	Mental Health Legislation Committee			
Report to:				
Dyddiad y Cyfarfod:	06/02/205			
Date of Meeting:				
Crynodeb Gweithredol:	<p>People who are subject to detention or Community Treatment Orders under the Mental Health Act can ask for their case to be reviewed by the Hospital Managers for possible discharge. Some renewals of a detention also trigger a review. The term Hospital Managers is used in the Mental Health Act to describe the organisation (i.e. the Health Board). This review and discharge power cannot be exercised by any employee of the organisation and so the Health Board has a number of people it can call upon to act on its behalf; these people are called Associate Hospital Managers (AHMs). Associate Hospital Managers are volunteers who are formally appointed by the Health Board and act independently on its behalf. They are not paid but receive allowances for the sessions they attend. They are not an employee of the organisation and are not allowed to have any financial interest in it.</p> <p>AHMs sit as part of a three-member panel appointed specially to look at whether people should be discharged from detention under the Mental Health Act.</p> <p>In this important role, AHMs ensure that patients' rights are fully explored and upheld. This requires the consideration of reports from the clinicians involved in a patient's care, and the views of the patient if given, before determining whether the criteria for detention are met.</p>			
Executive Summary:				
Argymhellion:	The Committee is asked to note the report.			
Recommendations:				
Arweinydd Gweithredol:	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
Executive Lead:				
Awdur yr Adroddiad:	Matthew Joyes, Deputy Director for Legal Services			
Report Author:				
Pwrpas yr adroddiad:	Purpose of report: I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd:	Arwyddocaol <i>Significant</i> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>High level of confidence/evidence in delivery of existing mechanisms/objectives</small>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>General confidence / evidence in delivery of existing mechanisms / objectives</small>	Rhannol <i>Partial</i> <input checked="" type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>Some confidence / evidence in delivery of existing mechanisms / objectives</small>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small> <small>No confidence / evidence in delivery</small>
Assurance level:				

<p>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:</p> <p><i>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:</i></p>	
<p>Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. Subject to capacity being restored to the team, the aim would be to include this in the next report.</p>	
<p>Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i></p>	<p>Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning</p>
<p>Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i></p>	<p>This report is generated quarterly. The Mental Health Act requires 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.</p>
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	<p>The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.</p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>N/A</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>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 has addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level. An advert has recently been shared on social media platforms, within the local university and with Welsh Language colleagues to promote the role.</p> <p>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:</p>

	<ul style="list-style-type: none"> • 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	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	<p>This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services.</p> <p>Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.</p>
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 N/A	
Rhestr o Atodiadau: List of Appendices: AHM Report	

1 Hearings

Hearings are held both remotely via Microsoft Teams and face to face.

26 hearings were held during the months October - December 2024.

13 held face to face and 13 via Teams. The hearings consisted of 17 section 3 renewals, six Community Treatment Orders (CTO) renewals, one section 47 renewal, two section 37 renewals, one discretionary review, and one section 3 appeal.

There have been no discharges to date for this period.

A breakdown of the hearing activity is below:

October

- **8 hearings arranged (six held); two held face to face and four via Microsoft Teams.**
All hearings were in relation to renewals.

Two of the eight hearings were postponed

- One was due to the Responsible Clinician taking urgent leave at the time of the hearing.
- Another was postponed due to the patient contesting the renewal (contrary to renewal proforma). Therefore, time was required for the patient to identify and instruct legal representative.

Outcomes of hearings held

- All detentions were upheld.

November

- **20 hearings arranged (14 held); six held face to face and eight via Microsoft Teams.**

All hearings were in relation to patient appeals.

Three of the hearings were cancelled

- These patients had been regraded to informal status by their respective Responsible Clinicians.

Two hearings were postponed

- One was moved to the following week, and was still held within the quality standard.
- Another was postponed due to reports not being received in sufficient time.
- One (discretionary) hearing was postponed as the Responsible Clinician was off work. This was then held the following month.

One hearing was adjourned

- The patient decided he wanted an alternate legal representative. The hearing was held the following week.

Outcomes of hearings held

- All detentions were upheld

December

- **12 hearings arranged (Six held); Five held face to face and one held via Microsoft Teams.**

Four hearings were relating to renewals, one was an appeal hearing, and one hearing was a discretionary review.

Two hearings were cancelled

- The patients had been regraded to informal status by their respective Responsible Clinicians.

Four hearings were postponed

- Three were due to the Responsible Clinician no longer being available.
- One hearing was postponed due to the legal representative not being available.

Outcomes of hearings held

- All detentions were upheld

Patient's choice of venue (Teams or Face to Face)

Patients with capacity are asked regarding the venue of their hearing. This is now a routine procedure. The patient's choice would be respected and was in all these cases.

