

## **Bundle BCU Mental Health Legislation Committee 7 August 2025**

- 1 PRELIMINARY MATTERS
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*Gareth Williams, Chair*
  - 1.2 MH25.37 - Declarations of Interest relating the the agenda - Verbal  
*Gareth Williams, Chair*
  - 1.3 MH25.38 - Unconfirmed Minutes of the Mental Health Legislation Committee – 8 May 2025 - Paper  
*Gareth Williams, Chair*  
MH25.38 - Unconfirmed Minutes of the Mental Health Legislation Committee – 8 May 2025 - Paper
  - 1.4 MH25.39 - Matters Arising & Table of Actions - Paper  
*Gareth Williams, Chair*  
MH25.39 - Matters Arising & Table of Actions
- 2 FOR ASSURANCE
  - 2.1 MH25.40 - Mental Health Act Assurance Report  
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  - 2.2 MH25.41 - Mental Capacity Assurance Report  
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  - 2.3 MH25.42 - HIW Assurance Report  
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  - 2.4 MH25.43 - Associate Hospital Managers Update Report  
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MH25.43 - Associate Hospital Managers Update Report
  - 2.5 MH25.44 - Report from the Power of Discharge  
*Matthew Joyes, Deputy Director for Legal Services*  
MH25.44 - Report from the Power of Discharge
  - 2.6 MH25.45 - CAMHS - Consultant on Call  
*Dr Peter Gore-Rees, Consultant Child & Adolescent Psychiatrist*
- 3 GOVERNANCE AND ASSURANCE
  - 3.1 MH25.46 - Committee Governance Report  
*Pam Wenger, Director of Corporate Governance*  
*Review Cycle of Business*  
*Key messages for Annual Report*  
*MHLC Committee Self Assessment*  
MH25.46 - Committee Governance Report  
MH25.46a Appendix 1 The Mental Health Legislation Cycle of Business 2025-2026  
MH25.46b Appendix 2 The Committee Annual Report  
MH25.46c Appendix 3 The Committee Self-Assessment
- 4 CLOSING BUSINESS
  - 4.1 MH25.47 - Agree Items for referral to Board / other Committees
  - 4.2 MH25.48 - Agree items for Chairs Assurance Report
  - 4.3 MH25.49 - Review of Meeting Effectiveness
  - 4.4 MH25.50 - Date of Next Meeting - 13 November 2025

**Betsi Cadwaladr University Health Board (BCUHB)**  
**UNCONFIRMED** Minutes of the Mental Health Legislation Committee  
 held in Public on 8<sup>th</sup> May 2025  
 in the Boardroom, Carlton Court, St Asaph and via Teams

<b>Committee Members Present</b>	
<b>Name</b>	<b>Title</b>
Gareth Williams	Health Board Vice Chair (Chair of Mental Health Legislation Committee)
Rhian Watcyn Jones	Independent Member (IM)
Dyfed Jones	Independent Member (IM)
<b>In Attendance</b>	
Dr Sree Andole	Interim Executive Medical Director
Michelle Denwood	Director of Safeguarding and Public Protection
Michelle Green	IHC Director East (via Teams)
Jenny Gilmore	Associate Hospital Manager
Matthew Joyes	Deputy Director for Legal Services
Wendy Lappin	Mental Health Act Legislation Manager
Teresa Owen	Executive Director of AHP and Health Science
Alberto Salmoiraghi	Medical Director, Mental Health & Learning Disabilities (MHLDD)
Chris Walker	Head of Safeguarding Adults
Iain Wilkie	Director of Mental Health and Learning Disabilities
Phil Williams	Associate Hospital Manager
<b>Committee Support</b>	
Philippa Peake-Jones	Head of Corporate Governance

<b>Agenda Item</b>
<b>PRELIMINARY MATTERS</b>
<b>MH25.18 - Welcome and Apologies</b>
Apologies were received for Dr Prashad, Consultant Child Psychiatrists, NWAS.
<b>MH25.19 Declarations of Interest</b>
No declarations of interest were received.
<b>MH25.20 Unconfirmed Minutes of the Meeting held 06.02.2025</b>
It was resolved that the Committee: <ul style="list-style-type: none"> <li>• <b>AGREED</b> that the minutes of the meeting held on 6 February 2025 were a true and accurate record.</li> </ul>
<b>MH25.21 Matters Arising &amp; Action Log</b>
The Committee reviewed the action log and noted the following actions should be added:

**MH25/05 – Mental Capacity Assurance Report –** It was noted that the Senior MHA Manager had returned to work on a phased return. The Deputy Director of Legal Services updated the Committee in terms of staffing across the three area teams, and CAMHS. Resilience within the team was an issue of concern given the specialised nature of the work and a review would be undertaken as to how to address this, including succession planning.

**MH25/06 – Mental Capacity Assurance Report -** This was with regard to patients admitted to hospital under DoLS. It was noted that the data was not currently captured on the NCAR system, and a request nationally had been made for this to be included. Discussion was on-going with CHC colleagues to identify those patients admitted to hospital under DOLS being funded. Members were advised on the process in place for patients who are admitted under Section 21a and the complexity of this area of work. It was noted that issues would be fed back to the National DoLS Network so that they were aware. Advice would also be sought from expert leads on this matter. This issue is included within the Directorate Risk Register. Also feedback had been provided to the NHS Executive as they were looking at Safeguarding and DOLS in its totality.

**MH25/07 – HIW Assurance Report –** With regard to the capturing of patient and carer feedback around the accessibility of patient information, it was noted that this would be within the remit of the QSE Committee. Following discussion it was agreed that a copy of the national standard of accessible / easy read information would come back to a future meeting the Committee as a pack for review. It was requested to ensure that this patient information was available bilingually. Members were advised that this appeared to be a general issue in other services across the Health Board. The Executive Director of AHP and Health Science agreed to action this item.

**Action:**

- **MH25/07.1** That a copy of the national standard of accessible / easy read information would come back to a future meeting as a pack for review. A request was made that this would be made available bilingually.

**It was RESOLVED that the Committee:**

- Agreed the updates provided

**FOR ASSURANCE**

**MH25.22 - Mental Health Act Assurance Report**

The Deputy Director of Legal Services presented the report as read.

The following issues were highlighted:

- The Performance Team would work with the Committee in terms of presenting and formatting of the report moving to a Power BI system in order to provide reports in real-time information. The work will commence in the autumn 2025.
- Section 2 (Admission for Assessment) and Section 3 (Admission for Treatment) - noted that there was an increase in the use of Section 2 and decrease in Section 3.



Members were advised that Section 2 was less prestrictive, and also included an automatic tribunal review which provided extra safeguards for patients. It was requested that future reporting on Section 3 is provided detail around length of stay.

- No Fundamental and Rectifiable Errors noted during the previous quarter, although caveated that these could yet be identified. The team were proactive in the management of these, and that an increase in establishment figures would see a reduction in the number of errors being identified.
- The new Mental Health Bill had passed the House of Lords and was now with the House of Commons, and it was likely that this would be passed during 2025. Implementation of the Act would take place over of longer period of time and this was being monitored.
- Sections 135 noted that this was lower in the central area. The Medical Director, (MHL) advised that this was due to rurality and population, with vicinity being a key issue. Members were pleased to note that there were no Section 135 or Section 136 for the under 18s. Members were advised that the implementation of the mental health electronic health record was progressing at pace.

In discussing the report, the Committee:

- Considered services for children and it was agreed that an item be put on the agenda for a future Committee meeting to discuss this. It was noted that the Chief Operating Officer had taken up post and would be instrumental in facilitating discussions going forwards.

*Michelle Green joined the meeting at 10.30am*

**Action:**

- **MH25.22.1** future reporting on Section 3 is provided detail around length of stay.
- **MH25.22.2** Arrange for an update on children's services to be agendad for a future Committee meeting.

It was resolved that the Committee

- **NOTED** the report and appendices.

**MH25.23 - Mental Capacity Assurance Report**

Members received the report and noted the following:

- A national review of the Mental Capacity Act to be undertaken. BCU were piloting in certain wards the new DoLS application form. Noted that other Health Boards have now commenced pilot phase.
- Further increase in terms of DoLS applications, although there has been slight reduction in the backlog.

- Actions completed in terms of those identified from the audit. These actions now form part of the working plan for the coming year. Actions remain under review to ensure they targets are achieved.
- Letters have been received from WG regarding funding. Whilst this is permanent funding, bids need to be submitted. A request is being made for WG to include this as part of the Health Board budget in the future, ringfenced specifically for IMCA, DoLS and the Mental Capacity Act work.
  - IMCA – challenges being faced in terms of procurement. Following a meeting with the procurement team a paper will be taken to the Executive Committee at a future date. Formal letter from WG awaited to progress this matter.
  - Best Interest Assessors based at each acute site, with attendance at community sites.
  - DoLS applications – reduction in relation to issues. This had further reduced to 17% since April 2025 following introduction of the new Form 1.
  - Training compliance good across services, and further work would be undertaken to improve this further.
  - Court of Protection cases remain active and well managed. In order to support CAMHS staff, the policy for 16/17 year old has been approved by the Safeguarding Performance and Governance Group for sharing.
  - Following comprehensive review of risks and actions associated with DoLS and the MCA, the team were in the process of updating / amending related risks.

In discussing the report, the Committee:

- Noted the difficulties being experienced regarding the IMCA service whilst awaiting formal WG letter, in terms of recruitment and retention, and the impact on the service. It was noted that this was a common issue and that the Executive Director of AHP and Health Science, and the Executive Director of Nursing and Midwifery, would write to WG to escalate this issue.
- In terms of the revised DoLS form positive feedback had been received to-date. The IMCA service would be providing feedback on its use. It was agreed that feedback would be brought back to the next Committee meeting for review. The roll out of the pilot scheme would be included as part of the services programme of work.

**Action:**

- **MH25.23.1** A paper to be prepared for the Chair of MHLC and Chair of P & C Committee regarding the IMCA service and the issues raised. Currently part of the review of principles of the wellbeing of Future Generation Act, which included reference to how we treat people who are employed / contracted by us.



- **MH25.23.2** The Executive Director of AHP and Health Science, and the Executive Director of Nursing and Midwifery, would write to WG to escalate this matter of confirmation of funding.
- **MH25.23.3** Feedback from the roll out of the paperless DoLS pilot scheme would be brought back to the next Committee meeting for review.

It was resolved that the Committee

- **NOTED** the report

### **MH25/27 – Update from Luke Hughes, North Wales Police**

*This item was brought forward on the agenda to accommodate Mr Hughes.*

Members welcomed Luke Hughes to the meeting.

Members received the report and noted that:

- A cross agency project was being undertaken 'Right Care, Right Person' and noted the four phases. Mr Hughes thanked staff in the BCU mental health establishments for their support.
- Transportation of individuals detained under the Mental Health Act remained an on-going issue and this was currently with the mental health service to formulate plans.
- With regard to Section 136 it was noted that an app had been developed by North Wales Police in conjunction with the Criminal Justice System to monitor weekly use of the powers, and where there had been no consultation had been made. Two months data was available showing 79% of all interactions were consulted appropriately. Data also indicated 65% of all Section 136 detentions ended up in the Emergency Department due to the suite not being available at time. Support was requested in relation to unblocking beds, or identifying a solution to finding alternative space to assess patients out of the ED setting. The issue of police officers waiting for up to 12 hours with patients in ED remained a concern.
- Mental Health Bill – two significant issues were noted:
  - Section 136 - Suggestion that Section 136 powers be broadened to an 'authorised' person which may not always be police. This would likely remove police custody as a place of safety for Section 136 patients, which would place additional burden on EDs.
  - Section 140 – May be amended under the current Bill. Places duty on health service to provide emergency provision for local authorities in urgent situations. It was noted that whilst BCU did not have a Section 140 policy at this time, this was also a national issue. Legislation may place duty on health organisations and there was a need to prepare for this possibility.
- Members were advised that the local authorities had written to the Health Board around Section 136 patients. A copy of the letter would be shared with members.



- Discussions would be held around what actions could be taken in the short term to free up police time, and avoid the need for Section 136 patients presenting to ED.
- The Executive Director of AHP and Health Science advised that this was a system issue and that she would report through to the Executive Team, and would update the Committee on progress. Members were advised that there were costed options that could be further explored, and this could be undertaken by the Crisis Group. A multi agency Task and Finish Group would be established to develop a proposal to address this issue. It was agreed that this would be highlighted on the Committee's Assurance Report to the Board. It was also agreed that the issue be referred to the Executive Committee and Quality, Safety and Experience Committee.

Members thanks Mr Hughes for his attendance at the meeting and thanked North Wales Police for their on-going support.

**Action:**

- **MH25.27.1** That a copy of the letter from the local authorities be shared with members for information.
- **MH25.27.2** That a multi-agency Task and Finish Group be established to look develop proposals to address the issues of availability of beds assessment space for Section 136 patients to avoid admission to ED. This would be highlighted on the Chair's Assurance Report to the Board.
- **MH25.27.3** That the issues raised be referred to the Executive Committee, and the Quality, Safety and Experience Committee

**Resolved:**

That members **RECEIVED** the report.

**MH25.24 - HIW Assurance Report**

The Deputy Director of Legal Services presented the report.

- It was noted that three inspections had been reported on since the last meeting. The rolling programme of updates on actions were reviewed by the Quality, Safety and Experience Committee.

Members received the report and the Committee discussed and highlighted:

- All draft inspection reports were submitted to the Quality Team to action. All responses were signed off by the Executive Director of Nursing and Midwifery. A robust process was in place to ensure actions were undertaken and evidence scrutinised before actions were closed.
- The importance of staffing levels to cover Section 17 leave was discussed. It was noted that there were currently 94 registered staff vacancies within the service. Members were advised that this had been an issue within the medium secure unit although this

had not been formally raised. It was agreed that this be added to action log and reviewed at a future date.

- With regard to prison healthcare, a paper had been received for the Safeguarding Board. It was noted that this would be progressed through QSE Committee. The Head of Safeguarding agreed to come back to Committee for any issues relating to the Mental Health Act.

**Action:**

- **MH25.24.1** Section 17 leave to reviewed at future date and reported back to Committee

It was resolved that the Committee

- **NOTED** the report

**MH25.25 Associate Hospital Managers Update Report**

Members received the report and the Associate Hospital Manager highlighted to the Committee:

- 31 Hearings were held in the last quarter (January to March 2025), which was an increase on the previous quarter.
- No discharges had been made for the period to-date.
- The local set standard to hold hearings of 6 weeks had achieved 71.3% compliance. Reasons for the delays were noted.
- The Associate Hospital Managers had raised concerns around the timeliness of reports being received from clinicians in advance of Hearings. This had been fed back to colleagues.
- There were currently 16 Associate Hospital Managers, with the service seeking to recruit an additional person.

The Committee members thanked the Associate Hospital Managers for their on-going work and support.

It was resolved that the Committee

- **NOTED** the report

**MH25.26 Report from the Power of Discharge – nothing to report here.**

Members received the report and the following key areas were highlighted:

The Power of Discharge Group meeting was held on 28<sup>th</sup> April 2025. Key discussions included:

- A review of the MHA Assurance Report.
- A review of the AHM Update Report
- A review of the HIW Assurance Report, to look at recommendations for photographs on MAR charts and Section 17 leave forms.



- An update on progress of the new Mental Health Bill
- Noting ongoing staffing pressures within the MHA Team.
- Discussion around the time period for report delivery prior to Panels.

It was resolved that the Committee:

- **NOTED** the report.

#### **MH25.27 – CAMHS Legal Case Study**

Members received the report, and the Deputy Director of Legal Services highlighted key issues within the CAMHS Legal Case Study.

In discussing the report, the Committee:

- Noted that Courts cannot order clinicians re their assessments, although they did have the power to judicially review the decision making process. It was noted that the local authority did not pursue the case through Court.

It was resolved that the Committee:

- **NOTED** the report.

#### **FOR INFORMATION**

#### **MH25.28 - Cycle of Business**

The Head of Corporate Governance advised members that Cycles of Business for all Committees were currently being refreshed. It was noted that this was a live document and would be amended as required to reflect the business of the Committee and to discuss emerging issues.

It was **resolved** that the Committee:

**APPROVED** the Cycle of Business for 2025/26

#### **MH25.29 Terms of Reference**

The Head of Corporate Governance presented the draft Terms of Reference to the Committee for its annual review. It was noted that no changes had been made. It was agreed the 'In Attendance' group should include representation from the CAMHS service along with formal representation from the Associate Hospital Manager's group. It was noted that the Executive Medical Director and Head of Safeguarding Adults could be interchangeable at meetings.

#### **Action:**

- MH25.29.1 The Executive Director of AHP and Health Science agreed to review this outside the meeting and report back.



- MH25.29.2 The Associate Hospital Managers requested that meeting papers be sent out to them as part of the distribution of meeting papers.

It was **resolved** that the Committee:

**NOTED** the Terms of Reference and await an update as discussed.

### **CLOSING BUSINESS**

#### **MH25.30 Agree Items for referral to Board / other Committees**

It was agreed that items for referral to the Board would be made via the Chair's Assurance Report.

#### **MH25.31 Agree items for Chairs Assurance Report**

The following would be referred to in the Chairs Assurance Report:

- Difficulty in accessing appropriate beds for Section 136 patients and reduce attendance at ED.

#### **MH25.32 Review of Meeting Effectiveness**

In discussing the item, the Committee agreed there had been good discussion around the agenda items.

#### **MH25.33 Date of Next Meeting**

The next meeting will be held on 7 August 2025

**Mental Health Legislation Committee Action Log**  
**Updated 30.06.2025**

Open Actions						
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH25/07.1		<p><b>MH25.21 Matters Arising &amp; Action Log</b></p> <p>That a copy of the national standard of accessible / easy read information would come back to a future meeting as a pack for review. A request was made that this would be made available bilingually.</p>	Teresa Owen	July 2025	<p><b>Suggest closure</b></p> <p>Information available below</p> <p><a href="https://jcc.nhs.wales/our-structure/mhldvg/mha/easy-read/">https://jcc.nhs.wales/our-structure/mhldvg/mha/easy-read/</a></p>
2	MH25.22.1	8/5/2025	<p><b>Mental Health Act Assurance Report</b></p> <p>Future reporting on Section 3 to provide detail around length of stay.</p>	Matt Joyes	August 2025	<p><b>Suggest closure</b></p> <p>Completed – data is included in the report.</p>
3	MH25.22.2	8/5/2025	<p><b>Mental Health Act Assurance Report</b></p> <p>Arrange for an update on children’s services to be agendad for a future meeting (alternatives to access) – General issues with compliance in CAMHS</p>	Prash/Louise Bell	August 2025	Verbal tem on agenda
4	MH25.23.2	8/5/2025	<p><b>Mental Capacity Assurance Report</b></p> <p>The Executive Director of AHP and Health Science, and the Executive Director of Nursing and Midwifery, would write to WG to escalate this matter of confirmation of funding.</p>	Angela Wood/Teresa Owen		Teresa has raised this with colleagues and will follow up.
5	MH25.23.3	8/5/2025	<p><b>Mental Capacity Assurance Report</b></p>	Chris Walker	August	<b>Suggest closure</b>



			Feedback from the roll out of the paperless DoLS pilot scheme would be brought back to the next Committee meeting for review		2025	Information included in agenda item MH25.41 - Mental Capacity Assurance Report
6	MH25.27.1	8/5/2025	<b>Update from North Wales Police</b> That a copy of the letter from the local authorities be shared with members for information.		August 2025	<b>Suggest Close</b>  Letter circulated
7	MH25.27.2	8/5/2025	<b>Update from North Wales Police</b> Work is ongoing on reviewing crisis arrangements which should help to address the issue of Section 136 patients being directed to ED. This would be highlighted on the Chair's Assurance Report to the Board.		August 2025	<b>Suggest Close</b>  AAA report highlighted this
8	MH25.27.3		<b>Update from North Wales Police</b> That the issues raised be referred to the Executive Committee, and the Quality, Safety and Experience Committee	Teresa Owen		
10	MH25.24.1	8/5/2025	<b>HIW Assurance Report</b> Section 17 leave to reviewed at future date and reported back to Committee	Teresa Owen	November 2025	PPJ to include on forward work plan

**Closed Actions (as agreed at meeting on 8 May 2025)**

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH25.03	6/2/25	<b>Matters Arising and Action Log</b>  MH 24/38 To invite the Luke Hughes, Chief Inspector of the North Wales Police to attend a future meeting to discuss the relationship and collaboration with the police.	Philippa Peake-Jones		Luke in attendance



2	MH25.03	6/2/25	<b>Matters Arising and Action Log</b>  MH 24/34 Ensure that risks associated with Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act are comprehensively covered in the appropriate risk registers.	Chris Walker		Included in paper
3	MH25.03	6/2/25	<b>Matters Arising and Action Log</b>  Change the wording from “monthly trend” to “monthly change” in the Mental Health Act Assurance Report	Matthew Joyes		This has been amended in the report
4	MH25.05	6/2/25	<b>Mental Health Act Assurance Report</b> Working with the People and Culture Committee and WOD, address MHA staffing challenges, step up succession planning, explore flexible staffing options, and review staff capacity for cross-cover roles.	Matthew Joyes		The new Legal Services Department is developing professional pathways as part of its business plan – this will include professional development routes for progression within the team – recommend close as this is a long term action.
5	MH25.05	6/2/25	<b>Mental Health Act Assurance Report</b> Distribute data on fundamental errors and low renewal numbers to members and IMs.	Matthew Joyes		The data is sent separately – recommend close.
6	MH25.05	6/2/25	<b>Mental Health Act Assurance Report</b> Investigate issues with possible incorrect coding	Matthew Joyes		The data was accurate at the time,



			of rectifiable errors due to the transfer of work to staff located in the Centre because of staff shortages in West and East. and the other IHC area.			however the Committee will note a number of errors in this report from West which reflects those issues now being identified during the period of staff absences – recommend close.
7	MH25.07	6/2/25	<b>HIW Assurance Report</b> Feedback to the Division the request to review and ensure any written information materials on MHA rights is accessible, with appropriate use of visual aids and plain English.	Matthew Joyes  Teresa Owen		This information was fed back – recommend close.  <b>8.5.25</b> – re capture of patient and carer feedback from previous minutes for transfer to QSE.  Copy of national standard information to come as pack to future MHLC meeting for review. Needs to be bilingual. Noted that this appeared to be a general issue across the Health Board.
8	MH25.12		<b>Cycle of Business</b> Bring an update on the Case Law [ <i>Matt to insert reference</i> ] to the next meeting	Matthew Joyes	May 2025	A report is on the agenda for the meeting in the private session.
9	MH24/34.2	07/11/24	<b>Mental Capacity Assurance Report</b> Provide an update on the Court of Protection cases at a future meeting.	Matthew Joyes/ Michelle Denwood	Feb 25	A COP report is on the agenda for the meeting in the private session.



