Bundle Mental Health Legislation Committee 2 May 2024

1 Opening Business

1.1 09:30 – MH24.5 – Apologies – Verbal – Chair

1.2 09:32 – MH24.6 – Declarations of Interest – Verbal – Chair

1.3 09:34 – MH24.7 – Minutes from the Previous Meeting – Attached – Chair
MH24.7 – Draft Minutes from the Previous Meeting

1.4 09:39 – MH24.8 – Matters Arising & Table of Actions
There were no action from the previous meeting

2 For Assurance

2.1 09:41 – MH24.9 – Mental Health Assurance Report – Attached – Deputy Director of Quality
MH24.9 – Mental Health Assurance Report
MH24.9 Appendix 1 MHAct Performance Report Jan-Mar 24
MH24.9 Appendix 2 S136 BCUHB Report March 2024
MH24.9 Appendix 3 S136 CAMHS Report March 2024
MH24.9 Appendix 4 Memo to Consultants and Independent Doctors
MH24.9 Appendix 5 Analysis of MHA training
MH24.9 Appendix 6 Compliance with the MHA Quarterly Audit Report Q1

2.2 09:56 – MH24.10 – Mental Capacity Assurance Report – Attached – Head of Safeguarding
MH24.10 – Mental Capacity Assurance Report

2.3 10:11 – MH24.11 – HIW Assurance Report – Attached – Deputy Director of Quality
MH24.11 – HIW Assurance Report

2.4 10:26 – MH24.12 – Associate Hospital Managers Update Report – Attached – Deputy Director of Quality
MH24.12 – Associate Hospital Managers Update Report

2.5 10:41 – MH24.13 – Report from the Power of Discharge (Associate Managers) Group – Attached – Deputy Director of Quality
MH24.13 – Report from the Power of Discharge (Associate Managers0) Group (2)
MH24.13a – Terms of Reference PoD V4.1 Review (2)

3 Closing Business

3.1 10:56 – MH24.14 – Agree Items for referral to Board / other Committees – Verbal – Chair

3.2 10:58 – MH24.15 – Review of Risks highlighted in the meeting for referral to Risk Management Group – Verbal – Chair

3.3 11:03 – MH24.16 – Agree items for Chairs Assurance Report – Verbal – Chair

3.4 11:05 – MH24.17 – Review of Meeting Effectiveness – Verbal – Chair

3.5 11:10 – MH24.18 – Date of Next Meeting – Verbal – Chair
1 August 2024

Mental Health Legislation Committee (MHLCCC)

Minutes of the Mental Health Legislation Committee meeting

held on 11th January 2024

Via Teams / Boardroom, Carlton Court

Present:

Gareth Williams	Health Board Vice Chair (Chair)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member

In Attendance:

Louise Bell	Assistant Director Children and Adolescents Mental Health Services
Phil Meakin	Interim Board Secretary and Associate Director of Governance
Matthew Joyes	Deputy Director of Quality
Carol Shillabeer	Chief Executive
Chris Walker	Head of Adult Safeguarding
Ceri McGaugie	Senior Secretary
Teresa Owen	Executive Director of Public Health
Ros Alstead	Advisor on Mental Health
Alberto Saimoiraghi	Consultant Psychiatrist/Medical Director, Mental Health and Learning Disabilities

Agenda item	Action
MH24/1 Welcome, introduction to Committee and apologies for absence The Chair welcomed everyone to the meeting thanking attendees. The Chair also noted this was the first meeting since the major change in the Board in March 2023. He noted that the meeting was being recorded to be shared with Audit Wales as they were unable on this occasion to send a representative. **Apologies were received from** Wendy Lappin, Angela Wood, Sam Watson, Iain Wilkie	
MH24/2 Review of the Terms of Reference for the Committee The Committee was asked to review and endorse the draft Terms of Reference The Chair stressed the importance of focusing the work of the committee on the important statutory duties under the Mental Health Act and Mental Capacity Act and that the purpose of the Committee was not to scrutinise the broader strategy and operations of Mental Health services: it was important that other	

Committees, particularly Performance, Finance and Information Governance and Quality, Safety and Patient Experience saw mental health as much part of their remit as other parts of the health board's services. A draft of the Terms of Reference had been shared with the group prior to the meeting and changes suggested by members' incorporated into the document. Members agreed that the name of the Committee should be simplified to the Mental Health Legislation Committee (MHLC). After a short discussion it was agreed that references to the Mental Health Measure were not needed in the Terms of Reference but that the Court of Protection should be referenced. The Chief Executive asked whether the Committee had a role in overseeing the advocacy arrangements for Mental Health patients as these were also required by legislation. It was agreed that it did have such a role and that representatives of the Associate Hospital Managers should be standing invitees to the Committee. A question was raised about whether membership of the Committee might be broadened, in particular to local authorities and other agencies such as the police. After a short discussion it was agreed that, in line with other Committees and our Standing Orders, only Independent Members of the Board should be full members, though other agencies could and should be invited when relevant. The Chair noted that one of the members of the Committee was also the local authority nominated Independent Member which should assist good communication. The group also discussed the importance of having input from the clinical directors' from the Integrated Health Communities (IHCs) to the meetings, given that Children's and Adolescent Mental Health Services (CAMHS) which also came under the Committee's remit were managed by the IHCs. The Associate Director of CAMHS agreed to facilitate this. The Acting Board Secretary said that the amended Terms of Reference would be taken to the Board on 25th January for approval.	**PM/CM** **LB** **PM**
MH24/3 Developing a Cycle of Business for the Committee The Chair referred to the comments made by Wendy Lappin (who had given her apologies) in an email. He stressed that meetings would be held quarterly with dates set well in advance. It was also agreed that rather than have a quarterly rolling audit, the Committee should provide an Annual Report. There was general agreement on the strong focus on providing assurance to the Board that the Health Board was meeting its statutory obligations and that the Cycle of Business should therefore be kept relatively simple. The question of whether additional assurance about the welfare and well-being of detained patients might be gained from e.g. visits to acute wards should be kept under review. Reports from Advocates as well as the Associate Hospital Managers should be brought to the Committee	**MJ/PM**

The Chair suggested that in advance of the next meeting of the Committee, members should receive a briefing as a development session on the various sections of the Mental Health Act and Mental Capacity Act.	**PM**
MH24/4 Mental Health Legislation Compliance and Capacity meeting 13.12.23 The Committee noted the papers and minutes which had been circulated. It was agreed that the Committee could not appropriately sign off the minutes since none of the members had been present: this should be remitted to the Executive. However, the Executive should be asked to take into account the comments made by Wendy Lappin in her email. The Mental Health Adviser, Ros Alstead, asked about the fact that Associate Hospital Managers had agreed to lift a Section despite opposition from the consultant psychiatrist and asked if this was usual. The Associate Director of Quality assured her it was very unusual.	**PM**
16:30 - MH24/5 Date of next meeting 2nd May 2024 9:30am	

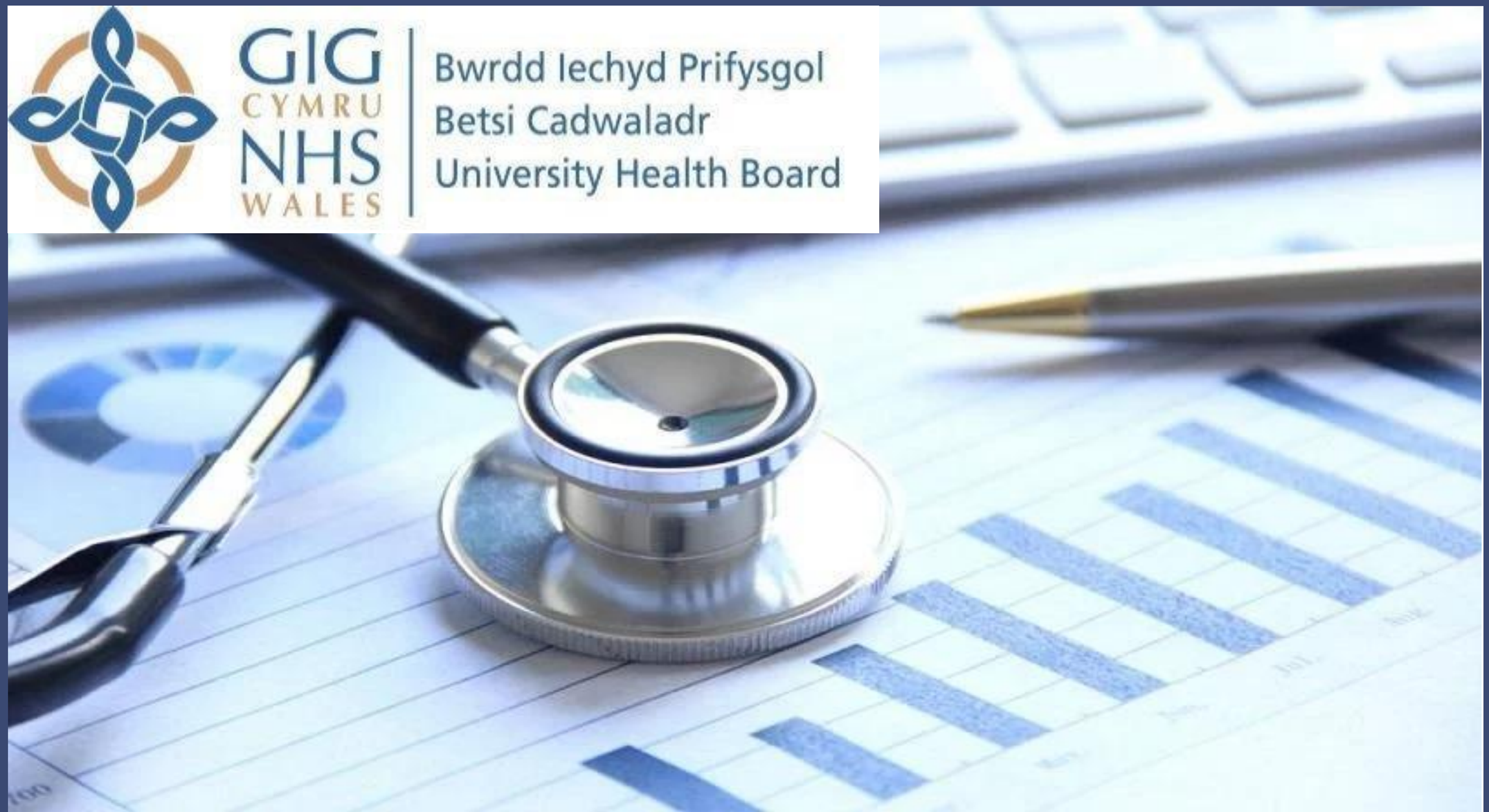
Teitl adroddiad: ***Report title:***	Mental Health Act Assurance Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee (MHLC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 02 May 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during January – March 2024. The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections. Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation. Lapsed sections are reported as 'exceptions' throughout the report, and invalid detentions recorded as 'fundamentally defective'. Any lapses or fundamentally defective sections are datixed and investigated. Up to date S136 reports are submitted to the Committee along with any ad hoc requests for information. A monthly report is submitted to the Deputy Director of Quality and the Medical Director for MHLD to ensure that the MHA is monitored with the exceptions highlighted including any mitigation and learning that has occurred. Appendices are included to support the report.			
Argymhellion: ***Recommendations:***	The Committee is asked to discuss and note the report and appendices.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Lead for Mental Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☒	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐

	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The use of the Mental Health Act is determined by patient need, and the priority is always to care for the patient under the least restrictive option.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.
Yn unol â WP7, a oedd 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 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?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The patient information recorded to produce the reports required for the Health Board, Welsh Government, and North Wales Police also assists the Health Board in the management of the Mental Health Act functions such as expiry dates, consent to treatment, patient history, movements and deadlines. This data is currently recorded within excel databases which have been identified as unsustainable and difficult to future proof due to the amount of data held and detentions the Health Board experiences. This was previously raised as a concern. Discussions are ongoing as to a more safe and robust way of storing and reporting data with a Digital Steering Group taking this forward as part of a wider improvement for the whole health board.

	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.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The increase in Mental Health Act detentions has financial implications.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None required
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	A monthly report is produced and the data submitted monthly to Alberto Salmoiraghi, Medical Director of Mental Health & Learning Disability Service and Matthew Joyes, Deputy Director of Quality. 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)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 MHA Committee Performance Report January – March 2024 Appendix 2 S136 BCUHB Report – March 2024 Appendix 3 S136 CAMHS Report – March 2024 Appendix 4 – Memo to Consultants and Independent Doctors Appendix 5 – Analysis of Mental Health Act Training Appendix 6 – Compliance with the Mental Health Act Quarterly Audit Report Q1	

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Mental Health Legislation Committee Performance Report

March 2024

CONTENTS:

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

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

Seven Domains

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

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

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Advisory Reports & Exception reports

Each report for the Mental Health Act will be presented as an advisory report.

Exceptions are noted throughout the report within this period reported on January - March) four sections lapsed and five detentions were considered to be fundamentally defective (two detentions were picked up on admission):

Fundamentally defective x 5

A **Section 3** detention was deemed to be fundamentally defective but on investigation it was found this was not the case, **Learning/Mitigation:** The MHA office staff have been appraised on what is deemed to be rectifiable under Section 15(1) and (2) for joint medical recommendations. 3 x **Section 2**'s were fundamentally defective two on admission and one following scrutiny (INC87047 & 89488 are still to be investigated)

Section 5(2) deeded fundamentally defective, the mental health unit was noted as the detention area when the patient was in the acute hospital (ED). **Learning/Mitigation**:Staff involved have been informed of the legal provisions for a S5(2).

Lapsed x 4

Section 5(4) - INC79390 section was used over the weekend, on call consultant not able to attend and advised that the section 5(4) be allowed to lapse, plan was that if needed this could be used again. **Mitigation**: There is a lack of on call provision for NWAS as mitigation the unit tries to identify early where mental health needs may be but this cannot always be mitigated against within the current processes.

Section 136 x 3 - 2 x Sections lapsed at the 36 hour timeframe due to patients not being fit for assessment. There is no mitigation in this regard one outcome was that an assessment was undertaken when fit and a detention enacted and one person did not require any formal detention. INC80255 section lapsed at 24 hour point, AMHP did not complete application due to no inpatient bed being available. Outcome was the patient was moved to the inpatient unit and a detention enacted when they were able to accomodate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

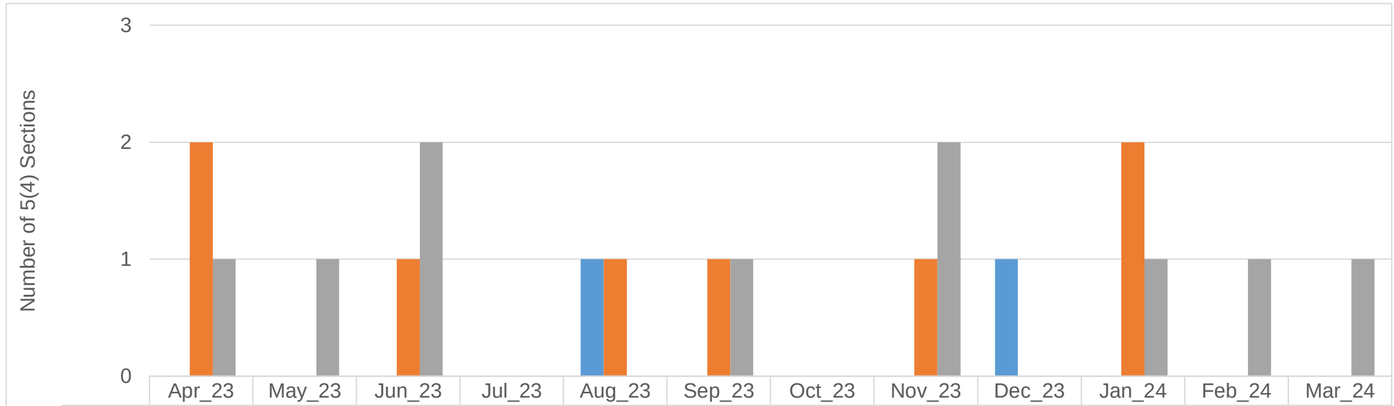
Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

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

Section 5(4) - BCUHB	March 2024	February 2024	Monthly Trend
Section 5: Application in respect of patients already in hospital	1	1	→

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

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



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	0	0	0	0	1	0	0	0	1	0	0	0
Centre	2	0	1	0	1	1	0	1	0	2	0	0
East	1	1	2	0	0	1	0	2	0	1	1	1

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

All sections this period met the criteria.

LAPSES

There was one 5(4) which lapsed this quarter Datix Ref 79390

WEST

The data above does	Duration (hh:mm)	Outcome

CENTRE

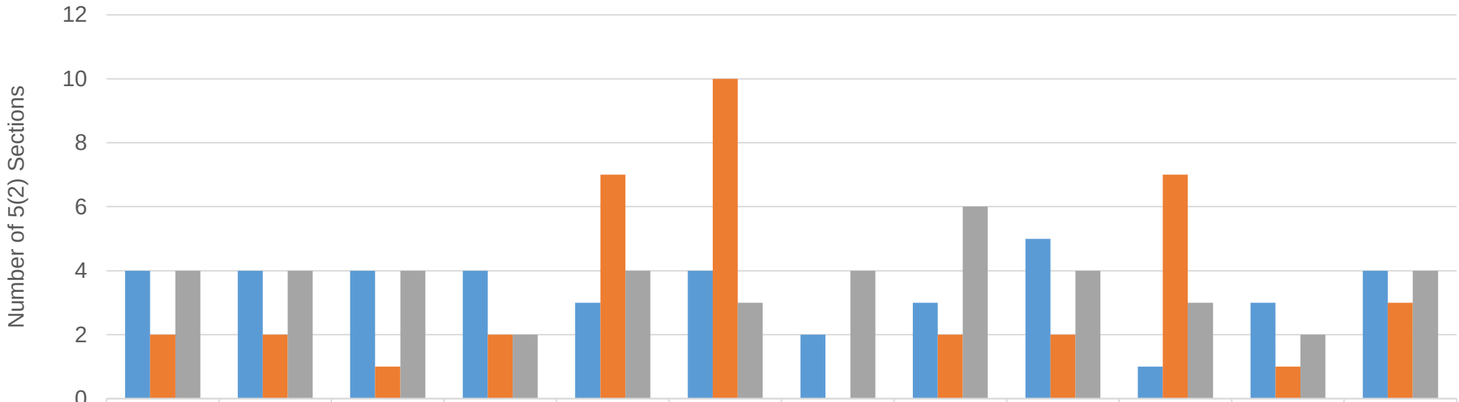
Month	Duration (hh:mm)	Outcome
Jan_24	02:55	Section 5(2)
Jan_24	06:00	Lapsed

EAST

Month	Duration (hh:mm)	Outcome
Jan_24	03:02	Section 5(2)
Feb-24	00:26	Section 5(2)
Mar-24	03:10	Section 5(2)

Section 5(2) - BCUHB	March 2024	February 2024	Monthly Trend
Section 5: Application in respect of patients already in hospital	11	6	↑

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
28	28	→	31	1	Centre	11
				2	East	9
				3	West	8



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	4	4	4	4	3	4	2	3	5	1	3	4
Centre	2	2	1	2	7	10	0	2	2	7	1	3
East	4	4	4	2	4	3	4	6	4	3	2	4

Section 5(2) Outcomes

	Jan 2024	Feb 2024	Mar 2024
Section 2:	3	2	3
Section 3:	3	3	3
Informal:	5	0	3
Lapsed:	0	0	0
Invalid:	0	0	1
Discharged:	1	0	0
Other:	0	0	0

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

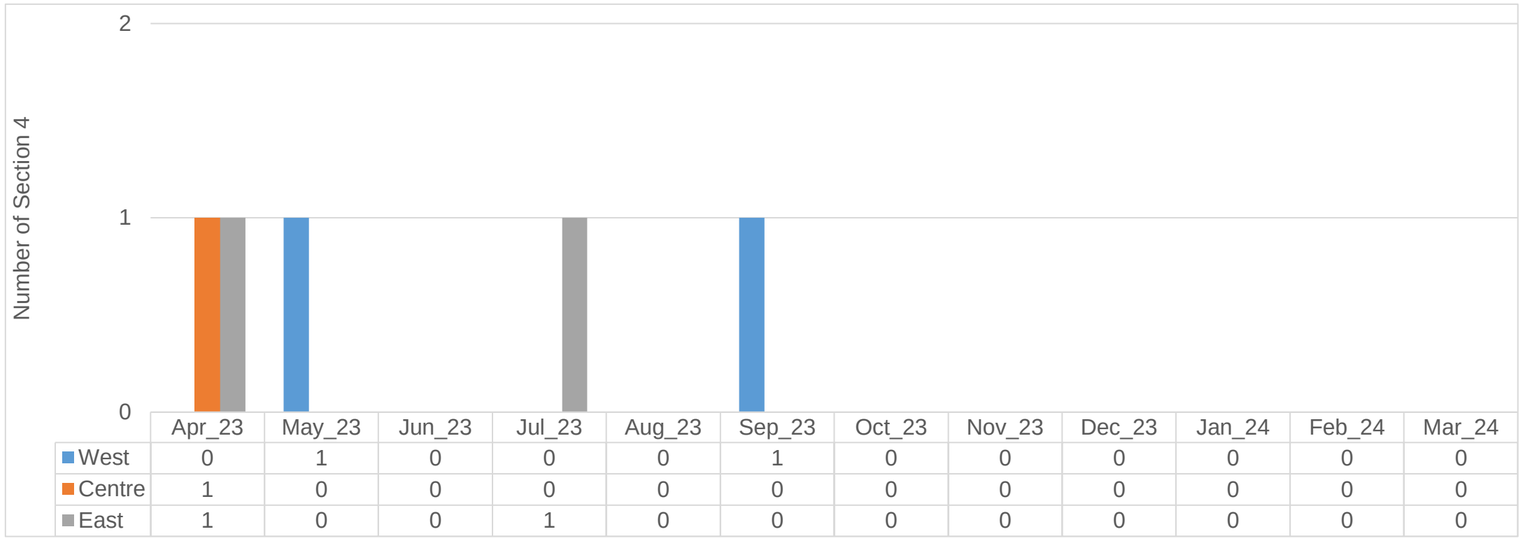
EXCEPTIONS

There is one exception to report this quarter.

West: 5(2) paperwork was completed whilst the informal patient had attended the general hospital in the Emergency Department this was made out to the Mental Health unit therefore making it invalid. A 5(2) cannot be used when someone is in the Emergency Department and is specific to a unit/hospital ward and does not allow the provisions of transfer or leave (INC85790).

Section 4 - BCUHB	March 2024	February 2024	Monthly Trend
Section 4: Admission for assessment: Cases of emergency	0	0	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
0	0	→	1	1	Centre	0
				1	East	0
				1	West	0



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	0	1	0	0	0	1	0	0	0	0	0	0
Centre	1	0	0	0	0	0	0	0	0	0	0	0
East	1	0	0	1	0	0	0	0	0	0	0	0

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

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

There are no exceptions to report.

The documents are considered to reveal if the S4 was used for emergency purposes or due to a lack of doctor availability.

There were no section 4s this quarter.

WEST

Month	Duration (hh:mm)	Outcome

CENTRE

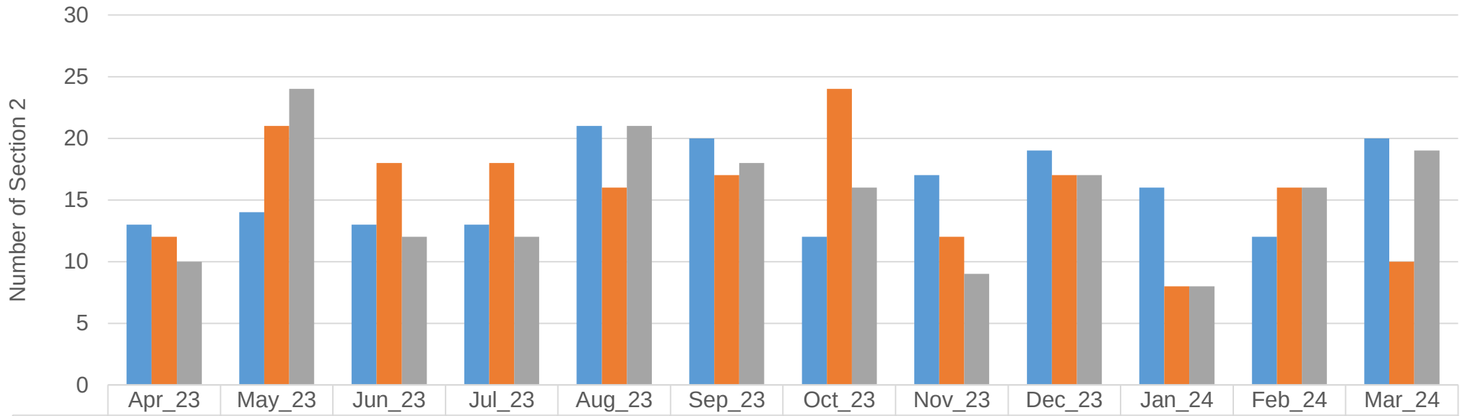
Month	Duration (hh:mm)	Outcome

EAST

Month	Duration (hh:mm)	Outcome

Section 2 - BCUHB	March 2024	February 2024	Monthly Trend
Section 2: Admission for assessment	49	44	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
125	143	↓	140	1	West	48
				2	East	43
				3	Centre	34



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	13	14	13	13	21	20	12	17	19	16	12	20
Centre	12	21	18	18	16	17	24	12	17	8	16	10
East	10	24	12	12	21	18	16	9	17	8	16	19

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

Section 2 Outcomes

	Jan 2024	Feb 2024	Mar 2024
Section 3:	10	10	11
Informal:	9	11	11
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	6	7	2
Transferred:	8	16	15
Invalid and Other:	0	1	1

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

Section 2 is also used as a direct admission detention.