Hearing Quality Standard

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 quality standard is set at 6 weeks 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. For those that appeal against their section 2 the quality standard is set at a week the same as a Mental Health Review Tribunal.

Currently 69.5% of hearings were held within the set quality standard.

Renewal Date	Hearing Date	Quality Standard (6 weeks = 42 days)
01/08/2024	02/10/2024	62 *1
22/09/2024	04/10/2024	21
14/09/2024	17/10/2024	33
23/08/2024	24/10/2024	66 *2
29/09/2024	28/10/2024	29
28/09/2024	29/10/2024	31

07/10/2024	06/11/2024	30	
12/08/2024	07/11/2024	48	*3
23/08/2024	12/11/2024	50	*4
19/10/2024	12/11/2024	24	
19/10/2024	13/11/2024	25	
15/10/2024	21/11/2024	37	
23/11/2024	22/11/2024	0	
18/10/2024	22/11/2024	35	
25/10/2024	25/11/2024	31	
24/07/2024	26/11/2024	124	*5
04/10/2024	26/11/2024	54	*6
20/11/2024	27/11/2024	7	
28/11/2024	28/11/2024	0	
13/11/2024	06/12/2024	23	
17/11/2024	16/12/2024	29	
31/07/2024	19/12/2024	141	*7
23/11/2024	19/12/2024	34	
Discretionary review following renewal hearing			
	31/12/2024	Discretionary Review	
Appeal by Patient Date	Hearing Date and section	Quality Standard (7 days for a section 2)	
25/11/2024	31/12/2024 s3	36	

*1 This hearing was initially scheduled to take place on the 29th August, however due to reports not being submitted from the clinical team in sufficient time, the hearing was rescheduled to allow the patient a fair hearing.

*2 Delay due to lack of staff covering the West MHA office.

*3 Delay due to lack of staff covering the East MHA office

*4 Delay due to lack of staff covering the West MHA office.

*5 Delay due to lack of staff covering the West MHA office.

*6 The patient's section was renewed whilst inpatient at Heddfan unit (East). However, the hearing was not held prior to the patient's transfer to the Ablett (Central), resulting in a delay. The hearing was then organised with the new clinical team.

*7 This hearing was initially arranged to take place on 31st October, however was postponed due to the patient's ill-health. This delay ensured the patient was able to be part of his renewal hearing.

Teitl adroddiad: Report title:	Power of Discharge Group Chair's Assurance Report			
Adrodd i: Report to:	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: Date of Meeting:	06 February 2025			
Crynodeb Gweithredol: Executive Summary:	The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services.			
Argymhellion: Recommendations:	The Committee is asked to note this report.			
Arweinydd Gweithredol: Executive Lead:	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: Report Author:	Matthew Joyes, Deputy Director for Legal Services (Chair of the PoD Group)			
Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: Assurance level:	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/ tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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:				
N/A				
Cyswllt ag Amcan/Amcanion Strategol: Link to Strategic Objective(s):		Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning		
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:		This report is generated quarterly. The Mental Health Act (MHA) and MHA Code of Practice for Wales (CoPW) requires 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? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	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.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i>	N/A
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i>	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i>	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i>	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services. Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.
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) <i>Reason for submission of report to confidential board (where relevant)</i>	N/A
Camau Nesaf: Gweithredu argymhellion <i>Next Steps: Implementation of recommendations</i> N/A	
Rhestr o Atodiadau: <i>List of Appendices:</i> N/A	



Chair's Report

Report to:	Mental Health Legislation Committee
Report from:	Power of Discharge Group Chair's Assurance Report
Report date:	January 2025
Presented by:	Matthew Joyes, Deputy Director for Legal Services (Chair of the PoD Group)