<b>Teitl adroddiad:</b> <i>Report title:</i>	Mental Health Act (MHA) Assurance Report		
<b>Adrodd i:</b> <i>Report to:</i>	Mental Health Legislation Committee		
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	07 August 2025		
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>The Mental Health Act Assurance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during January to March 2025.</p> <p>The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections.</p> <p>Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation.</p> <p>Lapsed sections are reported as 'exceptions' throughout the report, and invalid detentions recorded as 'fundamentally defective'. Any lapses or fundamentally defective sections are Datix reported and investigated.</p> <p>A monthly report is submitted to the Deputy Director for Legal Services and the Medical Director for Mental Health and Learning Disability Services to ensure that the MHA is monitored with the exceptions highlighted including any mitigation and learning that has occurred.</p> <p>Appendices are included to support the report.</p>		
<b>Argymhellion:</b> <i>Recommendations:</i>	The Committee is asked to note the report.		
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance		
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Wendy Lappin, Senior Legal Services Manager (Mental Health Act) Matthew Joyes, Deputy Director for Legal Services		
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>

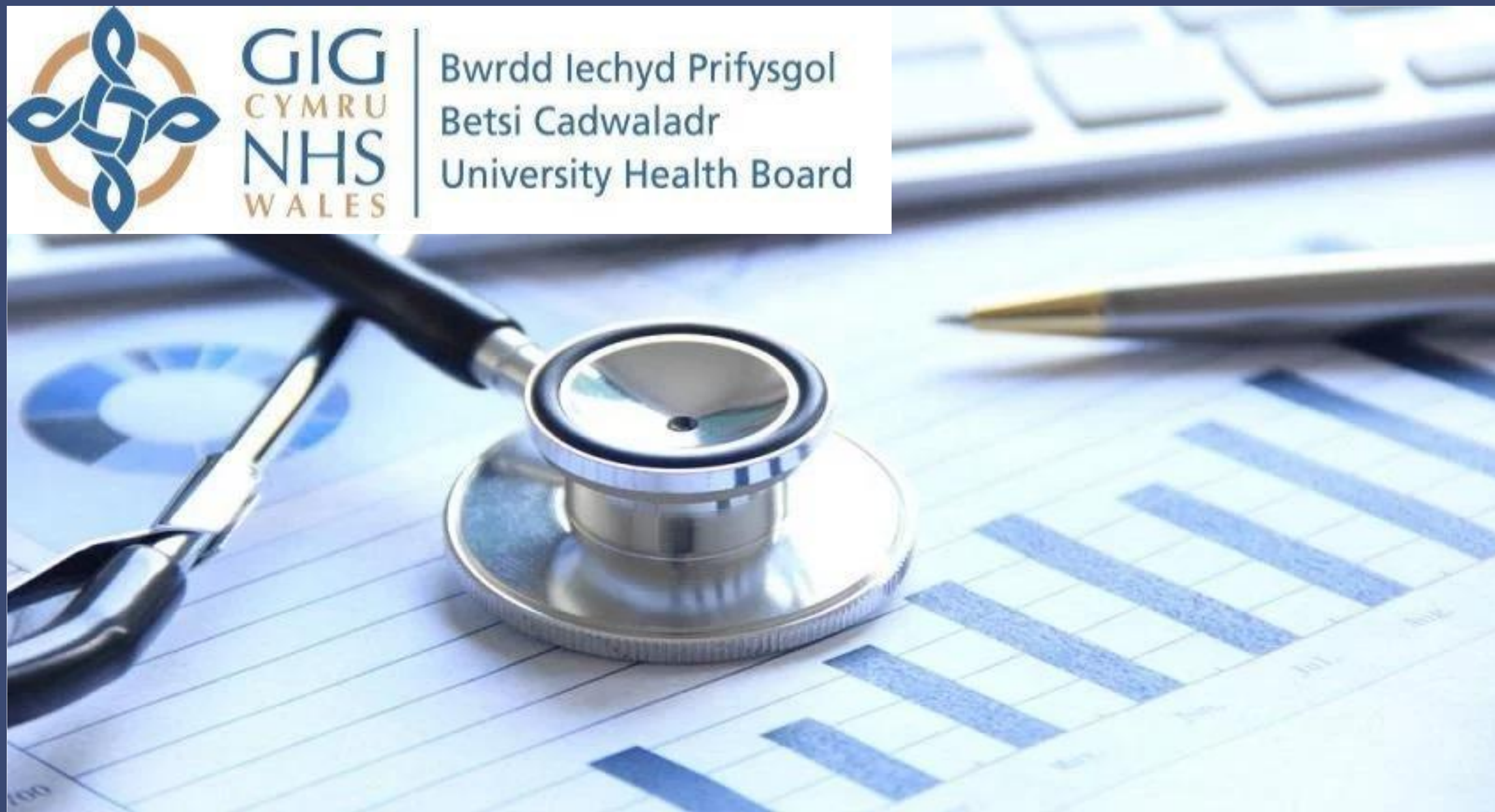
<b>Lefel sicrwydd:</b>  <b>Assurance level:</b>	<b>Arwyddocaol</b> <b>Significant</b> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <b>Acceptable</b> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <b>Partial</b> <input checked="" type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <b>No Assurance</b> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<p><b>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:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<p>Because of significant capacity pressures in the MHA Team over the last year, work continues to ensure data is valid and reliable.</p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b>Link to Strategic Objective(s):</b>	<p>Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning</p>			
<b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b>	<p>This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.</p> <p>The Mental Health Act detentions fall into categories of being either legal or illegal (invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked for validity, and any invalid detentions are reported through Datix, investigated and escalated as appropriate. These are reported as exceptions within the report.</p>			
<b>Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP7 has an EqlA been identified as necessary and undertaken?</b>	<p>The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.</p>			
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b>	<p>N/A</p>			
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>	<p>Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided.</p>			

<b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b>	
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <b>Financial implications as a result of implementing the recommendations</b>	N/A
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <b>Workforce implications as a result of implementing the recommendations</b>	N/A
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <b>Feedback, response, and follow up summary following consultation</b>	<p>This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services.</p> <p>A monthly report is produced and the data submitted monthly to Dr Alberto Salmoiraghi, Medical Director for Mental Health &amp; Learning Disability Services and Matthew Joyes, Deputy Director for Legal Services.</p> <p>Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.</p>
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	N/A
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	N/A
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b> <b>Next Steps:</b> <b>Implementation of recommendations</b>  N/A	
<b>Rhestr o Atodiadau:</b> <b>List of Appendices:</b>  MHA Assurance Report	



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WALES

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University Health Board



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

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

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

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

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

## Executive Summary:

During the previous quarter, the Mental Health Act (MHA) Team has gradually seen a return of staff who were previously on long term absence. It is worthy to keep in mind that there is still a lack of resilience in the team in that there is no deputy manager position to provide both management cover and cross-office cover.

The MHA Manager has resumed production of the reports in full since June 2025 due to this there is still some data in this report that could not be produced for this quarter, the reports are under review and will in the future be produced through PowerBI which will establish an up to date view, the audit reports will be produced on a yearly basis.

There have been a number of section 3 detentions which have been deemed invalid during this quarter, two invalid renewal documents were highlighted by an Associate Hospital Manager during scrutiny sessions. Following this a review of all the inpatients Section 3 paperwork and renewals was undertaken, from which a further four renewals were found to be invalid. All patients, nearest relatives and parties involved have been informed. All patients under went fresh assessments to which five were initially re-detained with a further one remaining informal but was re-detained days later.

It is important to recognise that whilst the detentions were invalid due to administrative errors this did not impact on the quality of the clinical care the patients received and the treatment delivered was always what our clinicians felt was right. In addition, patients had Tribunal Hearings and Hospital Manager Hearings; both the Mental Health Review Tribunal and Associate Hospital Manager Hearing members concluded independently on these occasions that the patients were receiving treatment in their best interests under the Mental Health Act and did not make any decisions to discharge. Whilst this does not excuse the errors, it should offer assurance that the detentions were correct and that the care being delivered was appropriate. All instances have been Datixed and are under review.

There were two under 18s within the adult units this month, one on a S5(2) detention following transfer as an informal patient, and one S2 patient following transfer from an out of area bed. Both were discharged from the unit back to thier respective residence.

**Section 5(4) Nurses Holding Power (up to 6 hours):** Criteria: "...the patient is suffering from mental disorder to such a degree that it is necessary for their health and safety or for the protection of others for them to be immediately restrained from leaving the hospital". Secondly the nurse must believe that "...it is not practicable to secure the immediate attendance of a practitioner or clinician for the purposes of furnishing a report under subsection (2). The nurses who can use this power are those registered in either Sub-Part 1 or 2 of the register maintained under article 5 of the Nursing and Midwifery Order 2001 whose registration includes an entry indicating that the nurse's field of practice is either mental health nursing or learning disabilities nursing.

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

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

**Section 2: Admission for assessment (up to 28 days):** Criteria needs to be met:

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

**Section 3: Admission for treatment (up to 6 months, renewable for 6 months, 12 monthly thereafter):** Criteria

- a) is suffering from mental disorder of a nature or degree which makes it appropriate for him/her to receive medical treatment in hospital;
- b) it is necessary for the health and safety of the patient or for the protection of other persons that he/she should receive such treatment and it cannot be provided unless he is detained under this section;
- c) appropriate medical treatment is available for him/her

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

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

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

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

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

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

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

**Section 37:** Hospital Order or Guardianship Order - up to 6 months, renewable for 6 months, 12 monthly thereafter

**Section 37/41:** Hospital Order with Restrictions – made with no time limit

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

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

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

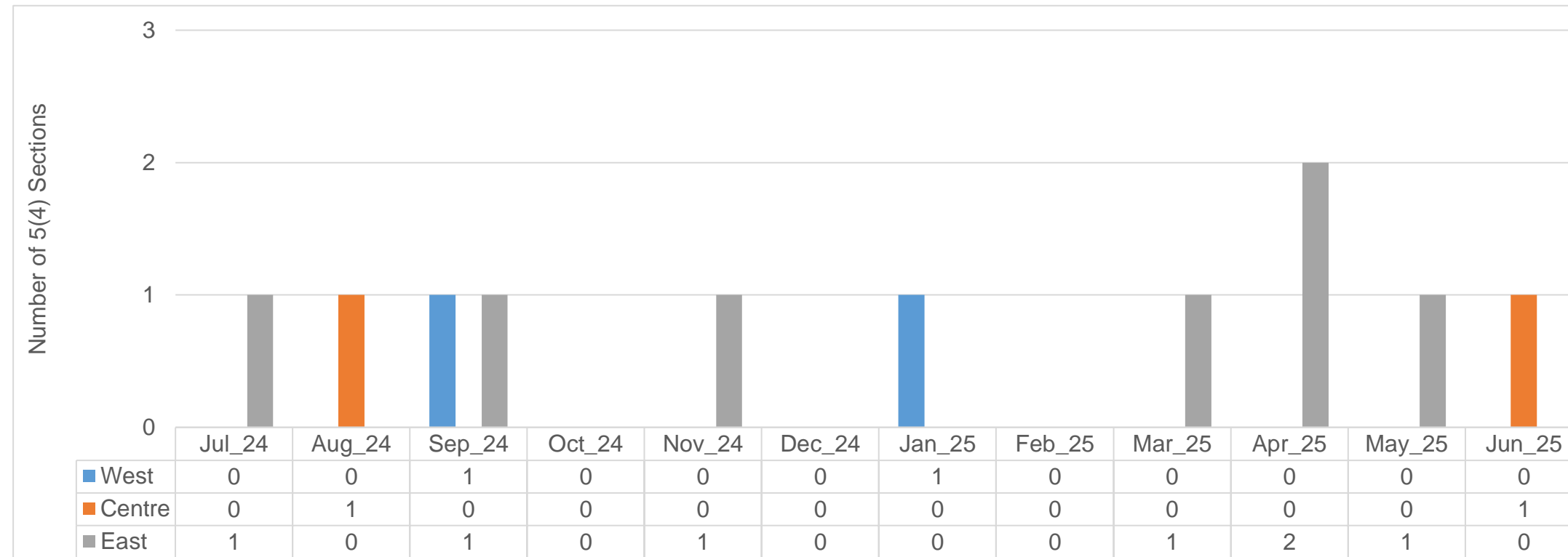
**Section 62:** Emergency Treatment of a detained patient regardless of section status

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

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

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

Section 5(4) - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter	Quarter 5(4) Sections
<b>Section 5:</b> Application in respect of patients already in hospital	1	1	➔	4	2	↑	3	1 East	3
								2 Centre	1
								3 West	0



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

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

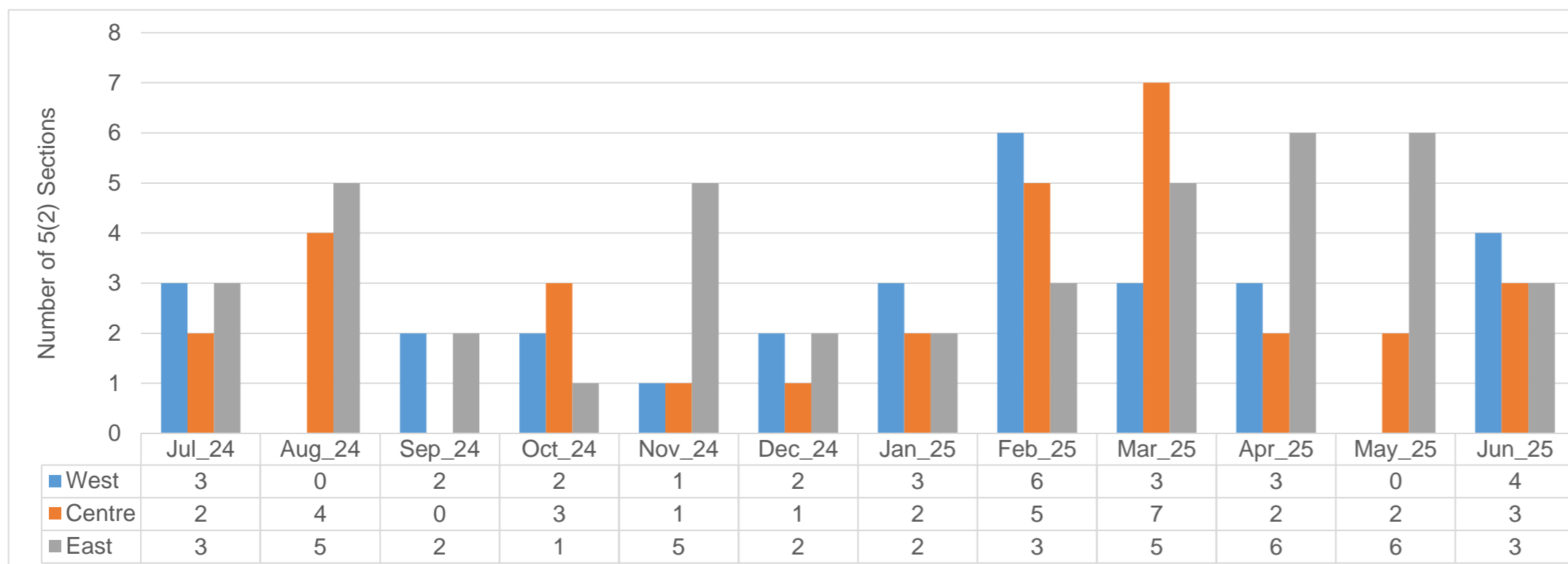
LAPSES
No exceptions to report.

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

CENTRE		
Month	Duration (hh:mm)	Outcome
Jun_25	00:15	Informal

EAST		
Month	Duration (hh:mm)	Outcome
Apr_25	01:45	Informal
Apr_25	02:15	Section 5(2)
May_25	01:35	Section 5(2)

Section 5(2) - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(2) during Quarter	Quarter 5(4) Sections
<b>Section 5:</b> Application in respect of patients already in hospital	10	8	↑	29	36	↓	26	1 East 2 Centre 2 West	15 7 7

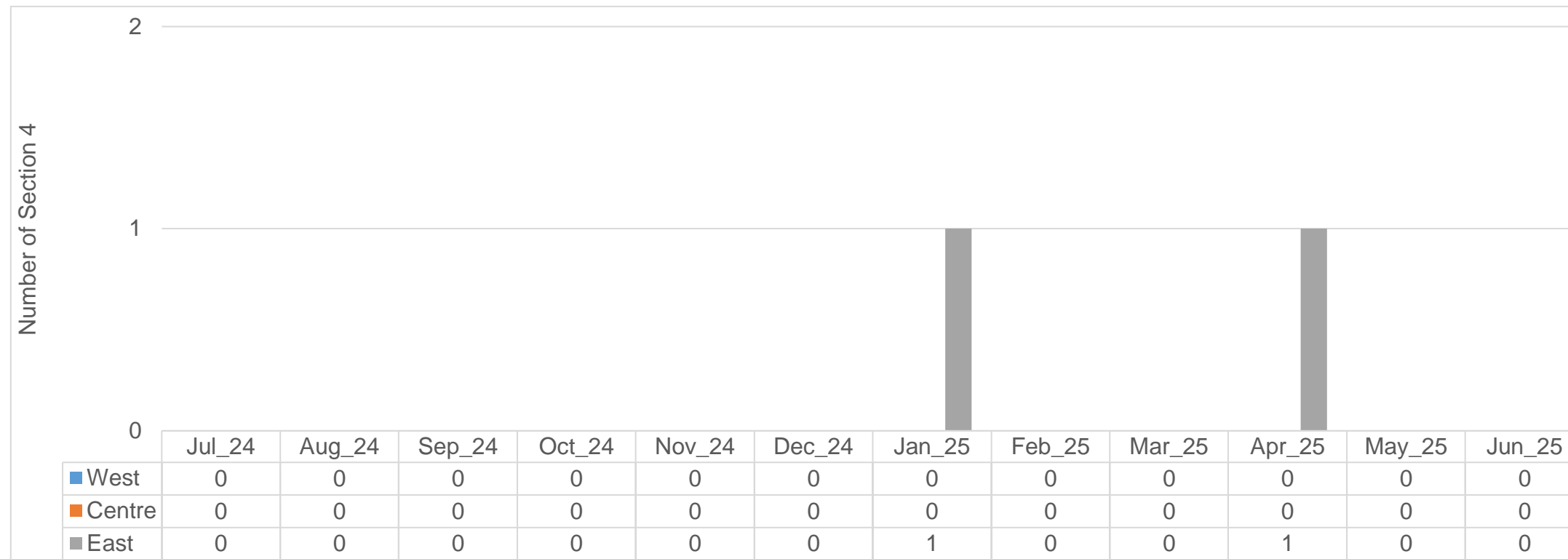


Section 5(2) Outcomes			
	Apr 2025	May 2025	Jun 2025
Section 2:	2	5	3
Section 3:	2	1	2
Informal:	4	2	3
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	2	1	2
Other:	0	0	0

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

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

Section 4 - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter	Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	0	0	➔	1	1	➔	1	1 East	1
								2 Centre	0
								2 West	0



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

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

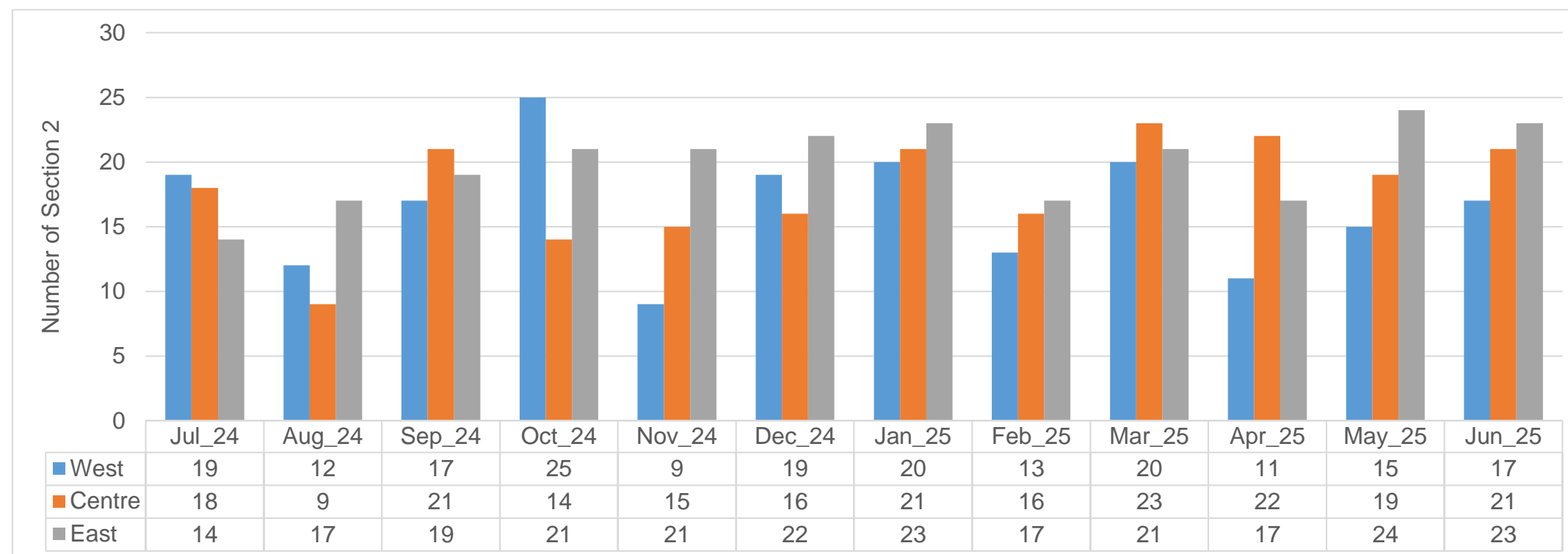
There are no exceptions to report.