There were six under 18s placed on a Section 2 this period one following a S136 detention, one from a section 5(2), two from admission and two regraded from informal.

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EXCEPTIONS:

There are four exceptions noted this period, two are not referenced in the figures above due to the errors being found on admission.

EAST: The section 2 was delayed in being enacted following admission due to the AMHP dating their application wrongly this was rectified the following day.

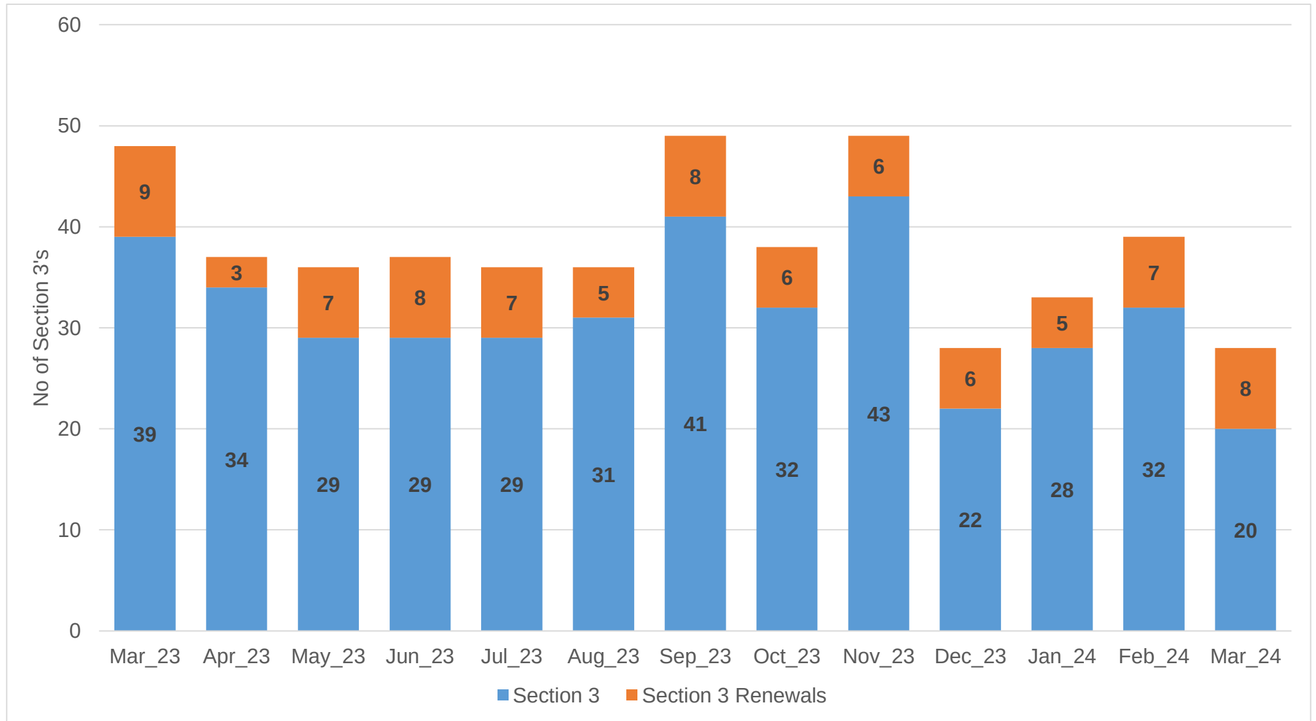
Two S2 were deemed invalid both on admission, one due to the paperwork being on English paperwork and not signed by the AMHP on further scrutiny one of the medical recommendations was found to be insufficient therefore a new assessment occured and one following the discovery that the AMHP had not completed the application at the time as there had been no bed this was completed when identified.

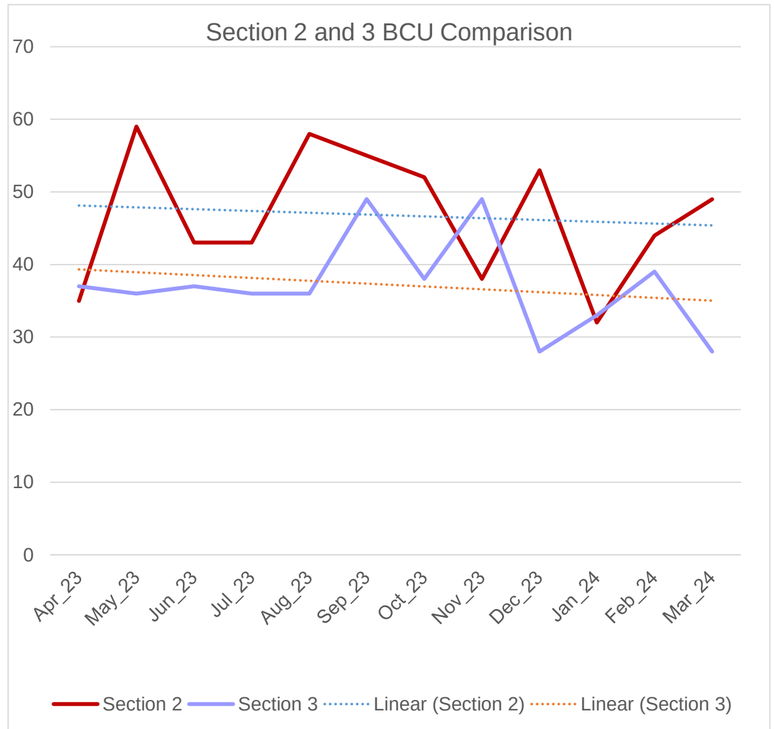
WEST: A joint medical recommendation was completed it was identified that this was not sufficient to warrant detention when scrutinised, a new assessment was conducted and a detention placed.

A

Section 3 - BCUHB	March 2024	February 2024	Monthly Trend
Section 3 (Including Renewals): Admission for treatment	28	39	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
100	115	↓	112	1	West	35
				2	Centre	34
				3	East	31





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

5

These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board. This period there were three under 18s made subject to a section 3, one from informal and two regraded from section 5(2)'s.

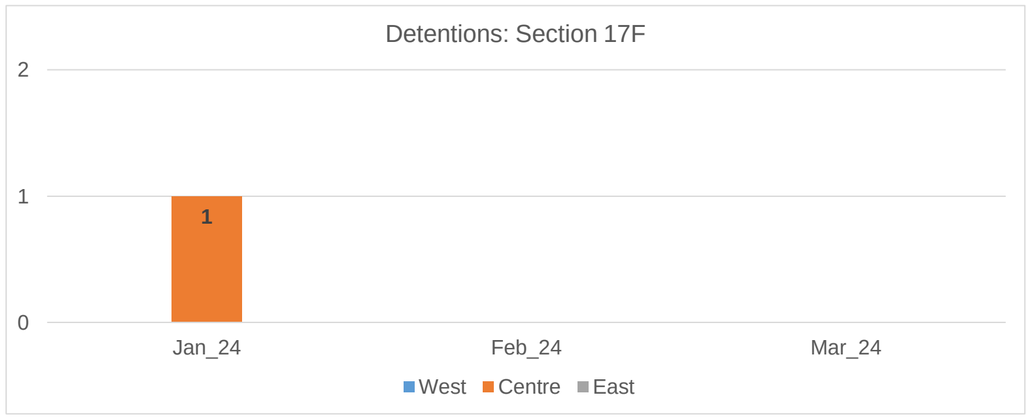
The trend over the 12 months at the end of February shows a decline for section 3 and section 2.

There is one exception to report this period. **EAST/CENTRAL**: It was wrongly concluded that a detention was invalid due to the joint medical recommendation not identifying the hospital for admission. INC83974.

Section 17 A-F - BCUHB	March 2024	February 2024	Monthly Trend
Section 17A (Including Renewals)-17F: Community Treatment Orders	6	6	→

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
18	22	↓	19

Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
1	Centre	8
2	East	5
2	West	5



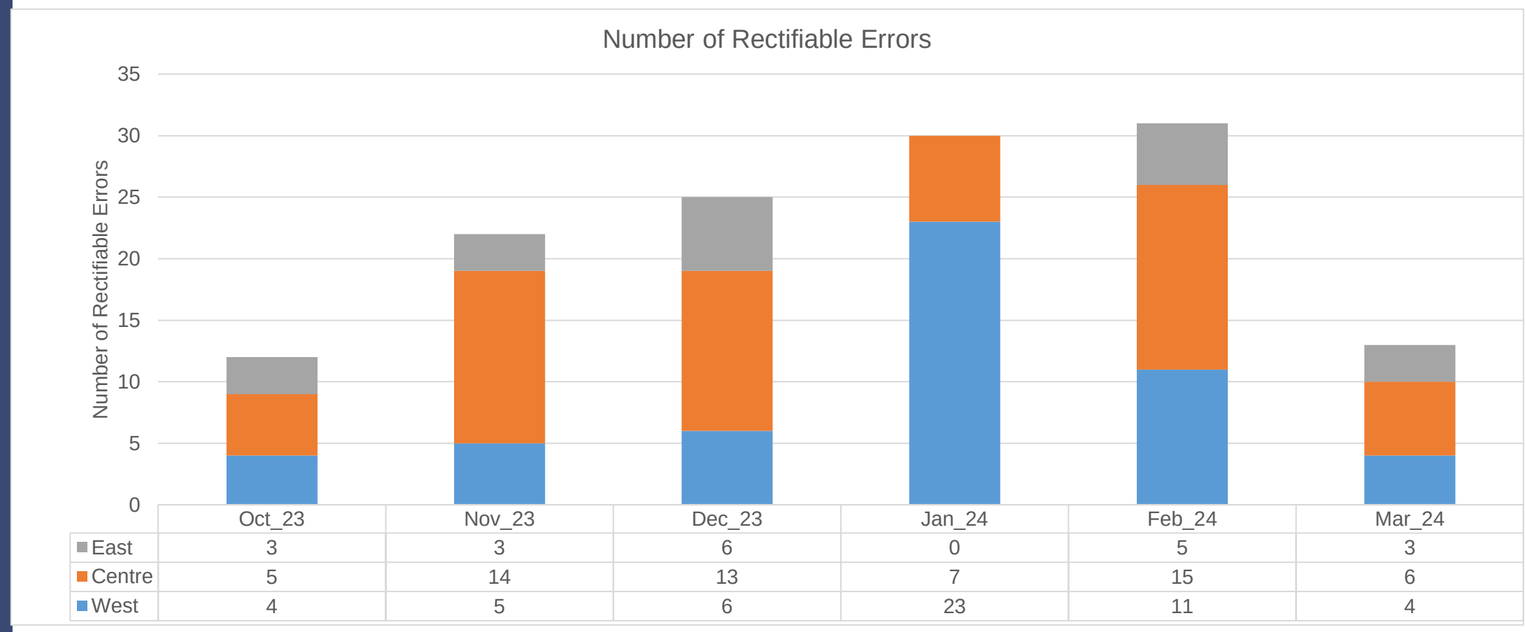
This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section 3.

The number of patients subject to a CTO at the end of February West: 8, Central: 13 and East: 10.
There has been an increase in the number of patients subject to a CTO for East and Central with West seeing a decline.

Exceptions: There are no exceptions to report this quarter, one CTO was allowed to come to an end as the covering RC was not approved in Wales to complete the form for discharge the plan had been to rescind the CTO.

Fundamental and Rectifiable Errors	March 2024	February 2024	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	14	33	↓

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	West	39
				2	Centre	29
				3	East	9



	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
East	3	3	6	0	5	3
Centre	5	14	13	7	15	6
West	4	5	6	23	11	4

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. The findings were reported last within the September quarterly report. Discussions are underway with a proposal that the BCU delivery unit will 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 2022 rather than 2023.

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

Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report the below information notes the learning/action from each incident.

Fundamentally defective x 5

Section 3 The MHA office staff have been appraised on what is deemed to be rectifiable under Section 15(1) and (2) for joint medical recommendations and the use of the MHA manual and linking in with colleagues for advice..

Section 2 x 3 Two are due to be investigated at the current time therefore no learning or actions are currently available, one the use of the out of hours acceptance form highlights issues to look at in regards to detention paperwork.

Section 5(2) Staff have been appraised of the constraints around the use of section 5(2) and informal patients within the Emergency Department.

Lapsed x 4

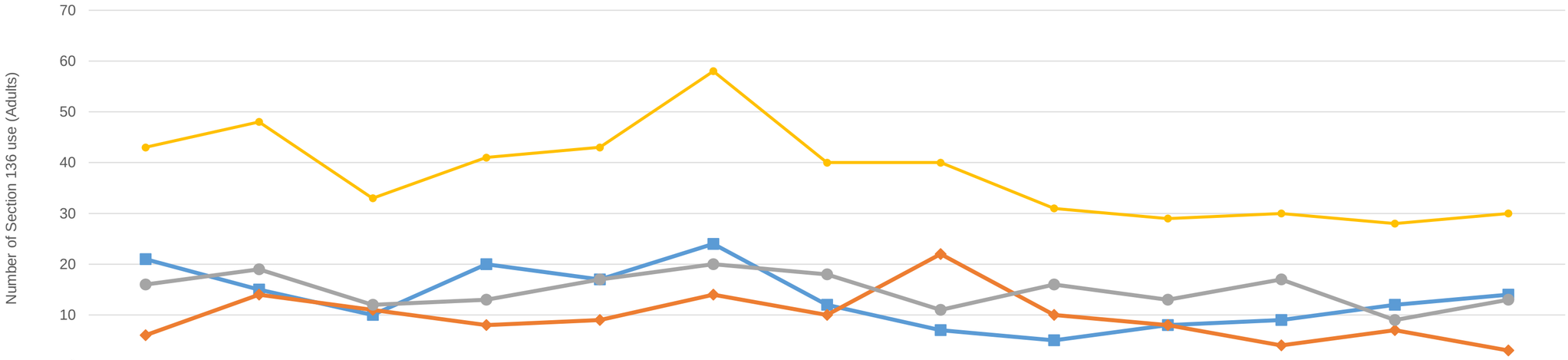
(Section 5(4)) - INC79390 There is a lack of on call provision for NWAS as mitigation the unit tries to identify early where mental health needs may be but this cannot always be mitigated against within the current processes.

Section 136 x 3 - all patients were monitored and escalation made appropirately at the time.

Section 135 - 136	March 2024	February 2024	Monthly Trend
Section 135 and 136: Patient transfers to a place of safety (Adults)	30	28	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
88	100	↓	113

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	39
2	West	35
3	Centre	14



	Mar_23	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	21	15	10	20	17	24	12	7	5	8	9	12	14
Centre	6	14	11	8	9	14	10	22	10	8	4	7	3
East	16	19	12	13	17	20	18	11	16	13	17	9	13
BCU	43	48	33	41	43	58	40	40	31	29	30	28	30

The data above does not include S135 or under 18's.
There were three under 18 S136s this period.

There has been three S135 detention this period resulting in two admissions under S2 and one under S3.

During this period there were no custody detentions noted as the first place of safety.
Two requests for an extension were made this period due to the detainees being unfit for assessment, one resulting in a S2 detention and one in a discharge from hospital.

Section 136	March 2024	February 2024	Monthly Trend
Section 136: Patient transfers to a place of safety (Adults)	30	28	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
88	100	↓	113

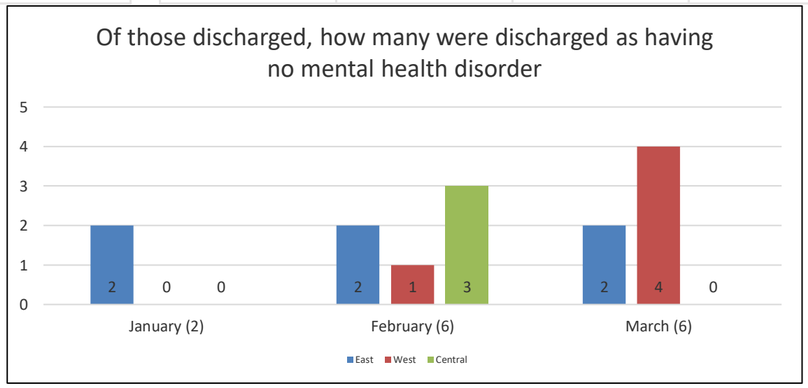
Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	East	39
2	West	35
3	Centre	14

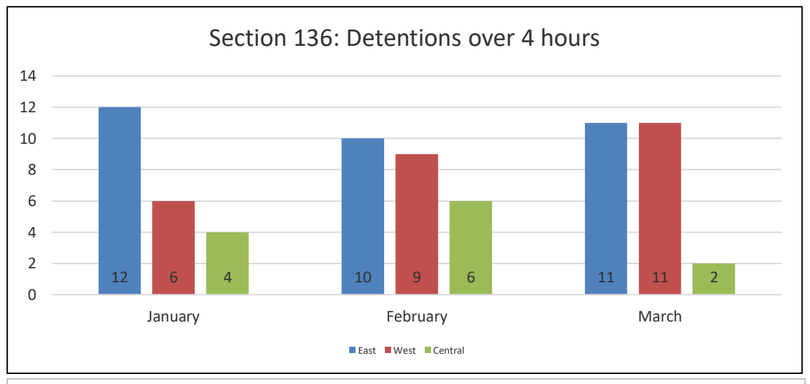
Section 136 Outcomes

	Jan 2024	Feb 2024	Mar 2024
Discharged:	20 69.00%	19 59.38%	19 63.34%
Informal Admission:	5 17.00%	5 15.62%	3 10.00%
Section 2:	4 14.00%	5 15.62%	7 23.33%
Section 3:	0 0.00%	1 3.13%	0 0.00%
Other:	0 0.00%	2 6.25%	1 3.33%

Section 136 - Known to Service

T	Jan 2024	Feb 2024	Mar 2024
Yes	18	20	13
Yes (percentage)	62.06%	65.50%	43.33%





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.

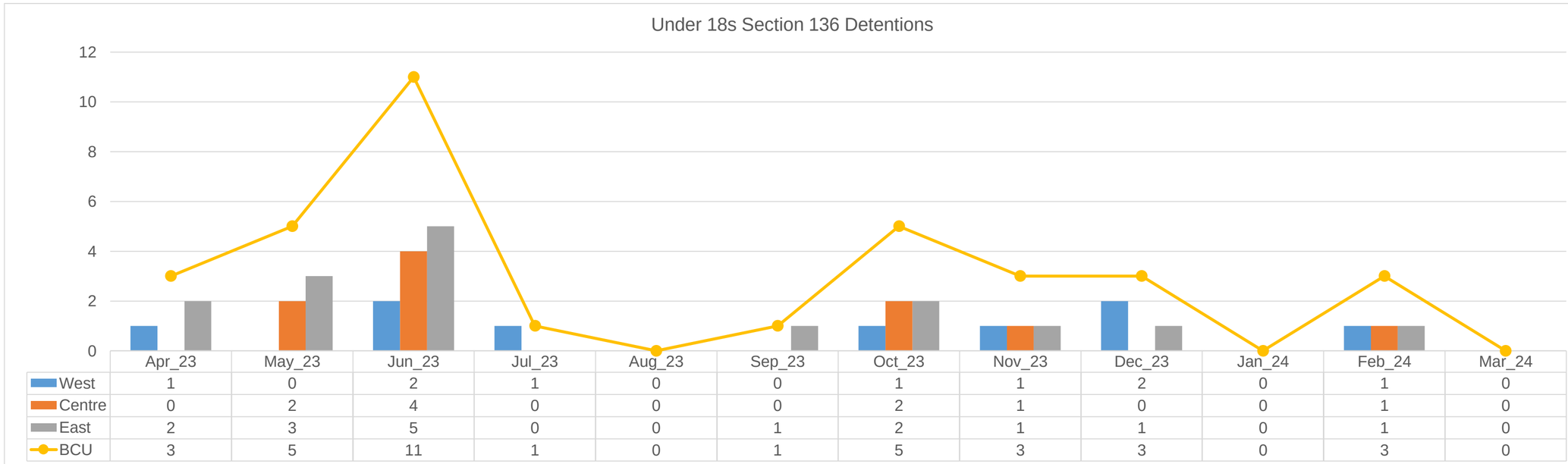
The data shows figures from outcomes recorded and whether a patient is known to service. A large proportion of 136's are discharged those with no mental disorder has historically been around 20%.

Total percentages of all detentions for those discharged with no mental disorder (rounded up) are:
January 7%
February 19%
March 20%

Data below shows the percentage of the detentions discharged that are followed up by services or new referrals into services these figures are rounded up/down as appropriate:
January 40% discharged follow up, 50% referred to services.
February 63% discharged follow up, 11% referred to services
March 42% discharged follow up, 26% referred to services.

The Criminal Justice Liaison Service has been working out of North Wales Police Headquarters and in the community since January 2020. The service has been actively involved in assisting the police and signposting people in crisis to other avenues rather than the police using the S136 power. To date 404 people have not become detained on a S136 due to CJLS intervention. This period accounts for five of those figures.
Data is recorded in relation to those that do progress to being detained on a S136 following consultation, since September 2020 there have been 214 instances with this period accounting for four of those figures.

Section 135 - 136 (Under 18)	March 2024	February 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)	0	3	↓	3	11	↓	9	1	Centre	1
								1	East	1
								1	West	1



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	1	0	2	1	0	0	1	1	2	0	1	0
Centre	0	2	4	0	0	0	2	1	0	0	1	0
East	2	3	5	0	0	1	2	1	1	0	1	0
BCU	3	5	11	1	0	1	5	3	3	0	3	0

There were three under 18s assessed under a S136 this period.

The tables below shows the ages of young persons assessed and the outcomes for the year period April 23 - March 24. In comparison to the last year 2022/2023 this is eight less.

5

Under 18 Assessments	
AGE	**Number of Assessments**
11 and 12	1
13	2
14	6
15	2
16	7
17	17

Outcome of Assessments	
Outcome	**Number**
Returned Home	9
Returned to Care Facility	12
Admission to childrens ward	1
Admission to Adult ward / S136 suite	4
Admission NWAS / CAMHS	7
Admission OOA	
Other (Friends, Hotel, B&B)	2

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
February	Hergest	Admission	CAMHS	03:20	14
February	YGC	Admission	CAMHS	18:20	17
February	Heddfan	Admission	CAMHS	21:00	17

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

Average PoS hours: 14:13 hrs this is an increase on the previous quarter figures of 13:34 hrs.

Under 18's admitted to Adult Psychiatric Wards
There has been one admission this reporting period where a young person remained in the S136 suite following assessment for 22 hours and 45 mins prior to transfer to an age appropriate unit.

The table below shows the county that the young persons originated from and where they were assessed for the period April 23 - March 24

County Originated from and where assessed:

	East	Central	West
Wrexham	15	1	1
Flintshire		2	1
Denbighshire		1	
Conwy	1	6	6
Gwynedd			
Ynys Môn			
Out of Area/NFA			1

Section	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Section 35:	0	0	0	0	0	0	0	0	0	1	0	0
Section 37:	2	2	2	1	1	1	1	2	2	2	2	2
Section 37/41:	8	8	8	8	8	8	9	8	8	8	8	8
Section 38:	0	0	0	0	0	0	0	0	0	0	0	0
Section 47:	3	4	5	5	5	5	5	5	5	5	5	3
Section 47/49:	3	4	3	2	2	2	2	2	2	1	1	1
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	0	1	2	2	1	1	1	1	1	1
Section 3:	2	2	2	2	3	3	3	3	3	2	2	2
Section 45A	0	0	0	0	0	0	0	0	0	0	0	0
Total:	18	20	20	19	21	21	21	21	21	20	19	17

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

There are no exceptions to report.

