Bundle BCU Mental Health Legislation Compliance and Capacity Committee 8 May 2025

1 PRELIMINARY MATTERS

1.1 10:00 - MH25.18 - Welcome and Apologies - Verbal
Chair

1.2 10:01 - MH25.19 - Declarations of Interest relating the the agenda - Verbal
Chair

1.3 10:02 - MH25.20 - Unconfirmed Minutes of the Mental Health Legislation Committee – 6 February 2025 - Paper
Chair

MH25.20 - Unconfirmed Minutes of the Mental Health Legislation Committee – 6 February 2025

1.4 10:04 - MH25.21 - Matters Arising & Table of Actions - Paper
Gareth Williams, Chair

MH25.21 - Matters Arising & Table of Actions

2 FOR ASSURANCE

2.1 10:09 - MH25.22 - Mental Health Act Assurance Report - Paper
Matthew Joyes, Deputy Director for Legal Services

MH25.22 - Mental Health Act Assurance Report - Cover Paper

MH25.22 - Mental Health Act Assurance Report

2.2 10:19 - MH25.23 - Mental Capacity Assurance Report - Paper
Michelle Denwood, Director Of Safeguarding And Public Protection

MH25.23 - Mental Capacity Assurance Report

2.3 10:29 - MH25.24 - HIW Assurance Report - Paper
Matthew Joyes, Deputy Director for Legal Services

MH25.24 - HIW Assurance Report

MH25.24 - HIW Assurance Report - MH, LD Hospitals and Mental Health Act Monitoring Annual Report 2023-24

2.4 10:39 - MH25.25 - Associate Hospital Managers Update Report - Paper
Matthew Joyes, Deputy Director for Legal Services

MH25.25 - Associate Hospital Managers Update Report

2.5 10:49 - MH25.26 - Report from the Power of Discharge - Paper
Matthew Joyes, Deputy Director for Legal Services

MH25.26 - Report from the Power of Discharge

2.6 10:59 - MH25.27 - Update from Luke Hughes, North Wales Police - Verbal
Gareth Williams, Chair

2.7 11:14 - MH25.28 - CAMHS Legal Case Study - Paper
Matthew Joyes, Deputy Director for Legal Services

MH25.28 - CAMHS Legal Case Study

3 11:24 - FOR INFORMATION

3.1 MH25.29 - Cycle of Business - Paper
Philippa Peake-Jones, Head of Corporate Governance

MHLC CoB V0.01

3.3 MH25.30 - Terms of Reference - Paper
To note for onward approval at the Board Meeting In May 2025
Philippa Peake-Jones, Head of Corporate Governance

MH25.31 - Terms of Reference - MHLC

4 11:29 - CLOSING BUSINESS

4.1 MH25.31 - Agree Items for referral to Board / other Committees - Verbal
Gareth Williams, Chair

4.2 MH25.32 - Agree items for Chairs Assurance Report - Verbal
Gareth Williams, Chair

4.3 MH25.33 - Review of Meeting Effectiveness - Verbal
Gareth Williams, Chair

4.4 MH25.34 - Date of Next Meeting - 7 August 2025 - Verbal
Gareth Williams, Chair

4.5 MH25.35 - Resolution to Exclude the Press and Public - Verbal
"Those representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."
Gareth Williams, Chair

Betsi Cadwaladr University Health Board (BCUHB)
UNCONFIRMED Minutes of the Mental Health Legislation Committee held in Public on 6 February 2025 in the Boardroom, Carlton Court, St Asaph and via Teams

Committee Members Present	
Name	**Title**
Gareth Williams	Health Board Vice Chair (Chair of Mental Health Legislation Committee)
Rhian Watcyn Jones	Independent Member (IM)
Dyfed Jones	Independent Member
In Attendance	
Angela Wood	Executive Director Of Nursing and Midwifery
Alberto Salmoiraghi	Medical Director, Mental Health & Learning Disabilities (MHLD)
Chris Walker	Head of Safeguarding Adults
David Evans	Associate Hospital Manager (AHM)
Dr. Prashant Bhat	Consultant Child Psychiatrist, North Wales Adolescent Service
Matthew Joyes	Deputy Director for Legal Services
Phil Williams	AHM
Committee Support	
Philippa Peake-Jones	Head of Corporate Affairs
Jody Evans	Regional Risk Manager

Agenda Item
PRELIMINARY MATTERS
MH25.01 - Welcome and Apologies Apologies were received for Teresa Owen, Michelle Denwood and Ian Willkie.
MH25.02 Declarations of Interest Associate Hospital Manager Phil Williams declared an interest as a Trustee of Conwy and Denbighshire Mental Health Advocacy Service (CADMHAS).
MH25.03 Unconfirmed Minutes of the Meeting held 07.11.24 It was resolved that the Committee: • **AGREED** that the minutes of the meeting held on 7 November 2024 were a true and accurate record.
MH25.04 Matters Arising & Action Log The Committee reviewed the action log and noted the following actions should be added:

- 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.
- 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.
- Change the wording from “monthly trend” to “monthly change” in the Mental Health Act Assurance Report

MH24/32.1 Policy for Information to Patients (S132/33 Mental Health Act)
The Policy for Information to Patients (S132/33 Mental Health Act) is now live. A summary of the compliance aspects was provided. The Chair acknowledged the progress made and emphasised the importance of ensuring that patients are aware of their rights. It was agreed to close this action.

MH24/32.2 Translation Services
The action had been referred to the Quality Safety and Experience (QSE) Committee to ensure that patients are provided with the opportunity to communicate in their preferred language.. It was agreed to close this action.

MH24/33.1 Mental Health Act Assurance Report
The Deputy Director of Legal Services provided an update on the ongoing support for staff. An updated report will be provided. It was agreed to close this action.

MH24/34.1 Mental Capacity Act Assurance Report: It was noted that information on Best Interest Assessors had been provided and that a report later in the agenda provided information on advocacy. It was agreed to close this action.

It was RESOLVED that the Committee:

- Agreed the updates provided

FOR ASSURANCE

MH25.05 - Mental Health Act Assurance Report

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

- Since spring 2024, the Mental Health Act (MHA) Team had faced significant staffing capacity challenges due to unprecedented absences, particularly at the managerial level and within the West Office. A phased return for the absent staff is anticipated in March or April, and best wishes from the Health Board have been conveyed to those staff members. Despite efforts to provide cross-cover, the specialist nature of the work has prevented successful mitigation via Bank Staff and Secondment attempts, resulting in delays in section renewals, management panels, tribunal logistics, reporting, and auditing. It is anticipated that by April, the Team will return to a more normal operational capacity.
- Section 5 (4): There was one instance of Section 5(4) in November, which lasted for a short period and was fully scrutinised.

- There have been no exemptions or escalations regarding Section 5(2)'s, with numbers remaining small in relation to Doctors holding powers. All instances were reviewed and scrutinised for appropriateness, with no issues identified.
- Section 4 has not been extensively utilised. It was noted that the use of this Section over the long-term is very low, which suggests common assumptions about the difficulty of locating Section 2 Doctors are not accurate.
- Section 2 usage increased slightly over the year. Although no legal issues were identified, potential clinical concerns were raised. Plans are in place to move the data to Power BI for better tracking through live dashboards. The need for further support and exploration of data, especially regarding repeated Section 2 usage and patient presentations was raised. It was suggested that triangulating this data with other information, such as out-of-area patient data, suggested the scale of the pressure on community services. Streamlining the data into Power BI should help answer related questions more effectively.
- Section 3 usage dropped off in December, with no delays in reporting which could be linked to previous discussions on Section 2 usage.
- Section 17 showed no significant highlights, with numbers remaining low.
- Data on rectifiable errors (all of which were reported on Datix) were noted and it was agreed to circulate additional information which had been provided to the Chair on fundamental errors. Imbalances in numbers between Health Board regions were thought to be linked to possible issues with file transfers and incorrect coding. A review of a few cases was suggested to confirm these imbalances.
- Section 135/136 - No significant issues or legal concerns identified. Two sections under 18 were reported.

In discussing the report, the Committee:

- Raised concerns regarding MHA staffing issues and their potential impact on patient care. They emphasised the need for succession planning to be further embedded, as staff have managed the situation but more flexible staffing options should be explored. The People and Culture Committee was identified as key to addressing this. The need to review staff capacity for cross-cover roles was also highlighted, along with challenges related to a lack of MHA knowledge among bank staff. Secondments remain difficult, as services are often reluctant to release staff.
- Agreed to discuss further the apparent increase over the longer-term of the use of Section 2 data.
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Action:

- Address MHA staffing challenges, emphasise succession planning, explore flexible staffing options, and review staff capacity for cross-cover roles.
- Further explore data on Section 2 and the repeated use of these Sections for the same individuals.
- Circulate to the Committee the information on fundamental errors.
- Investigate issues with file transfers and incorrect coding, considering factors like medical instability, sickness, and workforce changes.

It was resolved that the Committee

- **NOTED** the report and appendices**.**

MH25.06 - Mental Capacity Assurance Report

Members received the report and the Head of Safeguarding, Adults highlighted:

- That there had been difficulties in respect of the procurement of Independent Mental Capacity Advocate (IMCA) Services, related to the procurement of services on a national basis. This has resulted in payment to CADHMAS for IMCA provision had been severely delayed. Fortunately, the Health Board has an excellent relationship with the service.
- The Best Interest Assessors (BIA) summary was provided, detailing that five staff have completed their training and are expected to be added to the list by quarter 4.
- The backlog of Deprivation of Liberty Safeguards (DoLS) Assessments increased in December, but was still much lower than in previous years, despite the substantial increase in Health Board DoIS applications over recent years. There had been a significant reduction in errors, indicating that the emphasis on ensuring compliance with training requirements was proving effective.
- Succession planning is also a priority for the Safeguarding Team, who are collaborating with the National Safeguarding Network to address the issue.
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- It was clarified that Welsh Government approval of the new forms, developed on behalf by the BCUHB team as part of a national work programme was still awaited, meaning the piloting of the forms may now be postponed to quarter 1 of the next financial year.