WEST		
Month	Duration (hh:mm)	Outcome

CENTRE		
Month	Duration (hh:mm)	Outcome

EAST		
Month	Duration (hh:mm)	Outcome
Apr_25	00:50	Section 2

Section 2 - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter	Quarter Section 2
Section 2: Admission for assessment	61	58	↑	169	174	↓	163	1 East	64
								2 Centre	62
								3 West	43



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

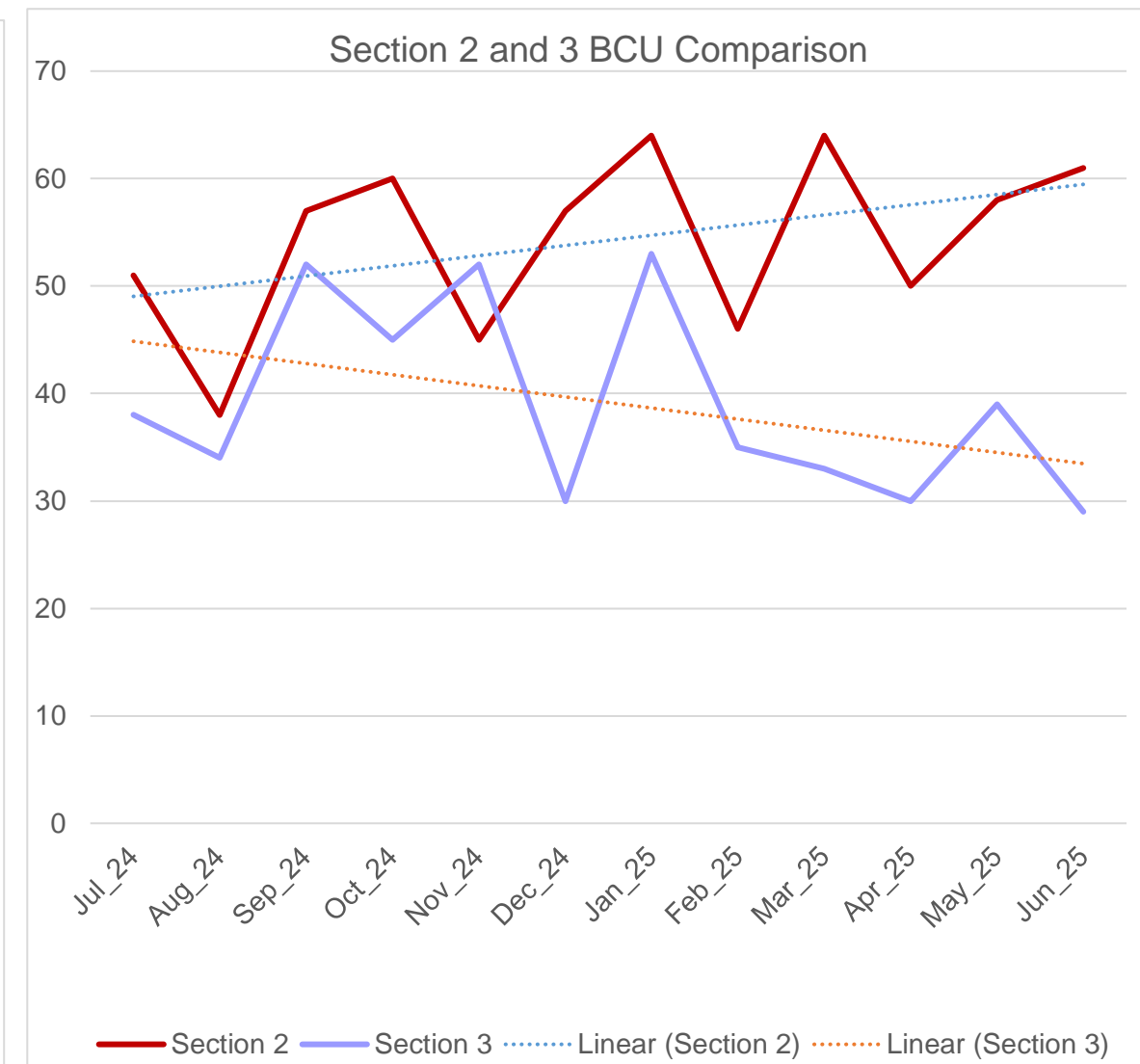
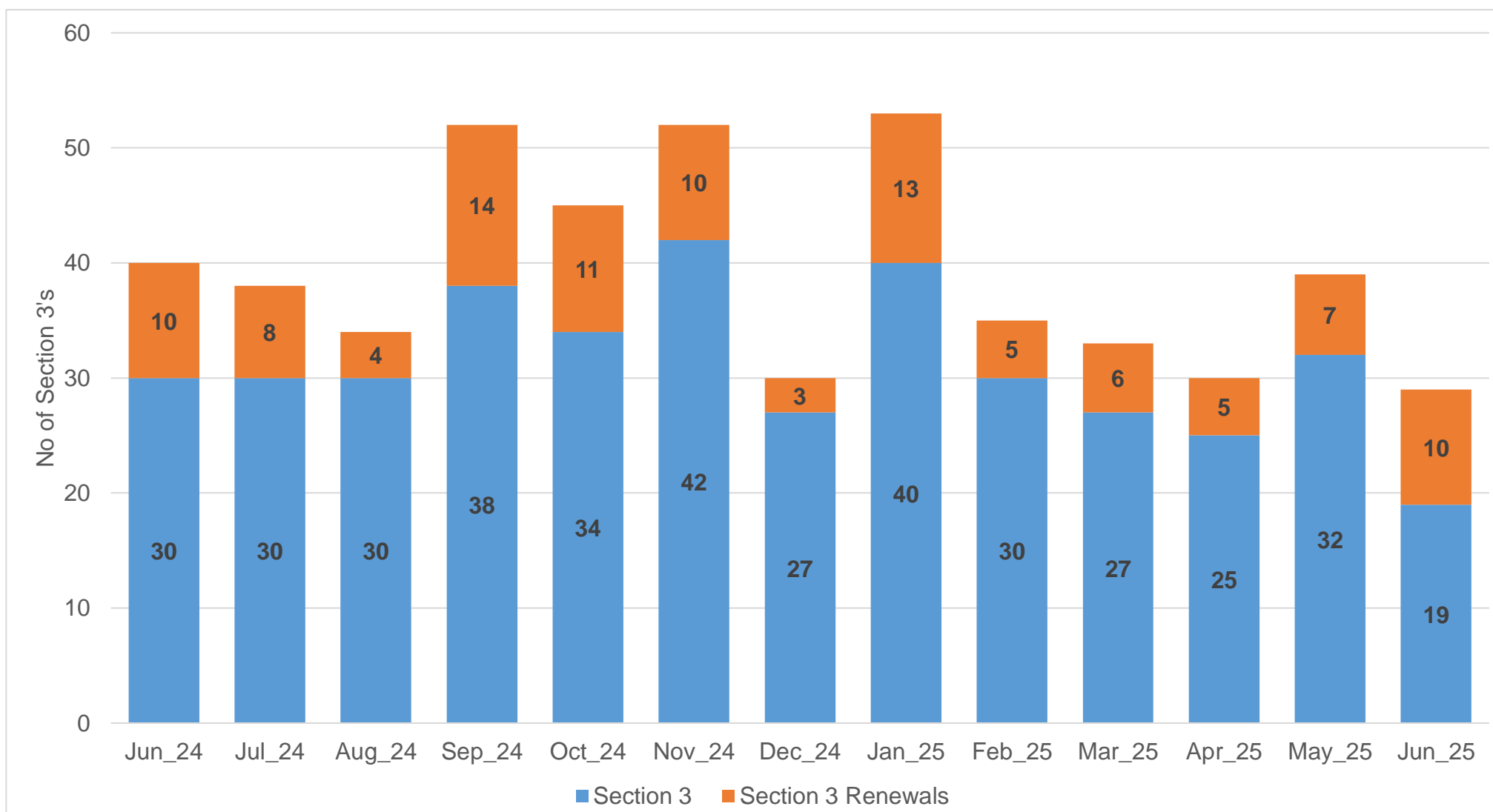
Section 2 Outcomes			
	Apr 2025	May 2025	Jun 2025
Section 3:	11	14	10
Informal:	22	13	20
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	12	7	10
Transferred:	17	16	16
Invalid and Other:	0	1	0

A section 2 will be enacted following holding powers 5(4) or 5(2) or via a regrade from a section 4 or an informal admission. Section 2 is also used as a direct admission detention.

There were seven young people placed on a section 2 this quarter, one originally in the general hospital prior to moving to NWAS. One young person was detained within an Adult Unit prior to being discharged.

EXCEPTIONS:  
There are no exceptions noted this period.

Section 3 - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter	Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	29	39	↓	98	121	↓	118	1 Centre	40
								2 East	32
								3 West	26



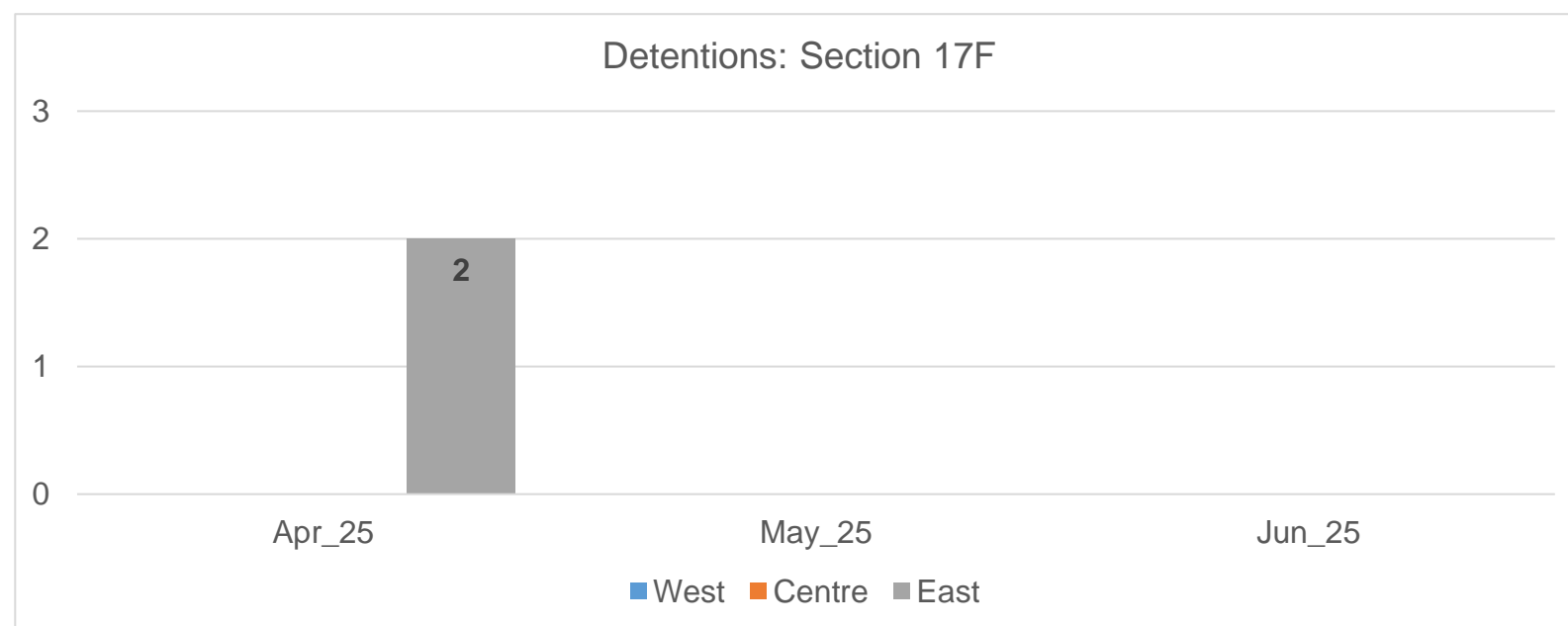
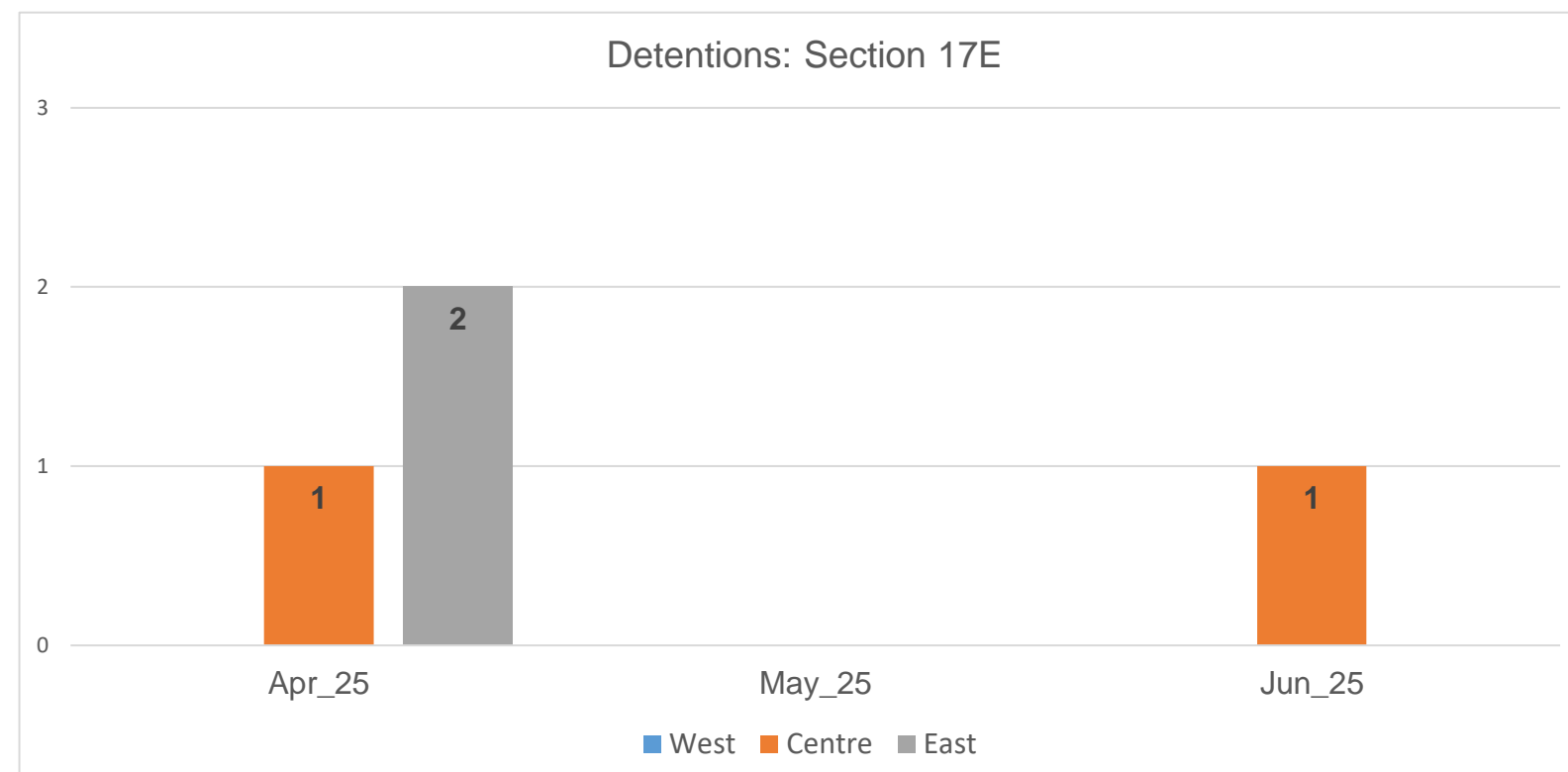
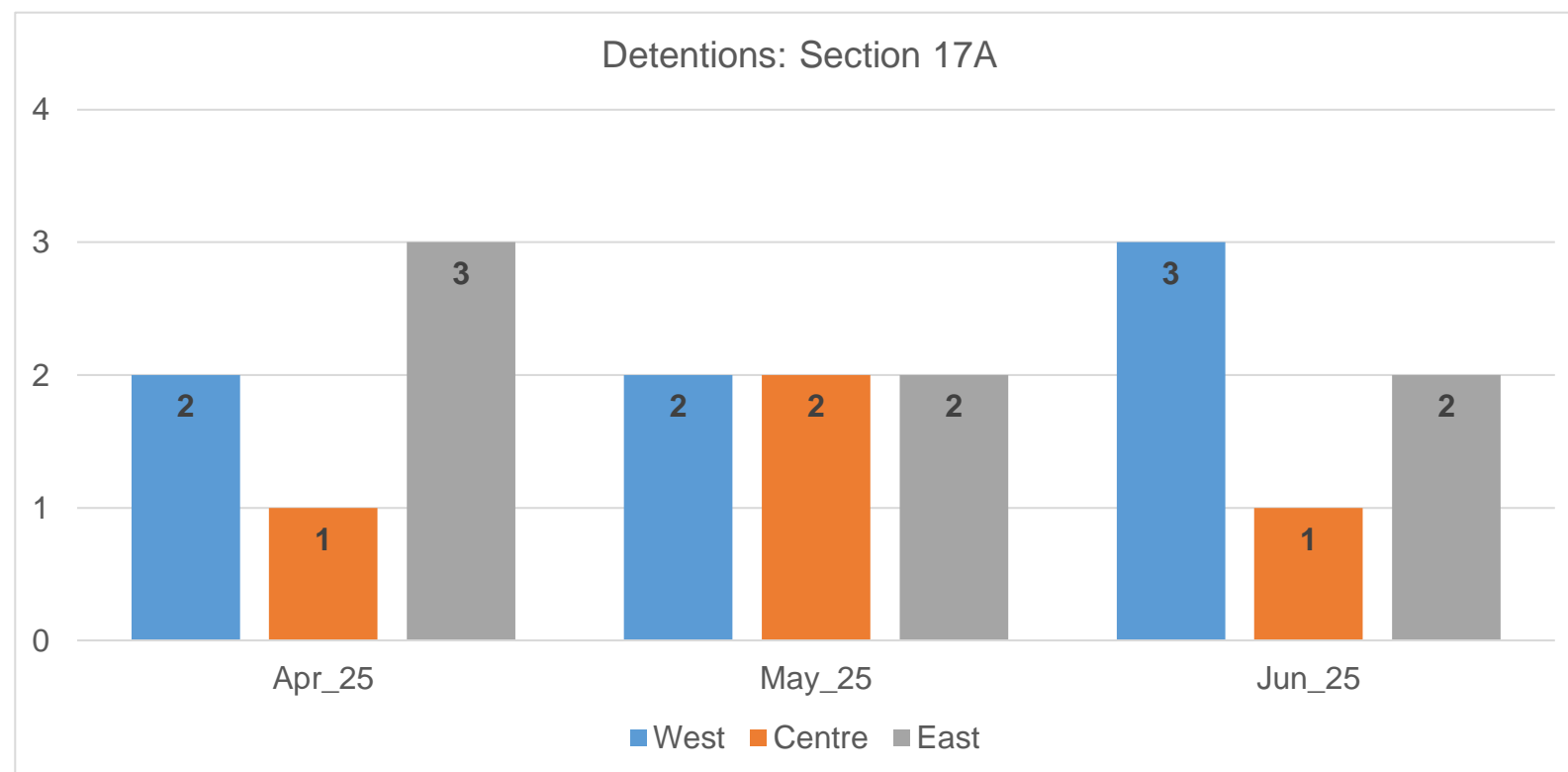
\* data is as at position and is subject to change

These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board. There are six section 3 exceptions reported this period due to previous detentions being identified as invalid. The use of Section 3 continues on a downward trend this period.