Total Transfers for the Quarter

	Jan 2024	Feb 2024	Mar 2024
Internal Transfers	4	8	6
External Transfers (Total)	9	12	10
External Transfers (In)	4	4	5
External Transfers (Out)	5	8	5

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

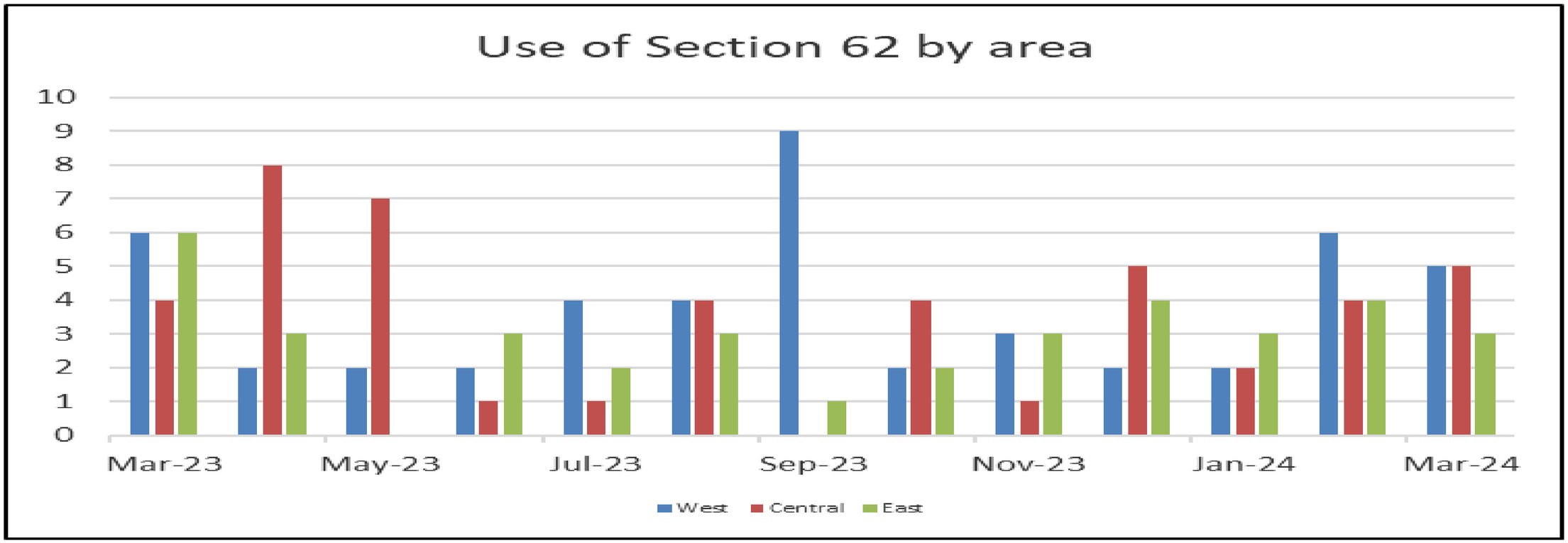
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised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

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

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

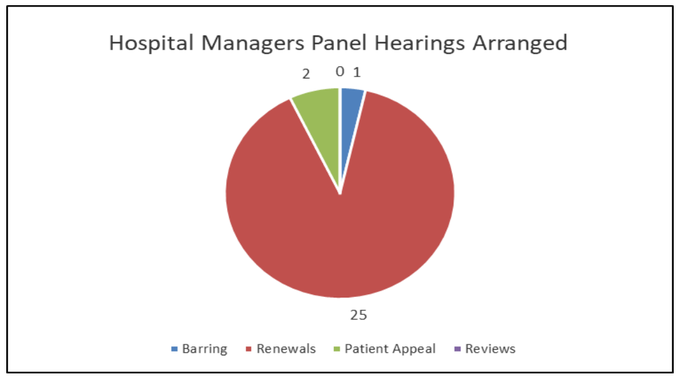
Month	Transfers In
Jan_24	Delfryn House (0)
Jan_24	St Andrews Healthcare, Northampton (Conwy)
Jan_24	Ty Grosvenor (Denbighshire)
Jan_24	Priory Bristol (Flintshire)
Feb_24	Priory Hospital Dorking (Conwy)
Feb_24	Priory Bristol (Denbighshire)
Feb_24	Cygnet Taunton (Denbighshire)
Feb_24	Farndon Unit (Flintshire)
Mar_24	Pinhoe View Hospital Exeter (Conwy)
Mar_24	Cygnet Bury (Denbighshire)
Mar_24	Thornford Park (Denbighshire)
Mar_24	Penine Care, Oldham (Denbighshire)
Mar_24	Nottingam (Wrexham)

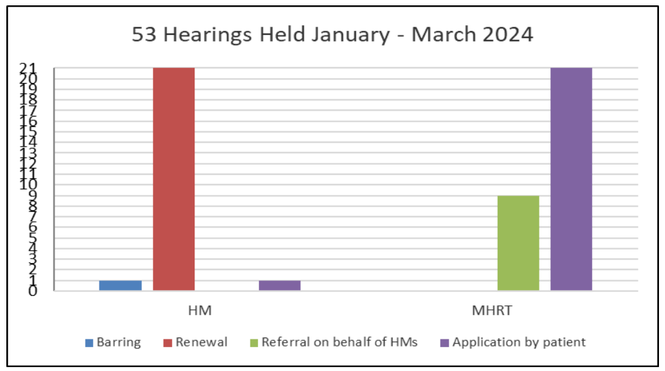
Month	Transfers Out
Jan_24	Chadwick Lodge - Milton Keynes (Gwynedd)
Jan_24	Trans to St Andrews (Denbighshire)
Jan_24	Priory Bristol (Conwy)
Jan_24	Cygnet Hospital Bradford (Gwynedd)
Jan_24	Transfer out to Cygnet Stevenage (Gwynedd)
Feb_24	0 (Denbighshire)
Feb_24	Coed Du (Denbighshire)
Feb_24	Cygnet Bury (Denbighshire)
Feb_24	Cygnet Bury (Gwynedd)
Feb_24	Macclesfield (Flintshire)
Feb_24	Priory Bristol (Denbighshire)
Feb_24	Park House, Manchester (Repatriated)
Feb_24	Cygnet Joyce Parker Hospital (Wrexham)
Mar_24	Cygnet Hospital Bury. (Conwy)
Mar_24	Pinhoe View, Exeter (Conwy)
Mar_24	Elysium Healthcare, Newark (Gwynedd)
Mar_24	Llandrindod Wells Memorial Hospital (Powys)
Mar_24	Priory Nottingham (Flintshire)

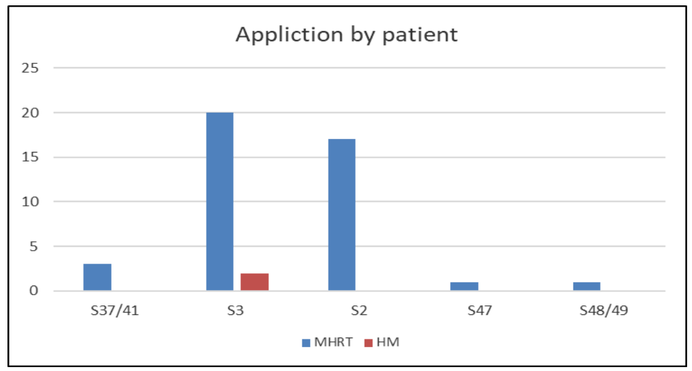


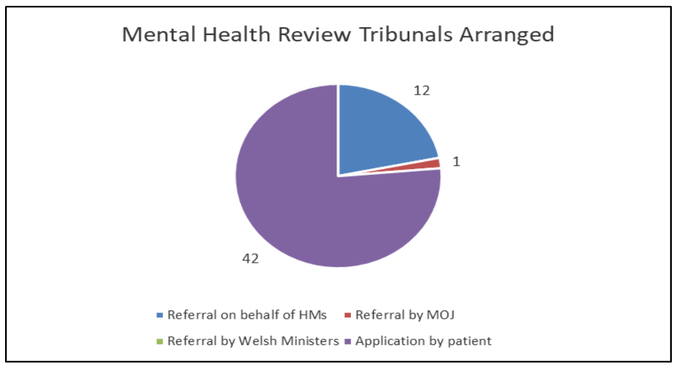
Monitoring of section 62 is a requirement of the Code of Practice (25.38)

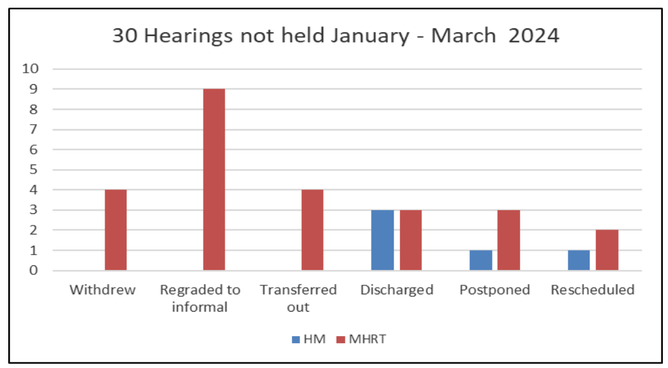
Reason for S62 use:
Medication changes
Patient no longer able to give consent to treatment or refusing consent
ECT
Awaiting a Second Opinion Appointed Doctor (SOAD) to arrive and three month consent to treatment has expired.

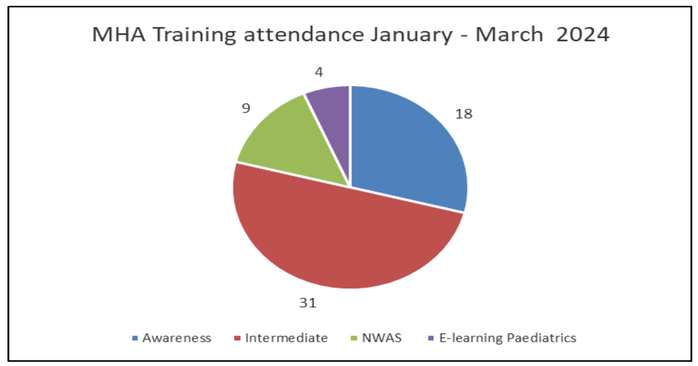












The above charts show the number of Associate Hospital Managers Hearings arranged and the number of Mental Health Review Tribunals arranged.

There were 44 applications from patients this period of which 22 took place, one barring hearing took place this quarter.

The MHRT discharged two patients this quarter, all other hearings held resulted in the patients remaining detained.

Training under the MHA is now recorded and an initial analysis report of the attendees for 2023 has been produced.
There were 213 staff members trained in 2023 through Teams sessions, face to face and via a new e-learning developed for the paediatrics department.
Training is advertised through Health Board publications and on the Mental Health Act sharepoint page.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

APPENDIX 2

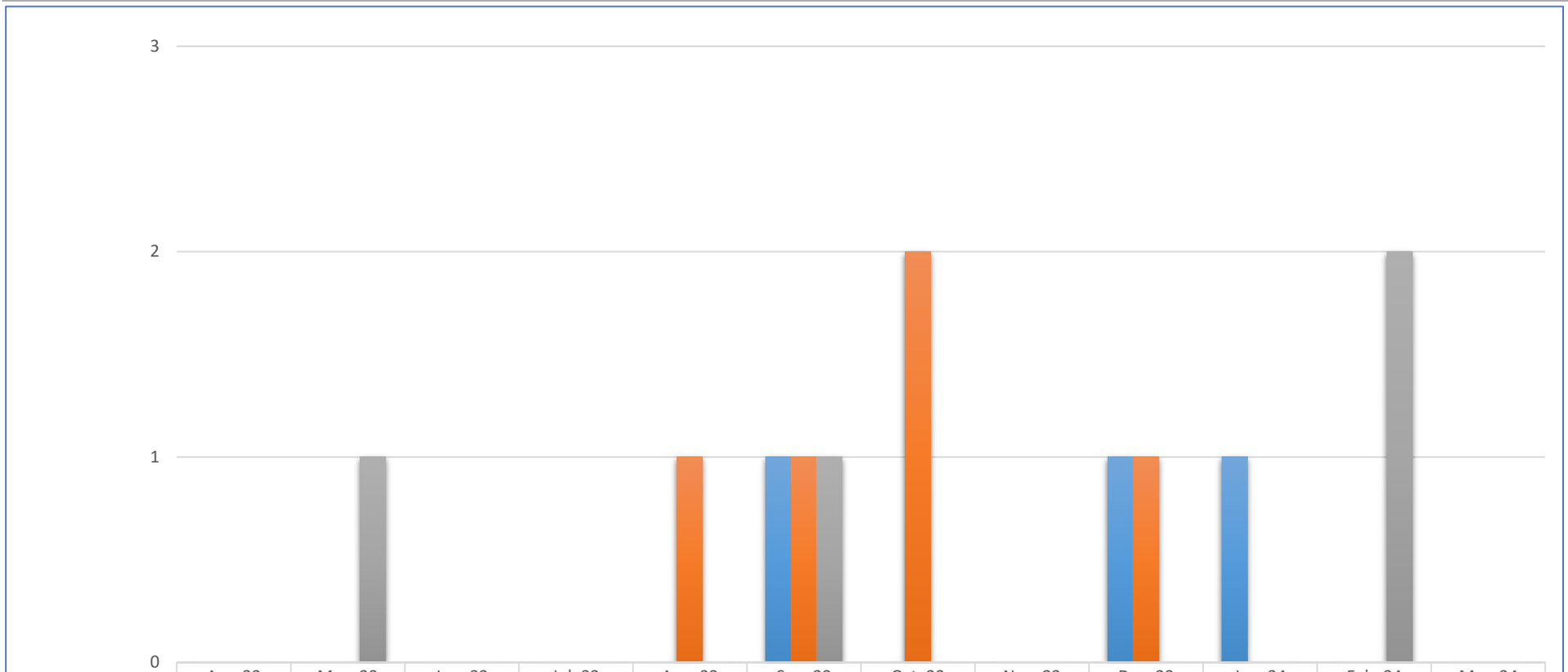
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

S.136/135 use in BCUHB	
KPI Report for:	**March 2024**

Data Source:	BCUHB MHA Database
Report Created on:	05/04/2024
Report Created by:	Performance Directorate

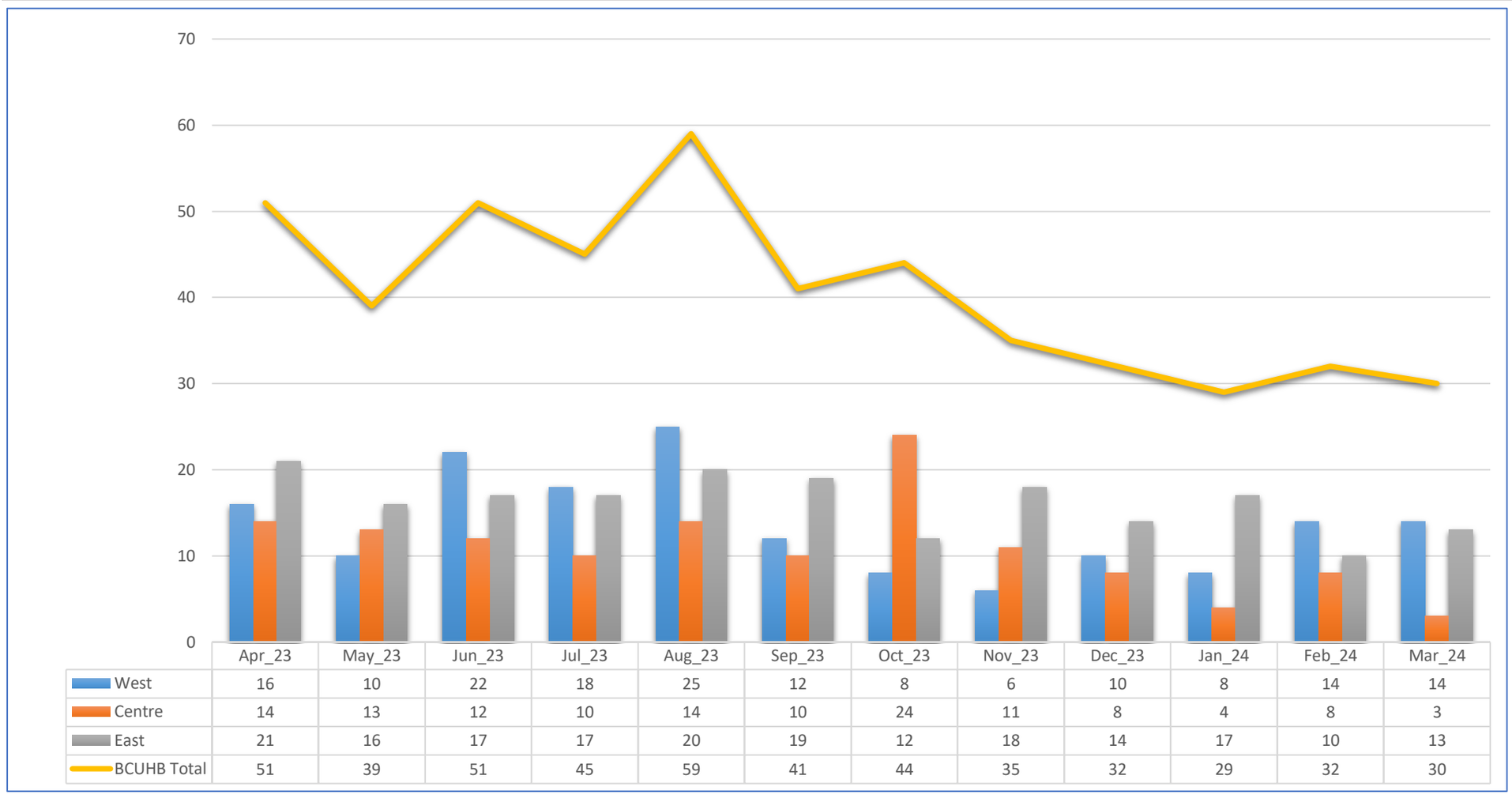
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Mar_24



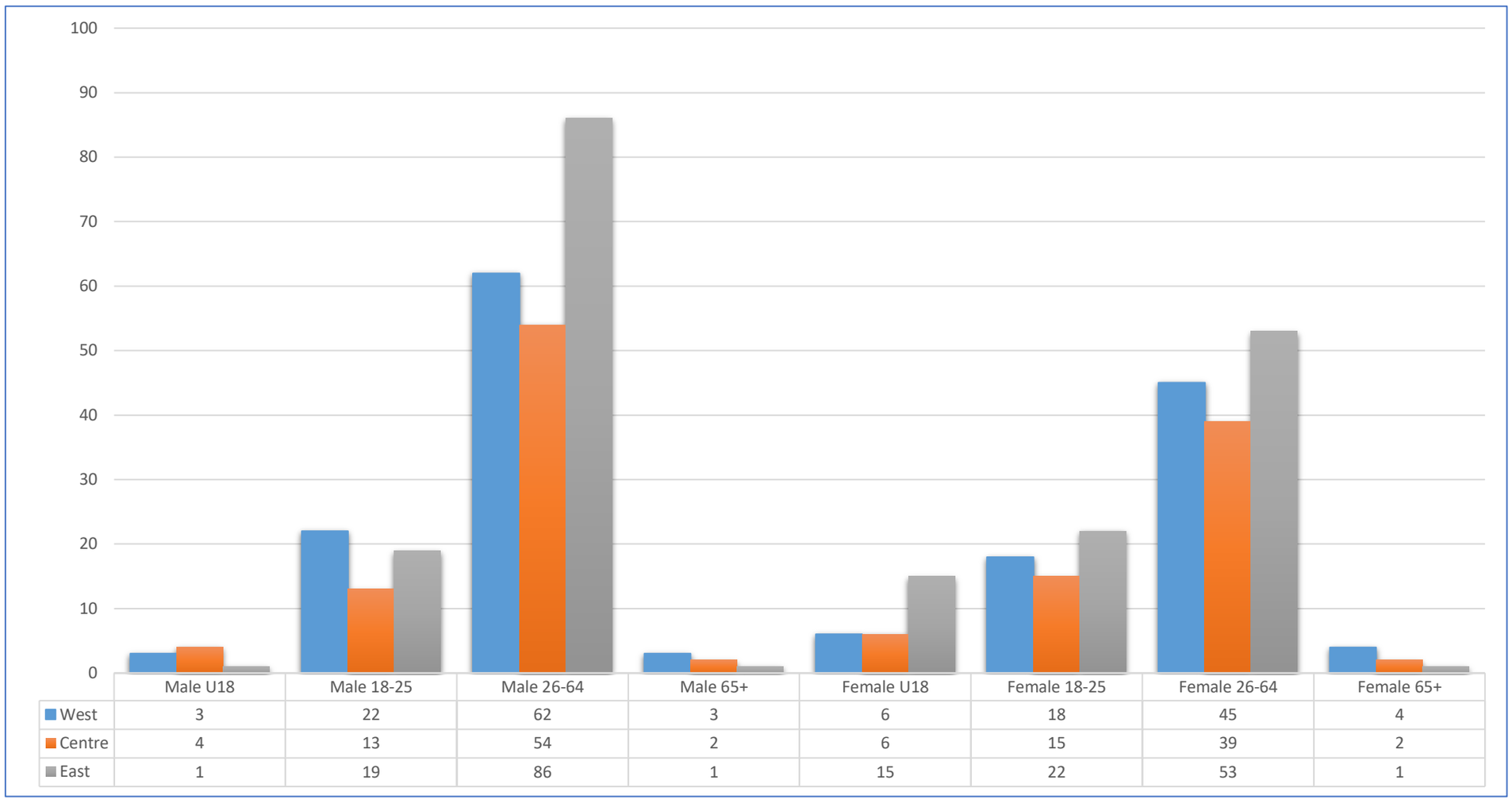
	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	0	0	0	0	0	1	0	0	1	1	0	0
Centre	0	0	0	0	1	1	2	0	1	0	0	0
East	0	1	0	0	0	1	0	0	0	0	2	0

2.1: Section 136 twelve month trend up to and including Mar_24



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	16	10	22	18	25	12	8	6	10	8	14	14
Centre	14	13	12	10	14	10	24	11	8	4	8	3
East	21	16	17	17	20	19	12	18	14	17	10	13
BCUHB Total	51	39	51	45	59	41	44	35	32	29	32	30

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



	Male U18	Male 18-25	Male 26-64	Male 65+	Female U18	Female 18-25	Female 26-64	Female 65+
West	3	22	62	3	6	18	45	4
Centre	4	13	54	2	6	15	39	2
East	1	19	86	1	15	22	53	1

4: 1st Place of Safety 12 month trend up to and including Mar_24

Area Split - 1st Place of Safety by category

	Mar_24			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	5	3	5	71	68	85
Ward	0	0	0	0	0	0
PICU	0	0	0	0	0	0
136 Suite	8	0	7	88	57	103
Hospital	0	0	1	0	0	2
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	0	0	0	2	5	2
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	0	0

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

1st Place of Safety: A&E Split	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	5	3	13	14	11	2	3	2	4	3	6	5
Centre	6	7	3	6	9	4	12	5	4	3	6	3
East	3	6	9	11	8	12	6	5	5	8	7	5

1st Place of Safety: 136 Suite Split	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	10	7	9	4	13	10	4	4	6	5	8	8
Centre	8	6	9	2	4	5	11	5	4	1	2	0
East	15	9	9	5	12	7	6	12	9	9	3	7

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

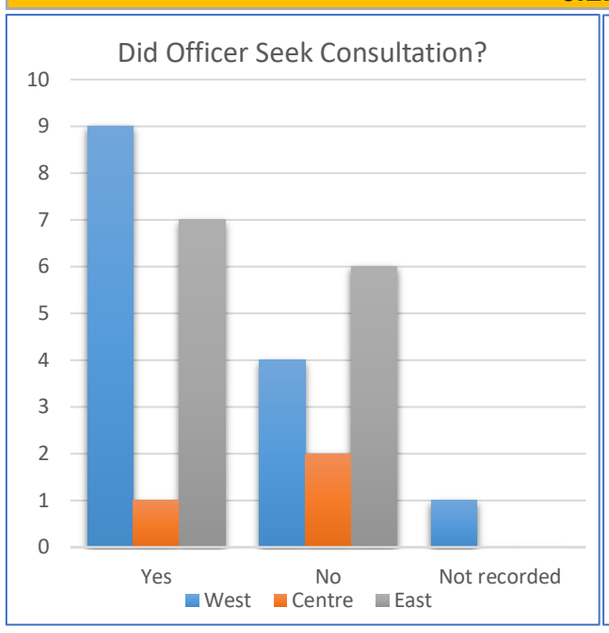
5.1: Area split 3 month table up to and including Mar_24 and latest 12 month total