Purpose of the group	<p>Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'.</p> <p>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'.</p> <p>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)</p> <p>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)</p> <p>In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels, made up of Associate Hospital Managers who are not employees. They are directly accountable to the Board in the execution of their delegated functions via the Mental Health Legislation Committee. (CoPW 37.6)</p> <p>The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services; reports are produced and presented by the Mental Health Act Manager to the group.</p>
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Summary of business conducted	<p>The most recent Power of Discharge Group meeting was held on 28 January 2025.</p> <p>A summary of the business is as follows:</p> <ul style="list-style-type: none">• The group reviewed the MHA Assurance Report;• The group reviewed the Associate Hospital Managers Update Report – the group requested an action to look at the trend in relation to discharges by the Responsible Clinician prior to a hearing;• The group reviewed the HIW Assurance Report – the group discussed whether MHA status in medication charts could be an area for them to consider in their scrutiny;• The group discussed the proposed changes to the MHA in the new Mental Health Bill and raised a number of positive observations and some concerns;• The group noted the continued staffing pressures within the MHA Team.
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Teitl adroddiad:	Mental Health Bill 2025			
Report title:				
Adrodd i:	Mental Health Legislation Committee			
Report to:				
Dyddiad y Cyfarfod:	06 February 2025			
Date of Meeting:				
Crynodeb Gweithredol:	On 6 November 2024, a new Mental Health Bill (2025) was presented in Parliament by the government. The Bill has now been published, alongside explanatory notes, and it introduces several significant changes to the Mental Health Act (the Act). The Bill has already passed its second reading in the House of Lords and has now entered Committee stage.			
Executive Summary:				
Argymhellion:	The Committee is asked to note the report			
Recommendations:				
Arweinydd Gweithredol:	Teresa Owen, Executive Director of AHPs and Health Sciences Pam Wenger, Director of Corporate Governance			
Executive Lead:				
Awdur yr Adroddiad:	Matthew Joyes, Deputy Director for Legal Services			
Report Author:				
Pwrpas yr adroddiad:	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
Purpose of report:				
Lefel sicrwydd:	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/>	Derbyniol <i>Acceptable</i> <input type="checkbox"/>	Rhannol <i>Partial</i> <input type="checkbox"/>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>
Assurance level:	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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:				
N/A – information item				

Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	This paper provides an overview of the draft Bill.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</i>	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	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) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i>	N/A
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i>	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i>	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i>	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services.
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: Next Steps: N/A	
Rhestr o Atodiadau: List of Appendices: Briefing - Mental Health Bill 2025	



Briefing - Mental Health Bill 2025

The Mental Health Act 2007 amended parts of the Mental Health Act 1983 and importantly extended the rights of people diagnosed with mental illness. However, much of the current legislation is over 40 years old and does not reflect modern understanding of mental illness.

On 6 November 2024, a new Mental Health Bill (the Bill) was presented in Parliament by the UK Government. The Mental Health Bill (the Bill) was introduced in the House of Lords and once progressed through that House, will progress through the House of Commons.

As health is a devolved matter, the Bill is subject to the legislative consent process. This is when the consent of the Welsh Parliament is sought by the UK Government to legislate on an issue which falls within the competence of the Senedd.

The Bill has already passed its second reading in the House of Lords, and is now in Committee stage.

The government has said that the primary aims of the Bill are to strengthen the voice of patients subject to the Act, to add statutory weight to patients' rights to be involved in planning for their care and to inform choices regarding their treatment. The reforms are designed to ensure that detention under the Act it is only used when, and for as long, as necessary. Additionally, the reforms aim to limit the use of the Act to detain people with learning disabilities and autism.

The proposed reforms are in response to recommendations for legislative change made by an Independent Review of the Act, spearheaded by Professor Sir Simon Wessely in 2018. Whilst the Bill closely mirrors the version published by the preceding UK government in 2022, it has been revised to incorporate recommendations previously made by the Joint Committee of both Houses of Parliament.

This report provides a summary of the critical elements of the Bill.

Additional principles to be added to the Code of Practice:

The Bill amends the "statement of principles" that must be included in the Mental Health Act Code of Practice (which contains statutory guidance and sits alongside the Act). These principles should inform particular decisions taken under the Act, and must be included in both the Code of Practice for England and the Code of Practice for Wales. The principles are:

Principle	Matters to be addressed
Choice and autonomy	Involvement of patients in decision-making, and consideration of the views of carers and other interested parties.
Least restriction	Minimising restrictions on liberty so far as consistent with patient wellbeing and safety and public safety.

Therapeutic benefit	Effectiveness and appropriateness of treatment.
The person as an individual	Treating patients with dignity and respect and considering their attributes and past experiences.

Grounds for detention and community treatment orders (CTOs) – “risk of serious harm” criteria added:

The criteria for detention under sections 2 and 3 of the Act will be amended to ensure that people can only be detained under these sections if they pose a risk of serious harm either to themselves or to others.

There are two new tests that must be met before a person can be detained under section 2 of the Act (admission for assessment):

1. serious harm may be caused to the health or safety of the patient or of another person, unless the patient is detained; and
2. given the nature, degree and likelihood of the harm, the patient ought to be detained.

For detentions under section 5(4) of the Act (nurses’ holding power), there will also be a requirement for risk of serious harm unless the patient is immediately restrained from leaving the hospital.

For detention under section 3 (admission for treatment), the Act will be amended to state that the following criteria must be met:

1. serious harm may be caused to the health or safety of the patient or of another person unless the patient receives medical treatment;
2. it is necessary, given the nature, degree and likelihood of the harm, for the patient to receive medical treatment;
3. the necessary treatment cannot be provided unless the patient is detained under this Act; and
4. appropriate medical treatment is available for the patient.