For those that were discharged from their section 3 in this quarter the lengths of stay have been calculated for the average days, longest and shortest day durations.

April = Average 151 days, shortest 36 days and longest 585 days.  
 May = Average 128 days, shortest 13 days and longest 317 days.  
 June = Average 155 days, shortest 25 days and longest 712 days.

Section 17 A-F - BCUHB	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter	Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	7	6	↑	24	9	↑	16	1 East 2 West 3 Centre	11 7 6

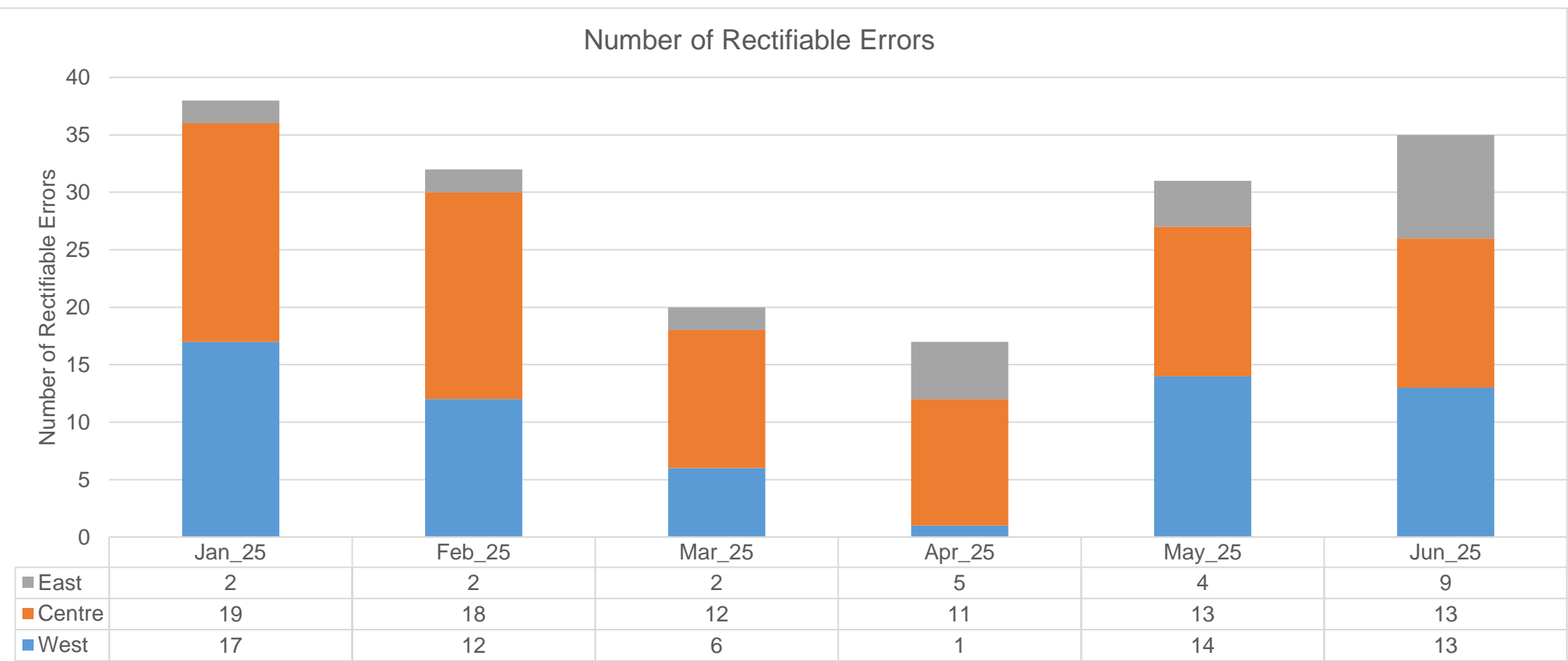


This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section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

There are no exceptions to report this quarter.

The number of patients on a CTO at the end of June are:  
 West = 11  
 Central = 10  
 East = 8

Fundamental and Rectifiable Errors	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter	Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	35	31	↑	76	80	↓	107	1 Centre	37
								2 West	28
								3 East	19



**Rectifiable Errors**

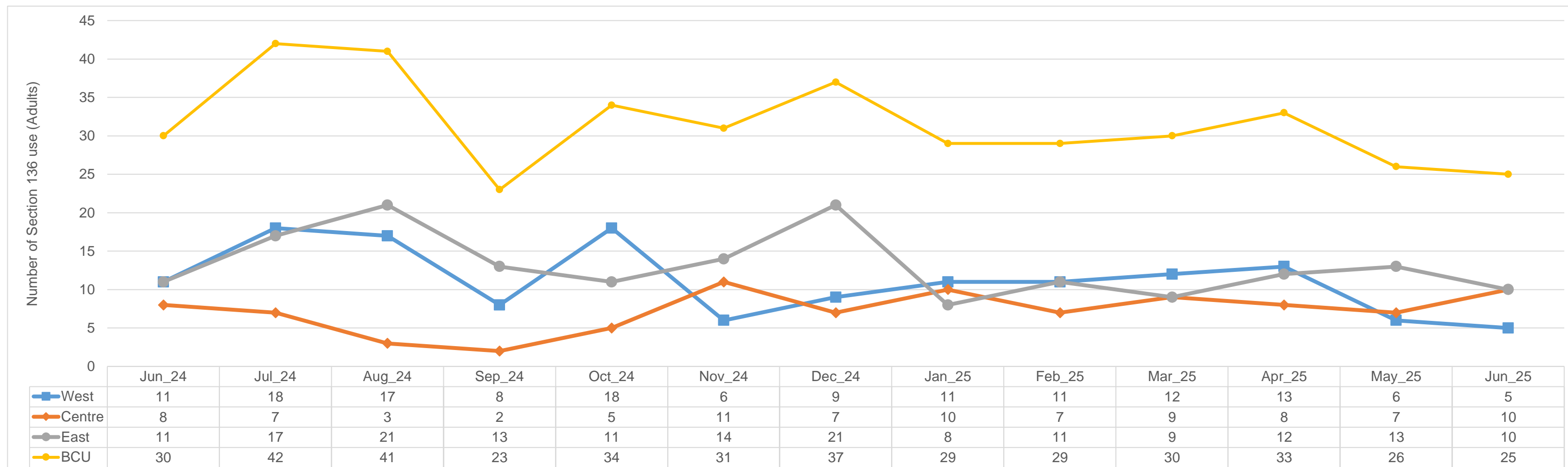
Rectifiable errors were previously reported on a quarterly basis and benchmarked with the other health boards throughout Wales. Due to capacity to produce this report Cardiff and Vale have discontinued the report. The last report received covered April - June 2023. Discussions are underway with a proposal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

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

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

The increased West position reflects a number of issues being identified now which relate to errors made during the period of staff absences (from summer to winter 2025).

Section 135 - 136	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	25	26	↓	84	88	↓	95	1 East 2 Centre 3 West	35 25 24



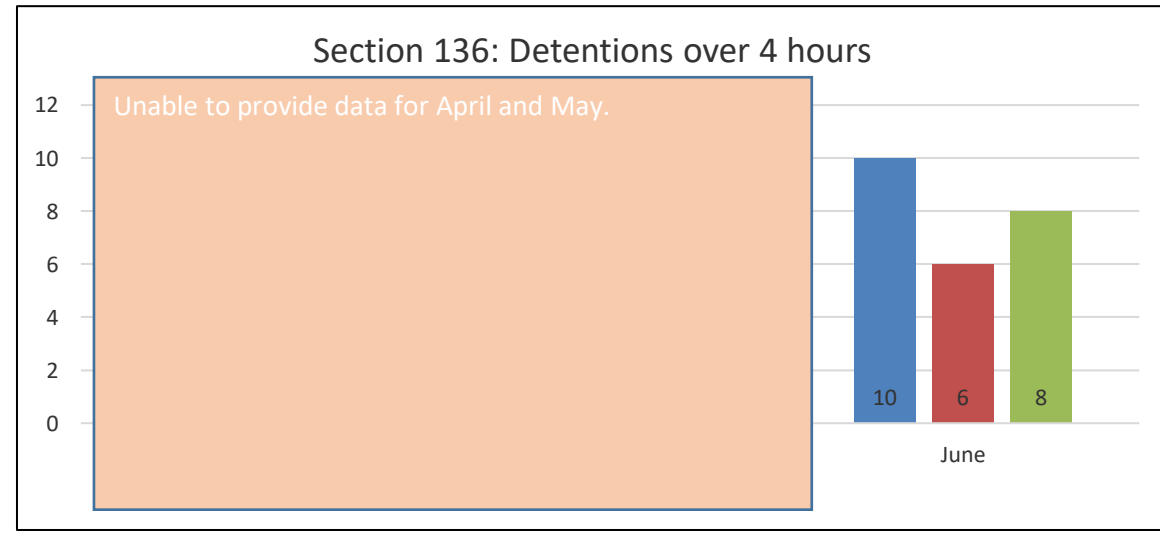
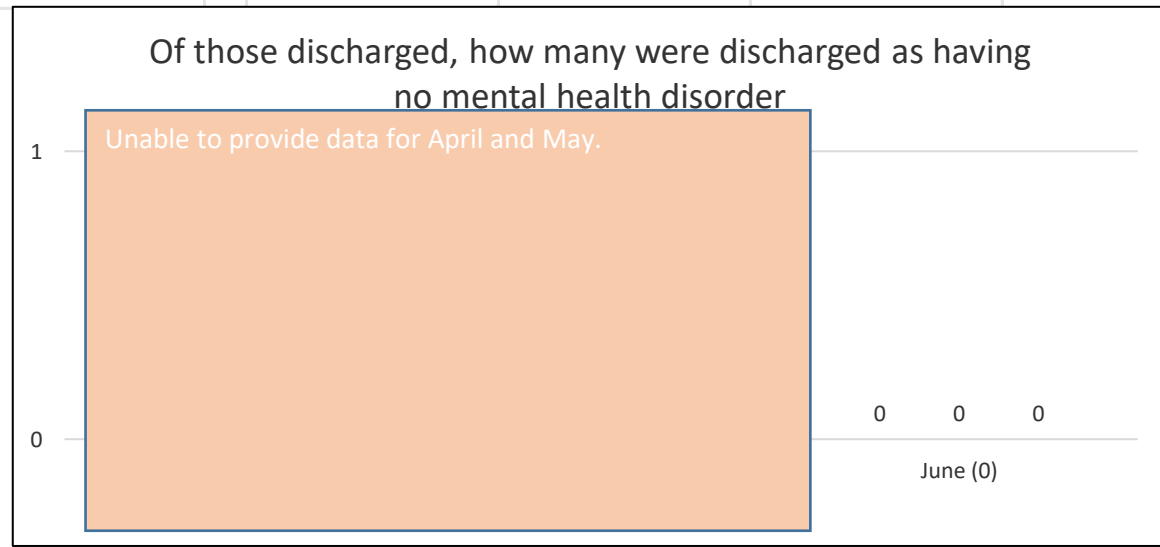
The data above does not include S135 or under 18's.

During the period there have been three detentions which originated within the police custody suite, two resulting in S2 admissions and one discharged with no mental disorder.

Two x S135 detentions occurred both resulting in S2 admissions.

Section 136	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	25	26	↓	84	88	↓	95	1 East 2 Centre 3 West	35 25 24

Section 136 Outcomes			
	Apr 2025	May 2025	Jun 2025
Discharged:	Unable to provide data		11 42.31%
Informal Admission:	Unable to provide data		6 23.08%
Section 2:	Unable to provide data		7 26.92%
Section 3:	Unable to provide data		0 0.00%
Other:	Unable to provide data		2 7.69%



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.

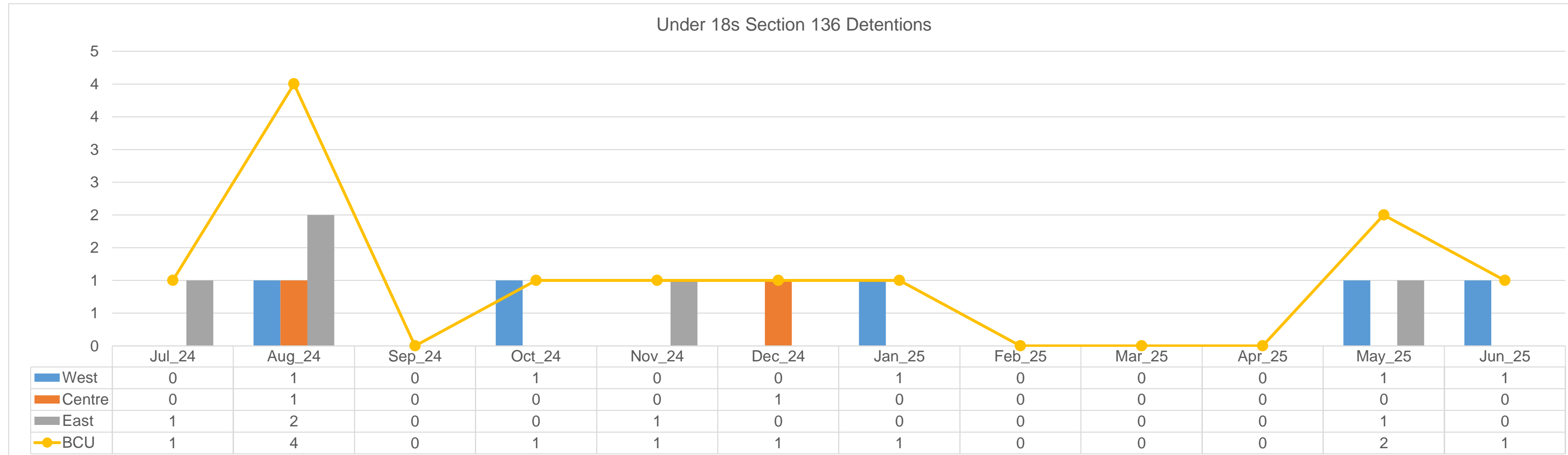
Section 136 - Known to Service			
	Apr 2025	May 2025	Jun 2025
Yes	Unable to provide data		15
Yes (percentage)	Unable to provide data		57.69%

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

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

There were no patients discharged with an outcome of No mental disorder for June 2025. The S136 reports in June have been produced once again by the MHA Manager therefore data prior to June 2025 is not available but will be going forward.

Section 135 - 136 (Under 18)	June 2025	May 2025	Monthly Change	Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter	Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	1	2	↓	3	1	↑	3	1 West 2 East 3 Centre	2 1 0



The tables below shows the ages of young persons assessed and the outcomes for the year period April 25 - March 26.

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

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

5

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
May	Hergest	Admission	CAMHS	17:48	17
May	Heddfan	Discharged	CAMHS	02:45	14
June	Hergest	Discharged	CAMHS	16:50	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: 12:27hrs

**Under 18's admitted to Adult Psychiatric Wards**

There was an under 18 admitted to the adult unit for a period of 10 days, 16 hours following transfer from an out of area bed. One under 18 year old was admitted informally, detained on a section 5(2) for a total of 20 hours prior to discharge back to thier placement.

The table below shows the county that the young persons originated from and where they were assessed for the period April 25 - March 26

**County Originated from and where assessed:**

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

Section	Unable to provide data - Forensic sections prior to May 2025		May 2025	Jun 2025
Section 35:			0	0
Section 37:			2	1
Section 37/41:			8	9
Section 38:			0	0
Section 47:			3	3
Section 47/49:			5	5
Section 48:			0	0
Section 48/49:			0	0
Section 3:			1	1
Section 45A			0	0
<b>Total:</b>			<b>19</b>	<b>19</b>

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			
	Apr 2025	May 2025	Jun 2025
<b>Internal Transfers</b>	16	15	15
<b>External Transfers (Total)</b>	11	16	6
<b>External Transfers (In)</b>	7	6	2
<b>External Transfers (Out)</b>	4	10	4

**Internal Transfers**

This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway. A transfer due to step down/up needs will include transfer to PICU or rehab wards, adult to older persons, MSU to rehab.

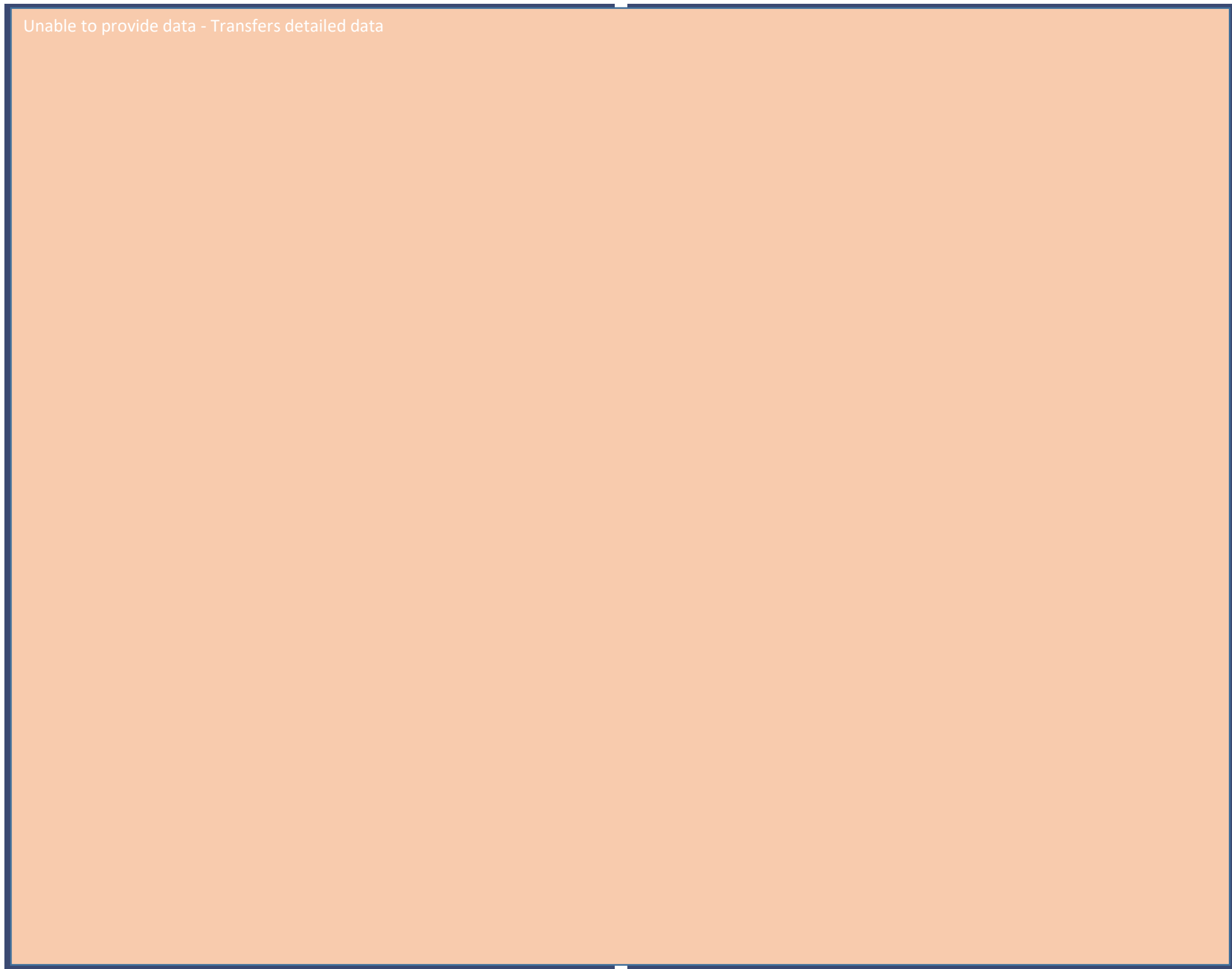
**External Transfers**

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

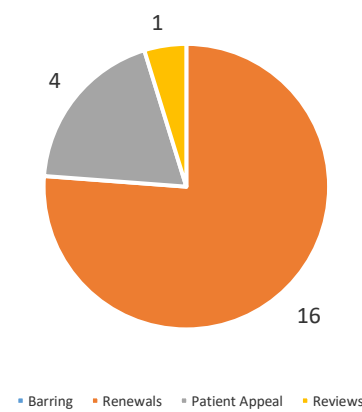
**Patients detained in Independent Hospitals (in Wales and outside of Wales)**