In discussing the report, the Committee:

- Requested further information on comparison data on DoLS applications and transfers between hospitals and care homes over the last five years to the next Committee.
- Noted the significant challenges faced by IMCA services across North Wales, including issues with procurement and funding, and acknowledged the strong relationship and support between the Health Board and CADHMAS.
- Welcomed the progress made in increasing the number of Best Interest Assessors (BIA), the reduction in the DoLS backlog and improvements in wait times and training compliance, noting the positive impact on reducing errors.
- Acknowledged the ongoing work on succession planning within safeguarding and the challenges regarding secondments, with recognition of the risk of a single point of failure.
- Noted the update on work to mitigate the problems associated with the DoLS process but agreed that the system was fundamentally flawed. This view was shared by other Health Boards and local authorities.
- Agreed that it was important to ensure information with regard to the Standard Operating Procedure for matters relating to the Court of Protection was shared across the organisation.

Action:

- Provide comparison data on DoLS applications and transfers between hospitals and care homes over the last five years to the next Committee.

It was resolved that the Committee

- **NOTED** the report

MH25.07 - HIW Assurance Report

Members received the report and the Chair of the Committee noted that, while broader issues identified were of course of interest, the Committee's Terms of Reference (TOR) meant its focus should be on the issue of compliance with MHA requirements. Other elements of the findings will be reviewed by the QSE Committee.

Members received the report and the Committee discussed and highlighted:

- The concerns raised relating to medical records, consent, and Section 17 leave forms, with the long-term solution of transitioning to electronic records. Assurances were provided for interim contingencies.
- Challenges regarding the training of agency staff regarding restraint.
- The need for assurance that other findings from HIW related to patient experience would be followed up. The Executive Director of Nursing and Midwifery outlined how progress in implementing HIW recommendations is tracked via a structured reporting system, with updates provided to the Executive Delivery Group, QSE Committee, and monthly briefings to Integrated Quality Planning Delivery meetings.
- Concerns regarding the low completion rates regarding the feedback questionnaires.
- Skill mix, gender balance, and staffing concerns for Section 17 leave.
- The importance of patient information being accessible, recommending the use of visual aids and appropriately pitched reading materials.

Action:

- Feedback to the Division the request to review and ensure patient information is accessible, with the use of visual aids and appropriately pitched reading materials.

It was resolved that the Committee

- **NOTED** the report

MH25.08 - Associate Hospital Managers Update Report

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

- Between October and December 2024, 26 hearings were held and that there were No discharges were recorded during this period.

In discussing the report, the Committee:

- Recognised the crucial role of Associate Hospital Managers (AHM) in reviewing sections and assessing the appropriateness of appeals.
- Noted the possible link between patients submitting appeals and Responsible Clinicians (RCs) deciding to remove Sections, with patients downgraded to voluntary admissions and suggested this needs further investigation..

- Noted the significant improvements in the hearing process, including the transition to a paperless system and enhanced scheduling of hearing dates.
- Recognised noted that although the AHM hearings had not resulted in any discharges, this does not mean that the process is not working, noting a case described by one of the AHMs which had identified some fundamental concerns and resulted in improvements in compliance with statutory requirements.
- Discussed how information regarding the right to appeal is conveyed to young people in CAMHS, stressing the need for age-appropriate materials and ensuring that this information is aligned with best practices across other Welsh services.

Action:

- Review available research on the impact of the submission of appeals to AHMs in terms of decisions by Responsible Clinicians (RCs) to discharge patients from Sections before hearings and subsequently explore further whether this could disadvantage patients who do not appeal.
- Review information regarding the right to appeal to young people in CAMHS.

It was resolved that the Committee

- **NOTED** the report

MH25.09 - Report from the Power of Discharge

Members received the report key areas were highlighted therein the report:

- The Power of Discharge Group meeting was held on 28 January 2025. Key discussions included -
  - A review of the MHA Assurance Report.
  - A review of the AHM Update Report, with an action to examine trends related to discharges by the Responsible Clinician before hearings.
  - A review of the HIW Assurance Report, with a suggestion to explore whether MHA status should be included in medication charts for scrutiny.
  - Discussion of proposed changes to the MHA in the new Mental Health Bill, with both positive feedback and concerns raised.
  - Noting ongoing staffing pressures within the MHA Team.

It was resolved that the Committee:

- **NOTED** the report.

MH25.10 - MH Bill 2025

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

- The Mental Health Bill (2025), which will introduce major changes to the Mental Health Act and was presented in Parliament on 6 November 2024. The Bill passed its second reading in the House of Lords and was currently in Committee stage. It is also expected to receive Royal Assent within the current year.
- Key changes were noted by the Committee therein the update and report provided.

In discussing the report, the Committee:

- Highlighted the importance of preparing for the changes, particularly in relationship to alternative pathways of support for neurodivergent people.
- Recognised the long-term timeline for the implementation.
- Noted that the changes will be accompanied by a code of practice and an impact assessment.
- Recognised the financial implications and the increased advocacy requirements arising from the Bill.
- Discussed how the changes would apply to Section 2 and section 3 detentions and the need for repeated requests for young people.
- Raised concerns about the practicalities of shorter detention periods and the need to balance patient rights with the increased advocacy required.
- Acknowledged that further detail into the Bill is available via the Deputy Director of Legal Services

It was resolved that the Committee:

- **NOTED** the report.

MH25.11 - Advocacy Services across North Wales

Members received the report, and the Consultant/Director of MHLD highlighted:

- Excellent compliance with KPIs and referrals to the MHA for both statutory and non-statutory services.
- The contract for the advocacy service is being renewed, though not all individuals are using the IMCA service.
- Community activity is high, with good communication between the service and patients, providing an additional layer of safeguarding.
- Advocacy services are available for individuals aged 16 and above, whereas MHA safeguards are available to all ages.

In discussing the report, the Committee:

- Welcomed the evidence of strong performance by CADMHAS.
- Gained clarification regarding recommissioning, with a separate paper on funding and procurement going to the Executive Board.
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- Noted that the appendix was embedded [circulated to Committee during the meeting].

It was resolved that the Committee:

- **NOTED** the report.

FOR INFORMATION

MH25.12 - Cycle of Business

The Cycle of Business was previously reviewed, it was noted that there were no changes to the current version.

The Committee referred and discussed:

- A case law update from late October was provided, and it was confirmed that the service has not yet had the opportunity to review it. It was suggested to simplify the case law for health professionals and discuss it at the next meeting.

MH25.13 - Forward Workplan

The forward work plan was set and was previously reviewed, no further changes noted to the current version.

CLOSING BUSINESS

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

It was agreed that the following would be referred:

- Concerns regarding non-clinical specialisms and lack of expertise, particularly in MHA administration; collaboration with People and Culture suggested.
- Use of agency staff and RPI raises concerns about quality and safety; QSE to remain aware.

MH25.15 - Agree items for Chairs Assurance Report

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

- Ongoing staffing issues and data challenges, with opportunities to improve data interrogation capabilities.
- Long-term increase in Section 2 usage, potentially indicating struggles within community services, with a focus on raising awareness.
- Clinicians adjusting decisions, including taking individuals off sections, with awareness raised.
- Positive discussion noted regarding the MHA Bill.
- Advocacy efforts recognised for their impressive performance.

MH25.16 - Review of Meeting Effectiveness

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

MH25.17 - Date of Next Meeting

The next meeting will be held on 8 May 2025.

Mental Health Legislation Committee Action Log
Updated 29.01.25

Open Actions						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**MH25.05**	6/2/25	**Mental Health Act Assurance Report** Further explore Section 2 data to examine whether Sections are being used repeatedly with the same individuals, ensuring this can be investigated through the new Power BI system.	Matthew Joyes/Prashant Bhat		**Remain Open** This action will be progressed with the return of the Senior MHA Manager. The work to develop the new MHA Reporting Tool in Power BI will start in summer.
2	**MH25.06**	6/2/25	**Mental Health Act Assurance Report** Share the Standard Operating Procedure for matters relating to the Court of Protection with CAMHS.	Matthew Joyes		**Remain Open** For clarity, there is no SOP which is the issue of concern. As part of creating the new Legal Services Department an SOP will be developed and this is planned for summer/autumn 2025.
3	**MH25.06**	6/2/25	**Mental Capacity Assurance Report** Provide comparison data on the overall number of DoLS applications and the number of Health Board DoLS applications	Chris Walker		**Remain Open** At this time we are unable to source this data. We are working locally with our data

			which relate to individuals already under DoLS in care homes over the last five years to the next Committee.			analyst to assess internal mechanisms an we have raised at the National DoLS Network for wider agreement to progress this data collection as part of the initial assessment paperwork.
4	**MH25.08**	6/2/25	**Associate Hospital Managers Update Report** Review available research on the impact of the submission of appeals to AHMs in terms of decisions by Responsible Clinicians (RCs) to discharge patients from Sections before hearings and subsequently explore further whether this could disadvantage patients who do not appeal.	Alberto Salmoiraghi/Matthew Joyes		**Remain Open** This action will be progressed with the return of the Senior MHA Manager.
5	**MH25.08**	6/2/25	**Associate Hospital Managers Update Report** Review information regarding the right of appeal to MHA AHMs to young people in CAMHS.	Dr. Prashant Bhat		
6	**MH24/34.3**	07/11/24	**Mental Capacity Assurance Report** Invite a member of CADHMAS to attend a future meeting.	Philippa Peake-Jones		**Remain Open** Teresa has linked in with the Team and look forward to attending a future meeting.
7	**MH24.13.1**	02/05/24	**Report from the Power of Discharge (Associate Managers) Group**	Iain Wilkie Teresa Owen	Feb 25	**Remain Open**