These same criteria will apply when renewing a patient’s detention under section 20 of the Act, and the first two “harm” criteria will apply when making or renewing a CTO.

The Bill does not define “serious harm” but further guidance will be provided in the Code of Practice.

The Bill removes the obligation for clinicians to consider “how soon” harm might occur – a requirement which had been included in the previous 2022 draft Bill.

Autism and learning disability – requirement for a co-occurring mental disorder for detention for treatment under section 3:

Due to numerous concerns about people with a learning disability and autistic people being subject to inappropriate lengthy detentions, which may provide little or no therapeutic benefit, amendments will be made to the Act to ensure that this cohort of patients can no longer be detained for treatment under section 3 of the Act unless they have a co-occurring psychiatric disorder that meets the detention criteria.

It will also no longer be possible to place a person with a learning disability or an autistic person on a CTO unless they have a co-occurring mental health condition.

This exclusion does not apply to Part 3 patients (those in the criminal justice system).

New definitions of “autism”, “learning disability” and “psychiatric disorder” will also be included in the Act.

Appropriate medical treatment:

There will be a new requirement in the Act, in line with the principle of therapeutic benefit, that when considering whether medical treatment is “appropriate” for a patient, consideration must be given to whether there is a reasonable prospect that the outcome of the treatment will have a therapeutic benefit for that patient.

Changes to section 58 – treatment certification:

Section 58 of the Act applies to medication for mental disorder once three months have elapsed from the day on which treatment was first given to the patient. Under section 58, treatment can only be given to a patient after three months have passed if:

1. the patient consents to it and either the approved clinician or a second opinion appointed doctor (SOAD) certifies that the patient understands the nature, purpose and effects of the treatment,
2. a SOAD certifies that the patient is incapable of giving consent to the treatment but that the treatment is appropriate, or
3. a SOAD certifies that the patient has not consented to the treatment but that it is appropriate for them to receive it.

The Bill will amend the Act so that in scenarios 1 and 2 above, the three-month time period after which certification must be provided will be shortened to two months. The certification must confirm the treatment is appropriate, within the new meaning. The reason for this change is so that the use of compulsory medication where the patient lacks capacity/competence to consent receives independent scrutiny at an earlier point in the patient’s treatment course.

Further, if a patient has capacity and is refusing treatment (as in scenario 3 above), or if the patient lacks capacity and treatment is in conflict with an advance decision or a decision made by a donee or deputy or by the Court of Protection, treatment can only be given if there is a “compelling reason” to do so and a SOAD has provided certification. In this context, a “compelling reason” includes there being no alternative medication available or no alternatives that the patient accepts. Certification must be given before treatment is given, which is a significant change from the current legislation.

Changes to section 62 – urgent treatment to alleviate serious suffering

Section 62 of the MHA allows for treatment in urgent circumstances. This section permits treatment without the usual consent and/or certification requirements if it is immediately necessary to (a) save the patient’s life, (b) prevent a serious deterioration of their condition, (c) alleviate serious suffering, or (d) prevent the patient from behaving violently or being a danger to themselves or others.

However, the new Bill removes the power to administer urgent treatment to patients with the relevant capacity or competence on the basis that it is considered immediately necessary to alleviate serious suffering by the patient. This change will allow patients who have capacity or competence at the time to decide on the degree of suffering they are willing to accept, strengthening the patient’s right to self-determination and autonomy. This change does not apply to patients who lack the relevant capacity.

The ability to administer compulsory medication in the other urgent circumstances remains however, providing a backstop for exceptional situations.

Shortened detention periods

The Bill shortens the period that a patient admitted to hospital may be kept in detention for treatment. Under the Bill, the revised detention periods will be as follows:

- Initial detention period: 3 months (reduced from 6 months)
- First renewal period: 3 months (reduced from 6 months)
- Second renewal period: 6 months (reduced from 1 year)
- Successive renewal periods: 1 year

These changes will mean that a patient's initial detention period will expire sooner and if the patient's detention is to continue it must be reviewed and renewed more frequently.

Statutory care and treatment plans

The Bill will introduce statutory care and treatment plans for all patients formally detained under the Act. The main purpose of these new plans is to ensure that all patients have a clear and personalised strategy in place describing what is needed to progress them towards recovery and their timely discharge from the Act.

The Mental Health (Wales) Measure 2010 has the same legal status in Wales as the Mental Health Act. The Measure became law in December 2010. Part 2 of the Measure gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.

CTOs – requirement for consultation with the community clinician

The Bill will require the community clinician, responsible for overseeing the patient's care as a community patient, to be involved in decisions regarding the use and operation of CTOs. This covers the decision to make a person subject to a CTO, to vary or suspend conditions made under a CTO, to recall to hospital a patient subject to a CTO, and to revoke a CTO after a patient has been recalled. This is to introduce a further professional opinion and check on whether people really need the support of a CTO.