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

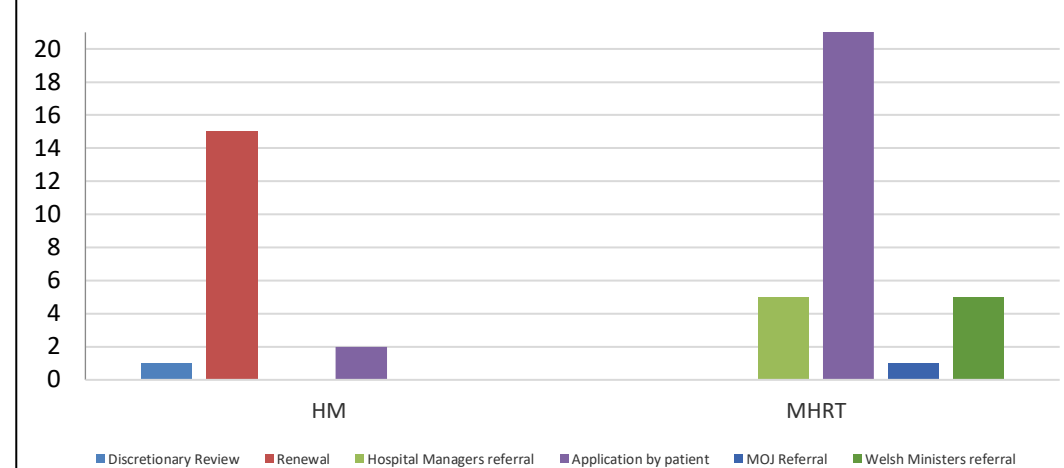
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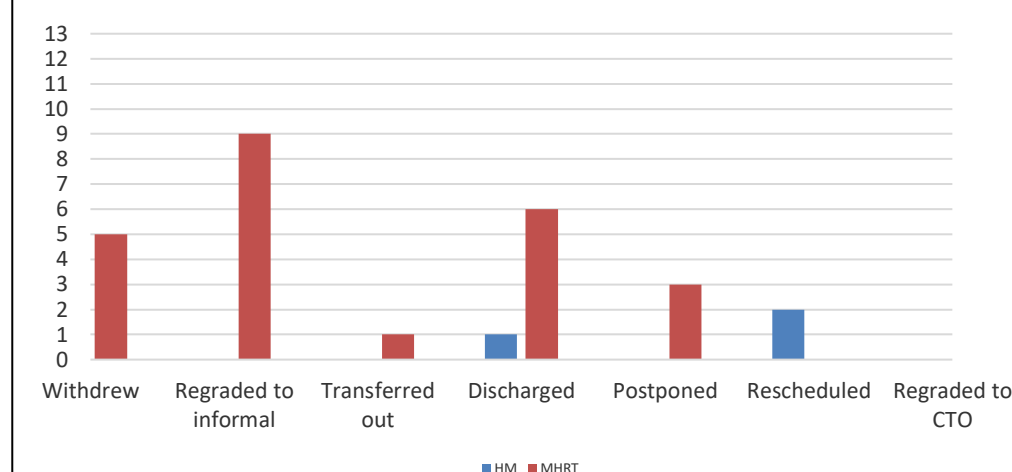
Hospital Managers Panel Hearings scheduled April - June 2025 (n21)



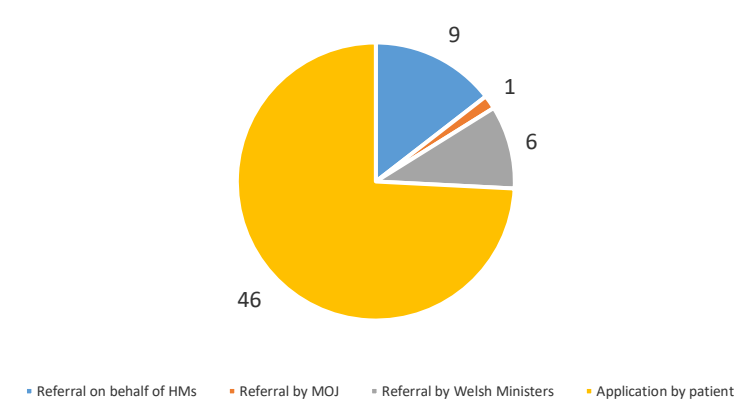
55 Hearings Held April - June 2025 by type



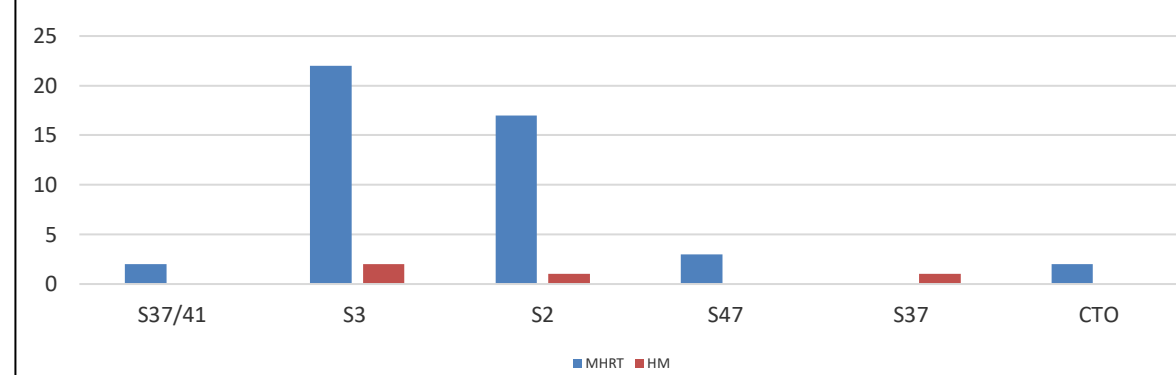
28 Hearings not held April - June 2025



Mental Health Review Tribunals scheduled April - June 2025 (n62)



Type of patient appeals received April - June 2025  
46 MHRT and 4 Hospital Managers



The above charts show the number of Associate Hospital Managers Hearings and Mental Health Review Tribunals scheduled to take place for the quarter April - June.

There were 83 hearing scheduled this period which included 50 applications from patients. 55 hearings took place of which 28 were patient applications.

The MHRT discharged two patients this quarter from S2 and S3, all other hearings held resulted in the patients remaining detained.

<b>Teitl adroddiad:</b> <i>Report title:</i>	Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q1 2025-26 Update			
<b>Adrodd i:</b> <i>Report to:</i>	Mental Health Legislation Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 07 August 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	This report provides the Quarter 1 update on the provision of DoLS and MCA activity within the Health Board.			
<b>Argymhellion:</b> <i>Recommendations:</i>	<p>The Board is asked to:</p> <p>Accept the DoLS and MCA Report and the identified activity for the period of Q1 2025-26</p> <p>Receive the DoLS and MCA Audit update and recorded progress.</p>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Michelle Denwood, Director of Safeguarding and Public Protection Hayley Lloyd, DoLS and MCA Regional Team Manager Mat Phillips, Safeguarding Adults/Adults with Dementia Lead Chris Walker, Head of Safeguarding Adults, DoLS and MCA			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<p><b>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:</b></p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <i>Link to Strategic Objective(s):</i>	N/A			
<b>Goblygiadau rheoleiddio a lleol:</b> <i>Regulatory and legal implications:</i>	Mental Capacity Act (MCA 2005)			

<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></p>	N/A
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	N/A
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></p>	The Risk relating to DoLS/MCA is identified within the report.
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	No financial implications
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	No workforce implications
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>This quarterly report is submitted directly to the Committee.</p> <p>Deprivation of Liberty Safeguards is held within the portfolio of the Executive Director of Nursing and Midwifery and this update has been reviewed by Angela Wood, Executive Director of Nursing and Midwifery.</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	N/A (see Risk below)
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	N/A
<p><b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b></p> <p><b>Next Steps:</b> <b>Implementation of recommendations</b></p>	
<p><b>Rhestr o Atodiadau:</b> <b>List of Appendices:</b></p> <p>Appendix: 1: Role of the Section 12 Doctor [page 13] <i>(Included as requested from the previous meeting).</i></p>	

## Cyflwyniad / Cefndir Introduction / Background

The activity recorded within the report provides oversight and organisational assurance in relation to the Health Board's statutory duty under the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA 2005) for the period of Q1 2025-26. The activity includes key actions to ensure that DoLS and the MCA as part of the wider Safeguarding and Public Protection agenda remains paramount to service delivery across the Health Board.

DoLS reports throughout the Organisation in accordance with the Safeguarding Reporting Framework. This Framework reinforces Organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group, and key Forums and Committees. The functions of the Safeguarding and Public Protection DoLS Team include the legal responsibility of Supervisory Body, which must provide scrutiny and independence.

## Corff yr adroddiad Body of report

### Legislation Update

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

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

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

### Current Health Board Position (Q1)

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

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

Update on each action.

- **Action 1 DoLS paperwork:** The Health Board continues to lead the Paperwork Subgroup and has developed a new DoLS Form 1 (DoLS Application Form). This updated form has undergone internal review and received approval by the National MCA/DoLS Group. The pilot commenced on the 1<sup>st</sup> April 2025. The pilot has been well received, with strong engagement from all hospital wards involved and the feedback so far has been positive. A questionnaire is currently being developed for the hospital wards, supervisory body (DoLS Team), service users and their families to complete in order to evaluate the pilot. A draft version of the questionnaire will be shared with the National Group for approval prior to distribution.

- **Action 2 MCA Training:** MCA Training remains a key priority for the Health Board, with further improvements in training compliance achieved during Q1 2025-26. New National training programmes have been developed to enhance awareness and understanding of the MCA. The updated All Wales Mandatory Level 1 and Level 2 MCA training modules are now live on ESR. These programmes are designed to equip staff with the knowledge and confidence to support patient's effectively and uphold their rights under the legislation. Work is also ongoing to align staff roles and responsibilities with the appropriate training levels, ensuring consistency with the Intercollegiate Guidance on the MCA. Running parallel with the Training Group, a new sub-group is being established to develop a revised National MCA Form. The Health Board will actively participate in this subgroup.
- **Action 3 DoLS Process:** This action focuses on identifying areas for improvement and exploring opportunities to implement new DoLS workstreams. Key areas under review include relevant policies and community DoLS processes to ensure alignment with current legislation. A particular focus is on the review and update of the All Wales Advanced and Future Care Plan (AFCP) policies. The aim is to promote a unified "One Wales" approach to Future Care Planning – emphasising shared decision-making and meaningful involvement. The framework is designed to empower individuals to make informed choices about their care, ensuring their preferences are clearly recorded and accessible to all relevant parties. Alignment with National initiatives in Wales supports improved healthcare access, integration and person-centred care. The Health Board will also engage in collaborative work through participation in the Digital Health Hand Care Wales (DHCW) National Framework for Care Planning and the hospital/inpatient Treatment Escalation Plan (TEP).

A significant area of progress relates to the reduction of the DoLS backlog. As of the 17<sup>th</sup> April 2025 the DoLS backlog stands at 52, a notable improvement from 71 in the previous quarter. This reduction has been made possible through targeted intervention and financial support from Welsh Government (WG). It is important to note that the number of applications received can vary month to month and as such, the backlog will fluctuate.

### Performance and Activity

The annual trend for DoLS applications continues to be an upward trajectory within the Health Board. This is in line with the National picture. During Q1 2025-26 a total of 602 DoLS applications were submitted, this is a 6.9% increase in comparison to last year's figure. Although the increase places pressure on the service it also continues to demonstrate learning and compliance with the statutory legislation.

Currently, there is an average delay of four to five weeks between receipt of a DoLS application and the completion of the standard authorisation process, referred to as the backlog. This position is not unique to the Health Board, as similar or more severe delays are being experienced by other Health Boards and Local Authorities.

WG acknowledges the increasing demand placed on the Health Board and has continued to provide financial support. This funding has enabled additional capacity through engagement of Best Interest Assessors (BIAs) and Section 12 (2) Doctors, who have been undertaking assessments during evenings and weekends. As a result, authorisation times has improved.

As previously reported the internal Audit of the MCA/DoLS Team was completed in April 2024-25, which included a thorough review of processes for managing DoLS activities within the Health Board. This review covered procedures, staff training and the monitoring and escalation of cases.

The overall outcome indicated Assurance and Limited Assurance, with progress noted in the following three key areas:

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

This action is now considered complete. Training compliance will continue to be reviewed and monitored instances of low compliance will be escalated appropriately.

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

In accordance with DoLS/MCA legislation, statutory timescales for completing DoLS assessments are clearly defined and adhered to once the application is allocated for assessment. However, the broader concern remains the increasing volume of applications, which continues to rise nationally, and is a trend recognised by both Welsh and UK Governments. Despite this upward trajectory, the Health Board has made significant progress in reducing the DoLS backlog, largely due to additional assessments being carried out during out of hours periods. To meet the increasing demand for DoLS applications, it was essential to expand the capacity of the BIAs. Five staff members have now successfully qualified as BIAs. Once they gain confidence in carrying out assessments independently, out-of-hours assessments will be introduced to further support ongoing service improvements.

This action is now considered complete and will be monitored through quarterly Safeguarding Performance and Governance Group (SGPG) meetings and reporting to the Mental Health Legislative Committee.

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

This action directly addresses the inaccuracies with DoLS documentation by front line practitioners. Improving the quality of information and reducing the errors is a key target for the Health Board. Various support and education methods have been provided to the wards and there has been significant improvement. This is evidenced in Table 3, within the report.

The MCA/DoLS Team continues to analyse the DoLS data produced by the Power BI Dashboard and then collaborates directly with each ward to offer additional support and advice to enhance the quality of the paperwork. Tailored training has been developed and continually offered to the wards, ensuring that all staff have a thorough knowledge and understanding of the MCA to be able to apply it correctly.

Any issues related to DoLS paperwork and low compliance with training data is reported through the IHC/MHLD Safeguarding Forums, the Mental Health Legislative Committee and the Safeguarding Governance and Performance Group.

Following a recommendation from the 2024-25 independent MCA/DoLS audit, it was deemed necessary for Best Interest Assessors [BIAs] to return to office-based working. This action has been approved by the Executive Director of Nursing and Midwifery and presented to the Executive Board.

The audit highlighted a gap in service provision and the need for on-site presence to provide assurance and support for DoLS and MCA related matters. This move also aligns with requests from IHC's within District General Hospitals.

Having BIAs based on-site, enhances visibility and enables quicker face-to face access when required. However, the transition has not been without challenges and while most of the BIAs are now working on-site, two staff members are not yet based on-site full time. A significant barrier has been the ongoing difficulty in securing adequate office space. Despite a prolonged effort, the issue remains unresolved. An application for office/desk space has been submitted to the 'Space Utilisation Group' (for the East area) and a decision is pending. Additionally, the team is managing a challenge to hybrid working. One flexible working application to continue to work from home is currently under appeal.

The MCA lead will continue to visit each site on a weekly basis, offering additional support, advice and training. The Supervisory Body continues to work directly with the wards to address any issues.

### **Welsh Government (WG) Monies**

WG confirmed that all additional funding will be made permanent in line with a bidding process and we wait an agreement regarding how the funding is shared with Health Boards and LA's. To meet the expectations of the funding we will continue to offer developmental opportunities for trained staff within the team to support the strategic and operational management of DoLS and the MCA. There are ongoing conversations with WG regarding the issue of funds. Currently Health Boards and LAs are required to 'bid' for funds which impacts on the Health Boards ability to recruit into permanent posts.

Although a bidding process is followed, confirmation of funding from WG was again not received until after the start of the financial year. This delay creates uncertainty, preventing the Health Board from progressing with planned activities, such as the appointment of additional staff and carrying out additional DoLS assessments. A significant challenge has also been in relation to the payment process for the Independent Mental Capacity Advocacy (IMCA) Service, with payments being delayed. This is included within the DoLS Risk.

WG have advised that work is underway to ensure this permanent, recurring funding is automatically allocated to Health Board budgets at the start of each financial year. Once this is implemented, these funds will be ringfenced to support the DoLS and MCA agenda and help mitigate associated risks.

Although we have not yet been able to recruit into permanent posts, the additional funding from WG has enabled us to continue offering secondment opportunities. Such as the MCA training lead, additional administration and a data analyst. These roles are designed to strengthen the existing DoLS/MCA system and expand capacity in response to increasing demand. WG continue to monitor these initiatives to evaluate the performance and progress, supporting the effective implementation of the legislation and enhancing the quality of patient care. Following further conversations between WG and the Health Board a decision on the amount of funding for Independent Mental Capacity Advocate (IMCA) services is pending an agreement regarding the commissioning of IMCA and the additional funding of RPR services. There will be no financial implications for the Health Board.

### **Independent Mental Capacity Advocate (IMCA)**

The Health Board hold geographical responsibility for the provision of an IMCA service across North Wales.

Meaning that the IMCA service enables the Health Board (HB) and Local Authorities (LA) to meet the statutory requirement of the offer of advocacy services to service users across North Wales. The provision of IMCA and paid RPR services is a statutory obligation introduced under the Mental Capacity Act 2005 (MCA) to ensure individuals are provided with a legal independent safeguard.

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

The provision is also a directive made by WG in preparation for the proposed new UK Government legislation known as the Liberty Protection Safeguards (LPS). The funding awarded by WG is done so with strict spending guidelines. This proposal meets those guidelines and will support IMCA provision for Health Boards and the LA's. WG have agreed that funding designated by them for the use of strengthening IMCA service in North Wales will be equally distributed amongst the Health Board and the LA's using a calculation tool to determine the amount each respective organisation receives. As referenced previously we await this detail. Quarterly contract review meetings for the provision of North Wales IMCA service are held.

It is important to note that IMCA figures represent the number of referrals and not the total number of interactions made per case. Each referral will result in several visits, telephone calls, emails, professional visits/contact, joining professional meetings and time taken to write the necessary reports.

Table 1 below presents the number of referrals made.

**Table 1**

YEAR	IMCA REFERRALS
1 <sup>st</sup> April 2022- 31 <sup>st</sup> March 2023	551
1 <sup>st</sup> April 2023- 31 <sup>st</sup> March 2024	573
1 <sup>st</sup> April 2024- 31 <sup>st</sup> March 2025	656

Referrals will primarily relate to decisions concerning serious medical treatment and changes in accommodation. However, referrals may also be made to support cases involving adult safeguarding or specific decisions around care planning.

The data highlights a clear upward trend in referral over the last three years, which can be attributed to the increased visibility on the hospital wards and proactive awareness-raising efforts by both the IMCA service and BIAs.

The steady increase is funded through WG monies, without this the IMCA service would be unable to provide this level of support resulting in delayed allocations and potentially the inability to provide a service which in turn would result in the Health Board's non-compliance with the legislation. Before we received WG funding there were 2.5 IMCA's to support individuals across North Wales. This has now increased to a minimum of 12.5 (qualified) IMCA's.

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

Highlighted in previous papers, the Service specification was developed on an 'All Wales', basis to ensure content and consistency. NHS Wales Shared Services Partnership (NWSSP) Procurement Service advertised the initial tenders as individual 'Lots' (Lot 1a and Lot 1b) for each Health Board and the separate contracts are between each individual Health Board and the appointed provider. Lot 1a provides the core IMCA service and Lot 1b was tendered in parallel to Lot 1a to cover the additional funding elements.

Following the commencement of the IMCA contract in 2024-25, the Health Board identified that the tendered financial value for Lot 1a was incorrect. To meet the service requirements, the contract value was increased. This adjustment presented challenges, resulting in significant delays in payments to the IMCA service. The situation required involvement from the Local and National Procurement Team, who sought advice and support from the NWSSP Legal and Risk (L&R) Services due to the potential risks posed to both the Health Board and vulnerable adults.

A formal paper was prepared and presented to the Executive Board, seeking approval to modify the contract value. Once approved, payment was processed, ensuring that individuals views were represented in accordance with the Human Rights Act and enabling the Health Board to fulfil its statutory obligations in delivering this essential service.

The Health Board is facing a similar situation for the 2025-26 financial year due to the timing of the current contracts. A new paper has been prepared, requesting approval to amend the contract value and will be presented to the Executive Board in Q2 for payment authorisation. The current contract is due to expire on the 31<sup>st</sup> May 2026, with an option to extend the contract for up to two years.

Also included in the paper, the Health Board has sought Executive-level approval to terminate the existing contract on the 31<sup>st</sup> May 2026 and initiate a re-tendering process rather than extend for a further two years. This would ensure that the future contract accurately reflects both the current funding position and the availability of permanent WG funding. A new contract would eliminate the need for additional papers requesting payment authorisation, as it would align with the full funding allocation. This approach would mitigate the risk of delayed payments to the IMCA service and ensure that vulnerable adults continue to have their rights upheld in accordance with the Human Rights Act. WG are fully updated with the challenges we face.

### **Strategic Implications Assessment and Analysis**

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

### **DoLS Documentation Audit**

The independent audit undertaken by the Health Board Audit Team in Q1 2025-26 included 602 DoLS applications. The submitted DoLS paperwork, on a whole, is of high quality but continues to demonstrate minor errors. However, these errors are identified by the Supervisory Body (DoLS Team) on the immediate receipt of the application and are returned to the Managing Authority to be amended. The paperwork is then returned by the Managing Authority within the legislative framework timescale and does not result in a delay in the authorisation of the DoLS. This also supports immediate operational reflection and learning to improve quality.