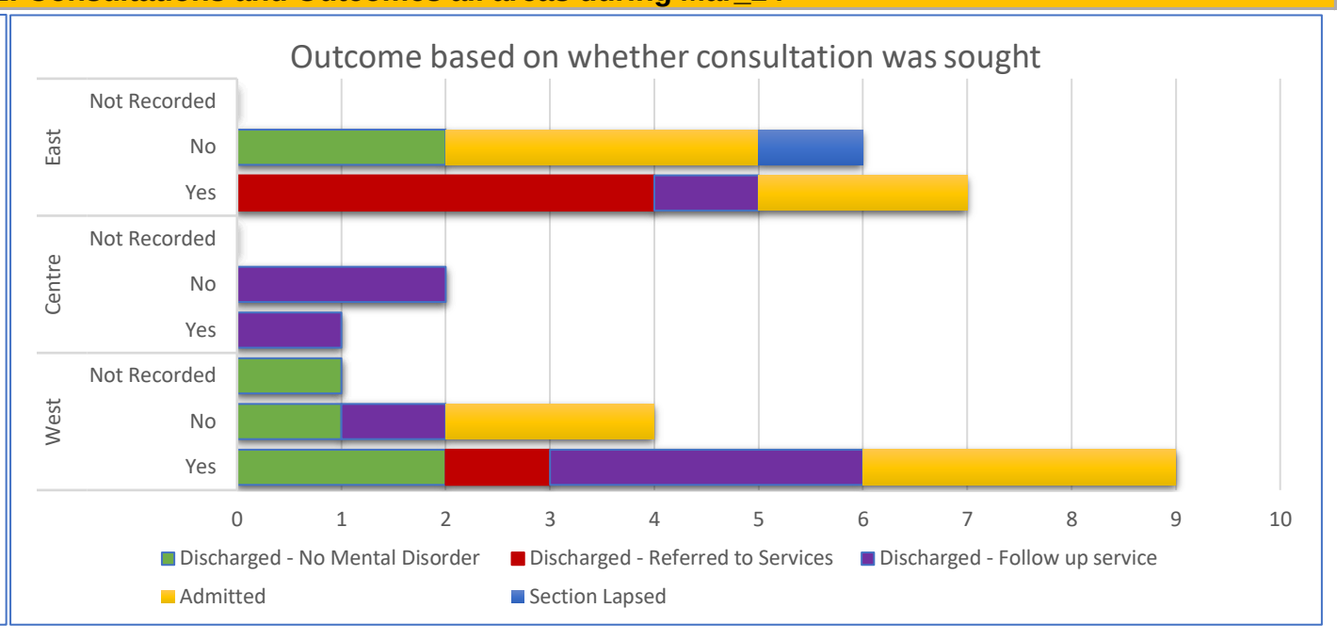
West	Jan_24	Feb_24	Mar_24	12 Month Total	Centre	Jan_24	Feb_24	Mar_24	12 Month Total	East	Jan_24	Feb_24	Mar_24	12 Month Total	Incident rate by county (12 mth total)	
Ynys Mon	3	2	1	**34**	Ynys Mon	0	0	0	**3**	Ynys Mon	0	1	0	**6**	Ynys Mon	**6.13**
Gwynedd	4	5	8	**61**	Gwynedd	0	0	0	**6**	Gwynedd	0	0	0	**11**	Gwynedd	**6.31**
Flintshire	0	0	0	**5**	Flintshire	0	1	1	**21**	Flintshire	3	4	2	**32**	Flintshire	**3.74**
Wrexham	0	1	0	**17**	Wrexham	0	0	0	**14**	Wrexham	12	5	7	**103**	Wrexham	**9.63**
Conwy	0	3	3	**26**	Conwy	3	0	0	**27**	Conwy	1	0	1	**18**	Conwy	**6.07**
Denbighshire	1	2	1	**13**	Denbighshire	1	5	2	**56**	Denbighshire	1	0	3	**19**	Denbighshire	**9.21**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	0	**0**	OOA	0	0	0	**1**	OOA	0	0	0	**1**	OOA	**#N/A**
Incident Rate per 10,000 population	0.41	0.67	0.67	**8.05**	Incident Rate per 10,000 population	0.19	0.28	0.14	**6.03**	Incident Rate per 10,000 population	0.58	0.34	0.44	**6.46**	BCUHB	**6.77**

***Please note:** The area data is not accurate at this current time and needs correcting, data that is used for any area reporting to be confirmed with the MHA department Manager for accurate records.

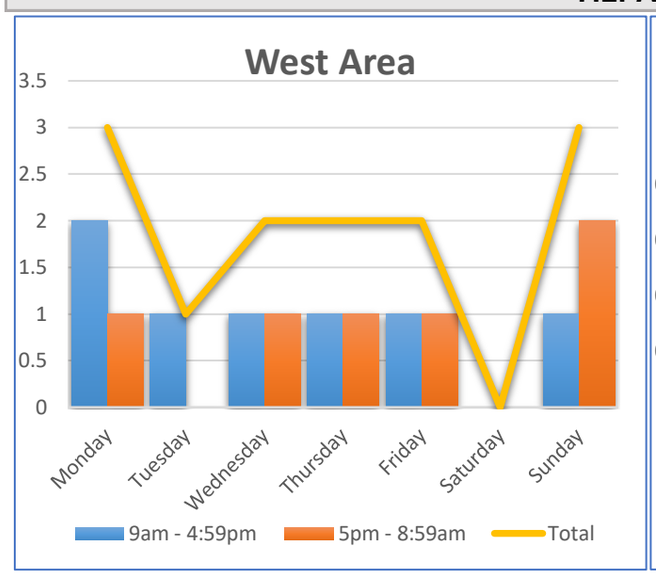
Section B: 12 Month Data for Mar_24

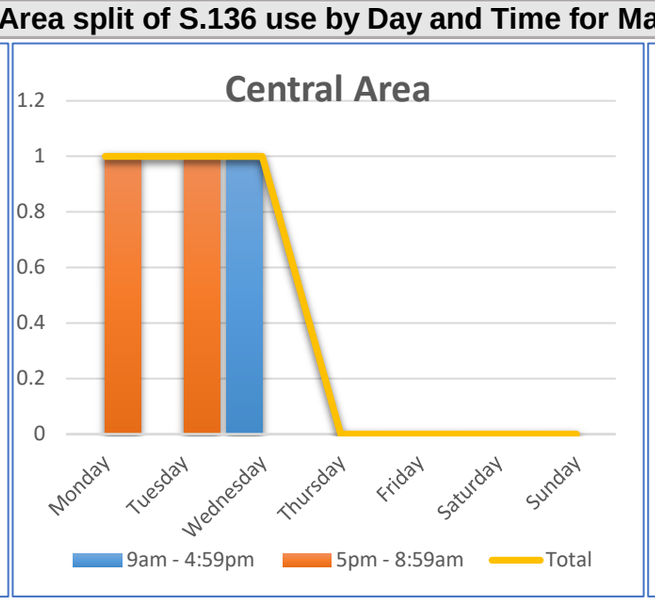
6.1: Consultations and Outcomes all areas during Mar_24

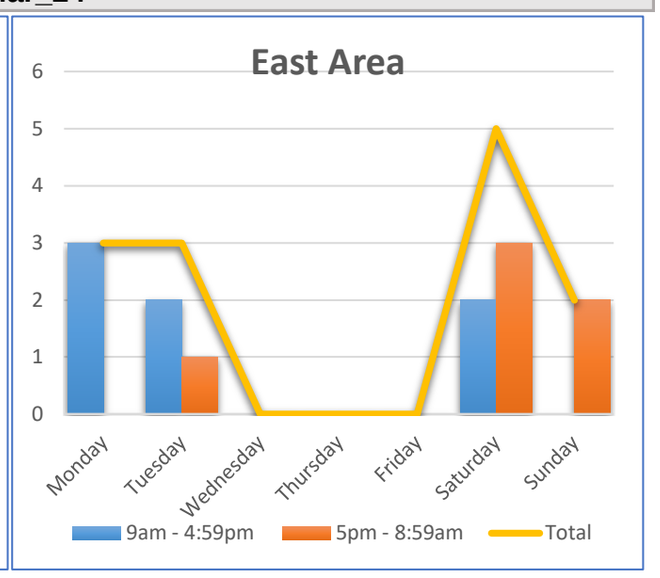




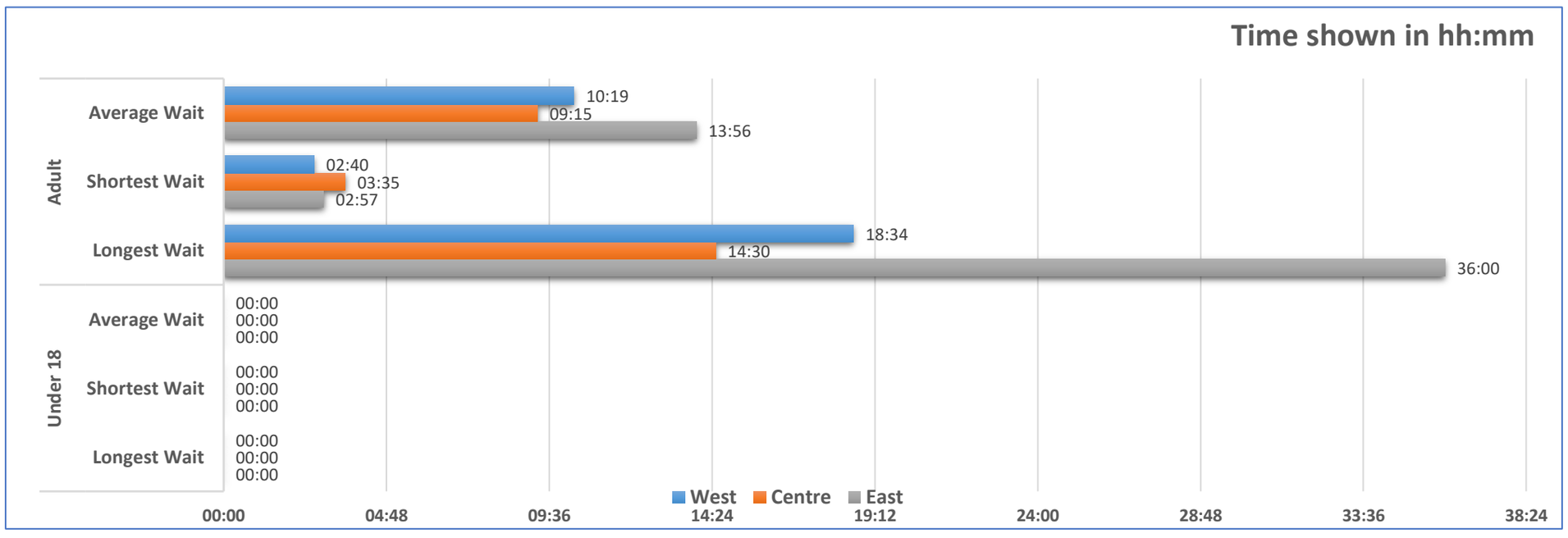
7.1: Area split of S.136 use by Day and Time for Mar_24



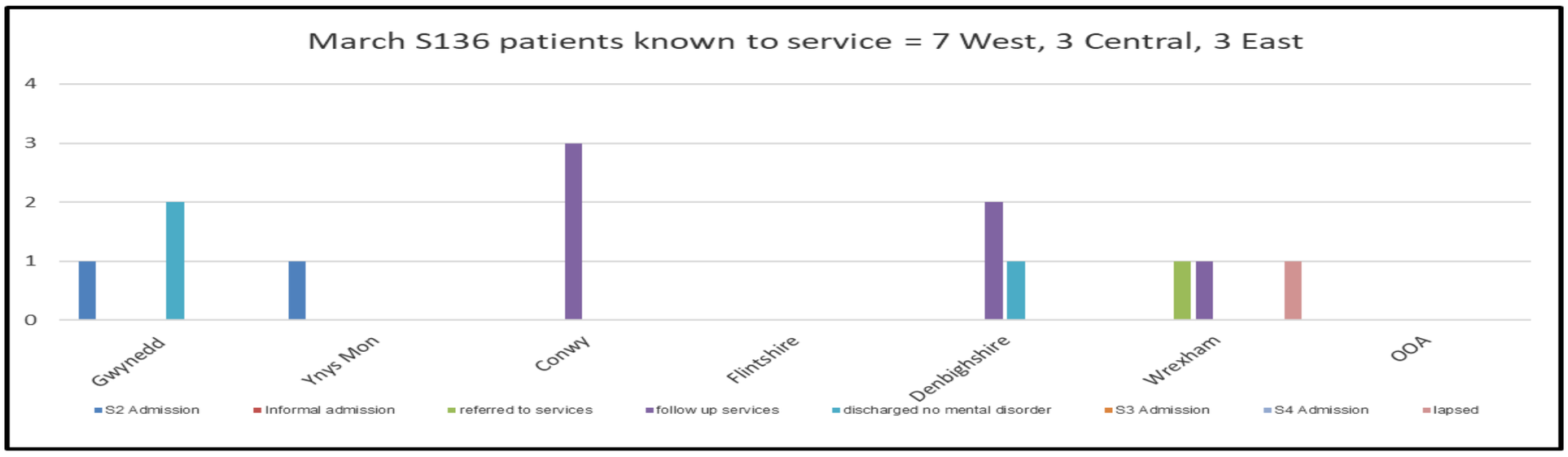




8.1: Duration in S.136 Suite for Mar_24



There was one lapsed detentions this month as the person was not fit for assessment prior to the expiry of the S136 despite having an extension of 12 hours. This person has not been made subject to a detention. There were no under 18 detentions this month. There were no S135 detentions this month.
24 assessments were noted to be over four hours, nine due to the detainees not being fit for assessment, 13 had no reason noted, one due to doctor and AMHP availability, and one due to no inpatient bed. The below graph shows the number of people known to services and the outcomes for the areas.



The table below shows the area that someone originates from, where they were detained and which S136 suite they were taken to. Out of the 30 S136 detentions seven people were not seen within the closest S136 suite.

One was noted to be due to no capacity within the closest suite, one had no reason recorded and five were due to the S136 suite in Ablett being closed.

Local Authority Originates from	Detained in	S136 Suite assessed at
Wrexham	Flintshire	YGC ED
OOA	Conwy	Heddfan
Denbighshire x 2	Denbighshire x 2	Heddfan
OOA	Denbighshire	Heddfan
Flintshire	Denbighshire	Hergest
Conwy	Conwy (C/Bay)	Hergest

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

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

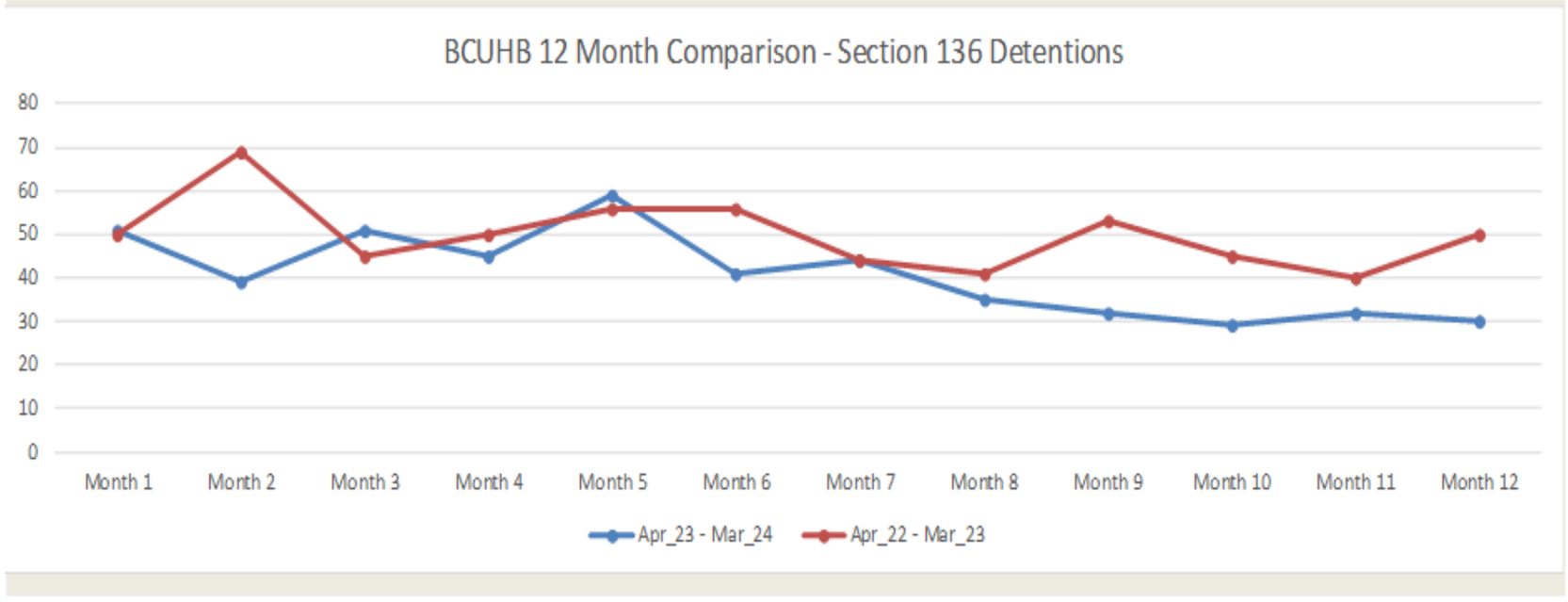
Within the month of March the Mental Health Act Office has received notification that there have been five instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.
There were four consultations with the service which lead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

There were 13 instances where the police did not consult.
These resulted in the outcomes as below:

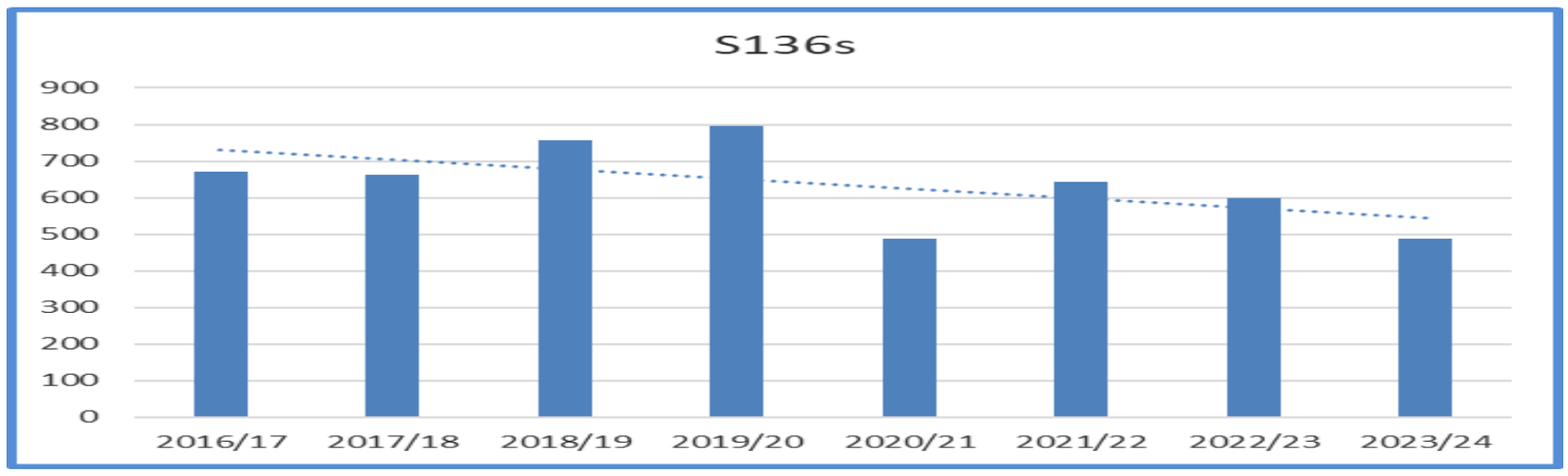
S2 admission x 3
S3 admission x 0
Informal admissions x 2
Discharged no mental disorder x 4 (total for the month = 6)
Discharged referred to services x 0
Discharged with follow up x 3
Detention Lapsed x 1

The below charts show the year on year data for the past two years broken down into months and a comparison graph.

BCU S136 Detentions	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
Apr_23 - Mar_24	51	39	51	45	59	41	44	35	32	29	32	30
BCU S136 Detentions	Apr_22	May_22	Jun_22	Jul_22	Aug_22	Sep_22	Oct_22	Nov_22	Dec_22	Jan_23	Feb_23	Mar_23
Apr_22 - Mar_23	50	69	45	50	56	56	44	41	53	45	40	50

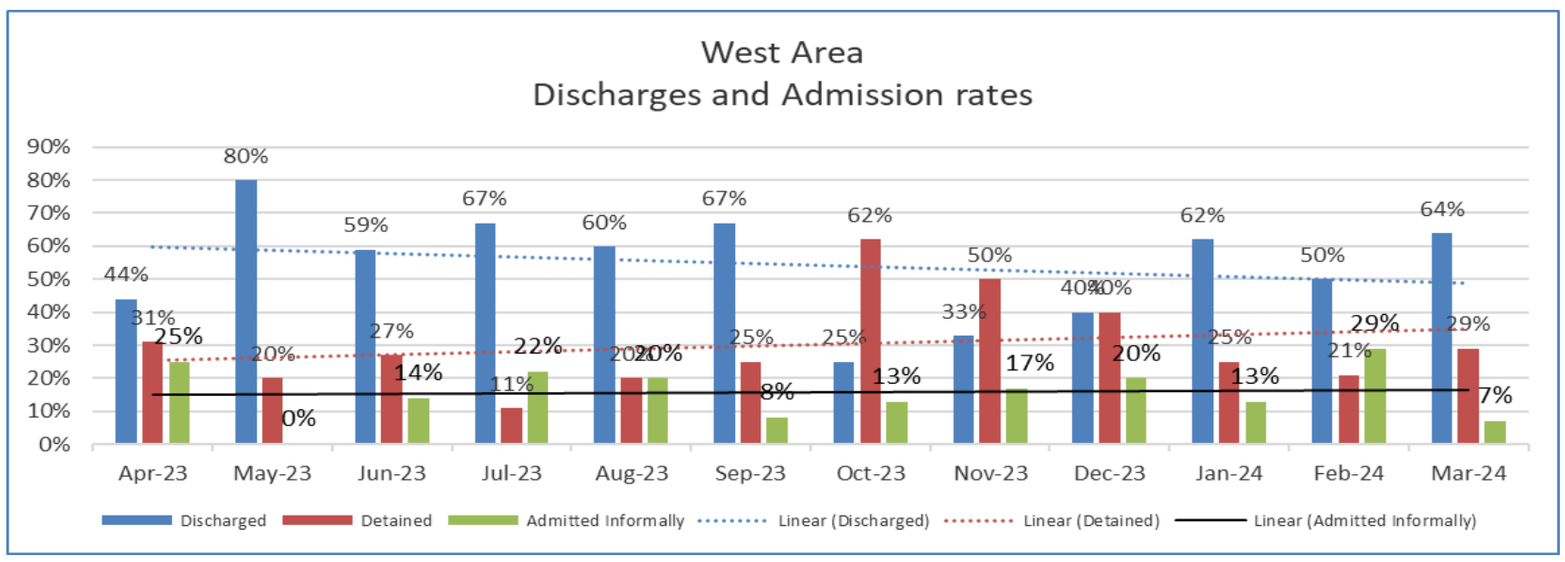


The below graph details the total number of detentions by fiancial year. There has been 111 less detentions than the previous year. S135 figures for 2022/23 were 21 with 2023/24 resulting in 12 detentions.