Change from nearest relative to nominated persons

In keeping with the previous draft Bill, the Bill includes the new statutory role of "nominated person". The nominated person will replace the role of "nearest relative", as the Independent Review found the current model of nearest relative to be outdated and insufficient.

The new Bill allows a patient to personally select a nominated person to represent them and exercise the relevant statutory functions included within the Bill, at any time when they have capacity or competence to do so – although it is envisaged that nominations will be made either in advance of detention under the MHA or at the time of assessment for detention. This supports the principle of choice and autonomy. If someone lacks the relevant capacity / competence to make a nomination at the point of detention or at any other time, and has not previously nominated anyone, a nominated person can be appointed by an Approved Mental Health Professional (AMHP).

The nominated person will have the same rights and powers as the nearest relative has now, but will also be given new ones, such as the right to be consulted about statutory care and treatment plans, renewals and extensions of the patient's detention and transfers between hospitals, and the power to object to the use of a CTO.

Tribunal reviews

The Bill enhances patient accessibility to the First-tier Tribunal (Mental Health) for England and Mental Health Review Tribunal of Wales (MHRTW). In particular, patients detained under section 2 will be able to apply to the Tribunal within 21 days following their detention (an extension from the current 14-day period). Further, should a patient not utilise their right to apply to the Tribunal, automatic referrals must be made earlier and at more frequent intervals – three months from the date of detention and every 12 months thereafter.

Requirement to consult before discharge

Currently, the patient's responsible clinician (RC) has the power to unilaterally decide to discharge an individual from detention under section 2 or section 3. The Bill will introduce a new requirement for the RC to consult with a person who has been professionally concerned with the patient's treatment, and who belongs to a different profession to them, before they can discharge the patient. The same will apply in the case of an RC discharging a patient from guardianship. Where someone is under a CTO, the RC must consult with the community clinician (if they are not themselves the community clinician) before they discharge from the CTO. This amendment seeks to formalise best practice and ensure safer discharge from a hospital bed.

Removal of police stations and prisons as places of safety

Prisons and police cells will be removed as "places of safety" under the Act. This is in response to evidence that suggests these settings are not suitable environments for individuals with a severe mental health, in crisis, awaiting assessment and treatment. Alternatives, such as hospitals and other healthcare-based settings, are more appropriate.

Increased access to Independent Mental Health Advocates (IMHAs)

The Bill will extend the right of access to IMHAs to voluntary patients (i.e. those not detained under the Act), and detained patients will be automatically referred to an IMHA provider.

Advance Choice Documents

The new Bill takes a different approach in relation to Advance Choice Documents, which are written records of a person's wishes, feelings and decisions about their care and treatment, made when the person has the relevant capacity or competence. Clinicians must have regard to these documents, but not necessarily follow them, when providing treatment under the Act. The new Bill seeks to introduce duties on Integrated Care Boards (ICBs), NHS England and Local Health Boards (Wales) to make arrangements so that people at risk of detention are informed of their ability to make an Advance Choice Document, and (if they accept) are supported to make one.


Time limits on transfers from prison to hospital

Under the Act, the Secretary of State is permitted to transfer mentally disordered persons from prisons and other places of detention to hospital for treatment. The new Bill introduces a statutory 28-day time limit within which agencies must seek to ensure individuals who meet the criteria for detention under the Act are transferred to hospital for treatment. This mirrors an approach consistent with good practice guidance on this issue.



Teitl adroddiad: <i>Report title:</i>	Advocacy Services across North Wales			
Adrodd i: <i>Report to:</i>	Mental Health Legislation Committee (MHLC)			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 06 February 2025			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>Betsi Cadwaladr University Health Board commissions a range of advocacy provision so that people are supported to say what they want, secure their rights, represent their interests and obtain the services they need, in order to:</p> <ul style="list-style-type: none"> Meet statutory requirements detailed in the Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010. Ensure service users rights are upheld and the local population has access to appropriate advocacy services to meet their needs <p>The attached report gives the legislative basis for the statutory service, eligibility and the different circumstances where this is appropriate.</p>			
Argymhellion: <i>Recommendations:</i>	<p>The Committee is asked to:</p> <p>Note the content of the report.</p>			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Teresa Owen, Executive Director of Allied Health Professionals and Health Science			
Awdur yr Adroddiad: <i>Report Author:</i>	Joanne Janes, MH&LD Commissioning Manager			
Pwrpas adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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:				