Table 2 below demonstrates a significant improvement in the quality of the paperwork over the last 12 months. This is credited to the DoLS/MCA Team and all Health Board services who submit DoLS applications.

**Table 2:**

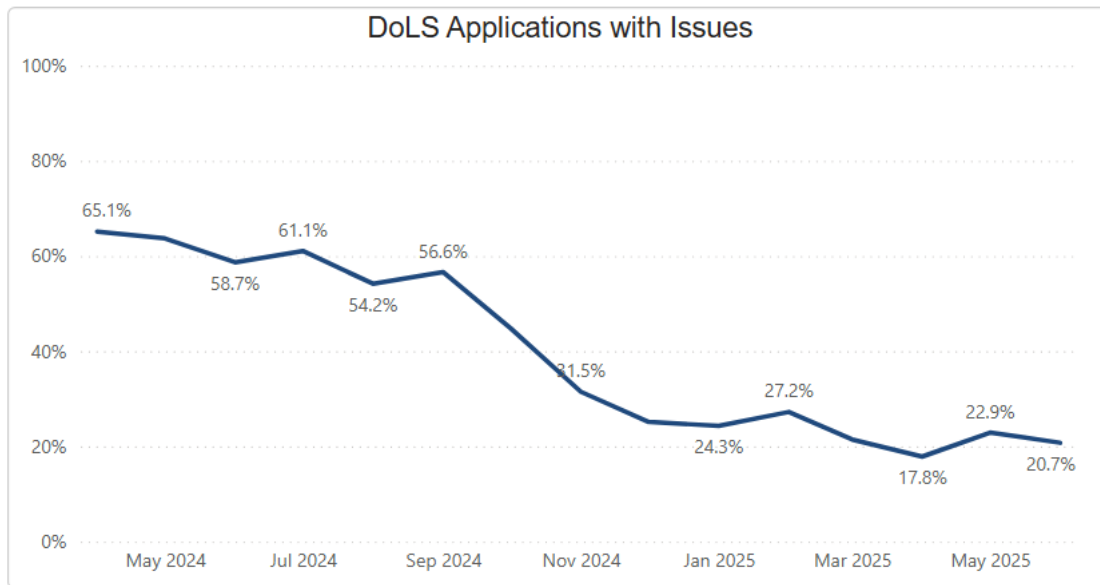
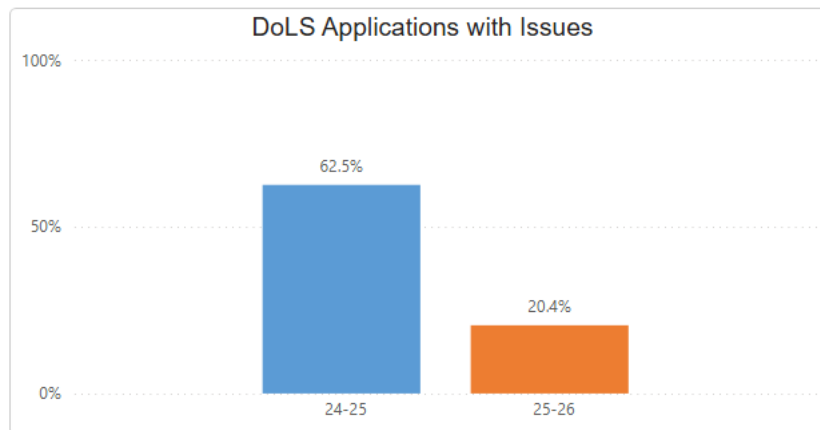


Table 3 below illustrates the percentage of applications during Q1 in both 2024-25 and 2025-26

**Table 3**



During Q1 2024–25 an average 62.5% of applications that were recorded to have had errors within the paperwork (represented by a blue bar). In Q1 2025–26 on average there were only 20.4% of applications that recorded errors (represented by an orange bar). This highlights a significant improvement made by frontline staff.

**Analysis**

Of the 123 applications that recorded issues during Q1, it is essential to note that all of them were rectified within the legislatively approved timeframe. Most of the issues from the applications continue to be minor with minimal amendments required. During Q1 2025-6, 20.4% of the applications received were noted to have issues with them. This is a decrease when compared to the previous quarter when 24.1% of the applications recorded issues.

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

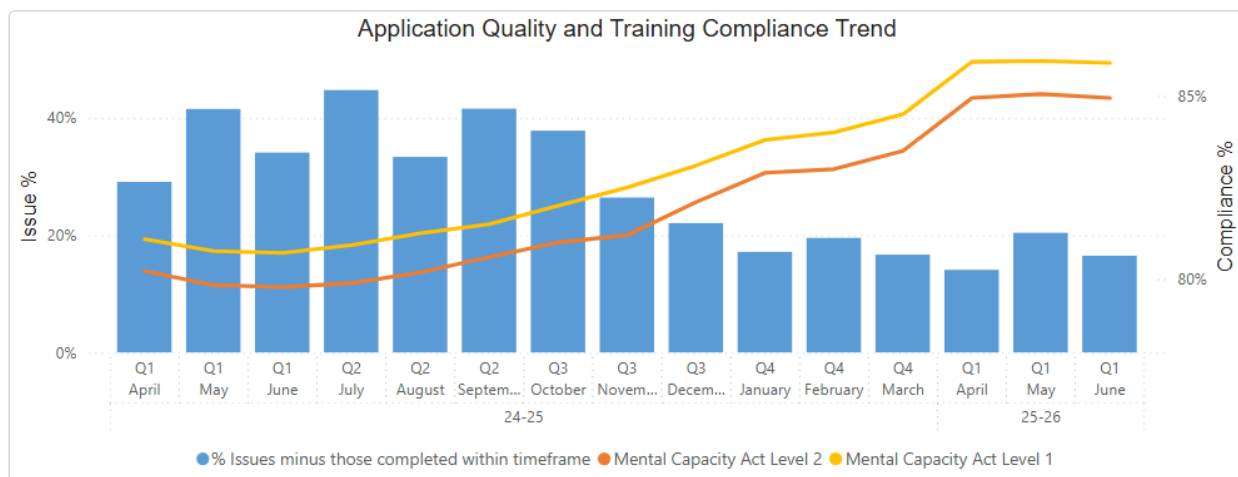
- No inclusion of the Mental Capacity Assessment Form. The findings from the audit reported that the Managing Authority (Hospital Ward) had completed the Form but had not included it as part of the initial set of paperwork.

- Mental Capacity Assessments were completed incorrectly. Similar to the omission of Mental Capacity Assessments the forms suffered from minor inaccuracies such as a lack of address or date of birth. These are resolved immediately by the Managing Authority.
- The DoLS application documentation was not completed correctly. It was reported that it was not signed or was not dated correctly. Issues were resolved quickly and we plan to include enhanced monitoring of timescales.
- Missing details regarding communication and medical information. When the application is submitted the Managing Authority it must provide current medical information.

It is important to note, whilst the errors are minor and do not have a negative impact on the patient’s journey, improving is necessary to ensure good governance, compliance with legislation and to mitigate potential challenges in the Court of Protection (CoP). Every application is quality assured and audited upon receipt by the MCA/DoLS Team, with feedback on the quality if the paperwork provided within 24 hours.

Table 4 below shows the trend between the quality of the DoLS applications and MCA Level 1 and Level 2 training compliance. There continues to be a clear improvement in compliance with Level 1 and Level 2 MCA training and a significant reduction to the errors in DoLS paperwork.

**Table 4: 2024-25**



### Training

The MCA Training Lead continues to provide additional MCA training, tailored specifically to the needs of each ward. The Level 3 MCA and DoLS training package continues to be available on a monthly basis. An additional bespoke training package is available to wards with high referral rates and the MCA lead will visit each ward to deliver at ward rounds, team meetings and training events. All qualified staff members Band 5 and above, are encouraged to undertake the Level 3 training. An MCA level 1 booklet is used for non-clinical staff to aid compliance. The updated All Wales Mandatory Level 1 and Level 2 MCA training modules are now live on ESR. and the Health Board can now commence the work to develop a work booklet for MCA Level 2 to aid staff to meet the mandatory training compliance.

The Health Board have recorded an improvement in MCA training compliance (see Table 5 and Table 6 below) in 2024-25.

**Table 5:**

### Compliance by Health Economy June 2025

Grouped Org L4	Staff	MCA Level 1	MCA Level 2	Average	Modules below 85%
Corporate Services	11734	80.6%	78.2%	79.4%	2
Health Community Centre (HCCX)	5392	88.3%	88.5%	88.4%	
Health Community East (HCEX)	5515	90.4%	89.5%	90.0%	
Health Community West (HCWX)	4422	88.8%	88.7%	88.8%	
Integrated Clinical Delivery - Primary Care (ICDP)	559	87.3%	89.0%	88.2%	
Integrated Clinical Delivery - Regional Care (ICDR)	1608	84.9%	86.4%	85.6%	1
Mental Health & LDS (MX00)	2248	91.3%	91.0%	91.1%	
Midwifery and Womens Services (WXXX)	848	87.4%	86.6%	87.0%	
<b>Total</b>	<b>32326</b>	<b>85.9%</b>	<b>84.9%</b>	<b>85.4%</b>	

**Table 6**

Competency	Q4 2024-25	Q1 2025-26	Trend
Mental Capacity Act Level 1	84.5%	85.9%	↑
Mental Capacity Act Level 2	83.5%	84.9%	↑

Q1 2025-26 has seen an overall improvement in MCA training compliance. Almost all individual Divisions and Services have a compliance rate above the organisational target of 85%.

#### Analysis

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

#### Court of Protection (CoP)

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

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

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

#### Court of Protection – Deprivation of Liberty (CoP DoL)

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

<p>The 2024-2025 Safeguarding and Public Protection Annual Report will include the work achieved during this period. We continue to drive the strategic agenda to safeguard service users and on completion of the review of the risk register the draft strategic objectives for 2025-2026 will be agreed and monitored in line with the Safeguarding Reporting Framework.</p>
<p><b>Goblygiadau Cyllidebol / Ariannol</b> <b><i>Budgetary / Financial Implications</i></b></p>
<p>There are no financial implications for this report.</p>
<p><b>Rheoli Risg</b> <b>Risk Management</b></p>
<p>Risk CRR 24-03. There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients. Following review at the Health Board Risk Management Group and the Formal Executive Group in Q1 the current risk score is recorded as 12 however, the Chief Executive Officer has requested that the risk associated to DoLS and the MCA are reported into the Executive Group.</p> <p>Following the new Risk Management Training the Safeguarding, DoLS and MCA Team were commended for their management of the risk. A comprehensive review of the risks and actions to support mitigation associated with DoLS and the MCA has taken place in Q4. As a result, the team are in the process of updating/amending DoLS/MCA related risks and will present them at the Office of the Nurse Director's Risk Management meeting for approval.</p> <p><b>Legal and Compliance</b></p> <ul style="list-style-type: none"> <li>• The Deprivation of Liberty Safeguards Code of Practice supplements the main Mental Capacity Act 2005 Code of Practice.</li> <li>• The Supreme Court Judgment, P v Cheshire West Council [2014] and P &amp; Q v Surrey County Council [2014] UKSC 19.</li> </ul>
<p><b>Goblygiadau Cydraddoldeb ac Amrywiaeth</b> <b><i>Equality and Diversity Implications</i></b></p>
<p>N/A</p>

## Appendix 1:

### Role of the Section 12(2) Approved Doctor

In the context of Deprivation of Liberty Safeguards (DoLS) assessments in England and Wales, a Section 12 (2) Approved Doctor is a medical practitioner approved by the Secretary of State to have special expertise in the diagnosis and treatment of mental disorder. The Section 12 (2) doctor plays a key role as a Mental Health Assessor within the DoLS process.

The Section 12 (2) Doctor plays a key role and conducts the mental health and eligibility assessments, known as the DoLS Form 4, one of the six key assessments required under DoLS. Their primary function is to conduct the mental health assessment, determining if the individual has a mental disorder as defined by the Mental Health Act 1983 that impairs their capacity to consent to care and treatment.

The doctor must be approved under Section 12 of the Mental Health Act 1983, which means they are recognised as having special experience in the diagnosis or treatment of mental disorders. Alternatively, they may be a registered medical practitioner with at least three years post-registration experience in mental health. The doctor must complete standard training as laid out by the Royal College of Psychiatrists. Annual refresher training is required to maintain their status as a DoLS mental health assessor.

The Supervisory Body (DoLS Team) appoints the Section (12) Doctor to carry out the mental health and eligibility assessment. The doctor is expected to provide a comprehensive report (a DoLS Form 4) to confirm whether the individual has a mental disorder and whether the individual meets the eligibility criteria for a DoLS Authorisation. The DoLS Team will make every attempt to utilise the same doctor for reviews or reassessments where possible to ensure continuity.

The role of the doctor is to assess and evaluate whether the deprivation of liberty is appropriate and necessary and whether the deprivation is likely to have a detrimental effect on the person's mental health. They may also be involved in eligibility assessments determining if an individual might be better placed under the Mental Health Act.

Working collaboratively with other professionals is key, in particular with the BIAs and wards staff to ensure a comprehensive assessment.



<b>Teitl adroddiad:</b> <i>Report title:</i>	Healthcare Inspectorate Wales (HIW) Assurance Report			
<b>Adrodd i:</b> <i>Report to:</i>	Mental Health Legislation Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	07 August 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>HIW is the independent inspectorate and regulator of all health care in Wales. HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board, considering how the services are meeting the Quality Health and Care Standards 2023 and the Mental Health Act.</p> <p>This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.</p>			
<b>Argymhellion:</b> <i>Recommendations:</i>	The Committee is asked to note the report			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Erika Dennis, Quality Lead Manager Clare Jones, Quality Assurance Manager			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<b>Arwyddocaol</b> <i>Significant</i> <input checked="" type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	<b>Derbyniol</b> <i>Acceptable</i> <input type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Rhannol</b> <i>Partial</i> <input type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	<b>Dim Sicrwydd</b> <i>No Assurance</i> <input type="checkbox"/>  Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>Cyflwyniad 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:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b>				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b><i>Link to Strategic Objective(s):</i></b>		Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning		

<p><b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b></p>	<p>The Health Board's Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is around the quality of patient experience, the delivery of safe and, the effective care and, the quality of management and leadership.</p> <p>The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.</p>
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</b></p>	<p>This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <b>In accordance with WP68, has an SEIA identified as necessary been undertaken?</b></p>	<p>Naddo N</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b> <b>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</b></p>	<p>N/A</p>
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <b>Financial implications as a result of implementing the recommendations</b></p>	<p>Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act) require no financial consideration at present.</p>
<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <b>Workforce implications as a result of implementing the recommendations</b></p>	<p>N/A</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <b>Feedback, response, and follow up summary following consultation</b></p>	<p>This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)</p>	<p>N/A</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b></p>	<p>N/A</p>

**Camau Nesaf:**  
**Gweithredu argymhellion**  
**Next Steps:**  
***Implementation of recommendations***

N/A

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

<b>New inspections, publications and updates relating to the Mental Health Act</b>
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**Healthcare Inspectorate Wales (HIW)**

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

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

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

**Inspections****1. Unannounced Visit: Carreg Faw**

Inspection Date: 21<sup>st</sup> to the 23<sup>rd</sup> January 2025

Publication Date: 1<sup>st</sup> May 2025

Responsible Director: – Iain Wilkie, Director of MHLD.

**HIW Recommendation (1)**

The Health Board must ensure that aspects of record keeping relating to the Mental Health Act Code of Practice are strengthened

**Service Improvement Action**

Action Reference MD10/1

With support from Mental Health Act Manager, complete 3 monthly Mental Health Act audits to ensure sustainable improvements

Progress Status

Fully Complete

**3. Unannounced Visit: Kestrel Ward, North Wales Adolescent Service**

Inspection Date: 13<sup>th</sup> to the 15<sup>th</sup> January 2025

Publication Date: 17<sup>th</sup> April 2025

Responsible Director: – Naomi Holder, IHC Director, Central

**HIW Recommendation (1)**

The Health Board must ensure that the MHA legal status of the young people is clearly recorded within their MAR charts, to provide clear guidance to staff.

**Service Improvement Actions**

Action reference MD12/1

Written standards to be developed and shared with the ward team

Action reference MD12/2

Current cohort of young people's MAR charts to be reviewed and amended accordingly.

Action reference MD12/3

Audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting

Progress Status

MD12/1: Fully complete (approved)

MD12/2: Fully complete (approved)

MD12/3: Fully complete (approved)

**HIW Recommendation (2)**

The Health Board should consider attaching patient photographs to their MAR charts, to reduce the risk of medication errors and support the safe administration of their medicines

**Service Improvement Actions**

Action reference MD13/1

Written standards to be developed and shared with the ward team.

Action reference MD13/2

NWAS to consistently adopt the recommendation of photographs attached to MAR charts.

Action reference MD13/3

Current cohort of young people's MAR charts to be reviewed and amended accordingly.

Action reference MD13/4

Audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting

Progress Status

MD13/1: Fully complete (approved)

MD13/2: Fully complete (approved)

MD13/3: Fully complete (approved)

MD13/4: Fully complete (approved)

**Recommendation (3)**

The Health Board must ensure MHA statutory documentation is accurately completed

**Service Improvement Actions**

Action reference MD17/1

A reminder to all staff on the importance of accurate recording within MHA documentation

Action reference MD17/2

To include within the weekly audit and monitored in the monthly Clinical Effectiveness Meeting

Progress Status

MD17/1: Fully complete (approved)

MD17/2: Fully complete (approved)

**Recommendation (4)**

The Health Board must ensure mental capacity assessments are undertaken on the young and suitably recorded within their records.

**Service Improvement Actions**

Action reference MD18/1

Provide internal focussed training to clinical staff to support regular assessment and documentation of mental capacity within health records

Action reference MD18/2

Ensure MHA and MCA training compliance is and remains above 85%

Action reference MD18/3

To include within the weekly audit and monitored in the monthly Clinical Effectiveness Meeting

Progress Status

MD18/1: Fully complete (approved)

MD18/2: Fully complete (approved)

MD18/3: Fully complete (approved)

**Recommendation (4)**

The Health Board should consider adding photographs to the Section 17 leave forms, to help identify young people in the event of them not returning from leave.

**Service Improvement Actions**

Action reference MD19/1

Written record keeping standards to be developed and shared with the ward team.

Action reference MD19/2

NWAS to consistently adopt the recommendation of photographs attached to MAR charts with immediate effect

Action reference MD19/3

Current cohort of young people's MAR charts to be reviewed and amended accordingly.

Action reference MD19/4

Weekly audit of MAR charts to be included within the weekly audit process and monitored via the Monthly Clinical Effectiveness meeting

Progress Status

MD19/1: Fully complete (approved)

MD19/2: Fully complete (approved)

MD19/3: Fully complete (approved)

MD19/4: Fully complete (approved)

## **Recommendation (5)**

The Health Board must improve care planning processes to ensure information is captured and recorded in a clear and consistent way within young people's records, to support their safety and ensure efficiency and accessibility for staff

### **Service Improvement Actions**

#### Action reference MD20/1

Processes to be reviewed to ensure information is captured and recorded in a clear and consistent way and a written Care Planning standard to be included within the record keeping standards for NWAS

#### Action reference MD20/2

All current health records to be reviewed and organised to enable easy access and navigation

#### Action reference MD20/3

Weekly notes audit to include a review of the standard of the health record and monitored in the monthly Clinical Effectiveness Meeting

#### Progress Status

MD20/1: Fully complete (approved)

MD20/2: Fully complete (approved)

MD20/3: Fully complete (approved)

## **Recommendation (6)**

The Health Board must:-

- Review the current arrangements for completing and sharing care plans between community and ward teams to ensure prompt sharing, effective communication and alignment of young people's records across community and inpatient services
- Ensure all Care and Treatment Plans reflect the domains of the Mental Health Wales Measure 2010

### **Service Improvement Actions**

#### Action reference MD21/1

Processes to be reviewed to ensure information is captured and recorded in a clear and consistent way and reflects the domains of the mental Health Measure 2010

#### Action reference MD21/2

A written Care Planning standard to be included within the record keeping standards for NWAS.