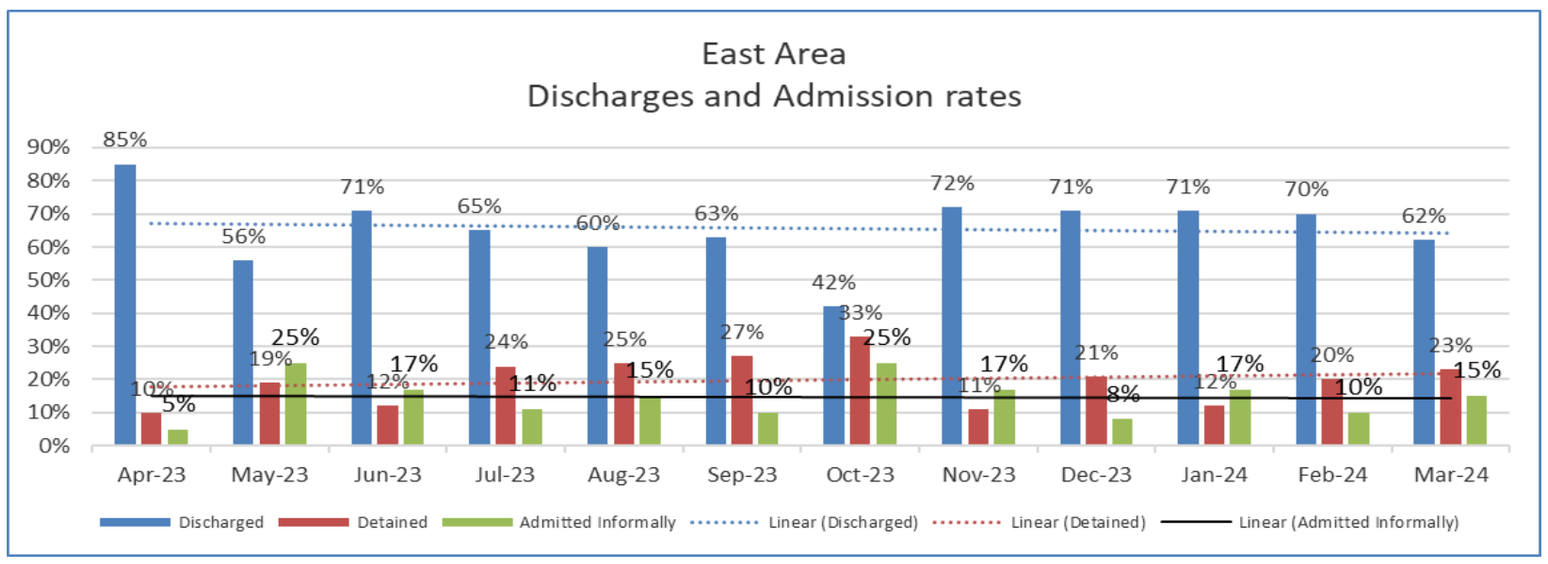


Year	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
S136s	670	663	758	796	489	642	599	488

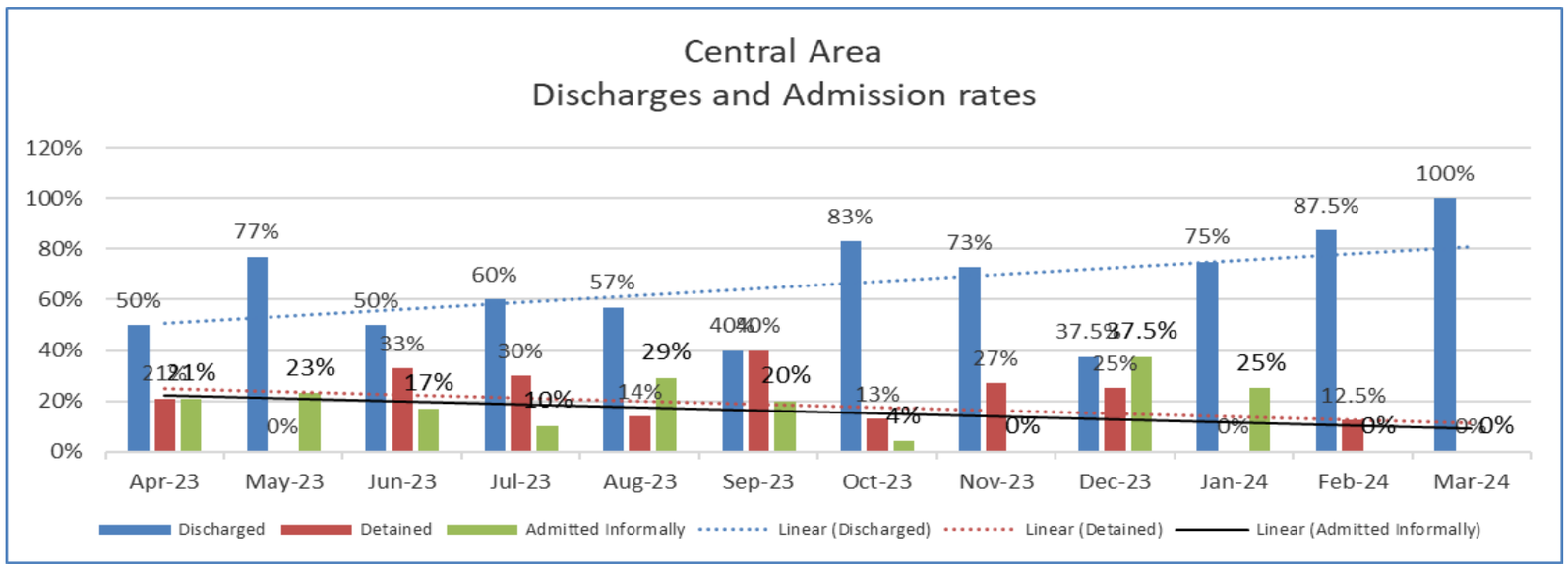
The below graphs detail the discharge and admission rates (detained or informal) by % for the past 12 months.
The tables detail the outcomes of the S136 for each area and for BCUHB.



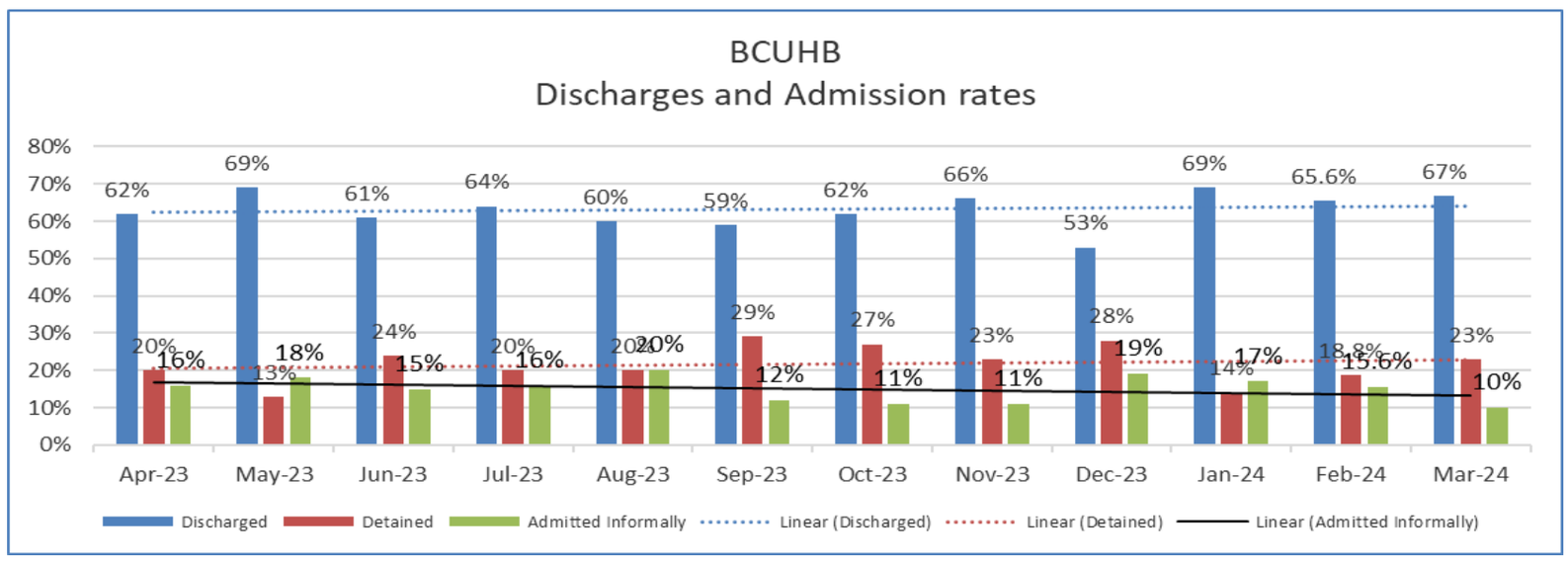
S136 Outcomes (WEST)	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Discharged follow up	2	5	6	5	9	8	2	1	3	2	3	4
Discharged referred	3	1	6	2	3	1	0	0	0	3	2	1
Discharged no mental disorder	2	2	1	1	3	3	0	1	1	0	1	4
Informal admission	4	0	3	1	5	4	1	1	2	1	4	1
S2 Admission	3	2	5	3	3	1	3	3	4	2	3	4
S3 admission	2	0	1	0	2		2	0	0	0	0	0
Other						1			0		1	
TOTAL	16	10	22	12	25	18	8	6	10	8	14	14



S136 Outcomes (EAST)	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Discharged follow up	11	7	10	3	9	9	3	5	5	3	4	1
Discharged referred	6	2	2	3	1	1	0	3	3	7	0	4
Discharged no mental disorder	1	0	0	6	2	1	2	5	2	2	2	2
Informal admission	1	4	3	2	3	2	3	3	1	3	1	2
S2 Admission	2	1	1	5	5	2	4	2	3	2	1	3
S3 admission	0	2	1	0	0	2	0	0	0	0	1	0
Other									0		1	1
TOTAL	21	16	17	19	20	17	12	18	14	17	10	13



S136 Outcomes (CENTRAL)	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Discharged follow up	6	5	3	2	2	3	12	6	2	3	4	3
Discharged referred	0	5	1	0	2	3	0	1	0	0	0	0
Discharged no mental disorder	1	0	2	2	4	0	8	1	0	0	3	0
Informal admission	3	3	2	2	4	1	1	0	3	1	0	0
S2 Admission	3	0	4	4	1	2	3	3	2	0	1	0
S3 admission	0	0	0	0	1	1	0	0	0	0	0	0
Other	1								1			
TOTAL	14	13	12	10	14	10	24	11	8	4	8	3



S136 Outcomes (BCU)	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Discharged follow up	19	17	19	10	20	20	17	12	10	8	11	8
Discharged referred	9	8	9	5	6	5	0	4	3	10	2	5
Discharged no mental disorder	4	2	3	9	9	4	10	7	3	2	6	6
Informal admission	8	7	8	5	12	7	5	4	6	5	5	3
S2 Admission	8	3	10	12	9	5	10	8	9	4	5	7
S3 admission	2	2	2	0	3	3	2	0	0	0	1	0
Other	1								1		2	1
TOTAL	51	39	51	41	59	45	44	35	32	29	32	30

Monitoring of the S136 suite used to admit detained patients or where patients remain in the S136 suite following a S136 assessment.

UNIT	SECTION	FROM	TIMEFRAME	OUTCOME
Heddfan	2	Transferred in	2 days 30 Minutes	Trans out of area
Heddfan	2	Admission	1 day, three hours 20mins	Moved to ward
Heddfan	2	S136	6 hours 40 mins	Moved to ward
Heddfan	2	Admission	1 day 5 hours 15 minutes	Trans within BCU
Heddfan	2	S136	2 days 20 hours 45 minutes	Discharged
Heddfan	2	Informal	2 days 14 hours 30 minutes	Trans out of area
Hergest	2	S136	3 days, 4 hours, 45 minutes (approx)	Moved to ward
Heddfan	2	S136	3 hours	Trans within BCU
Heddfan	2	S136	1 day 5 hours 15 minutes	Trans out of area
Heddfan	2	Informal	8 hours 50 minutes	Trans out of area
Hergest	2	Admission	1 day 21 hours 40 minutes	Trans within BCU
Hergest	2	Admission	1 day 12 hours 15 minutes	Trans out of area
Hergest	2	S136	1 day 1 hour 30 minutes	Trans out of area
Hergest	2	Admission	23 hours 15 minutes	Trans within BCU

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 3

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

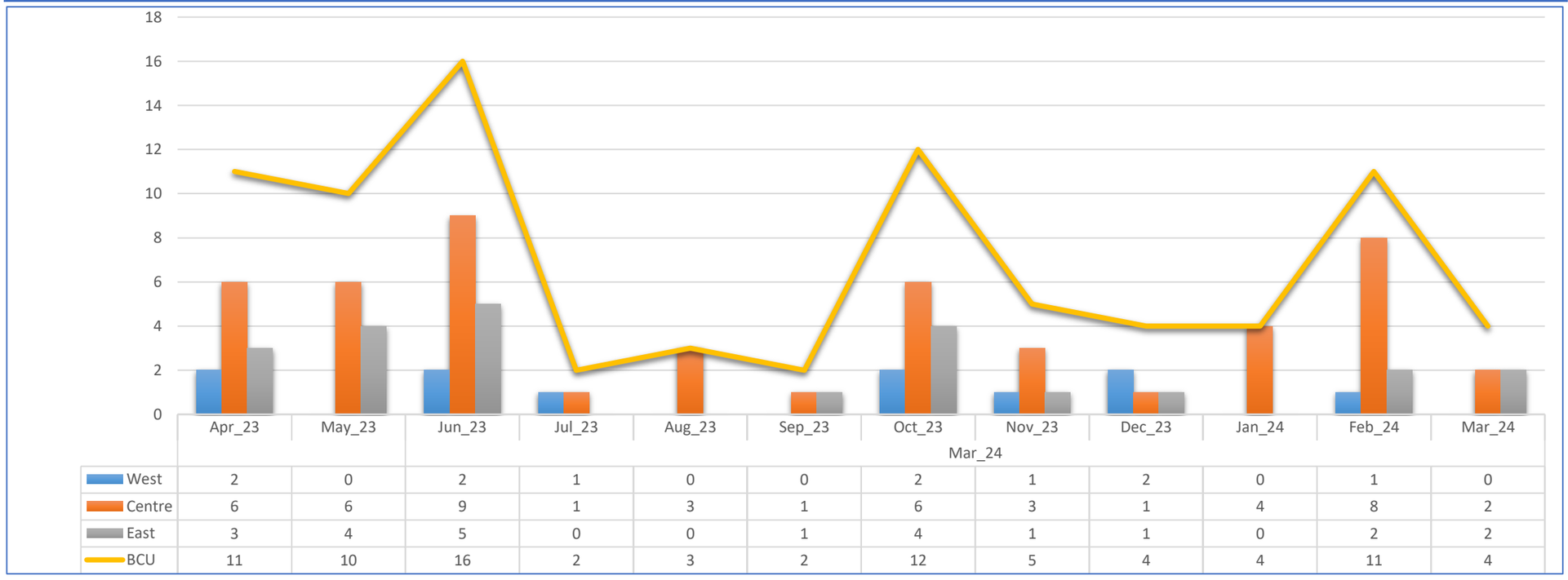
Under 18's detentions in North Wales

KPI Report for: March 2024

Data Source:	BCUHB MHA Database
Report Created on:	05/04/2024
Report Created by:	Performance Directorate

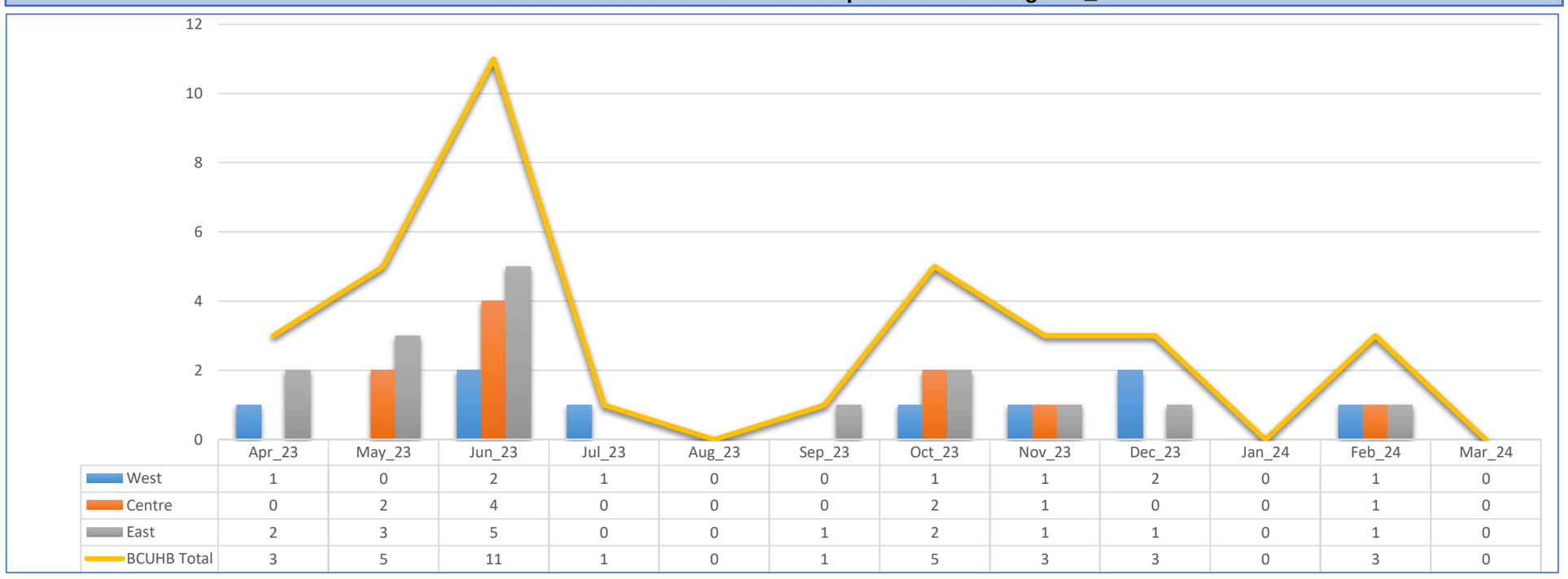
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Mar_24



	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
	Mar_24											
West	2	0	2	1	0	0	2	1	2	0	1	0
Centre	6	6	9	1	3	1	6	3	1	4	8	2
East	3	4	5	0	0	1	4	1	1	0	2	2
BCU	11	10	16	2	3	2	12	5	4	4	11	4

2.1: Section 136 twelve month trend up to and including Mar_24

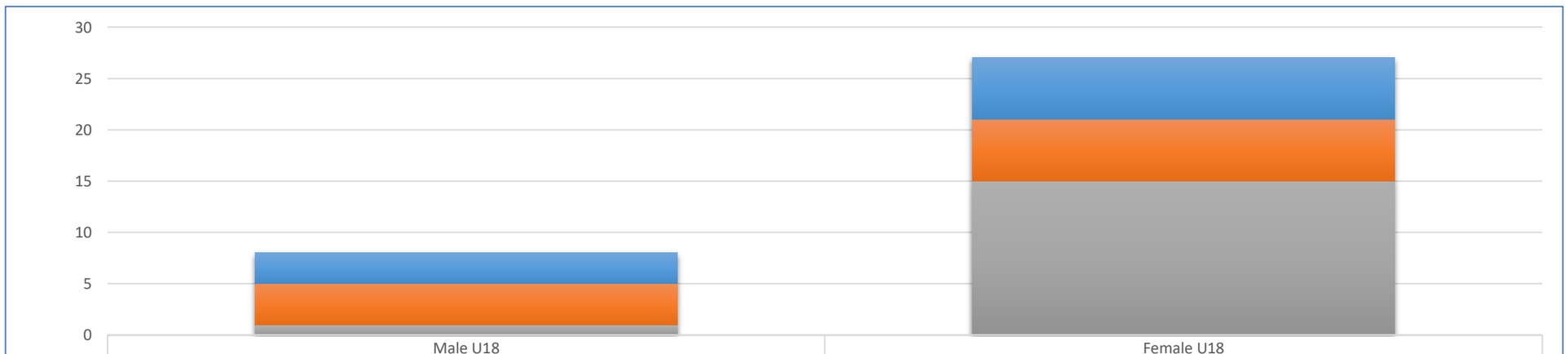


	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	1	0	2	1	0	0	1	1	2	0	1	0
Centre	0	2	4	0	0	0	2	1	0	0	1	0
East	2	3	5	0	0	1	2	1	1	0	1	0
BCUHB Total	3	5	11	1	0	1	5	3	3	0	3	0

2.2: Section 136 Outcomes twelve month trend up to and including Mar_24

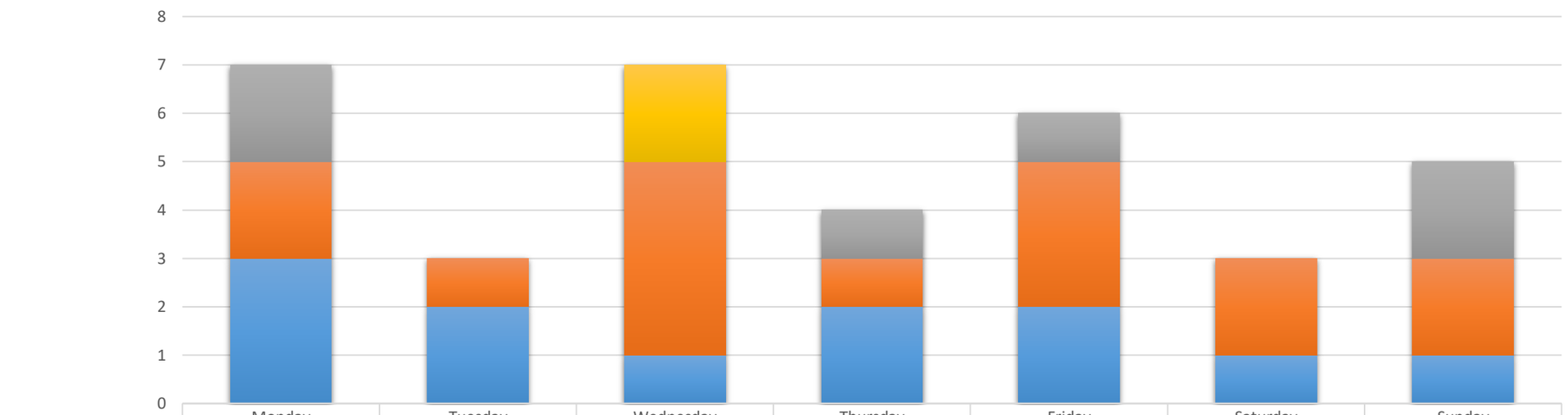
Outcome of 136 detention	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
Discharged - No Mental Disorder	0	0	0	0	0	0	0	0	0	0	0	0
Discharged - Referred to Services	0	1	1	0	0	0	0	1	1	0	0	0
Discharged - Follow up service	2	3	6	1	0	1	3	1	2	0	0	0
Admitted	1	1	3	0	0	0	2	1	0	0	3	0
Section Lapsed	0	0	1	0	0	0	0	0	0	0	0	0

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



	Male U18	Female U18
West	3	6
Centre	4	6
East	1	15

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



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Male 5pm - 8:59am	0	0	2	0	0	0	0
Male 9am - 4:59pm	2	0	0	1	1	0	2
Female 5pm - 8:59am	2	1	4	1	3	2	2
Female 9am - 4:59pm	3	2	1	2	2	1	1

4: 1st Place of Safety 12 month trend up to and including Mar_24

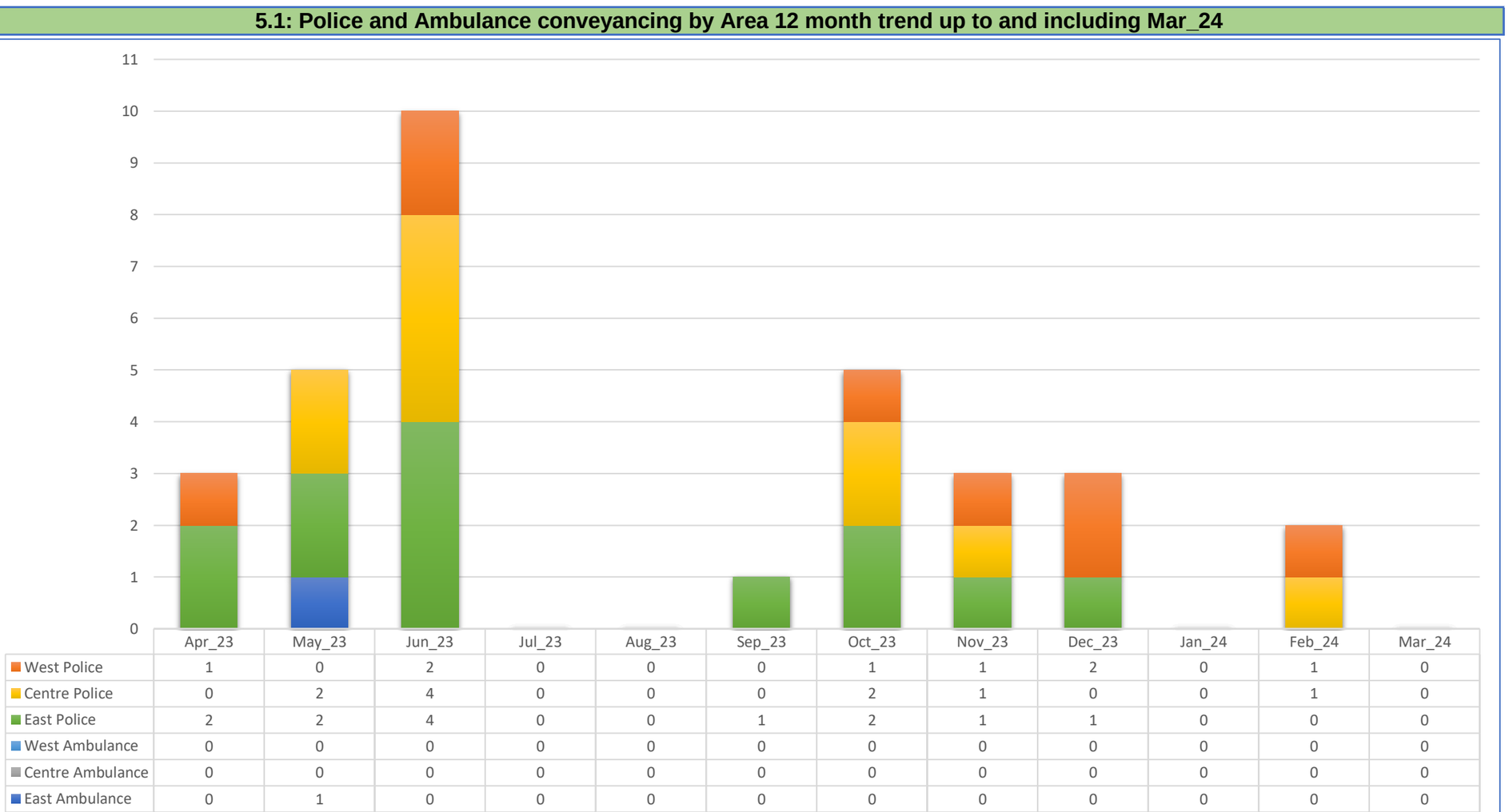
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
A&E	0	4	6	1	0	1	3	0	1	0	1	0
Ward	0	0	0	0	0	0	0	0	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	2	1	5	0	0	0	2	3	2	0	2	0
Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Independent Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0	0	0	0	0	0	0
Police Station (Custod)	1	0	0	0	0	0	0	0	0	0	0	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0	0	0	0	0	0	0
Any other place	0	0	0	0	0	0	0	0	0	0	0	0