			Iain Wilkie and Teresa Owen to pick up with the Local Authorities on capacity issues around Approved Mental Health Practitioners.			This will be picked up in the next round of meetings with Local Authorities.
ACTIONS PROPOSED FOR CLOSURE						
1	**MH25.03**	6/2/25	**Matters Arising and Action Log** 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		**Suggest Close** Luke in attendance
2	**MH25.03**	6/2/25	**Matters Arising and Action Log** 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		**Suggest Close** Included in paper
3	**MH25.03**	6/2/25	**Matters Arising and Action Log** Change the wording from “monthly trend” to “monthly change” in the Mental Health Act Assurance Report	Matthew Joyes		**Suggest Close** This has been amended in the report
4	**MH25.05**	6/2/25	**Mental Health Act Assurance Report**	Matthew Joyes		**Suggest Close**

			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.			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	**Mental Health Act Assurance Report** Distribute data on fundamental errors and low renewal numbers to members and IMs.	Matthew Joyes		**Suggest Close** The data is sent separately – recommend close.
6	**MH25.05**	6/2/25	**Mental Health Act Assurance Report** Investigate issues with possible incorrect coding 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.	Matthew Joyes		**Suggest Close** The data was accurate at the time, 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	**HIW Assurance Report** Feedback to the Division the request to review and ensure any written information materials on MHA rights is accessible, with	Matthew Joyes		**Suggest Close** This information was fed back – recommend close.

			appropriate use of visual aids and plain English.			
8	**MH25.12**		**Cycle of Business** Bring an update on the Case Law *[Matt to insert reference]* to the next meeting	Matthew Joyes	May 2025	**Suggest Close** A report is on the agenda for the meeting in the private session.
9	**MH24/34.2**	07/11/24	**Mental Capacity Assurance Report** Provide an update on the Court of Protection cases at a future meeting.	Matthew Joyes/ Michelle Denwood	Feb 25	**Suggest Close** A COP report is on the agenda for the meeting in the private session.
Closed Actions (as agreed at meeting on)						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1	**MH24/34.1**	07/11/24	**Mental Capacity Assurance Report** Monitor progress against action 3.0 relating to mandatory training for Bank, Locum, and Honorary Staff as part of the action log.	Philippa Peake-Jones	Feb 25	Closed 6/2/25 This is a continuous process
2	**MH24/32.1**	07/11/24	**Matters Arising and Action Log** Deputy Director of Legal Services to review the Policy for Information to Patients (S132/33 Mental Health Act) and provide an update at the next meeting.	Matthew Joyes	Feb 25	Closed 6/2/25 The policy has been updated and signed off and is now live.
3	**MH24/32.1**	07/11/24	**Matters Arising and Action Log** Translation services to be referred to the QSE Committee to ensure patients are being provided with the opportunity to	Philippa Peake-Jones	Feb 25	Closed 6/2/25 This has been transferred.

			communicate in the language of choice.			
4	**MH24/33.1**	07/11/24	**Mental Health Act Assurance Report** Deputy Director of Legal Services to address providing support for staff from local offices and external suppliers to gain advice on specific issues.	Matthew Joyes	Feb 25	Closed 6/2/25 Alternative staff resources were included in the verbal update in the meeting.
5	**MH24/34.4**	07/11/24	**Mental Capacity Assurance Report** Include additional information relating to best interest assessors, mental capacity advocates and relevant person representative services in a future paper.	Michelle Denwood	Feb 25	Closed 6/2/25 Covered in the MCA report and CADMHAS report

Teitl adroddiad: ***Report title:***	Mental Health Act (MHA) Assurance Report		
Adrodd i: ***Report to:***	Mental Health Legislation Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	08 May 2025		
Crynodeb Gweithredol: ***Executive Summary:***	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. The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections. Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation. Lapsed sections are reported as 'exceptions' throughout the report, and invalid detentions recorded as 'fundamentally defective'. Any lapses or fundamentally defective sections are Datix reported and investigated. 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. Appendices are included to support the report.		
Argymhellion: ***Recommendations:***	The Committee is asked to note the report.		
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance		
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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

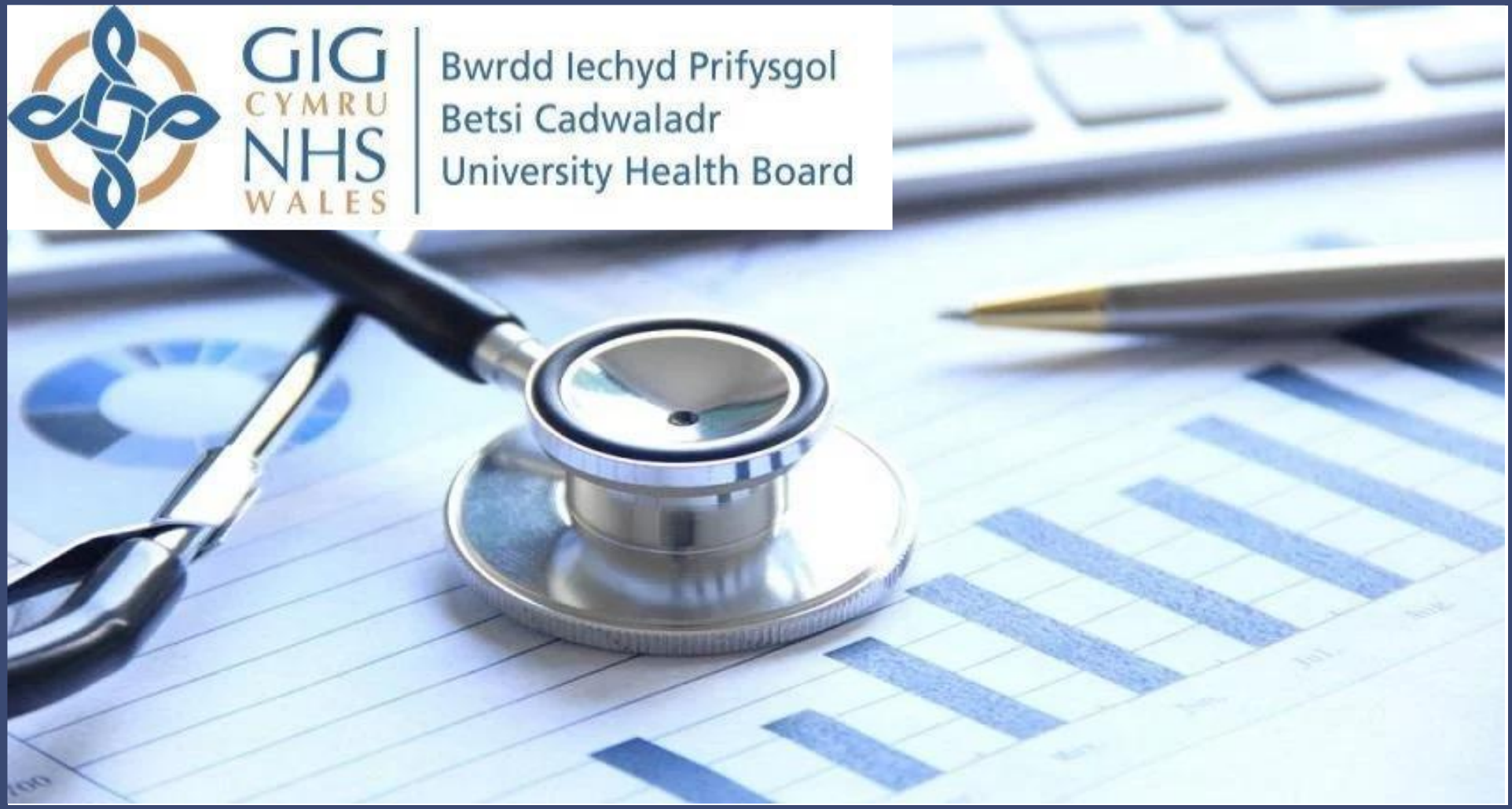
Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided. Subject to capacity being restored to the team, the aim would be to include this in the next report.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report is generated quarterly. The Mental Health Act 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. 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.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)	Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided.