<p>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:</p>	
<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p>Link to Strategic Objective(s):</p>	<p>Improve physical, emotional and mental health and well-being for all – Living Healthy Staying Well</p>
<p>Goblygiadau rheoleiddio a lleol:</p> <p>Regulatory and legal implications:</p>	<p>The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires all Health Boards to ensure the provision of Independent Mental <u>Capacity</u> Advocacy (IMCA) for qualifying compulsory and informal patients in Wales.</p> <p>The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires all Health Boards to ensure the provision of Independent Mental <u>Health</u> Advocacy (IMHA) for qualifying compulsory and informal patients in Wales.</p> <p>The provision of the IMHA service forms Part 4 of the Mental Health Measure. This has time critical requirements and the performance outcomes have to be reported to Welsh Government (WG) on a quarterly basis.</p>
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</p>	<p>An Equality Impact Assessment was completed nationally ahead of the commissioning of the North Wales Community Advocacy recommission. The assessment did not identify any negative impacts on groups with demonstrated characteristics and a positive impact for some of the groups.</p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP68, has an SEIA identified as necessary been undertaken?</p>	<p>A Socio-Economic Impact Assessment was completed nationally ahead of the commissioning of the Community Advocacy recommission. The assessment did not identify any negative impacts on groups with demonstrated characteristics and a positive impact for some of the groups.</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</p>	<p>Failure to have an Independent Mental Health Advocacy (IMHA) and Independent Mental Capacity Advocacy (IMCA) means that the Health Board will fail to meet the legal requirements described in the Mental Health Act 1983 and the Mental Health Measure Part 4, which may result in a legal challenge by patients or intervention by Welsh Government.</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p>	<p>N/A</p>

Financial implications as a result of implementing the recommendations	
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- 06 - Safe and Effective Mental Health Service Delivery as the health board is in breach the duty to provide Statutory Independent Mental Health Advocacy Service if there is any break in the provision of the service.
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: To be agreed	
Rhestr o Atodiadau:	
Appendix 1	Mental Health Measure Part 4 submission  Mental Health Measure Part 4 Pro F

MENTAL HEALTH LEGISLATION COMMITTEE

6th February 2025

ADVOCACY SERVICES ACROSS NORTH WALES

Introduction/Background

Betsi Cadwaladr University Health Board has a number of contracts in place for a range of advocacy services to meet statutory requirements and ensure the local population has access to appropriate advocacy services. These are delivered via three separate contracts, namely:

Service	Commissioned by
Independent Mental Health Advocacy (IMHA) (Statutory Advocacy)	Mental Health & Learning Disability Directorate
Independent Mental Capacity Advocacy (IMCA) (Statutory Advocacy)	Corporate Safeguarding service
Community Advocacy (non-statutory)	Mental Health & Learning Disability Directorate

Independent Mental Health Advocacy (IMHA) (Statutory Advocacy)

All health boards have a statutory duty to instruct and make available an Independent Mental Health Advocacy (IMHA) service. The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires all Health Boards to ensure the provision of independent Mental Health advocacy for qualifying compulsory and informal patients in Wales.

Under the Act the following people over the age of 16 are legally entitled to have an IMHA advocate.

- i) People who are detained under the Mental Health Act 1983, except where:
- They have been detained in an emergency under Section 4
 - They have been detained under Section 5 holding powers
 - They have been taken to a place of safety under Section 135 and 136 of the Mental Health Act
- ii) People who are "liable to be detained" including:
- Where people are on leave of absence from hospital
 - Where people are absent without leave from hospital
 - Where a court order or application for admission has been made
 - Where people are subject to a community treatment order (CTO)
 - Where people are subject to guardianship
 - Where people are a conditionally discharged restricted patient
 - where people are a voluntary/informal patient and certain treatments, including neurosurgery, are being considered for them

The purpose of the IMHA service is to provide assistance to qualifying patients to ensure that they understand the legal procedures of the Act and the rights and safeguards to which they are entitled.

This may include assistance in obtaining information about any of the following:

- The patient’s rights under the Act
- The provision of the Act under which the patient qualifies for an IMHA
- Any conditions or restrictions to which the patient is subject
- The medical treatment the patient is receiving, or which is being proposed or discussed, and the reasons for this
- The legal authority for providing such treatment
- The requirements of the Act which apply in relation to treatment

The responsibility for commissioning and managing the service sits with the Mental Health and Learning Disabilities Division (MH&LD), and Conwy and Denbighshire Advocacy Service (CADMAS) have been commissioned to deliver the regional Independent Mental Health Advocacy service. The contract has been in place since February 2022 and runs until 31st March 2027.