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

1st Place of Safety: A&E Split	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West	0	0	1	1	0	0	0	0	1	0	0	0
Centre	0	2	1	0	0	0	1	0	0	0	1	0
East	0	2	4	0	0	1	2	0	0	0	0	0

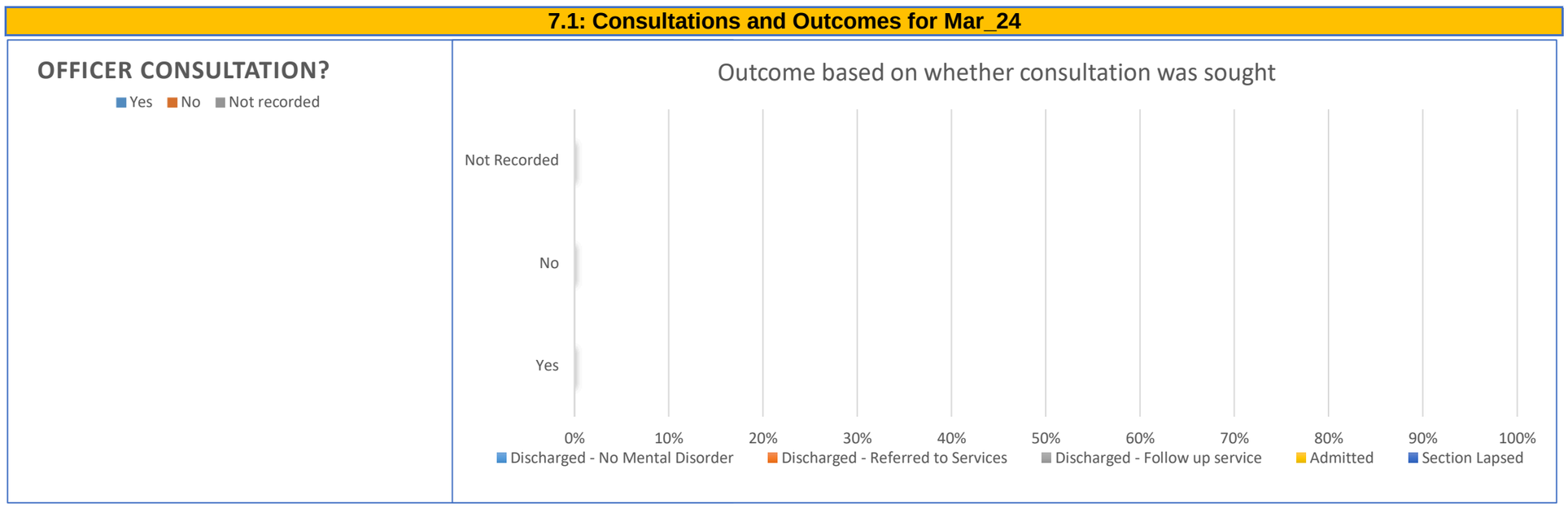
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Mar_24



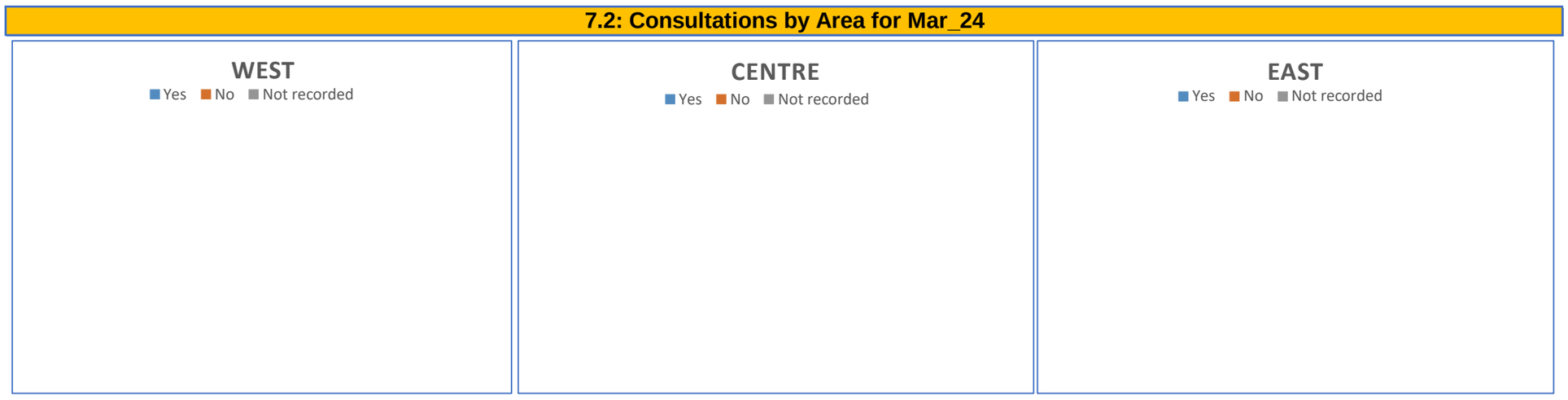
	Apr_23	May_23	Jun_23	Jul_23	Aug_23	Sep_23	Oct_23	Nov_23	Dec_23	Jan_24	Feb_24	Mar_24
West Police	1	0	2	0	0	0	1	1	2	0	1	0
Centre Police	0	2	4	0	0	0	2	1	0	0	1	0
East Police	2	2	4	0	0	1	2	1	1	0	0	0
West Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	1	0	0	0	0	0	0	0	0	0	0

Section B: Data for Mar_24

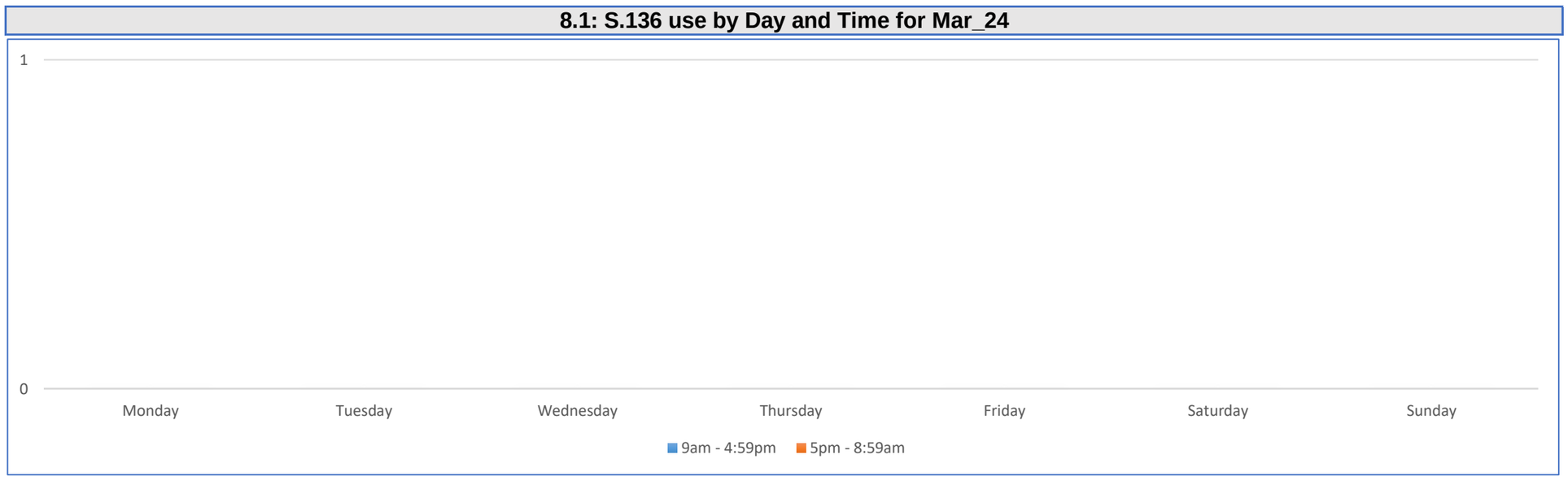
7.1: Consultations and Outcomes for Mar_24



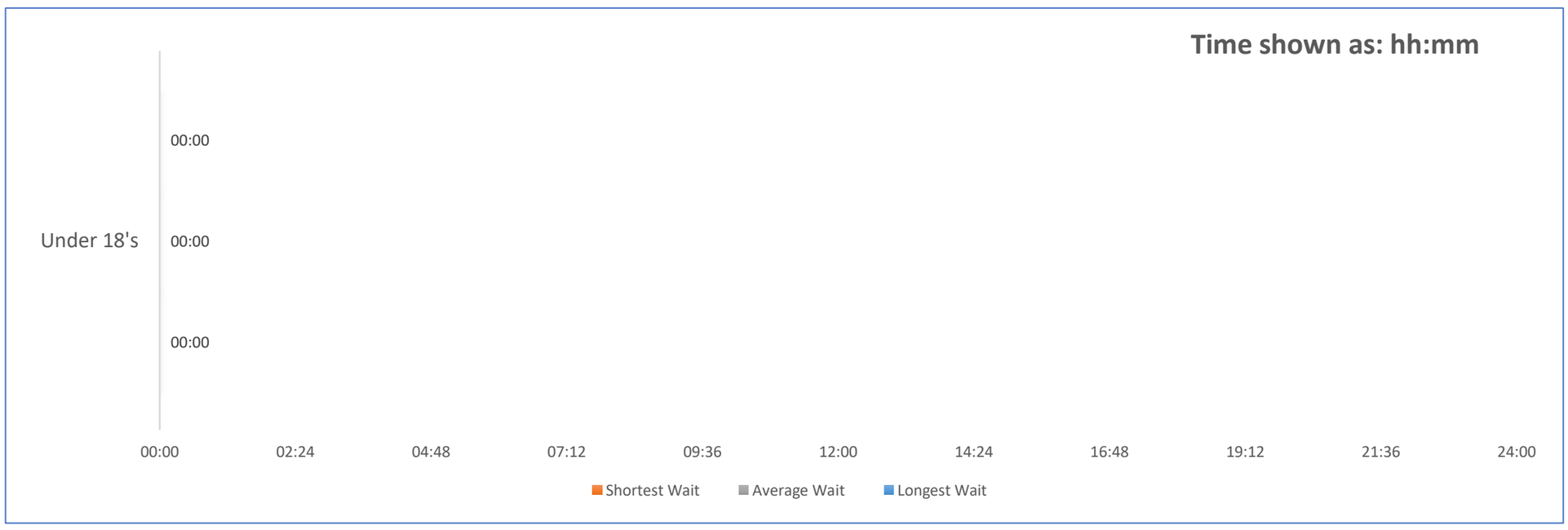
7.2: Consultations by Area for Mar_24



8.1: S.136 use by Day and Time for Mar_24

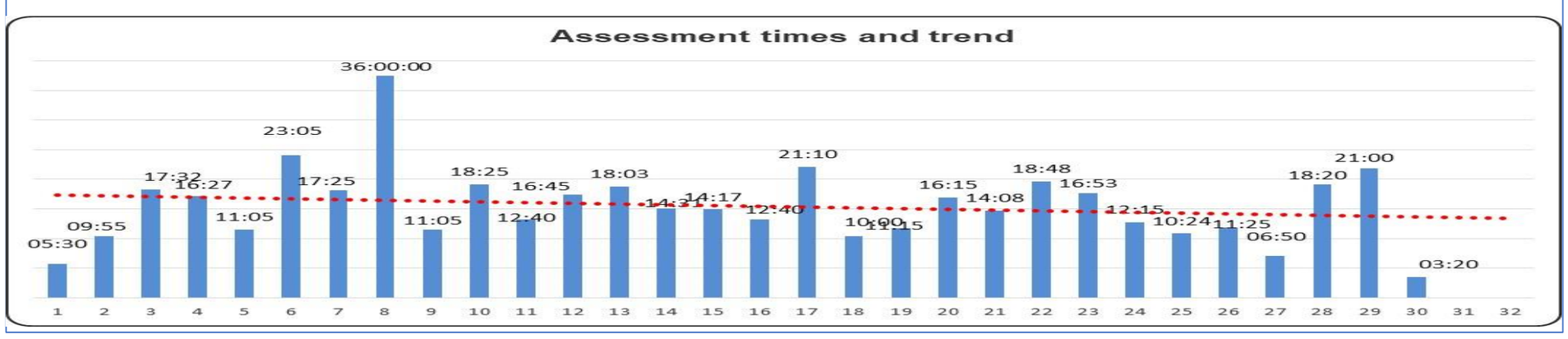


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Mar_24



10.1: Narrative for Mar_24

There were no S136 detentions for the month of March. There were four detentions recorded under the Act for two young people. One detention from informal under a S2 (following transfer out and back into the Health Board this accounted for two lines of detention). One young person was detained under a S5(2) from informal which progressed to a S3. One young person was initially in the general hospital at the time of their first detention. The graph below details the last 30 detentions and trendline for S136 detentions. Detention 27 was undertaken by an Adult Psychiatrist and a GP, all other assessments involved a CAMHS clinician, this has not changed from the previous report.



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

Reference	S136 applied	S136 Accepted /clock started	Duration
No S136 detentions			

The below information shows where the young person was detained, whether consultation took place and the outcome.

Area detained	Consultation	Outcome
No detentions for March		

Appendix 4

MENTAL HEALTH & LEARNING DISABILITY DIVISION

MEMO/ALERT

Document Type *(Please highlight in blue)*	Memo	Alert
Title:	Medical Recommendations Mental Health Act Paperwork	
To:	All Consultants and independent S12(2) doctors	
From:	Wendy Lappin, MHA Manager Alberto Salmoiraghi, Medical Director MHLD Matthew Joyes, Deputy Director of Quality, BCUHB	
Summary/Details:	For those who undertake the completion of medical recommendations for a patients detention under the Mental Health Act, we would like to remind you of the importance of your medical recommendations being: a) Legible And b) Covering the criteria as noted in the guidance on the side of the completion box on the medical recommendations. Section 2 *(your reasons should cover both (a) and (b) above. As part of them describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; explain why the patient ought to be admitted to hospital and why informal admission is not appropriate).* Section 3 *(your reasons should cover both (a), (b) and (c) above. As part of them describe the patient's symptoms and behaviour and explain how those symptoms and behaviour lead you to your opinion; say whether other methods of care nor treatment (e.g. out-patient treatment or social services) are available and, if so, why they are not appropriate; indicate why informal admission is not appropriate).* Whilst the MHA nor the regulations require a capacity assessment to be undertaken when considering if to make a medical recommendation the criteria above does require indication as to why informal admission is not appropriate, as there are a number of medics who scrutinise documents it is preferable that this is stated explicitly rather than it being implied; to avoid any confusion, unnecessary distress to a patient and additional workload to professionals. We would also like to remind all that any joint medical recommendations that are deemed insufficient in the criteria for detention as above are not able to be rectified under section 15(2) of the Mental Health Act and therefore separate medical recommendations are preferable.	

Appendix 4

Action Required:	All Medics to be aware.
Timescale:	Immediate

Appendix 5

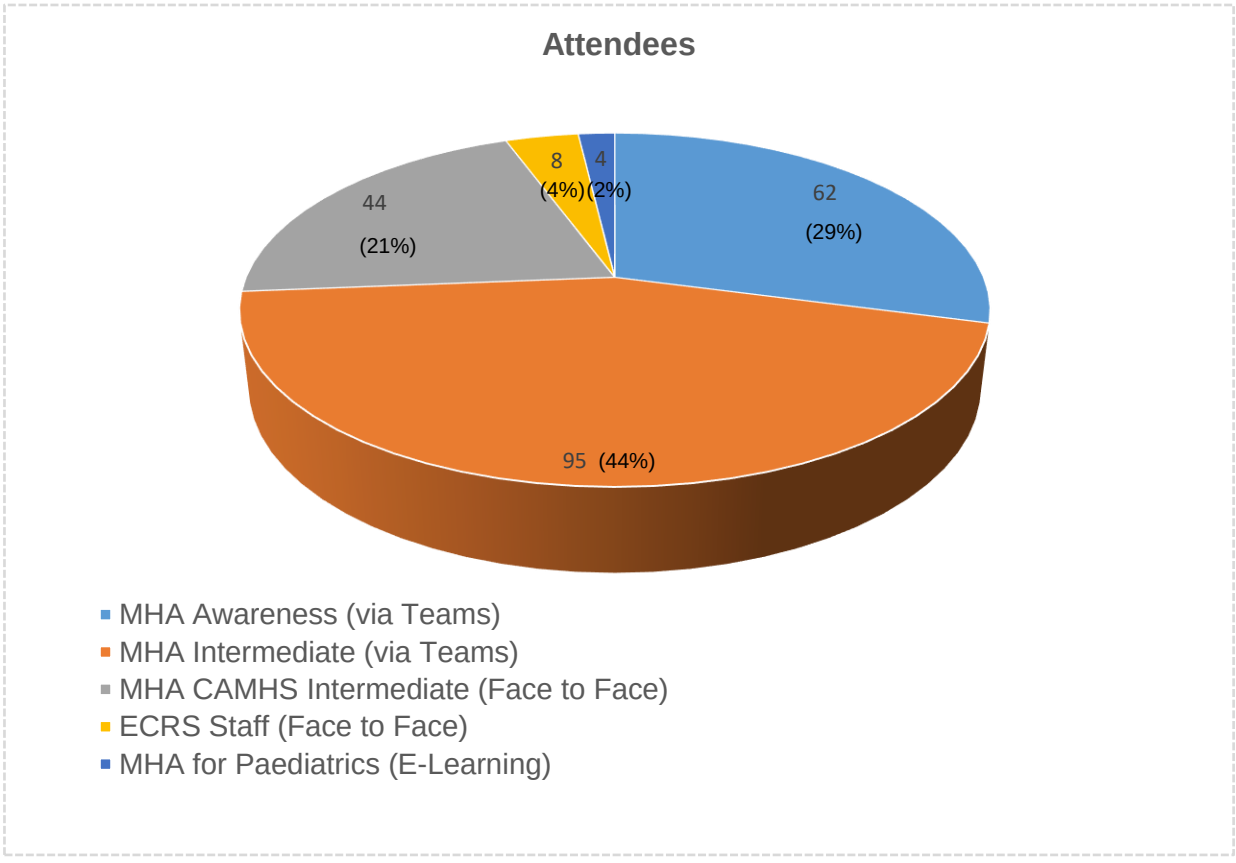
ANALYSIS

Of

Mental Health Act 1983 Training

Delivered in 2023

Attendees	213
Feedback Forms	65
People providing comments	58
Suggestions for Improvement	26



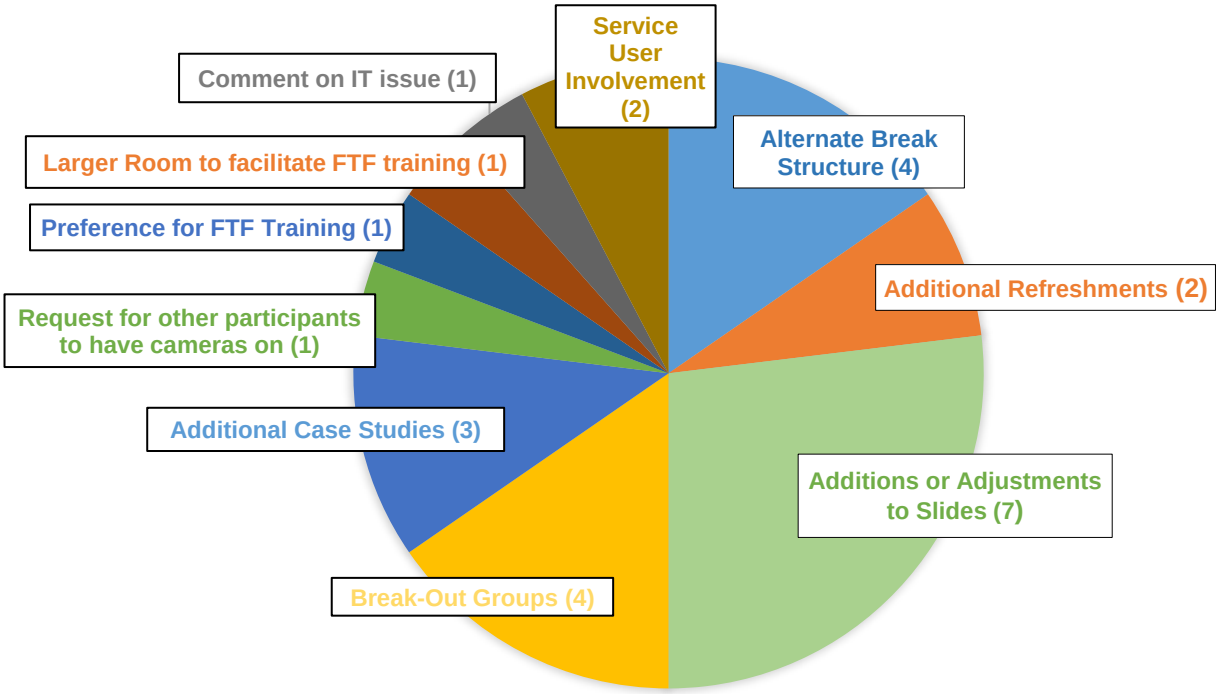
Feedback

	1 Very Poor	2 Poor	3 Average	4 Good	5 Excellent
Structure – Did the presentation flow?	0%	0%	3%	15%	82%
Content – Was the training pitched at the right level?	0%	0%	1%	13%	86%
Presentation – Did you find it interesting?	0%	0%	3%	23%	74%

Comments Received

- *"Very informative and presentation was well laid out."*
- *"Learnt a lot about sections that I was unaware of previously."*
- *"Insightful and it was broken down in an easy to understand format, which can be applied easily to practice."*
- *"I found the training informative and it was beneficial to refresh my knowledge about the application of the various sections."*
- *"Useful summary of the legislation and very relevant to my job. I feel much better equipped for understanding the legal context and responsibilities we have as a service. The training was very in-depth and well delivered."*
- *"Well-presented and relevant training. Enjoyed the entire training and presentation. For me it was an eye-opener."*
- *"Excellent presentation. Helped me to refresh my knowledge and great that it was online."*
- *"A very interesting and useful training session thank you. The training is clearly relevant and important. Both the facilitators were very knowledgeable of the subject area, able to answer questions fully, and I appreciate the 'real life' examples given by the AMHP. The facilitators also tried to keep the training engaging and were very encouraging of group participation. The slides were well formatted and clear. The additional resources provided were also helpful."*
- *"It was interesting to see the changes from when I used it in a past role."*
- *"Interesting and informing presentation with good scope to ask questions and discuss."*
- *"Such an empowering training session, I've learnt so much which will definitely improve my day to day practice."*

Suggestions for Improvement



Delivery of Training for 2024

Awareness and Intermediate Sessions

Mental Health Act Awareness and Intermediate sessions are available via Microsoft Teams. There are 7 Awareness sessions, and 9 Intermediate sessions scheduled to take place in 2024. Scheduled dates can be found on SharePoint. Booking onto these sessions is done through ESR, and an email is to be sent to Wendy.R.Lappin@wales.nhs.uk for a Teams Invitation.

CAMHS sessions

Mental Health Act Training for CAMHS staff is delivered face to face at the North Wales Adolescent Service in Abergele. There are 6 sessions scheduled to take place in 2024. For more information and to book a place, please contact Louise.Jones35c144@wales.nhs.uk

Paediatric E-Learning

E-Learning Training has recently been developed for Paediatric Staff within BCUHB. This is accessed via SharePoint. Compliance gained through completion of quizzes. A pass rate of 50% is required.

Awareness E-Learning

Currently in development. Expected to be available for staff in early 2024.