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

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Mental Health Legislation Committee Assurance Report

March 2025

CONTENTS:

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

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

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

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

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

Executive Summary:

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

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

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

Because of these pressures, some data in this report cannot be produced for this quarter. The quarterly audit report also cannot be provided. Subject to capacity being restored to the team, the aim would be to include this in the next report. Additionally, national data returns such as the "S136 Report" and "KP90"have been delayed although have been submitted due to staff working over normal time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

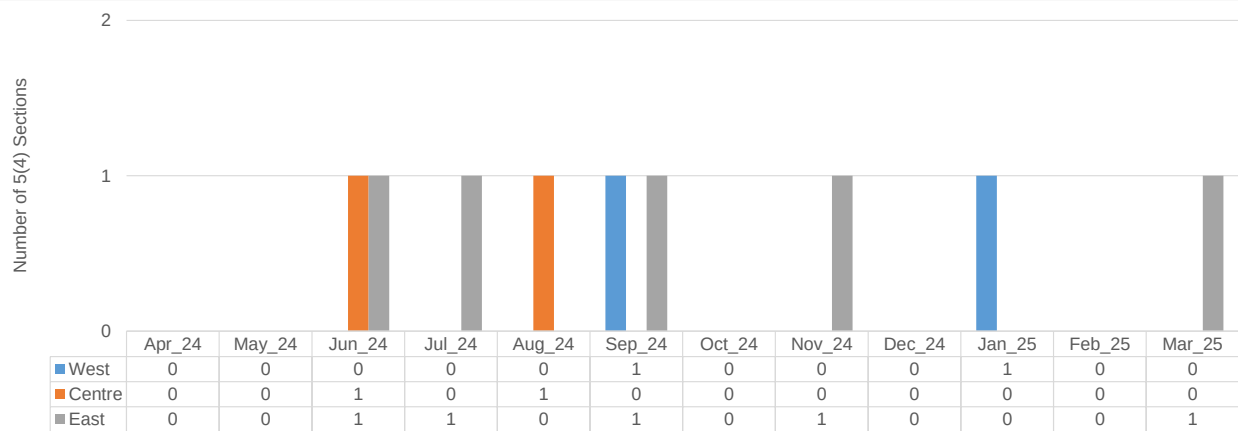
Rectifiable Errors: concerned with errors resulting from inaccurate recording, errors which can be rectified under Section 15 of the Act

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

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

Section 5(4) - BCUHB	March 2025	February 2025	Monthly Change
Section 5: Application in respect of patients already in hospital	1	0	↑

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
2	1	↑	2	1	East	1
				1	West	1
				3	Centre	0



	Apr_24	May_24	Jun_24	Jul_24	Aug_24	Sep_24	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
West	0	0	0	0	0	1	0	0	0	1	0	0
Centre	0	0	1	0	1	0	0	0	0	0	0	0
East	0	0	1	1	0	1	0	1	0	0	0	1

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
Jan_25	05:45	Section 5(2)

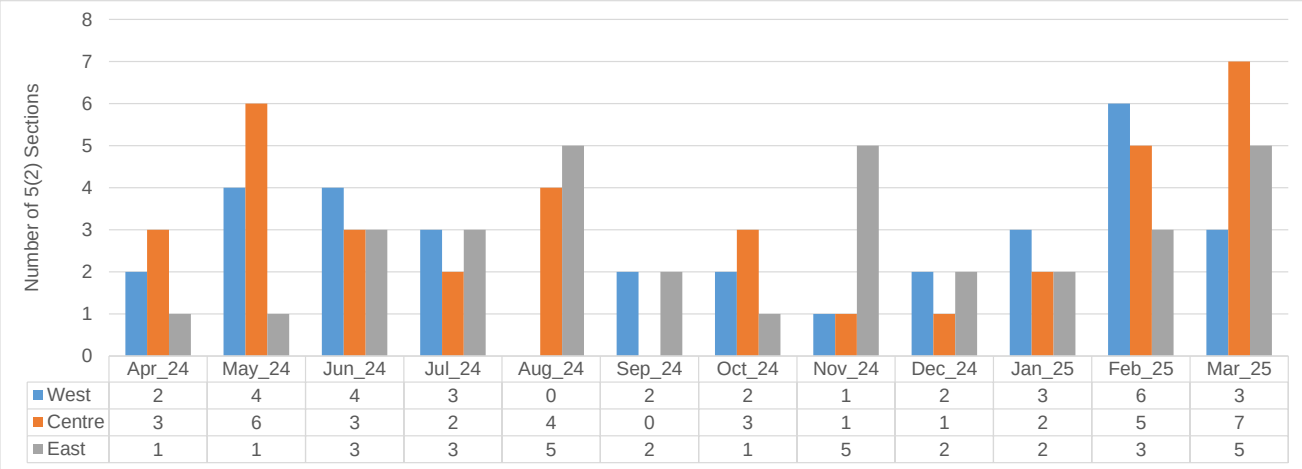
CENTRE

Month	Duration (hh:mm)	Outcome

EAST

Month	Duration (hh:mm)	Outcome
Mar_25	03:00	Section 5(2)

Section 5(2) - BCUHB	March 2025	February 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
Section 5: Application in respect of patients already in hospital	15	14	↑	36	18	↑	26	1	Centre	14
								2	West	12
								3	East	10



Section 5(2) Outcomes

	Jan 2025	Feb 2025	Mar 2025
Section 2:	1	6	5
Section 3:	3	2	5
Informal:	2	5	4
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	1	0	1
Other:	0	0	0

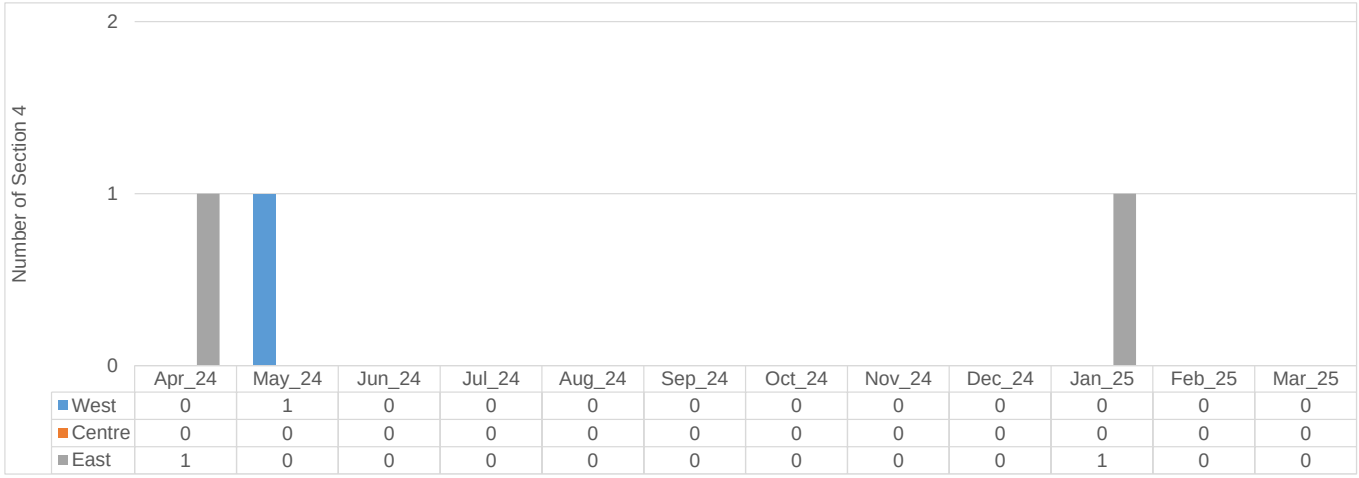
A Section 5(2) on occasions will be enacted within the acute hospital wards.

There were no exceptions to report in the period under review although of note, the figures are higher this quarter.

Section 4 - BCUHB	March 2025	February 2025	Monthly Change
Section 4: Admission for assessment: Cases of emergency	0	0	→

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)
1	0	↑	1

Area Rank by numbers of Section 4 during Quarter		Quarter Section 4
1	East	1
2	Centre	0
2	West	0



	Apr_24	May_24	Jun_24	Jul_24	Aug_24	Sep_24	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
West	0	1	0	0	0	0	0	0	0	0	0	0
Centre	0	0	0	0	0	0	0	0	0	0	0	0
East	1	0	0	0	0	0	0	0	0	1	0	0

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

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

There are no exceptions to report.

WEST

Month	Duration (hh:mm)	Outcome

CENTRE

Month	Duration (hh:mm)	Outcome

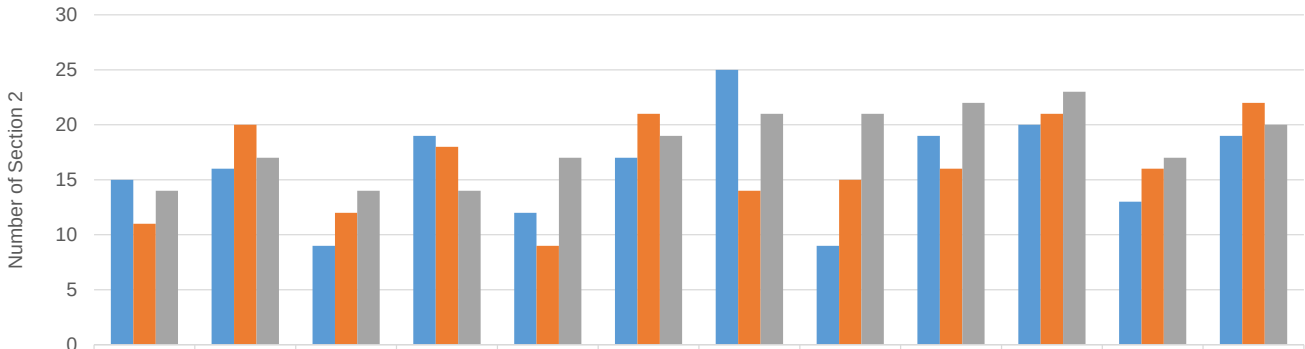
EAST

Month	Duration (hh:mm)	Outcome
Jan_25	05:45	Section 2

Section 2 - BCUHB	March 2025	February 2025	Monthly Change
Section 2: Admission for assessment	61	46	↑

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)
171	162	↑	152

Area Rank by numbers of Section 2 during Quarter		Quarter Section 2
1	East	60
2	Centre	59
3	West	52



	Apr_24	May_24	Jun_24	Jul_24	Aug_24	Sep_24	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
West	15	16	9	19	12	17	25	9	19	20	13	19
Centre	11	20	12	18	9	21	14	15	16	21	16	22
East	14	17	14	14	17	19	21	21	22	23	17	20

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

Section 2 Outcomes

Unable to provide data

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.