#### Action reference MD21/3

CTP's to be consistently reviewed and shared within the weekly patient Progress and Planning Meeting as a standing agenda. If Community colleagues not in attendance the CTP to be shared electronically post meeting

#### Progress Status

MD21/1: Fully complete (approved)

MD22/2: Fully complete (approved)

MD22/3: Fully complete (approved)

**Recommendation (7)**

The Health Board must ensure the CTPs reflect the voice and involvement of the young people, their social, cultural and spiritual needs, and identify a full range of interventions

**Service Improvement Actions**Action reference 22/1

Care Planning processes to be reviewed to ensure plans are collaboratively developed with young people and reflects their social, cultural and spiritual views alongside the range of interventions that will support these

Action reference 22/2

CTP documents/records to clearly and consistently reference the young persons voice

Action reference 22/3

To be included in the weekly quality audit and reported to the NWAS Clinical Effectiveness Sub-Group

Action reference 22/4

Ensure Equality and Diversity training compliance above 85% to promote awareness of social, cultural and spiritual aspects of care

## Progress Status

MD22/1: Fully complete (approved)

MD22/3: Fully complete (approved)

MD22/4: Fully complete (approved)

**Recommendation (8)**

The Health Board should reflect on this aspect of family/carer feedback and consider whether improvements in relation to communication with family/carers could be made

**Service Improvement Actions**Action reference 23/1

Continue to review PREMS and identify themes and respond to any themes identified

Action reference 23/2

Actively encourage and engage in feedback activity. Weekly 'drop in' session to be established

Action reference 23/3

Feedback to be discussed and shared within the NWAS Quality and Safety Sub-Group

## Progress Status

MD23/1: Fully complete (approved)

MD23/2: Fully complete (approved)

MD23/3: In Progress

**Recommendation (9)**

The Health Board must ensure that ward-based CTPs are reviewed in a timely manner and clearly identify the staff members involved

## **Service Improvement Actions**

### Action reference 24/1

Standard and proforma for Care Plan audit to be reviewed

### Action reference 24/2

To monitor compliance and address any deficits with individual staff

### Action reference 24/3

Report compliance for assurance to the NWAS Clinical Effectiveness Sub-Group

### Progress Status

MD24/1: Fully complete (approved)

MD24/2: Fully complete (approved)

MD24/3: Fully complete (approved)

<b>Teitl adroddiad:</b> <i>Report title:</i>	Mental Health Act (MHA) Associate Hospital Manager Report			
<b>Adrodd i:</b> <i>Report to:</i>	Mental Health Legislation Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	07 August 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	<p>People who are subject to detention or Community Treatment Orders under the Mental Health Act can ask for their case to be reviewed by the Hospital Managers for possible discharge. Some renewals of a detention also trigger a review. The term Hospital Managers is used in the Mental Health Act to describe the organisation (i.e. the Health Board). This review and discharge power cannot be exercised by any employee of the organisation and so the Health Board has a number of people it can call upon to act on its behalf; these people are called Associate Hospital Managers (AHMs). Associate Hospital Managers are volunteers who are formally appointed by the Health Board and act independently on its behalf. They are not paid but receive allowances for the sessions they attend. They are not an employee of the organisation and are not allowed to have any financial interest in it.</p> <p>AHMs sit as part of a three-member panel appointed specially to look at whether people should be discharged from detention under the Mental Health Act.</p> <p>In this important role, AHMs ensure that patients' rights are fully explored and upheld. This requires the consideration of reports from the clinicians involved in a patient's care, and the views of the patient if given, before determining whether the criteria for detention are met.</p>			
<b>Argymhellion:</b> <i>Recommendations:</i>	The Committee is asked to note the report.			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Author:</i>	Wendy Lappin, Senior Legal Services Manager (Mental Health Act) Matthew Joyes, Deputy Director for Legal Services			
<b>Pwrpas yr adroddiad:</b> <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <input type="checkbox"/>	<p>I Benderfynu arno <i>For Decision</i></p> <input type="checkbox"/>	<p>Am sicrwydd <i>For Assurance</i></p> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <input type="checkbox"/> <small>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>High level of confidence/evidence in delivery of existing mechanisms/objectives</small>	<p>Derbyniol <i>Acceptable</i></p> <input type="checkbox"/> <small>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>General confidence / evidence in delivery of existing mechanisms / objectives</small>	<p>Rhannol <i>Partial</i></p> <input checked="" type="checkbox"/> <small>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</small> <small>Some confidence / evidence in delivery of existing mechanisms / objectives</small>	<p>Dim Sicrwydd <i>No Assurance</i></p> <input type="checkbox"/> <small>Dim hyder/tystiolaeth o ran y ddarpariaeth</small> <small>No confidence / evidence in delivery</small>

<p><b>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:</b>  <b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>	
<p>Because of significant capacity pressures in the MHA Team over the last year, work continues to ensure data is valid and reliable.</p>	
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b>  <b><i>Link to Strategic Objective(s):</i></b></p>	<p>Objective 4 - Improving quality, outcomes and experience  Objective 5 - Establishing an effective environment for learning</p>
<p><b>Goblygiadau rheoleiddio a lleol:</b>  <b><i>Regulatory and legal implications:</i></b></p>	<p>This report is generated quarterly. The Mental Health Act requires that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.</p>
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b></p>	<p>The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.</p>
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b>  <b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>	<p>N/A</p>
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b>  <b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p>	<p>The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board has addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level. An advert has recently been shared on social media platforms, within the local university and with Welsh Language colleagues to promote the role.</p> <p>Hearings for patients should be conducted as close to the renewal date as possible. If a patient requests a hearing this should be given priority. Risks associated with not conducting a hearing as close as possible to the relevant date, would be:</p>

	<ul style="list-style-type: none"> <li>• Transfers impacting on hearings with the potential for a hearing to be missed or rearranged.</li> <li>• 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.</li> </ul>
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <b>Financial implications as a result of implementing the recommendations</b>	N/A
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <b>Workforce implications as a result of implementing the recommendations</b>	N/A
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <b>Feedback, response, and follow up summary following consultation</b>	<p>This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services.</p> <p>Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.</p>
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> <i>(or links to the Corporate Risk Register)</i>	N/A
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b>  <b>Reason for submission of report to confidential board (where relevant)</b>	N/A
<b>Camau Nesaf:</b> <b>Gweithredu argymhellion</b> <b>Next Steps:</b> <b>Implementation of recommendations</b>  N/A	
<b>Rhestr o Atodiadau:</b> <b>List of Appendices:</b>  AHM Update Report	

## Associate Hospital Managers (AHM) Update Report April – June 2025

### Quarterly Activity

#### 1 Hearings

At the time of writing (11.07.2025) hearings are held remotely via Microsoft Teams and face to face.

18 hearings were held during the months April – June 2024.

10 held face to face and eight via Teams. The hearings consisted of 12 section 3 renewals, one CTO renewals, one section 47 renewal, one discretionary review and three section appeals (S2, S3 and S37).

There have been no discharges to date for this period.

A breakdown of the hearing activity is below:

#### April

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

Four hearings were in relation to renewals, two were patient appeals and one discretionary review.

#### **Outcomes of hearings held**

- All detentions were upheld.

#### May

- **Three hearings arranged (all held); All held via Microsoft Teams.**

All hearings were in relation to renewals.

#### **Outcomes of hearings held**

- All detentions were upheld

#### June

- **11 hearings arranged (Eight held); Four held face to face and four via Microsoft Teams.**

Seven hearings were in relation to renewals and one patient appeal.

**Two hearings were cancelled and rearranged** – The Responsible Clinician left the service and a new one has been appointed the hearing is due to be held end of July. One hearing there was not enough managers available to make up a panel, the hearing is due to be held the end of July.

**One hearing was cancelled** – the patient was discharged.

#### **Outcomes of hearings held**

- All detentions were upheld
- One hearing the panel members requested a review in 6 weeks this is due to be held at the end of July.

### **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 quality standard is set at 6 weeks following the renewal date. An analysis of the hearings held this quarter is detailed below.

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

In instances where the patient appeals their detention, the hearing should be held as close as possible to the appeal date. For those that appeal against their section 2 the quality standard is set at a week the same as a Mental Health Review Tribunal.

Currently 70.5% of hearings were held within the set quality standard.

<b>Renewal Date</b>	<b>Hearing Date</b>	<b>Quality Standard (6 weeks = 42 days)</b>
12/04/2025	12/05/2025	30
04/04/2025	14/04/2025	10
24/04/2025	28/04/2025	4
16/04/2025	07/05/2025	21
16/01/2025	10/04/2025	84 *1
10/04/2025	08/05/2025	28
20/05/2025	12/06/2025	23
21/05/2025	19/06/2025	29
15/05/2025	27/06/2025	43
19/05/2025	20/06/2025	32
30/05/2025	26/06/2025	27
07/05/2025	05/06/2025	29
16/05/2025	12/06/2025	27
03/03/2025	16/04/2025	44
<b>Barring Hearing</b>	<b>None held</b>	
<b>Appeal by Patient Date</b>	<b>Hearing Date and section</b>	<b>Quality Standard (7 days for a section 2)</b>
13/04/2025	30/04/2025 S2	17
13/02/2025	01/04/2025 S37	48
15/05/2025	13/06/2025 S3	29

\*1- the delay was due to the legal representative's availability for the hearing.

## 2 Scrutiny

Scrutiny has been undertaken for 2025, 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.

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

AHMs are expected to undertake the following training sessions via the Health Boards Electronic Staff Record System. Each manager's training compliance is discussed in 1:1 meetings held with the Mental Health Act Manager. Compliance figures will be reported within the quarter two report.

Training required to be completed is detailed below.

Training	Training	
Environmental Waste and Energy	Violence and Aggression	
Equality Diversity and Human Rights	Welsh Language Awareness	
Fire Safety	Dementia Awareness	
Health, Safety and Welfare	Fraud Awareness	
Infection Prevention and Control	Violence against women, domestic abuse	
Information Governance	Mental Capacity Act	
Safeguarding Adults	Paul Ridd LD training	
Safeguarding Children	Mental Health Act	

## 4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of: 16 persons, 15 are actively involved with hearings, one member is currently taking a break due to family commitments. The active cohort consists of five male and 10 female members, of which three are Welsh speakers.

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

One new member has been appointed and is progressing through the workforce systems and one new applicant is to be interviewed in July.

## 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 18<sup>th</sup> of June with the next meeting scheduled for the 23<sup>rd</sup> of September 2025.

A training day for the Associate Hospital Managers will be organised for later within the year, the agenda is being prepared and suitable accommodation sought for the day.

<b>Teitl adroddiad:</b> <b>Report title:</b>	Power of Discharge Group Chair's Assurance Report			
<b>Adrodd i:</b> <b>Report to:</b>	Mental Health Legislation Committee			
<b>Dyddiad y Cyfarfod:</b> <b>Date of Meeting:</b>	07 August 2025			
<b>Crynodeb Gweithredol:</b> <b>Executive Summary:</b>	The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services.			
<b>Argymhellion:</b> <b>Recommendations:</b>	The Committee is asked to note this report.			
<b>Arweinydd Gweithredol:</b> <b>Executive Lead:</b>	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
<b>Awdur yr Adroddiad:</b> <b>Report Author:</b>	Matthew Joyes, Deputy Director for Legal Services (Chair of the PoD Group)			
<b>Pwrpas yr adroddiad:</b> <b>Purpose of report:</b>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
<b>Lefel sicrwydd:</b> <b>Assurance level:</b>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/>  Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/>  Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/>  Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/>  Dim hyder/ tystiolaeth o ran y ddarpariaeth  <i>No confidence / evidence in delivery</i>
<b>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:</b> <b>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:</b>				
N/A				
<b>Cyswllt ag Amcan/Amcanion Strategol:</b> <b>Link to Strategic Objective(s):</b>	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning			
<b>Goblygiadau rheoleiddio a lleol:</b> <b>Regulatory and legal implications:</b>	This report is generated quarterly. The Mental Health Act (MHA) and MHA Code of Practice for Wales (CoPW) requires that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated			

	agencies which may have contact with patients or influence on the Health Board.
<b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b> <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	N/A
<b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b> <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	This report does not inform strategic decisions, it relates to the Power of Discharge Group which meets quarterly to discuss the day to day operations of the Associate Hospital Managers who have delegated functions under the Mental Health Act.
<b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b> <i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i>	N/A
<b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b> <i>Financial implications as a result of implementing the recommendations</i>	N/A
<b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b> <i>Workforce implications as a result of implementing the recommendations</i>	N/A
<b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b> <i>Feedback, response, and follow up summary following consultation</i>	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services.  Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.
<b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <b>Links to BAF risks:</b> (or links to the Corporate Risk Register)	N/A
<b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b> <i>Reason for submission of report to confidential board (where relevant)</i>	N/A
<b>Camau Nesaf: Gweithredu argymhellion</b> <i>Next Steps: Implementation of recommendations</i> N/A	
<b>Rhestr o Atodiadau:</b> <i>List of Appendices:</i> N/A	



## Chair's Report

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

<b>Purpose of the group</b>	<p>Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'.</p> <p>In Wales, NHS hospitals are managed by Local Health Boards. The Local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.</p> <p>Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)</p> <p>In practice, most of the decisions the Hospital Managers take, are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)</p> <p>In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels, made up of Associate Hospital Managers who are not employees. They are directly accountable to the Board in the execution of their delegated functions via the Mental Health Legislation Committee. (CoPW 37.6)</p> <p>The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services; reports are produced and presented by the Mental Health Act Manager to the group.</p>
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<b>Summary of business conducted</b>	<p>The most recent Power of Discharge Group meeting was held on 22 July 2025.</p> <p>A summary of the business is as follows:</p> <ul style="list-style-type: none"><li>• The group reviewed the MHA Assurance Report.</li><li>• The group reviewed the Associate Hospital Managers Update Report.</li><li>• The group reviewed the HIW Assurance Report.</li></ul> <p>There were no issues to escalate to the Committee.</p> <p>Two Associate Hospital Managers attend the Committee as representatives of the group to ensure a direct link and to raise any issues directly.</p>
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<b>Teitl adroddiad:</b> <i>Report title:</i>	<b>CORPORATE GOVERNANCE REPORT</b>			
<b>Adrodd i:</b> <i>Report to:</i>	Mental Health Legislation Committee			
<b>Dyddiad y Cyfarfod:</b> <i>Date of Meeting:</i>	Thursday, 07 August 2025			
<b>Crynodeb Gweithredol:</b> <i>Executive Summary:</i>	The objective of this report is to provide the Committee with an update on key Corporate Governance matters and to provide an update to the Committee on a range of corporate governance matters as well as assurance.			
<b>Argymhellion:</b> <i>Recommendations:</i>	Members are asked to: <ul style="list-style-type: none"> <li>• <b>APPROVE</b> the Mental Health Legislation Cycle of Business 2025-2026;</li> <li>• <b>APPROVE</b> the Committee Annual Report</li> <li>• <b>NOTE</b> and <b>DISCUSS</b> the Committee Self-Assessment</li> </ul>			
<b>Arweinydd Gweithredol:</b> <i>Executive Lead:</i>	Pam Wenger – Director for Corporate Governance			
<b>Awdur yr Adroddiad:</b> <i>Report Authors:</i>	Philippa Peake-Jones – Head of Corporate Governance			
<b>Pwrpas adroddiad:</b> <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input checked="" type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input type="checkbox"/>	
<b>Lefel sicrwydd:</b> <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>High level of confidence/evidence in delivery of existing</i>	Derbyniol <i>Acceptable</i> <input checked="" type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>General confidence in evidence</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol  <i>Some confidence in evidence</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth  <i>No confidence in evidence in delivery</i>

	<i>mechanisms/objectives</i>	<i>delivery of existing mechanisms / objectives</i>	<i>delivery of existing mechanisms / objectives</i>
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><b><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></b></p>			
<p><b>Cyswllt ag Amcan/Amcanion Strategol:</b></p> <p><b><i>Link to Strategic Objective(s):</i></b></p>		<p>This work links to all strategic objectives of the Health Board as Corporate Governance is a key enabler for them.</p>	
<p><b>Goblygiadau rheoleiddio a lleol:</b></p> <p><b><i>Regulatory and legal implications:</i></b></p>		<p>The Health Board is required to act according to its Standing Orders. This report contains information to allow the Health Board to conform to this.</p> <p>It is essential that the Board has robust arrangements in place for Corporate Governance and failure to do so could have legal implications for the Health Board.</p>	
<p><b>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i></b></p>		<p>This is not applicable for this report.</p>	
<p><b>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</b></p> <p><b><i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></b></p>		<p>This is not applicable for this report.</p>	
<p><b>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</b></p> <p><b><i>Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)</i></b></p>			
<p><b>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</b></p> <p><b><i>Financial implications as a result of implementing the recommendations</i></b></p>		<p>The effective management of Governance has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality and less waste</p>	

<p><b>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</b></p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	<p>Failure to have effective Corporate Governance can impact adversely on the workforce.</p>
<p><b>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</b></p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Not applicable</p>
<p><b>Cysylltiadau â risgiau BAF:</b> (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	<p>BAF24-01 Building an Effective and Accountable Organisation</p> <p>CRR-16 – Leadership/Special Measures</p>
<p><b>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</b></p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>Not applicable</p>
<p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>To continue to improve and report on Corporate Governance</li> </ul>	
<p><b>List of Appendices:</b></p> <p><b>Appendix 1</b> The Mental Health Legislation Cycle of Business 2025-2026  <b>Appendix 2</b> The Committee Annual Report  <b>Appendix 3</b> The Committee Self-Assessment</p>	

## **CORPORATE GOVERNANCE REPORT**

### **1. INTRODUCTION**

The purpose of this report is to provide the Committee with an update on key corporate governance matters.

### **2. ANNUAL BUSINESS CYCLE 2025-26 (Formal, Informal and Board Development)**

The Business Cycle for the Mental Health Legislation Committee for 2025-26 is attached at **Appendix 1**

### **3. DRAFT COMMITTEE ANNUAL REPORT**

Under Standing Order 10.2.3, each Committee of the Board is required to submit an annual report “setting out its activities during the year and detailing the results of a review of its performance”. This first annual report from the Mental Health Legislation Committee details the activities and performance for the Committee for the reporting period 2024-2025.

### **4. COMMITTEE SELF ASSESSMENT**

The results of the Committee Self-Assessment are available in Appendix 3 of the report.

### **5. RECOMMENDATIONS**

Members are asked to:

- **APPROVE** the Mental Health Legislation Cycle of Business 2025-2026;
- **APPROVE** the Committee Annual Report
- **NOTE** and **DISCUSS** the Committee Self-Assessment



# Betsi Cadwaladr University Health Board Mental Health Legislation Committee

## Cycle of Business (1 April 2025 – 31 March 2026)

Betsi Cadwaladr University Health Board should, on an annual basis, receive a cycle of business that identifies the items which will be regularly presented for consideration. The annual cycle is one of the key components in ensuring that the Health Board is effectively carrying out its role.

The Committee Cycle of Business cover the period 1 April 2025 to 31 March 2026.

The Committee Cycle of Business has been developed to help plan the management of Health Board matters and facilitate the management of agendas and Health Board business. The Annual Cycle of Business will be complemented by a “Non-Routine Board Business (Forward Work Plan)” for ‘one-off’ Ad-hoc items raised during the course of meetings.

The role of the Mental Health Legislation Committee is set out in the Terms of Reference which is available here: [Insert here]

<p><b>Committee Chair</b> Gareth Williams</p>	<p><b>Independent Members</b> Dyfed Jones Rhian Watcyn Jones</p>	<p><b>Executive Members</b> Teresa Owen (Executive Director of Allied Health Professionals and Health Science) – Exec Lead Angela Wood (Executive Director of Nursing and Midwifery) Sreeman Andole (Interim Executive Medical Director) Tehmeena Ajmal (Chief Operating Officer)</p>	<p><b>In Attendance</b> Pam Wenger (Director for Corporate Governance) Alberto Salmoiraghi (Medical Director of Learning Disabilities) Iain Wilkie (Medical Director for Mental Health and Learning Disabilities) Matt Joyces (Deputy Director of Quality Governance) Wendy Lapin (Senior Manager for Mental Health Act) Chris Walker (Senior Manager for Mental Capacity Act) At least one Director of Operations from the Integrated Health Communities Michelle Denwood (Head of Safeguarding) Jenny Gilmour (Hospital Manager) Phil Williams (Hospital Manager)</p>
<p><b>Committee Vice Chair</b></p>			

## MENTAL HEALTH LEGISLATION COMMITTEE CYCLE OF BUSINESS 2025-26

Item of Business	Executive Lead	Reporting period	Q1			Q2			Q3			Q4			2026-27	
			April 2025	May 2025	June 2025	July 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	April 2026	May 2026
<b>Preliminary Matters</b>																
Minutes of the Previous Meeting	Chair	All Regular Meetings		℞			℞			℞			℞			
Action Log	Chair	All Regular Meetings		℞			℞			℞			℞			
<b>Routine Reporting for Assurance</b>																
Mental Health Act Assurance Report		All Regular Meetings		℞			℞			℞			℞			
Mental Capacity Assurance Report		All Regular Meetings		℞			℞			℞			℞			
Healthcare Inspector Wales (HIW) Assurance Report		All Regular Meetings		℞			℞			℞			℞			
Associate Hospital Managers Update Report	Associate Managers	All Regular Meetings		℞			℞			℞			℞			
Report from the Power of Discharge Group	Associate Managers	All Regular Meetings		℞			℞			℞			℞			
<b>For Information</b>																
Summary of Business to be reported from Private	Director of Corporate Governance	All Regular Meetings		℞			℞			℞			℞			
Forward Work Plan	Director of Corporate Governance	All Regular Meetings		℞			℞			℞			℞			
<b>Closing Business</b>																
Agree Items for Referral to Board / Other Committees	Chair	All Regular Meetings		℞			℞			℞			℞			
Review of meeting effectiveness	Chair	All Regular Meetings		℞			℞			℞			℞			
Date of the next meeting	Chair	All Regular Meetings		℞			℞			℞			℞			
Resolution to exclude the Press and Public	Chair	All Regular Meetings		℞			℞			℞			℞			

# **DRAFT MENTAL HEALTH LEGISLATION COMMITTEE**

## **Annual Report 2024-25**

## **FOREWORD**

I am pleased to present the 2024-25 Annual Report of the BCUHB Mental Health Legislation Committee which outlines the activity for the period 1 April 2024 – 31 March 2025.