Staff attendance for all of the above sessions is recorded on ESR.
For discussion regarding arrangement of any specific MHA training sessions, please contact Wendy.R.Lappin@wales.nhs.uk

APPENDIX 6

Quality Directorate / Healthcare Law Department

Compliance with the Mental Health Act Quarterly Audit Quarter 1 - 2024

Audits conducted by: Mental Health Act Department Staff
Report produced by: Wendy Lappin, Mental Health Act Legislation Manager
March 2024

CONTENTS

SUMMARY

A quarterly Compliance with the Mental Health Act Audit has been undertaken since 2021. Initial reports were produced on a quarterly basis until 2022 when the report was then presented as a combined report at the end of each year. Due to a fall in compliance it was recommended that the Mental Health Legislation Committee have sight of a report following each quarterly period until the committee is satisfied that the Health Board has made improvements and is showing positive progress.

In quarter 1 of 2024 eight units were audited reviewing a total of 61 files. A number of additional standards have been added around the Care and Treatment Plans. An additional standard has been added in relation to medication charts following Healthcare Inspectorate Wales (HIW) raising the importance of recording this information following a number of inspections throughout Wales.

It is noticeable this quarter, whilst there have been some improvements no one unit reached 100% across all standards. Compliance has fluctuated in some units but it has been deemed no unit required an additional audit the following month.

The lack of an explanation of rights form will have a negative impact on standards 4 and 5 as these questions cannot be answered.

The additional standards in relation to Care and Treatment plans (CTP) are reported against those that were in date, it is noted that in relation to recent admissions if someone is new to service they will not have a CTP. A CTP as noted within the Code of Practice for parts 2 and 3 of the Mental Health Wales Measure '*should be provided as soon as is reasonably practicable after the individual has become a relevant patient and the care coordinator has been appointed. (4.86). Whilst the Part 2 Regulations do not specify a time limit for the production of a Care and Treatment Plan it is recommended that in most cases it should be produced within 6 weeks of the appointment of a care coordinator and disturbed within 2 weeks of its completion (4.87).* The findings of the CTP standards are communicated to the Health Boards Mental Health Measure Team to support in their audits and knowledge of compliance across the Health Board.

Considering the combined results, at the end of the audit two standards (1 and 9) ended with a better compliance than they began but none of the standards achieved 100% this audit. The lowest compliance was 68.9% for standard 4 and the highest was 95.1% for standard 8. A number of standards decreased slightly but it was encouraging to note that standard 1 in relation to detention paperwork had seen an increase of 18.3%.

The Mental Health Act office staff continue to highlight to the unit managers what is missing from the files and replace any detention paperwork as necessary.

These audit report will be shared widely following the submission to the Mental Health Legislation Committee.

INTRODUCTION AND STANDARDS

For 2024 each unit is detailed within the audit in relation to the standards below. Additional standards have been added, Care and Treatment Plans and Medication Charts. It is noted that Care and Treatment Plans state they MUST be signed by a Care Coordinator and the

patient MAY sign. Within some units the lack of capacity may also affect if the patient signs the Care and Treatment Plan.
When considering standard 7 if there is a lack of up to date CTPs the following questions regarding date and signatures will be measured against those that were compliant with the initial question.

Following recent HIW inspections to Community Mental Health Teams which include the consideration of those subject to a CTO, the scrutiny the CTO patient files have also been added to the quarterly audits. These patients' files should also be compliant with the Mental Health Act and include statute documents along with patients being made aware of their rights. A sample will be audited each quarter. Standard 2, 6, and 10 are not included within the audit of a CTO file.

NUMBER	STANDARD
1	**Section papers** The correspondence file and case notes should contain the same detention paperwork.
2	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.
3	**Explanation of Rights** The correspondence file and case notes should contain the same document.
4	**Explanation of Rights** The patient should be made aware of their rights in their primary language
5	**Explanation of Rights** The patient should be offered a referral to IMHA services
6	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.
7	**Care and Treatment Plan** The integrated file should contain an up to date Care and Treatment Plan. • Is the CTP dated on the last page? • Has the CTP been signed by the Care Coordinator? • Has the CTP been signed by the patient?
8	**Mental Health Act Divider** The integrated file should contain a Mental Health Act divider.
9	**Paperwork** The documentation should confirm that the Mental Health Act documentation is filed correctly.

10 **Medication Charts**
The legal status should be recorded on the medication chart.

During each audit all detained patients' files are scrutinised and cross-referenced with the Mental Health Act correspondence files held by the Mental Health Act area office.

The below table shows the number of files scrutinised during quarter 1 of 2024 for each unit.

Specialism and Unit	Number of files scrutinised
Older Persons	
Cefni Hospital	10
Bryn Hesketh	10
Rehabilitation	
Tan Y Castell	4
Coed Celyn	5
Carreg Fawr	5
Forensic	
Ty Llywelyn	19

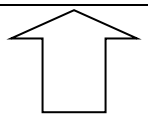
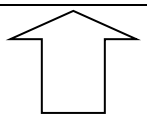
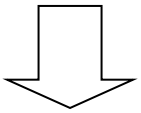
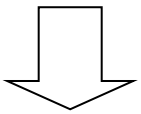
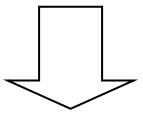
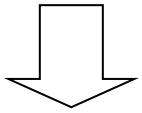
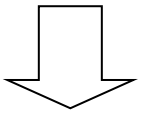
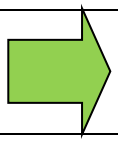
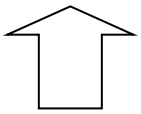
Specialism and Unit	Number of files scrutinised
Learning Disability Villas	
Tan Y Coed	0
Foelas	0
Mesen Fach	5
CAMHS	
North Wales Adolescent Service	1
CTO patients	
Patients within the community under a Community Treatment Order	2

RESULTS

Each unit's results are reported within a table detailing the result of to the previous audit at the end of 2023 and confirmation of an upward, downward or no change result. For those standards that the unit met 100% the arrow is shaded green.

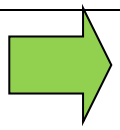
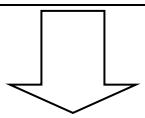
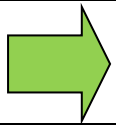
For each unit any notes of concern or good practice are recorded along with any immediate actions taken at the time of the audit.

Cefni

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**16.7%**	**70%**	**30%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**75%**	**90%**	**10%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**83.3%**	**60%**	**40%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**66.7%**	**50%**	**50%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**75%**	**60%**	**40%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**91.7%**	**80%**	**20%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**70%**	**30%**	
	Care and Treatment Plan Is the CTP dated on the last page	**-**	**70%**	**30%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**	**70%**	**30%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**		**100%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**41.7%**	**50%**	**50%**	
10	**Medication Charts** Is the legal status correct on the medication chart	**-**	**50%**	**50%**	**New measure**

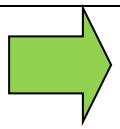
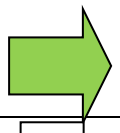
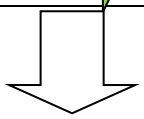
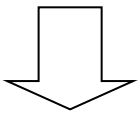
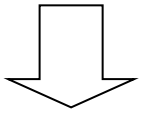
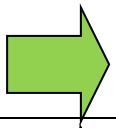
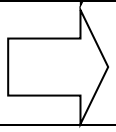
Notes: In this quarter a number of files appeared to have missing paperwork which had to be resent. This was resent to the ward manager and the ward clerk. In regards to standard has the CTP been signed by the patient for this unit the patients are likely to not have capacity so this will not be achieved. There had been an improvement in the section papers being within the files which may be due to the return of the ward clerk.

Bryn Hesketh

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**66.6%**	**60%**	**40%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**83.3%**	**100%**		
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**83.3%**	**100%**		
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**83.3%**	**100%**		
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**91.7%**	**100%**		
	Care and Treatment Plan Is the CTP dated on the last page	**-**	**100%**		**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**	**90%**	**10%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**		**100%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**100%**		
10	**Medication Charts Is the legal status correct on the medication chart**	**-**	**100%**		**New measure**

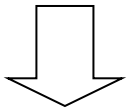
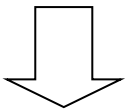
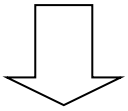
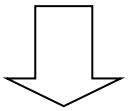
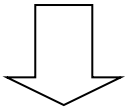
Notes: In regards to the standard 'has the CTP been signed by the patient?' for this unit the patients are likely to not have capacity so this will not be achieved.
This unit always has a high compliance for the standards and is well ran and documentation monitored efficiently.

Tan Y Castell

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**100%**		
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**75%**	**25%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**75%**	**25%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**75%**	**25%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**75%**	**75%**	**25%**	
	Care and Treatment Plan Is the CTP dated on the last page	**-**	**75%**	**25%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**	**75%**	**25%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**	**50%**	**50%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**100%**		
10	**Medication Charts Is the legal status correct on the medication chart**	**-**		**100%**	**New measure**

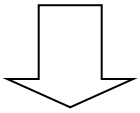
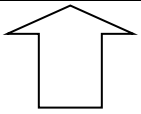
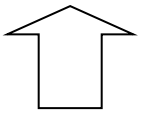
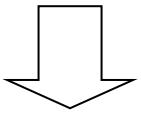
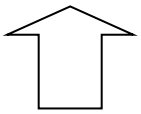
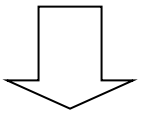
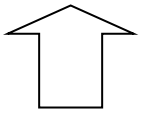
Notes: This unit always has a high compliance for the standards and is well ran and documentation monitored efficiently. The lack of one explanation of rights form affected compliance this quarter.

Carreg Fawr

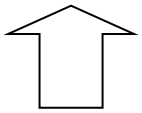
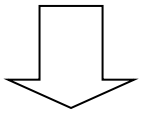
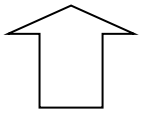
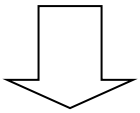
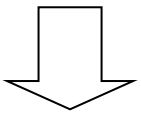
No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**50%**	**40%**	**60%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**100%**		
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**60%**	**40%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**60%**	**40%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**60%**	**40%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**75%**	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**	**60%**	**40%**	
	Care and Treatment Plan Is the CTP dated on the last page		**100%**		**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator		**66.7%**	**33.3%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient		**33.3%**	**66.7%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**75%**	**100%**		
10	**Medication Charts Is the legal status correct on the medication chart**		**100%**		**New measure**

NOTE: Legal documentation was replaced within the files and this highlighted to the Ward Manager. The unit has received support in relation to documentation and additional training.

Ty Llywelyn

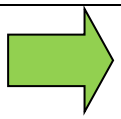
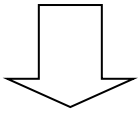
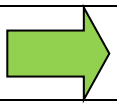
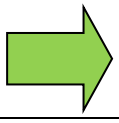
No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**85.7%**	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**90.5%**	**73.7%**	**26.3%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**90.5%**	**100%**		
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**61.9%**	**78.9%**	**21.1%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**90.5%**	**94.7%**	**5.3%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**94.7%**	**5.3%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes	**90.5%**	**94.7%**	**5.3%**	
	Care and Treatment Plan Is the CTP dated on the last page	**-**	**89.5%**	**10.5%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**	**78.9%**	**21.1%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**	**63.2%**	**36.8%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**90.5%**	**89.5%**	**10.5%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**76.2%**	**84.2%**	**15.8%**	
10	**Medication Charts** Is the legal status correct on the medication chart	**-**	**84.2%**	**15.8%**	**New measure**

Mesen Fach

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**60%**	**80%**	**20%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**80%**	**100%**		
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**60%**	**40%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**40%**	**60%**	**40%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**60%**	**40%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**40%**	**60%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**80%**	**100%**		
	Care and Treatment Plan Is the CTP dated on the last page		**100%**		**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator		**100%**		**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient			**100%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**60%**	**100%**		
10	**Medication Charts Is the legal status correct on the medication chart**		**80%**	**20%**	**New measure**

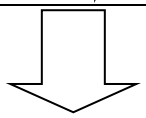
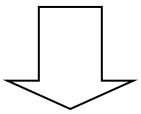
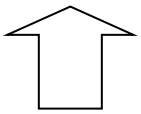
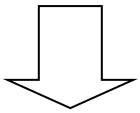
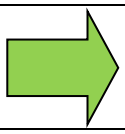
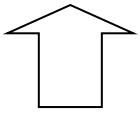
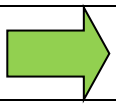
NOTE: The unit has been reminded in regards to the explanation of rights for patients and the need for the documentation to be completed fully.
In regards to the standard ‘has the CTP been signed by the patient?’ for this unit the patients are likely to not have capacity so this will not be achieved.

CAMHS – North Wales Adolescent Service

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**100%**		
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**100%**		
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**100%**	**100%**		
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**100%**	**100%**		
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**100%**		**100%**	
	Care and Treatment Plan Is the CTP dated on the last page	**-**		**100%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**		**100%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**		**100%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**100%**	**100%**		
10	**Medication Charts Is the legal status correct on the medication chart**			**100%**	**New measure**

NOTE: The staff have been informed that they should be using the correct medication chart which has a dedicated question on the front in regards to the section status of a patient. The unit only had one detained patient at the time, admission was recent but a CTP was within the notes from a different Health Board which required updating.

Coed Celyn

No	Standard	2023 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**100%**	**100%**		
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**100%**	**60%**	**40%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**100%**	**60%**	**40%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**33.3%**	**40%**	**60%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**66.7%**	**40%**	**60%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**100%**	**100%**		
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes	**50%**	**60%**	**40%**	
	Care and Treatment Plan Is the CTP dated on the last page		**60%**	**40%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator		**60%**	**40%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient		**40%**	**60%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes.	**100%**	**100%**		
9.	**Paperwork** Was the Mental Health Act documentation filed correctly.	**66.7%**	**100%**		
10	**Medication Charts** **Is the legal status correct on the medication chart**		**60%**	**40%**	**New measure**

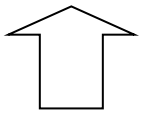
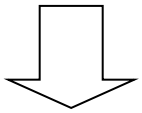
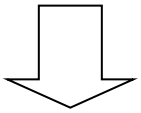
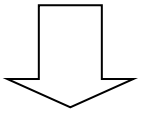
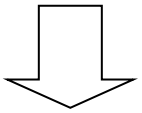
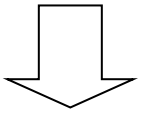
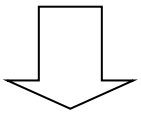
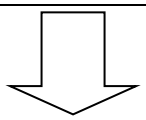
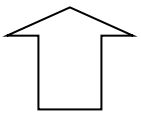
CTO Patient Files (Patients currently on a Community Treatment Order)

No	Standard	% achieved	% not achieved
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**50%**	**50%**
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**0%**	**100%**
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**0%**	**100%**
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**0%**	**100%**
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**0%**	**100%**
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes.	**50%**	**50%**
	Care and Treatment Plan Is the CTP dated on the last page	**50%**	**50%**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**0%**	**100%**
	Care and Treatment Plan Has the CTP been signed by the patient	**0%**	**100%**
8	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes	**100%**	**0%**
9	**Paperwork** Was the Mental Health Act documentation filed correctly	**0%**	**100%**

NOTE: The CTO patient files audited were for the West, East did not have access in time for the audit report completion and Central had recently been visited by HIW and the documentation noted to be correct for the Conwy CTO patients. This will be expanded as the audit progresses as an addition to the regular audits. Not all of the standards can be reported against for CTO patients as they will not have section 17s and there is no access to the medication charts.

All documents that was missing was placed within the files whilst they were in the Mental Health office and filed correctly.

Combined results from the inpatient units

No	Standard	2023 (starting position)	% achieved	% not achieved	Comparison to previous audit
1.	**Section papers** The correspondence file and case notes should contain the same detention paperwork.	**68.6%**	**86.9%**	**13.1%**	
2.	**Section 17 Leave documentation** The correspondence file and case notes should contain the same information.	**83.3%**	**77%**	**33%**	
3.	**Explanation of Rights** The correspondence file and case notes should contain the same document.	**87.3%**	**78.7%**	**21.3%**	
4.	**Explanation of Rights** Was the patient made aware of their rights in their primary language	**77.5%**	**68.9%**	**31.1%**	
5.	**Explanation of Rights** Was the patient offered a referral to the IMHA services	**90.2%**	**75.4%**	**26.6%**	
6.	**Medication Certificates** The correspondence file and case notes should contain the same documents, certificate and consent.	**95.1%**	**86.9%**	**13.1%**	
7.	**Care and Treatment Plan** Is there an up to date Care and Treatment Plan within the case notes	**84.3%**	**81.9%**	**18.1%**	
	Care and Treatment Plan Is the CTP dated on the last page	**-**	**72.1%**	**27.9%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	**-**	**72.1%**	**27.9%**	**New measure**
	Care and Treatment Plan Has the CTP been signed by the patient	**-**	**36.1%**	**63.9%**	**New measure**
8.	**Mental Health Act Divider** Was there a Mental Health Act divider in the case notes	**96.1%**	**95.1%**	**4.9%**	
9.	**Paperwork** Was the Mental Health Act documentation filed correctly	**68.6%**	**81.9%**	**18.1%**	
10	**Medication Charts** Is the legal status correct on the medication chart	**-**	**73.8%**	**26.2%**	**New measure**

ACTIONS TAKEN

Following each scrutiny session the areas have been informed of their results and areas of concern highlighted with confirmation of actions as requested being undertaken examples have included the receipt of explanation of rights forms or care and treatment plans, the insertion of missing documents into the files.

The MHA office staff request on a weekly basis the explanation of rights forms if these are missing and now highlight to the Mental Health Act Manager at the end of each month those that are missing so that this can be addressed, this has made an improvement on receipt.

ACTION PLAN FROM THE YEARLY AUDIT AND PROGRESS

Target Area	Action Required	Lead	Evidence of completion	Target Date / update
Explanation of Rights Referral to IMHA	If an incomplete form is received the ward managers to be made aware and a new form requested. To also be noted on the Area Clinical Meeting (ACM) emails.	Area MHA Administrators	Confirmation from the MHA office staff that this is being completed, an improvement should be seen at the following scrutiny sessions.	31.01.2024 21.03.2024 This is undertaken as required
Explanation of Rights	The Mental Health Act office at the end of each month to document those outstanding onto the monthly stat form. Missing forms to be followed up by the Mental Health Act Manager	Area MHA Administrators Mental Health Act Manager	Confirmation within the monthly stats that all current patients have an explanation of rights form.	Monthly 31.01.2024 21.03.2024 This is undertaken as a regular occurrence
Audit Standards	If a quarterly audit results in a concerning return a further follow up audit of that unit to be undertaken the following month and reported as a separate undertaking.	Area MHA Administrators	Audit results received by the MHA Manager and reported to the unit in question.	Quarterly 31.03.2024
Medication Charts	Medication charts to be checked for the	Area MHA Administrators	Audit results received by the MHA manager	Quarterly 31.03.2024

	section status of the patient		and reported to the unit in question.	21.03.2024 Comparisons will be made quarterly going forward.
Care and Treatment Plans	To be checked to record if the Care Coordinator and patient have signed the form and if the document is dated.	Area MHA Administrators	Audit results received by the MHA manager and reported to the unit in question.	Quarterly 31.03.2024 21.03.2024 Comparisons will be made quarterly going forward

RECOMMENDATIONS / SHARING OF INFORMATION

The report will be shared with the Mental Health Legislation Committee, the Head of Operations, Clinical Operations Managers and Heads of Nursing for each unit.
The Information to Patients Policy to be highlighted to staff by the Heads of Nursing in relation to Explanation of Rights and the process, work still needs to be undertaken to ensure that the forms are fully completed. This policy with the form can be accessed and is available on the intranet. MHLD 0030 Policy for information to patients (s132/3 MHA).
The audit will be shared with the Business Support Managers in relation to filing so that this can be shared in admin meetings with administration staff. The importance of documentation and audits undertaken is to be highlighted within the MHA training sessions provided to the MHLD staff.

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Legislation Committee** 2nd May 2024
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q4 2023-24 Update**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Michelle Denwood, Director of Safeguarding and Public Protection Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Hayley Lloyd, DoLS and MCA Regional Team Manager Chris Walker, Head of Safeguarding Adults, DoLS and MCA
Craffu blaenorol: **Prior Scrutiny:**	Due to the non-alignment of the cycles of business, this quarterly report is submitted directly to the Committee. 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.
Atodiadau **Appendices:**	Appendix 1: DoLS and MCA Action Plan

Argymhelliad / Recommendation:

The Committee is asked to:

1. Accept the DoLS and MCA Report and the identified activity for the period of Q4 2023-24
2. Receive the DoLS and MCA Action Plan and progress.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	No

Sefyllfa / Situation:

Governance

The activity recorded provides oversight and organisational assurance in relation to the Health Board's statutory duty under DoLS and the MCA 2005 for the period of Q4 2023-24. The activity includes key actions and activities 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.

Legislation Activity
As previously confirmed the implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) remains on hold. Despite LPS being postponed, Welsh Government (WG) were keen for elements of the LPS to be implemented and therefore additional funding from WG continues to be made available to strengthen the current DoLS system. The direction received from WG is to continue to deliver MCA training and address the DoLS backlog (legal term for applications awaiting authorisation). WG are also eager for elements of the LPS to be implemented into the All-Wales Independent Mental Capacity Advocacy (IMCA) Service commissioning contract. The Health Board has moved to a fully commissioned IMCA and paid Relevant Person Representative (RPR) service under MCA and DoLS. This funding continues to be fundamental to protect the rights of individuals who lack Mental Capacity.

The WG led DoLS National Workforce Group continues to focus on the MCA and DoLS 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.

Current Health Board Position (Q4)
In partnership with other Health Boards, the National Workforce Group continues to meet every quarter. The current action plan looks to address the following:

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.

Addressing each action in turn. Action 1 will support an improvement in the current compliance of the completion of the DoLS and MCA documentation. The forms are cumbersome and require extensive in-depth detail taking too much time for frontline staff to complete. A reduction in the amount of statutory paperwork and repetitiveness of the documentation would improve compliance and the number of assessments that can be submitted and subsequently authorised to prevent an unlawful deprivation.

Action 2 is a key activity for the Health Board with progress on MCA training compliance having been achieved during Q4. National training programmes will offer a standardised approached to MCA awareness and understanding, providing staff with the necessary skills to confidently support patients in their care and uphold their rights under the legislation.

Action 3 is directly linked with the work acknowledged by WG and all partner agencies in tackling the issue of the number of DoLS assessments that are submitted and that require assessment. As of the end of Q4 2023-24 the DoLS Backlog at the Health Board stands at 44 (see table 1 below). Prior to WG funding, the Health Board had a Backlog of approximately 144 cases. The reduction is a testament to the work undertaken by the MCA/DoLS Team. Our Best Interest Assessors and Section 12(2) Doctors complete additional DoLS Assessments during evenings and weekends to ensure patients are protected by the Legal Framework. It is important to note applications received can differ significantly from month to month. The Backlog will fluctuate.

The Health Board has seen the Backlog as low as 16 during 2023-24 with the figure dependant on a number of factors that include good communication, accuracy of reporting, and the increase in reports received. The success of improved training compliance and MCA awareness has resulted in an increase of 27.3% in DoLS applications during 2023-24.

Table 1

Urgent Applications (1-7 Days)	28
Extended Applications (8 - 14 days)	35
Backlog	**44**
Applications Allocated to BIA	17
Applications Allocated to Section 12(2) Doctors	8
Applications Pending Authorisation	2

Utilising the additional WG funding we have been able to continue to offer secondment opportunities in order to strengthen the current DoLS/MCA system. With confirmation having been received from WG that temporary funding will now be permanent funding a further review of the service is underway to strengthen the Health Boards provision of DoLS and MCA support.

As a result of the MCA Trainer post we have seen an overall improvement in MCA training compliance for substantive staff and as reported a significant increase to the DoLS applications and a number of applications received from previously lower referring areas.

To improve compliance within the temporary staffing teams there are targeted sessions being planned for Q1 and Q2 2024-25.

Cefndir / Background:

Performance and Activity

It remains evident that the annual trend for DoLS applications is an upward trajectory within the Health Board. This is in line with the National picture. During 2023-24 a total of 2008 DoLS applications were submitted, a 27.3% increase in comparison to last year's figure.

We are currently reporting an average of a four 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 are in a similar position. WG have responded to organisational challenges and the financial support offered to address the DoLS Backlog has resulted in a reduction in authorisation times prior to receipt of WG funding.

An internal Audit DoLS review commenced during Q4 2023-24 reviewing the processes in place for the management of DoLS activity in the Health Board, including procedures, staff training, monitoring and escalation of cases. In line with the final submission of the internal audit report the statutory authority have responded to the factual accuracy of the report and are currently completing the management response to the recommendations. The final report and progress against the recommendations will be reported as part of the Q1 2024-25 committee report.

Welsh Government (WG) Monies

In Q4 WG have confirmed that additional funding will be made permanent and will be available during 2024-25 in line with a bidding process. To meet the expectations of the funding we have developmental opportunities for trained staff within the team to support the strategic and operational management DoLS and the MCA.