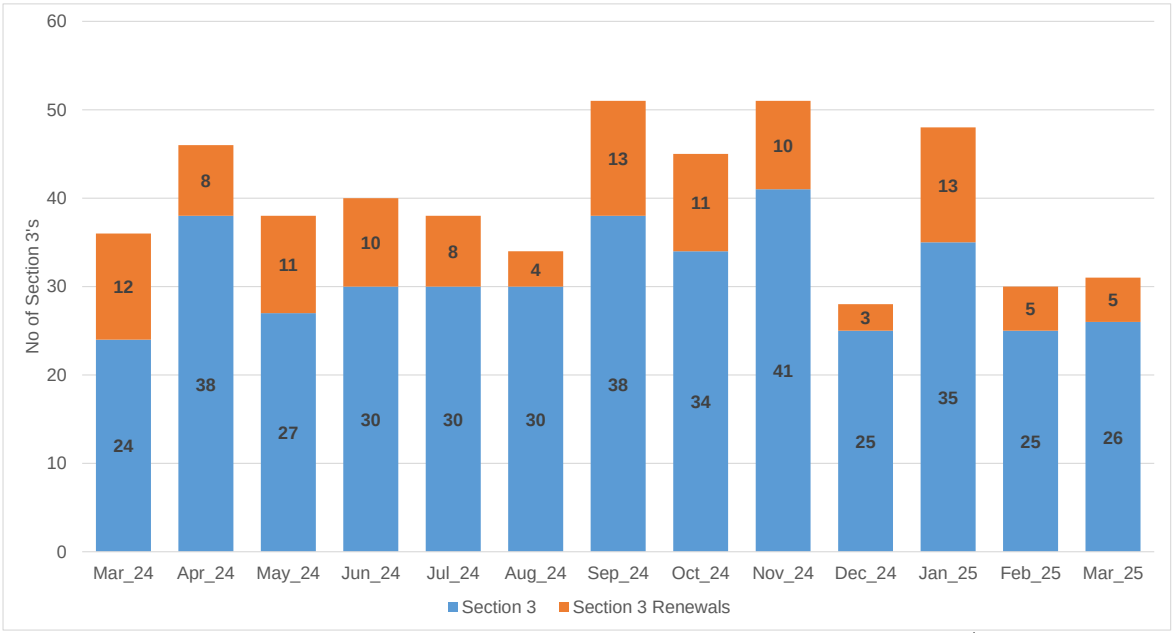
EXCEPTIONS:

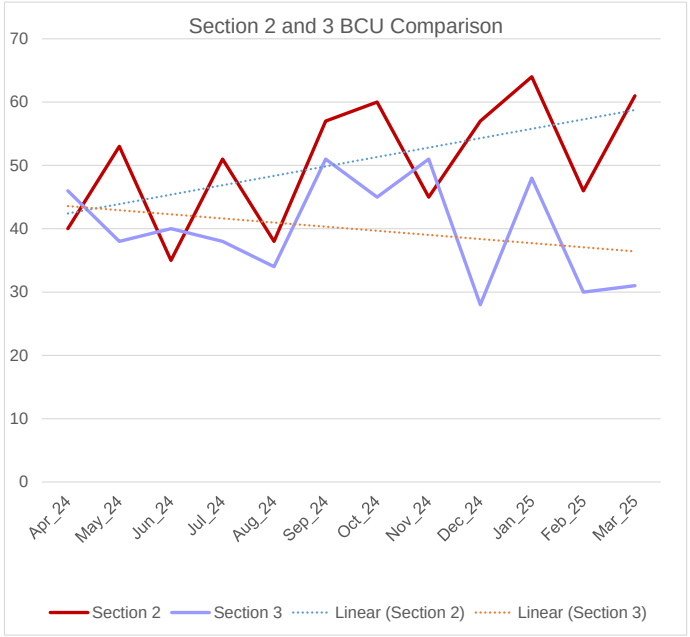
There are no exceptions noted this period however, for noting: the use of Section 2 is slightly higher this quarter than previous and indicates an increasing trend.

A

Section 3 - BCUHB	March 2025	February 2025	Monthly Change
Section 3 (Including Renewals): Admission for treatment	31	30	↑

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter		Quarter Section 3
109	124	↓	120	1	East	43
				2	Centre	33
				2	West	33





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

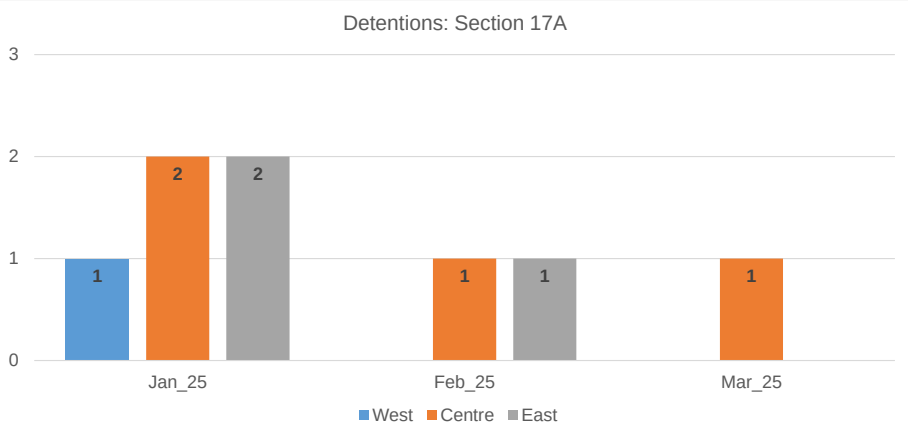
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

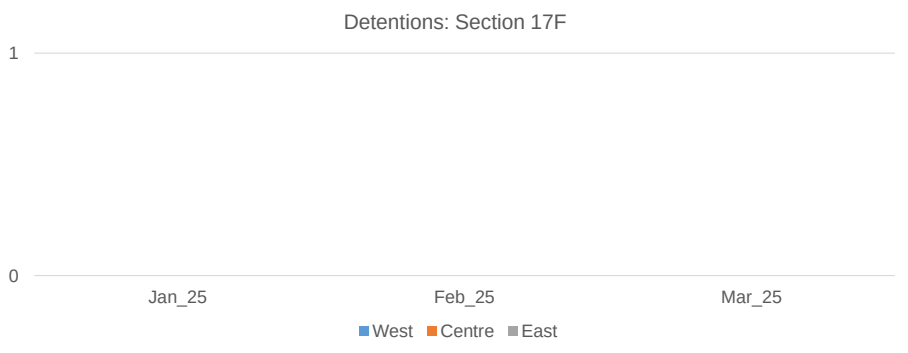
There are no exceptions to report this period although of note, the use of Section 3 is down this period.

Section 17 A-F - BCUHB	March 2025	February 2025	Monthly Change
Section 17A (Including Renewals)-17F: Community Treatment Orders	1	2	↓

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)
8	11	↓	14

Area Rank by numbers of Section 17 during Quarter		Quarter Section 17
1	Centre	4
2	East	3
3	West	1

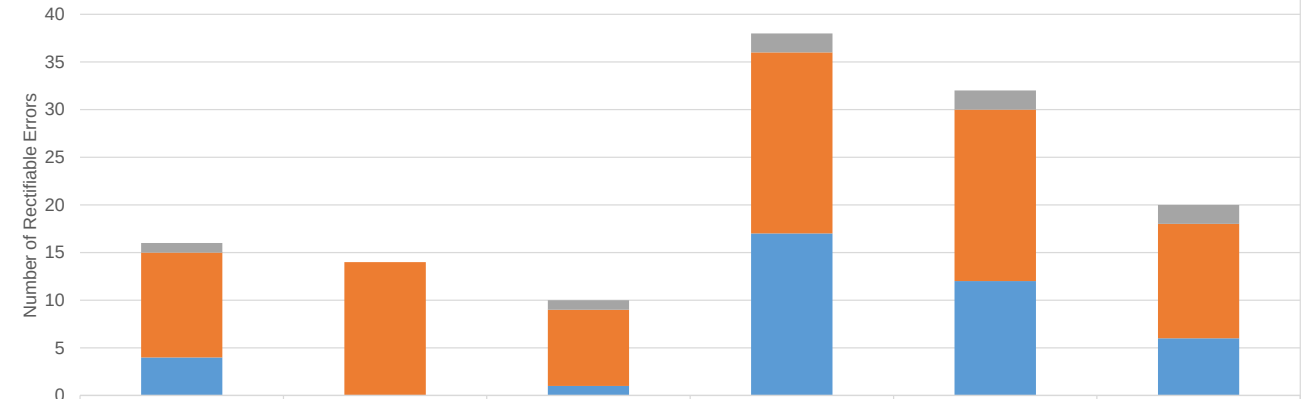




This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section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

Fundamental and Rectifiable Errors	March 2025	February 2025	Monthly Change
Fundamental and Rectifiable Errors in line with Health Boards in Wales	20	33	↓

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	Centre	49
				2	West	36
				3	East	6



	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
East	1	0	1	2	2	2
Centre	11	14	8	19	18	12
West	4	0	1	17	12	6

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.