The current service specification for the service for the IMHA was developed on an All Wales basis to ensure the consistency for the service across Wales. North Wales Shared Services Partnership (NWSSP) advertised the tenders as individual ‘lots’ for each Health Board and the separate contracts are between each individual Health Board and the successful provider. The provider CADMAS secured the contract for BCUHB and Powys Health Board through the competitive tender process.

The contract is performing well against the specification with positive feedback from service users. Monitoring and reporting is completed on a quarterly basis, and always on time with in-depth information including activity data, arising themes and issues and service users’ feedback. The service deals with approximately 250 cases per quarter.

The service has a statutory 5 day response time scale for responding to a request for an IMHA. The table below provides details of the response times for the 2023/24 period, and demonstrates there have been no breaches of the ‘time’ requirements.

Response times 2023 - 24				
	ALL	Long Term (Formal)	INFORMAL	Short Term
Within 4 hours	34	19	14	1
Same Day	559	446	111	0
Next Day	158	111	46	1
Within 2 days	149	114	35	0
Within 3 days	113	84	29	0
Within 4 Days	43	39	4	0
Within 5 Days	89	68	19	2
Within 10 Days	0	0	0	0
Within 15 Days	0	0	0	0
More than 15 Days	0	0	0	0

As the service forms Part 4 of the Mental Health Measure, the contract activity and performance are reported to the Welsh Government using a prescribed template. (Appendix 1 is an example of Part 4 Mental Health Measure submission)

Independent Mental Capacity Advocacy (IMCA) (Statutory Advocacy)

All health boards have a statutory duty to instruct and make available an Independent Mental Capacity Advocacy (IMCA) service. The Mental Capacity Act 2005 (MCA) introduced the role of the Independent Mental Capacity Advocate (IMCA). IMCAs as a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. The Act is supported by Welsh Regulations and two statutory Codes of Practice

Under the Mental Health Act 1983, amended by the Mental Health (Wales) Measure 2010, the Health Board has a duty to make appropriate arrangements to enable IMCAs to be available and also to instruct an IMCA to support an individual to all qualifying patients in its area.

The Act covers decisions and actions taken on behalf of adults, aged 16 years and over, who lack capacity to make the decision in question themselves.

Patients that qualify for an IMCA include:

Compulsory patients who:

- are liable to be detained under the 1983 Act (which include in a hospital or registered establishment, whether in a hospital or registered establishment located within the area of the Local Health Board, and are present in the area of the Local Health Board at the time when the independent mental health advocacy service is to be provided;
- are subject to guardianship under the 1983 Act or are a community patient and are present in the area of the Local Health Board at the time when the independent mental health advocacy service is to be provided; or
- qualify under Section 130I(3) of the 1983 Act and are present in the area of the Local Health Board at the time when the independent mental health advocacy service is to be provided;

and also, informal patients who are:

- inpatients in a hospital or registered establishment situated in the Local Health Board's area;
- receiving treatment for, or assessment in relation to, mental disorder at that hospital or registered establishment; and
- not subject to powers under the 1983 Act which would render them liable to be detained.

The purpose of the Mental Health Capacity Advocate supports people, irrespective of age or diagnosis, to understand their rights under the said Act and participate in decisions about the care and treatment they receive for their mental disorder.

The circumstances where an IMCA would need to be appointed include:

- Any serious medical treatments
- A move to a hospital that would be for more than 28 days
- A move to a care home that would be for more than 8 weeks
- Any circumstance which is likely to result in the patient being deprived of their liberty

In addition, an IMCA would need to be appointed / referred if the person/patient lacks capacity to make a decision about either:

- A Care review (if he/she has no 'appropriate' family and friends)
- An Adult Protection referral (whether he/she is the victim or alleged perpetrator, regardless of whether they have family and friends)
- An IMCA can challenge decisions made by a decision maker, including the capacity assessment itself. They are allowed to meet with the client in private and can ask to see all relevant health, social services and care home records.

Similar to the IMHA service, the current specification for the service for the IMHA was developed on an All-Wales basis to ensure the consistency for the service across Wales. NWSSP advertised the tenders as individual 'lots' for each Health Board and the separate contracts are between each individual Health Board and the successful provider. The provider CADMAS secured the contract for BCUHB and Powys Health Board.

The responsibility for commissioning and managing the service sits with the Corporate Safeguarding Team. Conwy and Denbighshire Advocacy service (CADMAS) have been commissioned to deliver the North Wales and Powys Independent Mental Health Advocacy service. The contract has been in place since February 2022 and runs until 31st March 2027.

The current contract has been in place since the 1st of June 2024 and was subject to a full tender process. The contract runs until the 31st of March 2026 with an option to extend for two further periods of up to one year each time taking the awarded contract up to the 31st of March 2028.

The contract is performing well with positive feedback from service users. Monitoring and reporting is completed on a quarterly basis and always on time with in-depth Information including activity data, arising themes and issues and service user's feedback. The service deals with approximately 150 cases per quarter.