Asesu a Dadansoddi / Assessment & Analysis

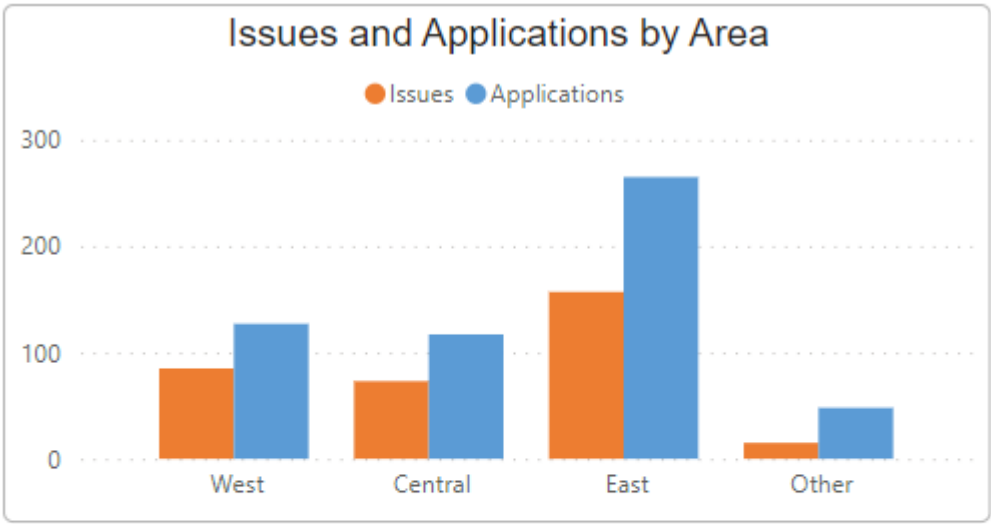
Strategic Implications Assessment and Analysis

The following 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 Safeguarding legislation and statutory guidance.

DoLS Documentation Audit

The internal audit undertaken in Q4 2023-24 included 1073 DoLS applications. Although the findings demonstrated a decrease in the quality of the paperwork when compared to Q1 and Q2 resulting in applications having to be initially returned to the Managing Authority (Hospital Wards), the issues were minor and required minimal input and time to rectify. The slight decrease in quality can be attributed to the overall increase in applications as a result of the MCA training resulting in DoLS applications being submitted from new wards. Where non-compliance or concerns with regard to the completion of paperwork is identified the DoLS administration team now offers additional training in documentation competence.

Fig 1: Q4 2023-24 Applications and issues by area



Area	Applications	Issues	%
West	127	85	66.9%
Central	117	73	62.4%
East	265	157	59.2%
Other	48	15	31.3%
Total	**557**	**330**	**59.2%**

Analysis
Of the 330 applications that recorded issues during Q4, 39.1% (n=129) applications were rectified within the two-week timeframe, allowing the Supervisory Body (DoLS Team) to extend the Urgent Authorisation providing lawful deprivation.

It should be noted that the majority of the issues from the applications were minor with minimal amendments required. The time taken to rectify errors in the majority of cases was under an hour. The submitted applications continue to identify four (4) main themes (see table 2).

- 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.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority should provide current medical information.
  Some details were included, however to fully adhere to the legal framework the Managing Authority must provide all necessary information. This issue is usually addressed immediately by the Managing Authorities.

Table 2

Issue	Number of Applications with this issue	% of Applications recording this issue
A - Incomplete patient details (cannot accept)	0	0.0%
B - Missing details regarding communication and medical information	161	28.9%
C - Incomplete MA details	2	0.4%
D - Section details missing (MHA only)	0	0.0%
E - Urgent Authorisation not completed	13	2.3%
F - Urgent Authorisation also completed (MHA only)	0	0.0%
G - No Care and Treatment Plan (CTP) (MHA only)	3	0.5%
H - No Consultant name (MHA only)	1	0.2%
I - No Capacity Form	69	12.4%
J - Capacity Form - issue: poor or wrong decision	99	17.0%
K - Q10 or Q12 not completed correctly	181	32.5%

The ongoing concern remains the delay in the submission of correct paperwork which then results in the delay in the assessment and authorisation of the DoLS which increases the risk of a legal challenge to the Health Board. An action has been taken to look at the digitalisation of the documentation. This will add further assurance to the correct completion of the paperwork on submission and reduce any unnecessary delays.

Training
Best Interest Assessors (BIA's) provide advice and support directly to the staff on the wards on a daily basis. The MCA Training Lead provides additional MCA training tailored specifically to the wards need. A more in depth, Level 3 MCA/DoLS training package is also available on a monthly basis. All qualified staff members Band 5 and above are encouraged to undertake the Level 3 training. An MCA level 1 booklet has been developed for non-clinical staff to aid compliance.

Competency	Q2	Q4	Trend
Mental Capacity Act Level 1	79.1%	80.4%	↑
Mental Capacity Act Level 2	79.5%	79.6%	↑

2023-24 has seen an overall improvement in MCA training compliance. An identified priority for 2024-25 is to review and action training provision and compliance to students, bank, agency and non-substantive staff. Some individual Divisions and Services have a compliance rate above the organisational target of 85%. Training compliance is shared monthly with respective services to ensure compliance is reviewed and actions taken as appropriate.

Analysis
Training compliance and an understanding of DoLS and the MCA is a key target so the approach taken is to ensure all areas or departments with a reduced compliance are afforded extra training and support. A revised virtual training programme is also available and remains in place to encourage ongoing training. MCA training is also included within the mandatory Adult Level 2 Safeguarding Module to utilise all available opportunities.

In Q4 there has been a 34% reduction in wards with one or more modules below KPI of 85%. This equates to a reduction from 35 wards to 23 wards. This is a significant improvement. The appointment of an MCA Training Lead is likely a contributory factor to this trajectory.

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)
Recent cases have highlighted the need to strengthen the organisations procedures in relation to CoP DoL cases within community placements. This includes all known and unknown activity specific to the CoP DoL Legal Framework. The development of a Standard Operating Procedure for 16-17 year olds within the CoP DoL process to reflect the legislative policy and to ensure good practice and governance is in place is near completion and will follow agreed governance process for approval.

Opsiynau a ystyriwyd / Options considered
N/A

Goblygiadau Ariannol / Financial Implications
There are no financial implications for this report.

Risk Analysis

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 in Q4 and Formal Executive Group April the current risk score is 16.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

- The Deprivation of Liberty Safeguards Code of Practice supplements the main Mental Capacity Act 2005 Code of Practice.
- The Supreme Court Judgment, P v Cheshire West Council [2014] and P & Q v Surrey County Council [2014] UKSC 19.

Asesiad Effaith / Impact Assessment

N/A

Appendix 1

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

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

RAG Rating- Red 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.	• 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	Update Q4 2023-24: This action will be ongoing until March 2025 following confirmation from WG that funding is available for 2024-25. The additional BIA post has now ceased. The MCA training lead will provide targeted sessions for our temporary staffing establishment within the Health Board. In conjunction with this the health boards temporary staffing team have been requested to assure competency of agency staff being utilised in this area parable with substantive staff.	**31.03.2025 On Track**	**Amber**

2.0	Development of a Standard Operating Protocol (SOP) for assessing existing patients and for assessing future funded patients.	• Further engagement with commissioning services. • Development of a Standard Operating Procedure (SOP) for assessing existing patients and for assessing future funded patients. • Support the development of a protocol to help manage the complex interface between the Mental Health Act and the Mental Capacity Act and review service users accessing Mental Health services (individuals who are not objecting to their care and treatment as defined under the Mental Health Act).	CW HL	**Update Q4 2023-24:** A secondment opportunity has been made available to continue to progress this activity. Engagement has taken place with L&R Services to establish the legislative position, accountability and responsibility. Engagement with Commissioning Services to support the development of a SOP is ongoing. A draft SOP has been developed and is currently progressing through the governance process for ratification and approval.	**30.06.2023**	**Amber**

Teitl adroddiad: ***Report title:***	Healthcare Inspectorate Wales (HIW) Assurance Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 02 May 2024			
Crynodeb Gweithredol: ***Executive Summary:***	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. This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Clare Jones, Quality Assurance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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. The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act and Mental Health Measure) require no financial consideration at present.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by: - Mental Health & Learning Disability Service Quality Delivery Group - Matthew Joyes, Deputy Director of Quality
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	N/A

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim **List of Appendices:** Appendix 1 – Inspections	

Inspections within the last 6 months

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

1 Announced Visit: Nant Y Glyn Community Mental Health

Inspection Date: 23rd and 24th January 2024
Publication Date: To be confirmed

.

HIW Recommendation

The health board must set up an auditing and review process for care and support records to ensure accuracy and consistency

Service Improvement Actions

MD15/1 - Continue with Mental Health Measure (MHM) 6 monthly audit and share outcome of MHM audit with Nant y Glyn staff.

Responsible Lead – Iain Wilkie

Progress Status – **Complete**
Audit completed on 11th April 2024 and shared with Service and Team Managers on 15th April 2024

MD15/2 - Agree appropriate actions from MHM audit to ensure accuracy and consistency of care and support records

Responsible Lead – Iain Wilkie

Progress Status – **In Progress**
Audit report completed and improvements required noted. Action plan to be formulated to address recommendations

Teitl adroddiad: ***Report title:***	Associate Hospital Managers Update Report (January – March 2024)			
Adrodd i: ***Report to:***	Mental Health Legislation Committee (MHLC)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 02 May 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Associate Hospital Managers update report provides details regarding the Associate Hospital Managers activity within the Health Board for the detailed period. The report describes activities in the following areas: Hearings, Scrutiny, Training, Recruitment, Forums and Meetings. This report provides assurance that the individuals who form the Hospital Manager Discharge Panels (namely **Mental Health Act Associate Hospital Managers** (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards. The report details the activity of the Associate Hospital Managers in relation to hearings and activity undertaken, concerns raised and improvements to the division or service to which they have input for the period January – March 2024.			
Argymhellion: ***Recommendations:***	The committee is asked to note the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Lead for Mental Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Mental Health Act 1983 (amended 2007) The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A This report does not inform strategic decisions, it relates to the day to day operations of the Associate Hosptial Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board addressed this by having an open direct hire advert to ensure that the cohort is kept

Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	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. Hearings for patients should be conducted as close to the renewal date as possible. If a patient requests a hearing this should be given priority. Risks associated with not conducting a hearing as close as possible to the relevant date, would be: • Transfers impacting on hearings with the potential for a hearing to be missed or rearranged. • The Associate Hospital Managers Discharge Panel may not agree with the professionals and feel that patient should be discharged any delay in the hearing may result in the patient being detained for longer than necessary.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The Associate Hospital Managers are paid a sessional fee for each activity. The Associate Hospital Managers are now provided with devices to ensure that costs in relation to posting reports are minimised along with ensuring protection and confidentiality of patient's personal information.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Matthew Joyes, Deputy Director of Quality And Alberto Salmoiraghi, Medical Director, Mental Health & Learning Disability Division have seen the report prior to submission. The Power of Discharge Group is held prior to the MHLC to discuss the activity.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Appendix 1 – Associate Hospital Managers Update Report*	

Appendix 1

Quarterly Activity

1 Hearings

At the time of writing (05.04.2024) hearings are held both remotely via Microsoft Teams and face to face.

23 hearings were held during the months January – March 2024.
Nine held face to face and 14 via Teams. The hearings consisted of 14 section 3 renewals, four CTO renewal, two section 47 renewals, one section 2 barring and one section 3 appeal.

There have been no discharges to date for this period.

There has been two appeal requests this period one hearing did not go ahead as the patient withdrew.

A breakdown of the hearing activity is below:

January

- ***Five hearings arranged (four held); Three held face to face and one via Microsoft Teams.***
  Three hearings were in relation to renewals and one was a section 2 barring.

  One hearing was cancelled – The patient was regraded to informal by the RC.

  Outcomes of hearings held
  - All detentions were upheld.

February

- ***Eight hearings arranged (six held); Two held face to face and four via Microsoft Teams.***
  All hearings were in relation to renewals one being a CTO renewal.

  One hearing was postponed – The patient was transferred to another unit, the hearing was rearranged for within the same month and went ahead.

  One hearing was rescheduled – The RC did not provide the report in time, the solicitor asked for this to be rescheduled, the hearing was held within the same month and went ahead.

  Outcomes of hearings held
  - All detentions were upheld.

March

- ***15 hearings arranged (13 held); four held face to face and nine via Microsoft Teams.***
  One hearing was a request for discharge from the patient, three CTO renewals and nine section 3 renewals.

  Two hearings were cancelled – One patient was discharged by their RC and one was discharged by the Mental Health Review Tribunal.

  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.

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 Division has set a quality standard at one month following the renewal date. An analysis of the hearings held this quarter is detailed below.

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

In instances where the patient appeals their detention, the hearing should be held as close as possible to the appeal date. The quality standard for appeals focused on working days to allow for reports to be produced and distributed. A discussed has been held in regards to the Quality Standard and if this is a realistic timescale currently. A proposal is to be taken to the Power of Discharge Group in April to amend the current Quality standard.

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

Renewal Date	Hearing Date	Quality Standard (31 days)
19/10/2023	24/01/2024	98 days *1
07/12/2023	07/03/2024	91 days *2
24/12/2023	17/01/2024	24 days
30/12/2023	16/01/2024	17 days
30/12/2023	15/02/2024	47 days
05/01/2024	15/02/2024	41 days
11/01/2024	06/03/2024	55 days
13/01/2024	26/02/2024	44 days
20/01/2024	02/02/2024	13 days
23/01/2024	09/02/2024	17 days
29/01/2024	27/02/2024	29 days
07/02/2024	04/03/2024	26 days

14/02/2024	19/03/2024	34 days
15/02/2024	13/03/2024	28 days
22/02/2024	22/03/2024	29 days
23/02/2024	08/03/2024	14 days
24/02/2024	20/03/2024	25 days
29/02/2024	21/03/2024	21 days
01/03/2024	22/03/2024	21 days
08/03/2024	20/03/2024	12 days
11/03/2024	20/03/2024	9 days
Barring Hearing		
28/12/2023	10/01/2024	13 days
Appeal by Patient Date	**Hearing Date**	**Quality Standard (31 days)**
28/02/2024	22/03/2024	23 days

*1&2 The delays occurred due to the office waiting for a proforma form to be returned from the patients, due to the patients fluctuating capacity this was not returned. As part of the standardisation of documents for the MHA department a letter has been created for instances when the proforma form is not returned to the office. Because the hearing is a statutory requirement when a renewal occurs a timeframe of two weeks has been agreed for return of the document if the patient wishes to make a preference to how their hearing is held, whether they are attending and support/representation they wish to have. It must be noted that any IMHA working with the patient or solicitor would be informed of the hearing as would be usual practice so they can discuss with their client and the patient also has the right change their mind in relation to attending and if time allows the venue.

2 Scrutiny

Scrutiny has been undertaken with the first being held at the beginning of February, this is conducted on a monthly basis within the three psychiatric units, Heddfan, Ablett and Hergest. Issues raised via scrutiny are also reported within the AHMs newsletter. The scrutiny form has been expanded to include more detail for CTPs and to provide further clarity, this will be reviewed at the next Forum meeting.

Bryn Y Neuadd, Ty Llywelyn, NWAS, Tan Y Castell, Coed Celyn, Cefni, and Bryn Hesketh are audited on a quarterly basis by the Administrators as part of a wider audit reported to the Mental Health Legislation Committee.

3 Training

The training compliance now includes MHA training for which all managers aside two are booked for this training or have completed. A new training has been added ‘Paul Ridd Learning Disability Training’, as the AHMs will sit on panels for learning disabled patients it was felt this was a training that also required completion. Due to the new additions there are eight AHMs who are 100% compliant with the 16 training sessions.
The compliance for the sessions is recorded on 15 managers this includes one new appointment.

Compliance is as below:

Training	**Compliance**	**Training**	**Compliance**
Environmental Waste and Energy	93%	Violence and Aggression	87%

Equality Diversity and Human Rights	87%	Welsh Language Awareness	80%
Fire Safety	87%	Dementia Awareness	93%
Health, Safety and Welfare	87%	Fraud Awareness	87%
Infection Prevention and Control	93%	Violence against women, domestic abuse	87%
Information Governance	100%	Mental Capacity Act	93%
Safeguarding Adults	93%	Paul Ridd LD training	60%
Safeguarding Children	93%	Mental Health Act	87%

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of: 16 persons, 15 are actively involved with hearings. The active cohort consists of five male and ten female members, of which three are Welsh speakers.

Of the active members, there are six chairpersons, (two male and four female), of which one is a Welsh speaker.

One of the new appointed persons has now become a panel member and one is progressing through the recruitment process following a successful interview.

A resignation was received in February from one male member due to the inability to commit to the role, he has asked in future to be able to apply again when circumstances change. A further resignation was received in March following a period of being unable to commit to hearings it is hoped as with the other member that he may return in the future.

The Welsh Language department has been circulating the advertisement poster to assist in attracting a larger number of Welsh speakers, the poster has also been shared with Bangor University to try and target younger audiences. The advert has been shared on Linkedin and social media platforms from the 4th of April this has generated a number of enquiries, it is therefore hoped the cohort can be expanded in the coming months.

5 Forums and Meetings

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

The last meeting was held on the 11th of January with the next meeting scheduled for the 11th of April 2024.

An All Wales Hospital Managers Conference was arranged by Cardiff and Vale University Health Board held on the 29th of February in Builth Wells, four AHMs attended, some of the content of the training will be used to provide training to our AHM cohort in particular information regarding Barring hearings.

Teitl adroddiad: ***Report title:***	Power of Discharge Group Chairs Assurance Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 02 May 2024			
Crynodeb Gweithredol: ***Executive Summary:***	The Power of Discharge Group is held on a quarterly basis to review the Associate Hospital Managers activity within the Health Board for a detailed period. The Chair's assurance report informs any issues of significance that require consideration by the Mental Health legislation Committee. The report discussed within the meeting covered the three month period January to March 2024.			
Argymhellion: ***Recommendations:***	The committee is asked to note the report and approve the attached Terms of Reference.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Lead for Mental Health			
Awdur yr Adroddiad: ***Report Author:***	Wendy Lappin, Mental Health Act Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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)
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?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	This report does not inform strategic decisions, it relates to the Power of Discharge Group which meets quarterly to discuss the day to day operations of the Associate Hospital Managers who have delegated functions under the Mental Health Act. Stategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The chairs assurance report has been approved by Matthew Joyes, Associate Director of Quality Assurance, patient Safety and Experience.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A

Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Power of Discharge Group 23/04/2024 Appendix 2 – POD Terms of Reference	

BACKGROUND

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

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

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

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

The Power of Discharge Group is held on a quarterly basis, chaired by the Deputy Director of Quality, reports are produced and presented by the Mental Health Act Manager to the group.

The Power of Discharge Group meeting was held on the 23rd of April 2024.

Discussions included:

- **Actions for escalation from the minutes**
  - The timely receipt of AMHP reports which sit alongside the detention paperwork. These are chased up by the MHA office staff but are often still outstanding when the AHMs conduct their scrutiny.
  - Expressions of interest to become a representative for the MHLC have been received from two members these will be taken forward to the Committee for a decision to be made.

- **Terms of Reference**
  - The terms of reference were agreed with some minor amendments with approval to escalate to the Mental Health Legislation Committee for approval.
  - Appointment period is noted as four years and a further four year appointment it was agreed that the MHA Manager will review all the members and provide a detail of service to the next meeting.

- **The Associate Hospital Manager update report**.
  - The report was highlighted in reference to 23 hearings had been held, no patients discharged during the period.

- The quality standard will move to six weeks going forward rather than 31 days for renewal hearings, appeals and barrings to stay at 31 days, S2 appeals to be heard within a week or ten days if the patient has also appealed to the Tribunal.
- Training compliance has improved with ten managers being compliant and seven of the modules all AHMs have completed.
- There has been an interest in the role following the sharing of the information by the Welsh Language department and on social media.
- The mix of AHMs backgrounds was noted to be of importance.
- Continual improvement was noted concerning consultation between the AHMs, the MHA Manager and documents in use.
- Two AHMs had recently resigned due to outside commitments, one of which was a member of the POD group, Sean Holcroft was formally acknowledged and noted that he had received thanks for his contribution to the Group and the AHM cohort.

- **The MHA performance report submitted for information only**
  - It was noted the language on the section 5(4) page should be amended to note 'a nurse of prescribed class' rather than staff nurse.
  - New information is now provided in relation to hearings both Managers Panels and MHRT for comparisons along with the detail of appeals and hearings not held. MHA training is also noted.

The group felt areas which required escalation and highlighting to the Mental Health Capacity and Compliance Committee were:

1. **The timely receipt of AMHP reports.**
2. **The Terms of Reference for the POD group for approval.**
3. **Expressions of interest to be an AHM representative on the Mental Health Legislation Committee have been received from Phil Williams and Jenny Gilmore. There is currently one representative who is already engaged for the Committee who is wishing to continue in this role (Louise Cunliffe).**

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

POWER OF DISCHARGE GROUP
TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

1.1 The Board shall establish a Group to be known as the Power of Discharge Group. The detailed terms of reference and operating arrangements in respect of this Group are set out below.

2. PURPOSE

2.1 The purpose of the Power of Discharge Group (hereafter, the Group) is to advise and assure the Board that the processes associated with the discharge of patients from compulsory powers that are used by the Group are being performed correctly and in accordance with legal requirements.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Group, in respect of its provision of advice and assurance will and is authorised by the Board to:-

- Comment specifically upon the processes employed by the Group's Panel in relation to the discharge of patients from compulsory powers, and whether these processes are fair, reasonable and compliant with the Mental Health Act and are in line with other related legislation, including, the Mental Capacity Act 2005, the Human Rights Act 1998 and the General Data Protection Regulations 2018 and that the appropriate systems are in place to ensure the effective scrutiny of associated discharge documentation.

- Undertake the functions of Section 23 of the Mental Health Act 1983, in relation to hearing cases of detained powers ensuring that three or more members of the Group form a Panel and only a minimum of three members in agreement may exercise the power of discharge. The Panel will be drawn from the pool of members formally designated as Associate Hospital Managers as reported to the Group.

- Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

    - employee (and all employees are directed to cooperate with any legitimate request made by the Group); and

    - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

- obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

3.2 The Group will, as part of its process of hearing cases, be made aware of operational issues affecting the patient's care and treatment, including discharge arrangements. These are not matters for which the Group shall have responsibility. Even so, Group members are not precluded from raising such matters with those holding operational responsibility. In addition, such issues can be raised on an anonymised basis or through the Board itself.

4. MEMBERSHIP

4.1 Members

- Chair: Associate Director of Quality
- Vice Chair: Director of Nursing Mental Health & Learning Disability
- Director of Mental Health & Learning Disability
- Medical Director of Mental Health & Learning Disability
- Eight (8) appointed Associate Hospital Managers (as nominated and agreed by the Group. Appointed for a period of four years with appointment not to exceed a maximum of eight years in total) a minimum of **six** must be in attendance, it is noted that the Associate Hospital Managers should not be outnumbered by the number of Health Board staff.
- Mental Health Act Manager

4.2 Attendees

Other Directors will attend as required by the Group Chair, as well any others from within or outside the organisation who the Group considers should attend, taking into account the matters under consideration at each meeting.

4.3 Member Appointments

4.3.1 The membership of the Group shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Group's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Group.

4.4 Secretariat

4.4.1 Mental Health Act Administrators or Assistant.

4.5 Support to Group Members

4.5.1 The Mental Health Act Manager, on behalf of the Group Chair, shall:

- Arrange the provision of advice and support to Group members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Group members.

5. GROUP MEETINGS

5.1 Quorum

At least six Associate Hospital Managers must be present to ensure the quorum of the Group and the Chair or Vice-Chair.

The number of Health Board staff cannot outnumber the Associate Hospital Managers.

The Health Board staff must include a senior member of the Mental Health & Learning Disability Division.

If the meeting is not quorate no decisions will be able to be made but the meeting shall not be stood down.

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis considering the requirement to report into the Mental Health Legislation Committee.

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

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

6.2 The Group is directly accountable to the Board (via the Mental Health Legislation Committee) for its performance in exercising the functions set out in these Terms of Reference.

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

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

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

6.4 In terms of the Board's assurance on the Mental Health Act requirements, the remit of the Group is limited to the exercise of powers under Section 23 of the Mental Health Act 1983, rather than the wider operation, which would be the remit of the Mental Health Legislation Committee.

6.5 The Group shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Group Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Group's activities, via the Chair's assurance report;

7.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs' of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Health Board's Standing Orders are equally applicable to the operation of the Group, except in the following areas:

- Quorum
- Owing to the nature of the business of the Group, meetings will not be held in public.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Group and any changes recommended to the Board, with reference to the Mental Health Legislation Committee for approval.

Approval: Power of Discharge Group 23/04/2024
Mental Health Legislation Committee: X/XX/XX

V4.1 Review