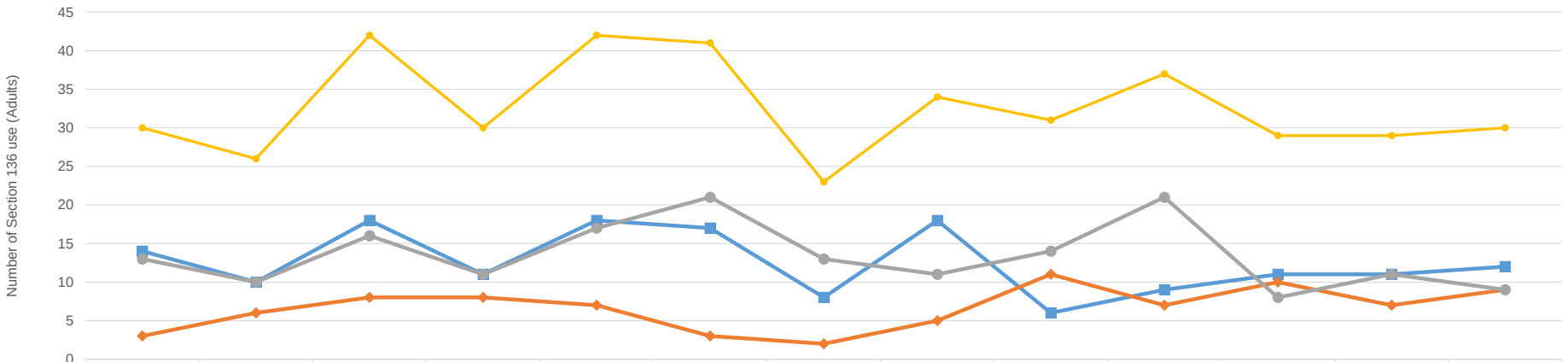
It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

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	March 2025	February 2025	Monthly Change
Section 135 and 136: Patient transfers to a place of safety (Adults)	30	29	↑

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)
88	102	↓	99

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	West	34
2	East	28
3	Centre	26



	Mar_24	Apr_24	May_24	Jun_24	Jul_24	Aug_24	Sep_24	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
West	14	10	18	11	18	17	8	18	6	9	11	11	12
Centre	3	6	8	8	7	3	2	5	11	7	10	7	9
East	13	10	16	11	17	21	13	11	14	21	8	11	9
BCU	30	26	42	30	42	41	23	34	31	37	29	29	30

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

Section 136	March 2025	February 2025	Monthly Change
Section 136: Patient transfers to a place of safety (Adults)	30	29	↑

Latest Quarter	Previous Quarter	Quarter Change	Quarter Average (last 4 quarters)
88	102	↓	99

Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
1	West	34
2	East	28
3	Centre	26

Section 136 Outcomes

Unable to provide data

Section 136 - Known to Service

Unable to provide data

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

Unable to provide data

Section 136: Detentions over 4 hours

Unable to provide data

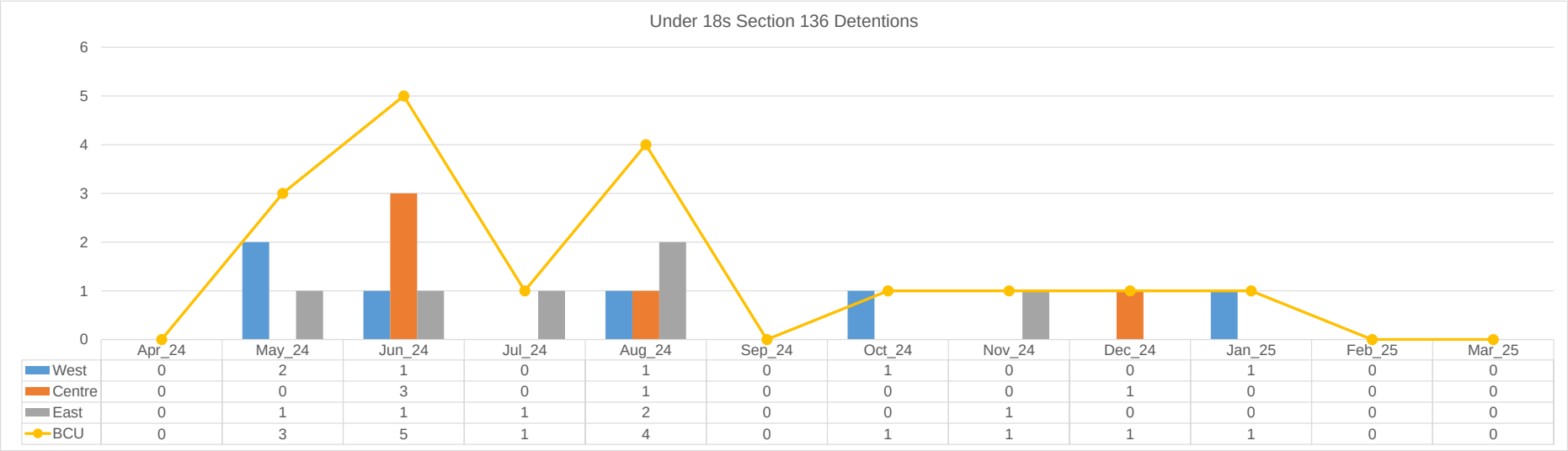
Whilst the Health Board notes detentions that may last over four hours in some instances this may be unavoidable due to the requirement for medical needs to be met prior to an assessment, or in some circumstances risks may be greater if discharge occurs out of hours.

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

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

Section 135 - 136 (Under 18)	March 2025	February 2025	Monthly Change
Section 135 and 136: Patient transfers to a place of safety (<18)	0	0	→

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
1	3	↓	4	1	West	1
				2	Centre	0
				2	East	0



	Apr_24	May_24	Jun_24	Jul_24	Aug_24	Sep_24	Oct_24	Nov_24	Dec_24	Jan_25	Feb_25	Mar_25
West	0	2	1	0	1	0	1	0	0	1	0	0
Centre	0	0	3	0	1	0	0	0	1	0	0	0
East	0	1	1	1	2	0	0	1	0	0	0	0
BCU	0	3	5	1	4	0	1	1	1	1	0	0

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

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

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

Unable to provide data - Section 136 Under 18 Detailed Data

Unable to provide data - Forensic sections

Total Transfers for the Quarter

	Jan 2025	Feb 2025	Mar 2025
Internal Transfers	13	16	13
External Transfers (Total)	7	3	18
External Transfers (In)	4	2	11
External Transfers (Out)	3	1	7

Unable to provide data - Transfers detailed data

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

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

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

Unable to provide data - Section 62

Unable to provide data - Hospital Manager Reviews and Tribunals

Teitl adroddiad: ***Report title:***	Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q4 2024-25 Update			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 08 May 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Quarter 4 update on the provision of DoLS and MCA activity within the Health Board.			
Argymhellion: ***Recommendations:***	The Board is asked to: Accept the DoLS and MCA Report and the identified activity for the period of Q4 2024-25 Receive the DoLS and MCA Audit Action Plan and recorded progress.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Michelle Denwood, Director of Safeguarding and Public Protection Hayley Lloyd, DoLS and MCA Regional Team Manager Mat Phillips, Safeguarding Adults/Adults with Dementia Lead Chris Walker, Head of Safeguarding Adults, DoLS and MCA			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	N/A			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Mental Capacity Act (MCA 2005)			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The Risk relating to DoLS/MCA is identified within the report.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No financial implications
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No workforce implications
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This quarterly report is submitted directly to the Committee. Deprivation of Liberty Safeguards is held within the portfolio of the Executive Director of Nursing and Midwifery and this update has been reviewed by Angela Wood, Executive Director of Nursing and Midwifery.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A (see Risk below)
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1: DoLS and MCA Audit Action Plan Appendix 2: The new DoLS Form 1 (Pilot) Appendix 3: The role of the Relevant Persons Representative	

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 Q4 2024-25. The activity includes key actions to ensure that DoLS and the MCA as part of the wider Safeguarding and Public Protection agenda remains paramount to service delivery across the Health Board.

DoLS reports throughout the Organisation in accordance with the Safeguarding Reporting Framework. This Framework reinforces Organisational engagement, reporting and escalation by the Safeguarding Governance and Performance Group, and key Forums and Committees. The functions of the Safeguarding and 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 (Q4)
In collaboration with other Health Boards, the National Workforce Group continues to hold quarterly meetings. The action plan remains focused on addressing the following points:

1. DoLS paperwork – Develop National DoLS Forms to update and simplify the forms incorporating the necessary information only to ensure continued working within the Law.

2. MCA Training – Explore and develop National Training Standards and training packages.

3. DoLS Process – Explore areas for improvement and the implementation of a potential new DoLS work stream.

Update on each action.

- **Action 1 DoLS paperwork:** The Health Board continues to lead the Paperwork Subgroup and has developed a new DoLS Form 1 (DoLS Application Form). This form has been internally reviewed and approved by the National MCA/DoLS Group and it was agreed for the pilot to commence with the target date of 1st April 2025. Three Health Boards in total are part of the pilot, we are the only Health Board to progress with the pilot, which commenced on the 1st April. The pilot will run for six months and it will then be reviewed with a questionnaire for the Managing Authority (wards) and the Supervisory Body (DoLS Team) to complete. The pilot has been registered as an audit within the Health Board.

- **Action 2 MCA Training:** This is a key activity for the Health Board, with progress on MCA training compliance achieved during 2024-25 In addition, National training programmes have been developed to offer a standardised approach to MCA awareness and understanding. These programmes will equip staff with the necessary skills to confidentially support patients and uphold their rights under the legislation.

- **Action 3 DoLS Process:** Action 3 relates to the DoLS Backlog. As of the 17/04/2025 the DoLS Backlog for the Health Board stands at 52. This is an improvement when compared to last quarter when the Backlog was 71. This is due to the intervention and financial support from the Welsh Government [WG]. It is important to note, applications received can differ significantly from month to month and the backlog will fluctuate.

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

Performance and Activity
The annual trend for DoLS applications continues to be an upward trajectory within the Health Board. This is in line with the National picture. During Q4 2024-25 a total of 589 DoLS applications were submitted, this is a 5.6% increase in comparison to last year's figure. Although the increase places pressure on the service it also continues to demonstrate learning and compliance with the statutory legislation.

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

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

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

  As previously reported after engaging with the relevant services, the Training Procedure has been amended and it has been confirmed that all mandatory training for Bank, Locum, Honorary and agency staff will now include MCA Level 1 and Level 2 (where applicable). Training compliance is monitored and any instances of low compliance will be escalated appropriately. Although the training compliance will continue to be reviewed in line with quality and data monitoring arrangements, this action is now complete.