The service has a statutory 5-day response timescale for responding to a request for an IMCA. The table below provides details of the response times for the 2023/24 period, and demonstrates there were no breaches of the time requirements.

Response times 2023 - 24							
	ALL	ANG	CON	DENB	FLINT	GWYN	WRX
Within 4 hours	6	0	1	1	3	1	0
Same Day	37	2	12	9	6	6	1
Next Day	31	4	5	4	9	9	0
Within 2 days	68	7	8	23	17	8	5
Within 3 days	0	0	0	0	0	0	0
Within 4 Days	0	0	0	0	0	0	0
Within 5 Days	0	0	0	0	0	0	0
Within 10 Days	0	0	0	0	0	0	0
Within 15 Days	0	0	0	0	0	0	0
More than 15 Days	0	0	0	0	0	0	0

New legislation around the Liberty Protection Safeguards (LPS) which form part of the Mental Health Act were due to be implemented in 2022. This has been delayed by the former government and there is no date for implementation, so the Deprivation of Liberty Safeguards (DoLS) remains in place.

Community Advocacy

Although not a statutory requirement, the Mental Health and Learning Disabilities Division currently commissions three Community Advocacy services across the region.

The current contracts are delivered on an Integrated Health Community (IHC) footprint by three different providers.

Integrated Health Community (IHC) area	Provider
East	Advocacy Services North East Wales (ASNEW)
Central	Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS)
West	North Wales Advice and Advocacy Association (NWAAA) with support from CADMHAS

The Community Advocacy service is focussed on early intervention and prevention support that will enable and empower people by supporting them to say what they want, secure their rights, represent their interest, resolve their issues and prevent the escalation of issues. The service plays an important role in providing advocacy where vulnerable people fall outside the eligibility criteria for statutory provision. The service is for people aged 18 (16 years and over if known to Child and Adolescent Mental Health Services (CAMHS)).

The service includes:

- Supporting people to address specific issues and life events (such as difficulty accessing services or addressing poor experiences of services)
- Providing assistance (by way of representation or otherwise) to persons for purposes relating to the issues they present with
- Supporting people to find and understand relevant information from appropriate sources
- Supporting people to access, engage with and understand generalist and specialist advice services
- Assisting people to talk to third parties or to talk to them on their behalf (this might include helping a person to write a letter or email, support with making phone calls or assistance with preparing for and attending meetings)

The service is available to, but is not restricted to:

- Adults with mental health problems
- Adults with learning difficulties
- Adults in receipt of NHS Continuing Health Care

The provision of the Community Advocacy service supports both service users and also statutory advocacy provision as it enables service users to retain advocacy support when they no longer meet the legislative criteria for a statutory advocate, thus releasing capacity within the statutory advocacy service.

In particular, the service supports the discharge of patients from Mental Health Hospitals by being based at the hospitals to provide support and representation for issues such as, financial / benefit claims and housing provision prior to discharge. This can reduce potential delayed discharges and the risk of escalation of issues after discharge. This is particularly important and relevant given the increase in utilisation of out of area beds and the work ongoing to tackle this.

The service sees on average 700 service users per year. The providers have stated that the demand for advocacy is increasing, this is due to a number of reasons including changes in legislation and policy, changing demographics with people living longer, welfare reforms, reduction in funding for public services, changes to eligibility criteria and also the desire to improve service user experience, which have all had an impact.

The issues that people present with are far ranging and often include more than one issue, the primary referral issue includes -

Primary Referral Issue	
Financial Abuse	Financial
Domestic / Sexual Abuse	Housing
Access to Services	Information
Benefits & Medicals	Legal
Care Provision	CAMHS transition
CAMHS	Care & Support Reviews
Complaints	Support at Appointments
Criminal	Support at Meetings

Debt / Bankruptcy	Understand Rights
Discharge	Accessing services
Divorce	Employment

Referrals are predominantly self-referral but a number of other agencies also refer to the services including

- Mental Health hospitals
- Third Sector Organisations
- Statutory advocates
- Care homes
- Adult social care
- Community Mental Health Teams
- Citizens Advice
- Housing services
- Family / Friends
- Carer's organisations
- CAMHS

The contracts have been in place since 01/07/2015 and all expire in March 2025. The MH&LD Division are seeking approval from the Divisional Senior Leadership Team and Executives to recommission the service and that the contracts be let on a 3-year term with options to extend by a further two x one-year options.

The contracts are performing well with good feedback from service users. Monitoring and reporting is completed on a quarterly basis and always on time with in-depth Information including activity data, arising themes and issues, service users' feedback and case studies. The service deals with approximately 250 cases per quarter.