**Gareth Williams**  
**Chair of the Mental Health Legislation Committee**

DRAFT

# MENTAL HEALTH LEGISLATION COMMITTEE

## Annual Report 2024 - 2025

### 1. Introduction

- 1.1 This report summarises the key areas of business activity undertaken by the Committee between 1 April 2024 and 31 March 2025 and highlights some of the key issues which the Committee intend to give further consideration to over the next 12 months.
- 1.2 The Committee's Annual 'Business Cycle' was reviewed on 7<sup>th</sup> August 2025 and was a key component in ensuring that the Committee effectively carried out its role during 2024 – 25.
- 1.3 This report reflects the Committee's key role in the development and monitoring of the Governance and Assurance framework with respect to the (activity/function).

### 2. Role and Responsibilities

- 2.1 The primary purpose of the Committee is to act on behalf of the Board to:
  - 2.1.1 Provide assurance that those functions of the Mental Health Act 1983, as amended and Mental Capacity Act, 2005, as amended which have been delegated to officers and staff are being carried out correctly:
    - The wider operation of the two Acts in relation to the Health Board's area is appropriate and effective;
    - The Health Board's responsibilities as Hospital Managers are being discharged effectively and lawfully; and.
    - The Health Board is compliant with Codes of Practice for the two Acts.
  - 2.1.2 Identify any areas of concern in relation to compliance with mental health legislation and agree issues to be escalated to the Board with recommendations for action.
  - 2.1.3 Seek assurance on the management of principal risks within the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) allocated to the Committee and provide assurance to the Board that risks are being managed effectively and report any areas of significant concern.

### 3. Agenda Planning Process

- 3.1 The Chair of the Committee, in conjunction with the Executive Lead and Meeting Secretary develops the final agenda for the Committee meetings.
- 3.2 The venue, location and other administrative arrangements are organised a year in advance where possible.
- 3.3 The secretariat for the meeting is provided by Philippa Peake-Jones.
- 3.4 The agenda and papers are disseminated to Committee members prior to the date of the meeting. Where appropriate all papers are accompanied by a cover sheet which provides an executive summary and guidance to the Committee on the action required.

#### **4. Operating Arrangements**

- 4.1 Only very minor amendments were considered necessary in respect of the Terms of Reference and Operating arrangements for the Mental Health Legislation Committee.
- 4.2 The new Committee Cycle of Business for the Mental Health Legislation Committee is being presented for approval on 7<sup>th</sup> August 2025, however the agenda for each meeting is sufficiently flexible to allow the Committee to consider any emerging issues.

#### **5. Membership, Frequency and Attendance**

- 5.1 The Terms of reference of the Committee state that the Committee should consist of a minimum of three members of the Board.
- 5.2 During the year the Committee met on four occasions with member attendance as follows:

<b>Name</b>	<b>Mental Health Legislation Committee (out of four possible meetings)</b>
Gareth Williams (Committee Chair)	Four out of four meetings
Dyfed Jones	Four out of four meetings
Rhian Watcyn Jones	Four out of four meetings

- 5.3 The Committee requires the attendance of other Health Board Officers for advice, support and information routinely at meetings. It may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

#### **6. Committee Activity**

- 6.1 The Committee fulfilled its work plan for 2024-2025 covering a wide range of activity. This work can be summarised under the following headings;
- a) Mental Health Act Assurance Report
  - b) Mental Capacity Assurance Report
  - c) Healthcare Inspector Wales
  - d) Associate Hospital Managers Update Report
  - e) Report for the Power of Discharge Group

#### **7. Key Achievements/Benefits:**

- 7.1 As a reader you will see from this report what a successful and varied year the Mental Health Legislation Committee has had during 2024-25. Although detailed more fully above and within the Committee papers, some of the key highlights were:
- Fulfilled statutory duty to seek assurance on the Mental Health Act and the Mental Capacity Act

#### **8. Key Challenges**

- 8.1 As indicated earlier in the report a focus for the Committee in 2025 forward into 2026, will be the work which is underway to give assurance at a strategic level.
- 8.2 Finally, although these challenges remain, the Committee will continue to monitor activity and develop innovative ways to support new developments and opportunities.

#### **9. Committee Effectiveness & Performance**

- 9.1 The Committee regularly reviews its own performance by completing this report on an annual basis, reviewing the cycle of business which provides the Committee with the basis on which it will monitor its progress during the year and also provide clarity for all of those who contribute to the agenda as to the expectations of them.
- 9.2 A Committee effectiveness questionnaire will be issued again circa February 2026, the outcome of which will be reported to the Committee in respect of recommendations and subsequent actions in response to areas identified for improvement.

## **9. Reporting the Committee's Work**

- 9.1 The Committee Chair reports the key issues discussed at each of its meetings by way of a 'AAA Report' to the Board.
- 9.2 These reports are supported by the relevant and more detailed Committee minutes. Committee papers, including minutes are routinely published on the Health Board's website.

## **10. Conclusion and way forward**

- 10.1 The Committee is very grateful to all those involved in the work of the Committee for their support over the past 12 months, and for the constructive and positive way in which they have contributed to the activity.
- 10.2 The Committee will continue to ensure that it conducts its business in accordance with legislation and best practice.
- 10.3 It will provide the assurance that the Committee has in place the appropriate governance arrangements and resources to ensure success in achieving its objectives.

## **11. Further Information**

Please visit the Health Board's websites for further information as outlined below:  
[Committees and Advisory Groups - Betsi Cadwaladr University Health Board](#)



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# Mental Health Legislation Committee Self-Assessment Results Corporate Governance August 2025



# Purpose

- Present results of the 2024–25 Mental Health Legislation Committee self-assessment.
- Provide insights into strengths gaps, and opportunities.
- Recommend next steps for continuous improvement.

Following Special Measures: “**BCUHB is committed to strengthening governance, accountability, and decision-making**”

- This self-assessment ensures the Committee function effectively, driving continuous improvement and delivering better outcomes.

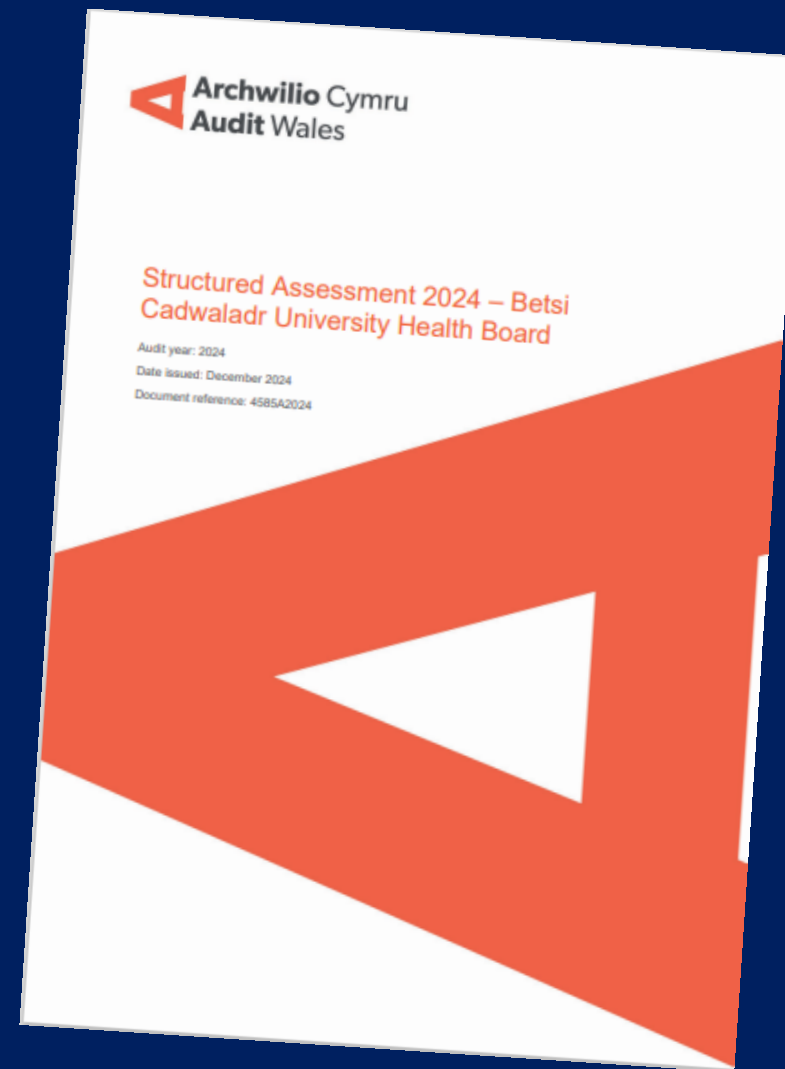
## Why It Matters

- **Accountability & Assurance:** Strong governance builds trust and oversight.
- **Strategic Focus:** Ensures alignment with key priorities for improvement.
- **Continuous Learning:** Identifies strengths and areas needing development.
- **Sustained Progress:** Supports long-term transformation and cultural change.
- **By embedding effective governance, BCUHB can move forward with confidence, clarity, and impact.**



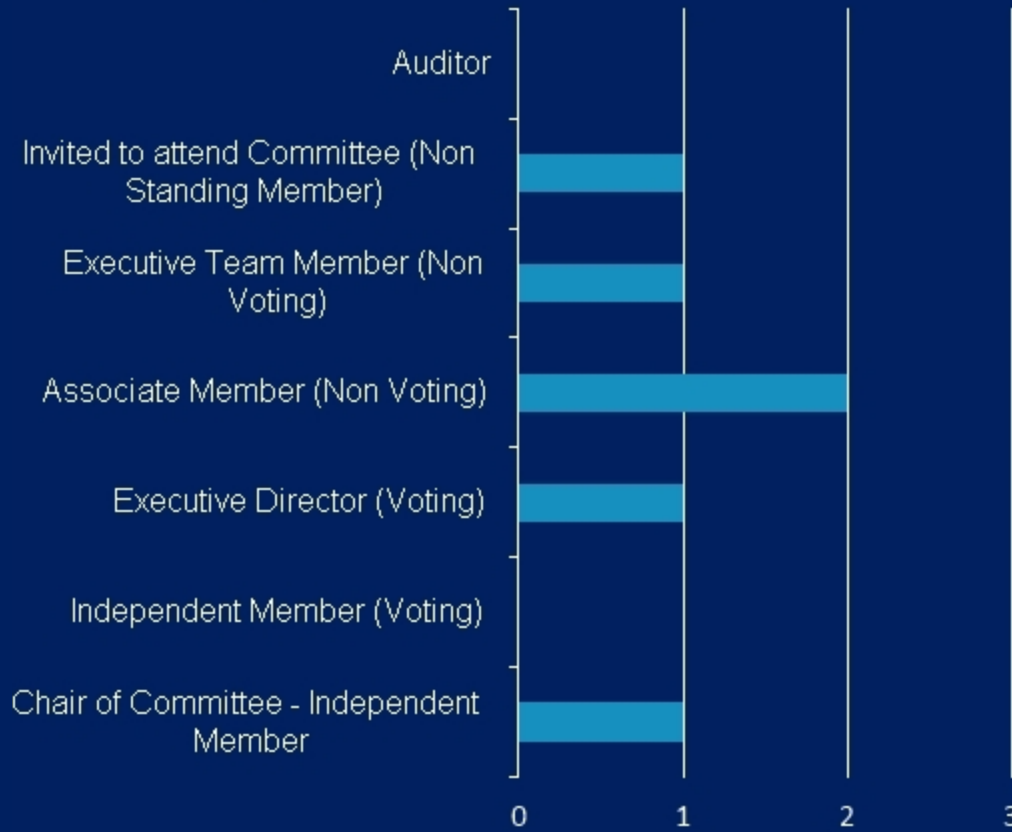
# Ensuring ‘Sound Governance’

- “We found that Board and Committee meetings are conducted appropriately and effectively, but there is scope to further improve...”
- “Length & quality of papers”
- “...focus on more strategic issues”
- “Remuneration Committee... effectiveness”
- “Transparency of Board and Committee business, 2023 ongoing”

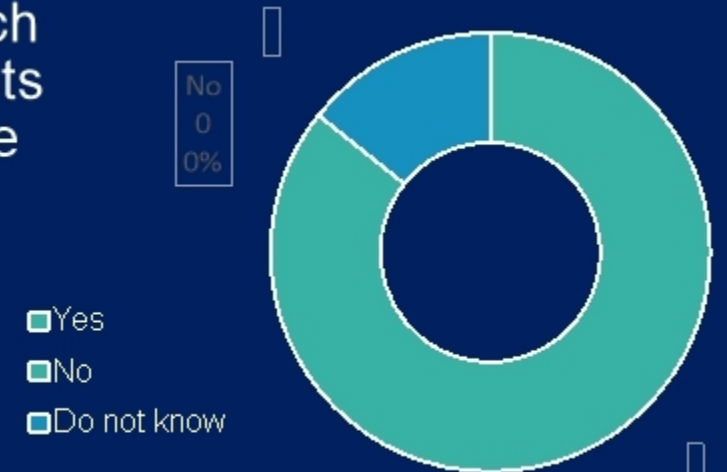


# Role Response

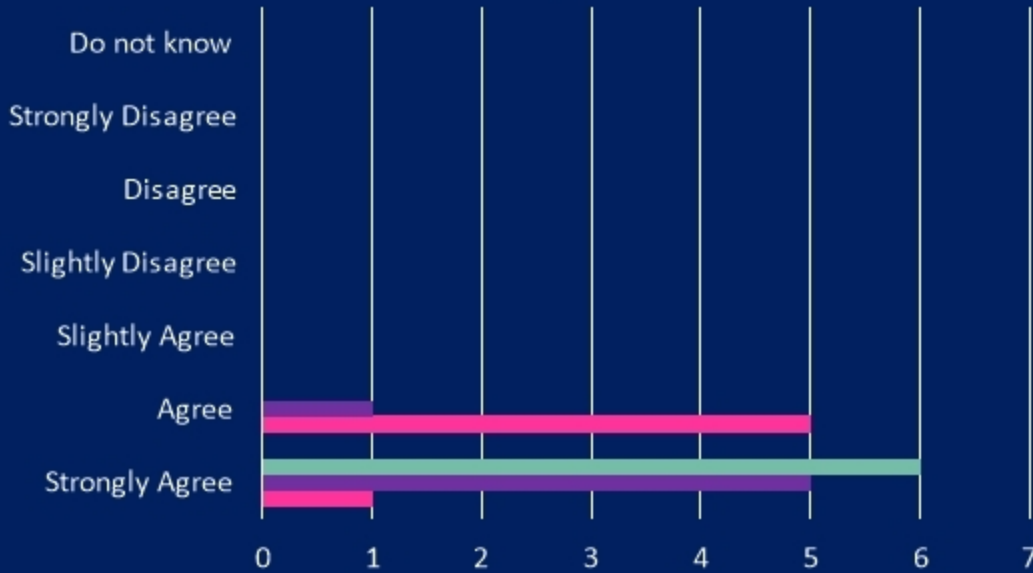
## Role Response Breakdown



Does the Committee have written Terms of Reference, which adequately define its role in accordance with Welsh Government guidance?



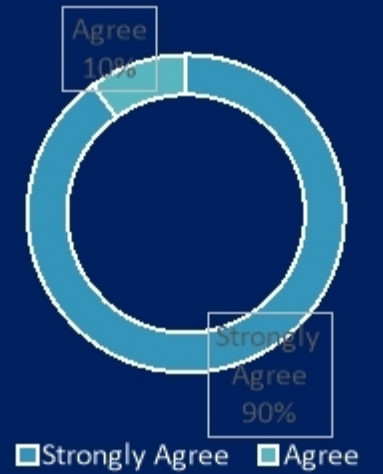
# Role Response



- The atmosphere at Committee meetings are conducive to open and productive debate
- The Committee meets sufficiently frequently to deal with planned matters and enough time allowed for questions and discussions
- The Committee has been provided with sufficient authority and resources to perform its role effectively

The behaviour of all members and attendees is courteous and professional

Response	Percentage
Yes	33%
No	33%
Do not know	33%



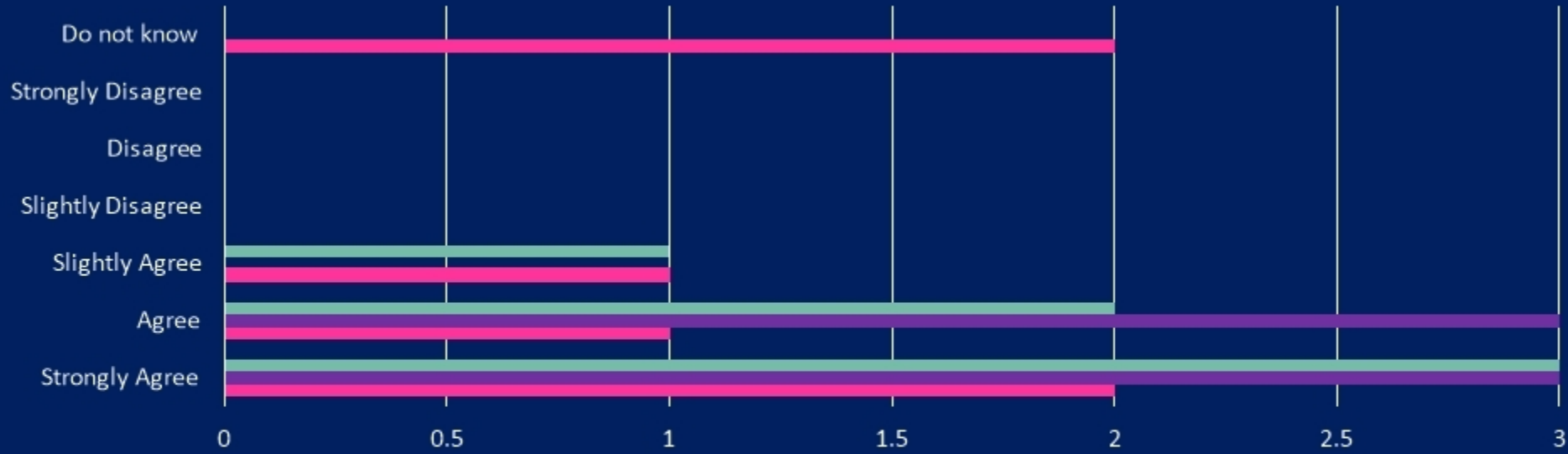
Does the Committee prepare an Annual Report on its work and performance in preceding year, for consideration by the Health Board?

Has the Committee established a cycle of business to be dealt with across the year?

100%



# Committee Response



- The Committee is focused on seeking assurance and providing robust scrutiny and does not stray into managing business / operational detail
- The Committee has a clear remit, aligned with organisational priorities
- Committee outcomes positively influence Board decisions

Committee meetings are chaired effectively and with clarity of purpose and outcome?



Strongly Agree Agree



# Key Findings – Governance & Function

- 100% confirmed written Terms of Reference are reviewed annually taking into account governance developments and the remit of other Committees.
- Positive feedback was received relating to private meetings being used appropriately.
- It was agreed that meetings are chaired effectively, 83% agreed that the Committee Chair provides clear information to the Board on the activities of the Committee and 100% agreed that the Committee is adequately supported.
- The assessment highlighted that the Committee is adequately supported by the Executive Directors in terms of attendance, quality and length of papers and response to challenges and questions.

# Key Findings – Information & Risk

- It was agreed that the committee has good oversight of the risks for which it is responsible for, as well as reports received in a timely manner and have the right format and content in relation to internal controls and risk management.
- The assessment highlighted uncertainty in relation to reviewing the robustness of the organisation's internal assurance system.
- There was slight agreement that the Committee effectively monitors the implementation of management actions from Audit Reports.

# Key Findings - Training & Development

- All felt confident in fulfilling their role and do not require additional training.

# Improvements

Of 28 questions, there were...

Response	Number of responses
Do not know	9
Slightly Disagree	0
Disagree	0

## *Do Not Know*

- The committee positively influences Board decision*
- The committee has reviewed the robustness & effectiveness of the content of the organisations internal assurance system.*
- The committee effectively monitors the implementation of management actions from audit reports*



# Comments:

## In relation to Committee Effectiveness –

*“The meeting appears to be more streamlined and focused than previously which is good progress and change”*

## In relation to Committee Leadership & Support –

*“It would be helpful to receive the minutes after a meeting on a shorter timescale rather than a few weeks prior to the next meeting considering they are held every three months. Sometimes they have produced the week before the following meeting.”*

## In relation to Internal Controls and Risk Management –

*“There are limited risks aligned to this committee for monitoring because of the role however it has the structure to do so”*

## In relation to Composition, Establishment and Duties –

*“The committee have not needed to meet in private thus far”*



**Mental Health Legislation Committee  
Self-Assessment  
Corporate Governance  
August 2025**

**Diolch yn Fawr**