The DoLS/MCA Team continues to provide targeted intervention to areas of poor compliance and strive to support the wards to improve their MCA level 1 and 2 mandatory training and continue to quality assure the DoLS applications. The DoLS backlog has also reduced significantly due to the additional assessments being undertaken during out of hours.
The five staff members have now passed the BIA qualification and can therefore begin to shadow staff, improving knowledge and confidence with a view to completing additional assessments independently. This action will be monitored through quarterly SGPG and Mental Health Legislative Committee reporting. A full breakdown of training is provided later within this report.

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

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

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

  This action directly addresses the inaccuracies with DoLS documentation by front line practitioners. Improving the quality of information and reducing the inaccuracies is a key target for the Health Board.

  Additional support has already been in place and there has been significant improvement to the quality of the paperwork received. This is evidenced in Table 2, 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 is also developed and offered to the wards, ensuring that all staff have a thorough knowledge and understanding of the MCA to be able to apply it correctly.

  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.

  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.

  Progress has been made and we have been able to secure office space for the BIA's on the three DGH sites. This will allow more visibility and speedy face to face access if needed. The MCA lead continues to visit each site regularly 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 until an agreement is reached 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.

This has caused a delay in the appointment of additional staff and the undertaking of additional DoLS assessments. This is included within the DoLS Risk. WG have advised that work is ongoing to ensure that this permanent recurring funding is automatically included within Health Board funds for each respective financial year. Once agreed these funds will be ringfenced to support the DoLS and MCA agenda.

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 independent mental capacity advocacy are held. A recent review identified an increase in referrals received, this is a result of the increased presence on the wards and awareness raising around the IMCA Service.

Table 1:

YEAR	IMCA REFERRALS	Paid RPR REFERRAL
2022-2023	551	133
2023-2024	573	196
2024-2025	656	266

Table 1 above, shows the steady increase of referrals received over the three-year period. It is important to note, the figures represent the number of referrals and not the total number of interactions as this would be significantly higher. Each referral will result in several visits, telephone calls, emails, professional visits/contact, joining professional meetings and time taken to write the necessary reports.

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 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.

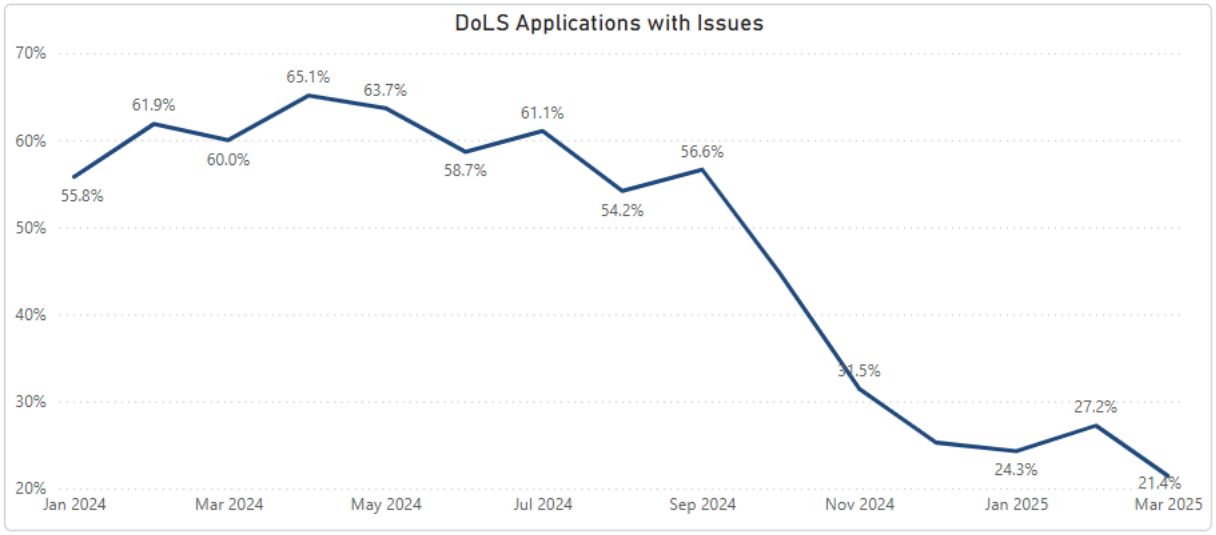
Strategic Implications Assessment and Analysis

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 Q4 2024-25 included 589 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 in Q4. This is credited to the DoLS/MCA Team and all Health Board services who submit DoLS applications.

Table 2:

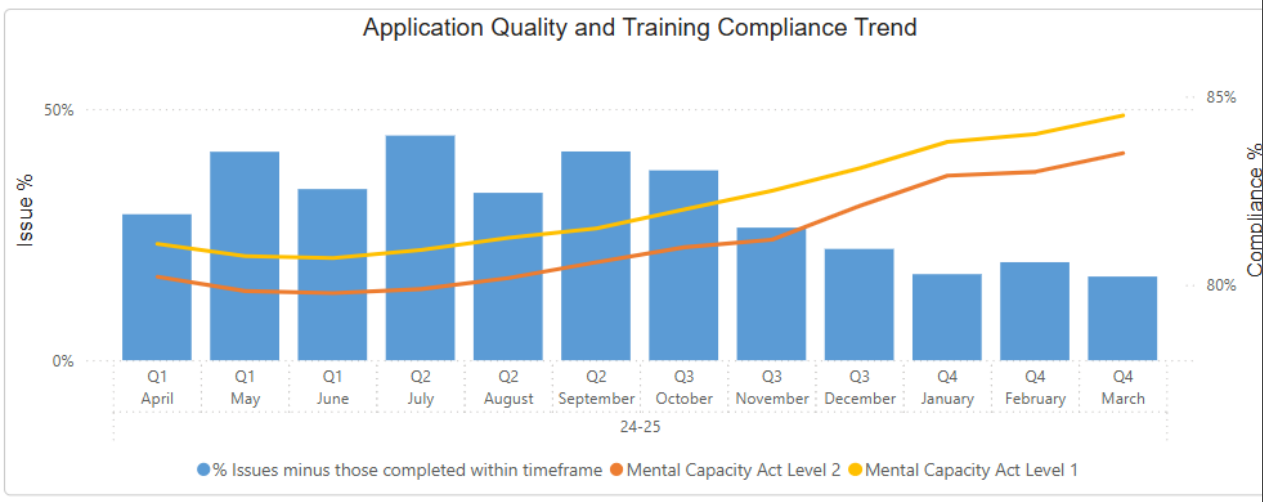


Analysis
Of the 142 applications that recorded issues during Q4, it is essential to note that all of them were rectified within the legislatively approved timeframe. Most of the issues from the applications continue to be minor with minimal amendments required. During March 2025, 21.4% of the applications received were noted to have issues with them. This is a decrease when compared to last month when 27.2% 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 should provide current medical information.

Table 3 below shows the trend between the quality of the DoLS applications and MCA Level 1 and Level 2 training compliance. There is a clear improvement in compliance with Level 1 and Level 2 MCA training and a significant reduction to the errors in DoLS paperwork.

Table 3: 2024-25



Training
The Health Board have recorded an improvement in MCA training compliance (see Table 4 and Table 5 below) in 2024-25.

Table 4:

Compliance by Health Economy March 2025

Grouped Org L4	Staff	MCA Level 1	MCA Level 2	Average	Modules below 85%
Corporate Services	12500	78.2%	75.6%	76.9%	2
Health Community Centre (HCCX)	5440	87.5%	88.0%	87.7%	
Health Community East (HCEX)	5556	89.0%	88.3%	88.6%	
Health Community West (HCWX)	4456	88.2%	88.0%	88.1%	
Integrated Clinical Delivery - Primary Care (ICDP)	593	86.8%	88.1%	87.5%	
Integrated Clinical Delivery - Regional Care (ICDR)	1624	85.0%	86.7%	85.8%	
Mental Health & LDS (MX00)	2245	91.3%	91.3%	91.3%	
Midwifery and Womens Services (WXXX)	851	89.2%	88.7%	88.9%	
Total	**33265**	**84.5%**	**83.5%**	**84.0%**	**2**

The MCA Training Lead continues to provide additional MCA training, tailored specifically to the needs of each ward. A Level 3 MCA and DoLS training package is also available monthly. 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 development of Training packages is now being facilitated by the Welsh Government National Group.

Therefore, the planned BCUHB work booklet for MCA Level 2 to aid staff to meet the mandatory training compliance will be developed once the National training program has been agreed.

Table 5

Competency	Q3 2024-25	Q4 2024-25	Trend
Mental Capacity Act Level 1	83.1%	84.5%	↑
Mental Capacity Act Level 2	82.1%	83.5%	↑

Q4 2024-25 has already 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.

The MCA/DoLS Team has also reported into the HIW National Review of the 'DNACPR Decisions in Adults' improvement plan. The recommendation was that Health Boards should undertake a training needs analysis relating to the Mental Capacity Act and completion of mental capacity assessments, and this should be considered widely across the organisation in addition to the completion of DNACPR decision forms. We were able to evidence how utilising WG monies has allowed us to appoint additional seconded positions, strengthening the DoLS/MCA Team which in turn has resulted in improved MCA level 1 and Level 2 training compliance and improved knowledge and quality of the MCA paperwork.

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

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

The number and complexity of cases engaged in the Court of Protection arena 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.

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.

Goblygiadau Cyllidebol / Ariannol
Budgetary / Financial Implications

There are no financial implications for this report.

Rheoli Risg
Risk Management

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

Following the new Risk Management Training the Safeguarding, DoLS and MCA Team were commended for their management of the risk. A comprehensive review of the risks 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.

Legal and Compliance

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

Goblygiadau Cydraddoldeb ac Amrywiaeth ***Equality and Diversity Implications***
N/A

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix 1

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

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

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	Welsh Government funding, actions and objectives.	• Fund additional Best Interest Assessments to reduce the DoLS Backlog. • Embed MCA training across BCUHB. • Prepare for the implementation of LPS. • Improve MCA training compliance for Locum and temporary staff.	CW HL	Q4 2024-25 Update: This action is complete for 2024-25. Additional BIA assessments continue out of hours. The MCA training compliance has improved significantly throughout the Health Board. The MCA Lead continues to provide targeted sessions for areas of low compliance and our temporary staffing establishment within the Health Board. All mandatory training for Bank, Locum, and Honorary staff will now include MCA Level 1 and Level 2 (where applicable), and this requirement has been extended to agency staff and any newly employed agency staff members.	**31.03.2025 Completed**	**Green**
2.0	DoLS Internal Audit Actions and Objectives	• Improve MCA Level 1 and 2 compliance for Bank Locum and Honorary staff:	CW HL	Q4 2024-25 Update: All mandatory training for Bank, Locum, and Honorary staff will now include MCA Level 1 and Level 2	**30/09/2024 Completed**	**Green**

		Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate.		(where applicable), and this requirement has been extended to agency staff and any newly employed agency staff members. Training compliance will be monitored through Safeguarding Forums. Revised MCA Level 1 and 2 programs continue to be updated and reviewed on a National level.		
3.0	DoLS Internal Audit Actions and Objectives	• DoLS Authorisations: Address quality issues with relevant areas and review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor) to improve the authorisation process ensuring Standard Authorisations are completed within the 2-week timeframe	CW HL	Q4 2024-25 Update: The data analyst has developed a Power BI dashboard to capture key performance data related to compliance of applications within timescales and other relevant data. Monthly reports are generated to identify areas needing improvement. Five Health Board staff have now passed the BIA qualification and will shadow assessments before competing independent assessments. The March DoLS monthly report indicates further improvement of the quality of paperwork for March 2024.	**31/03/2025 Completed**	**Green**
4.0	DoLS Internal Audit Actions and Objectives	• DoLS Documentation: Managing Authorities to ensure that the applications are completed	CW HL	Q4 2024-25 Update: The Supervisory Body (DoLS Team) continues to link directly with wards, requesting necessary amendments,	**31/03/2025 Completed**	**Green**

		appropriately and returned in a timely manner. Where issues are identified with quality or timeliness, the Supervisory Body will communicate issues with relevant staff, provide support and ensure staff have undertaken appropriate training. Where issues remain, this will be escalated as appropriate.		ensuring documentation is satisfactory. The March 2024 DoLS monthly report shows further improvement in the quality of the paperwork. It is noted that all of the applications were rectified and returned within the legislatively approved timeframe. Office space has been secured on the three DGH sites for all BIA's. The MCA training lead maintains daily contact and visits the DGH's on a regular basis offering additional bespoke MCA training to areas of low compliance. The SB continues to work directly with the wards to address any issues daily. A pilot of the new DoLS Form 1 commenced on the 1st April for a period of six months. The Health Board are leading on the digitalisation of the documentation.		

Appendix 2: **The New DoLS Form 1**

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 **MANAGING AUTHORITY'S REQUEST FOR STANDARD AUTHORISATION and MANAGING AUTHORITY'S URGENT AUTHORISATION**		
Full name of person being deprived of liberty:	Click or tap here to enter text.	**Male:** ☐ **Female:** ☐ **NHS Number:** Click or tap here to enter text.
Date of Birth *(or estimated age if unknown)*:	Click or tap here to enter text.	
Person to contact and details of the hospital (Managing Authority)		
Name:	Click or tap here to enter text.	
Address *(including ward if appropriate)*:	Click or tap here to enter text.	
Telephone:	Click or tap here to enter text.	
Email:	Click or tap here to enter text.	
Usual address of the person liable to be deprived of liberty, *(if different to above)*:	Click or tap here to enter text.	
Telephone Number:	Click or tap here to enter text.	
Admission date:	Click or tap to enter a date.	
Reason for admission:	Click or tap here to enter text.	
Does the patient have capacity to consent to their admission for care and treatment:	**Has a capacity assessment been completed for this specific decision?** **Yes** ☐ **No** ☐ **Date of capacity assessment:** Click or tap to enter a date.	

	PLEASE ATTACH RELEVANT CAPACITY ASSESSMENT

Person to contact and details of Supervisory Body:	
Name and address of the Supervisory Body where this form is being sent:	BCUHB, DoLS Supervisory Body Preswylfa Hendy Road MOLD, Flintshire, CH7 1PZ (BCU.DoLSAdmin@wales.nhs.uk) Tel: 03000 858745
Details *(including telephone number)* **of Care Coordinator/Care Manager:**	Click or tap here to enter text.
Communication Needs and any relevant medical history:	**Yes ☐ No ☐ Does the patient need an interpreter? ☐** **First language:** Click or tap here to enter text. **Does the person need: Hearing aids ☐ Glasses ☐** **What help does the person need to express themselves, their decisions and their preferences?** *Please explain if alternative methods of communication are required:* Click or tap here to enter text. **Relevant Medical History:** Click or tap here to enter text.
DoLS Care Plan	**Completed and attached: Yes ☐ No ☐** **Expand:** Click or tap here to enter text.
REQUEST FOR STANDARD AUTHORISATION – TO BE COMPLETED IN ALL CASES	

THE NATURE OF THE PROPOSED DEPRIVATION OF LIBERTY

Explain why the person is or will not be free to leave and why they are under continuous supervision and continuous control (Acid Test).

Is the person free to go out on their own	**Yes ☐**	**No ☐**
If the person goes out alone are staff aware when they leave and return?	**Yes ☐**	**No ☐**
If the person doesn't return, would they be returned by a staff member/police?	**Yes ☐**	**No ☐**
Is a sensor mat/door sensor/PIR sensor used?	**Yes ☐**	**No ☐**
Does the person have any tracking devices (On a phone or a GPS watch?)	**Yes ☐**	**No ☐**

Please explain further:
Click or tap here to enter text.

What are the restrictions the person is under?

Does the person have 1:1 or 2:1 support?	**Yes ☐**	**No ☐**
Are bed rails used? *(If so, a specific risk assessment, capacity assessment and best interest decision paperwork needs to be completed. Refer to your local documentation/policy)*	**Yes ☐**	**No ☐**
Is a lap strap/chest harness on wheelchair/armchair used? *(If so, a specific risk assessment, capacity assessment and best interest decision paperwork needs to be completed. Refer to your local documentation/policy)*	**Yes ☐**	**No ☐**
Is sedative medication prescribed? *Please list medication:* Click or tap here to enter text.	**Yes ☐**	**No ☐**
Is covert medication in place? *(If so, a capacity and best interest decision paperwork needs to be completed and NICE guidelines followed. Refer to local covert medication policy)* Click or tap here to enter text.	**Yes ☐**	**No ☐**
Is the person subject to any physical restraint? *Explain what restraint and the rationale around this:* Click or tap here to enter text.	**Yes ☐**	**No ☐**
Is there a Positive Behavioural Management Plan in Place?	**Yes ☐**	**No ☐**

Is the person restricted to visiting anyone or restrictions on family and/or friends visiting them? **Yes ☐** **No ☐**

Explain further and the rationale around this:
Click or tap here to enter text.

Is the person's access to their phone and/or correspondence restricted or monitored closely? **Yes ☐** **No ☐**

Explain further and the rationale around this:
Click or tap here to enter text.

Is the person's access to the internet/social media restricted or monitored? **Yes ☐** **No ☐**

Explain further and the rationale around this:
Click or tap here to enter text.

Is the Court of Protection currently involved? **Yes ☐** **No ☐**

If so, please explain further:
Click or tap here to enter text.

Please expand on any issues mentioned above and/or any other restrictions in place and why:
Click or tap here to enter text.

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT: *including relationship to person being deprived of their liberty:*

- Family member or friend;
- Anyone named by the person as someone to be consulted about their welfare;
- Anyone engaged in caring for the person or interested in their welfare;
- Any donee of a Lasting Power of Attorney for Health and Welfare granted by the person;
- Any Deputy for Health and Welfare appointed for the person by the Court of Protection;
- Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005 ***(PLEASE EXPAND LIST IF NEEDED)***

Name: Click or tap here to enter text.	**Relationship:** Click or tap here to enter text.

Does the person have Lasting Power of Attorney for Health and Welfare? Yes ☐ No ☐ *(Ensure a copy of the LPA is obtained)*	
Address:	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
Has the person been informed about the request for a DoLS Authorisation and explained what this means? Yes ☐ No ☐	
Name: Click or tap here to enter text.	**Relationship:** Click or tap here to enter text.
Does the person have Lasting Power of Attorney for Health and Welfare? Yes ☐ No ☐ *(Ensure a copy of the LPA is obtained)*	
Address:	Click or tap here to enter text.
Telephone	Click or tap here to enter text.
Has the person been informed about the request for a DoLS Authorisation and explained what this means? Yes ☐ No ☐	

IS IT NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED? *Place a cross in EITHER box below*	
YES: Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests.	☐
NO: There is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment.	☐

IS THERE A VALID AND APPLICABLE ADVANCE DECISION? *Place a cross in EITHER box below*	
YES: The person has made an Advance Decision that may be valid and applicable to some or all of the treatment.	☐
NO: The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment.	☐

IS THE PERSON SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT 1983?	
Yes ☐ **No** ☐	If Yes please describe further: Click or tap here to enter text.

Is the person subject to any provisions under the Mental Health Act, such as a hospital or community treatment order or guardianship order? **Yes ☐** **No ☐**

If yes, please explain further providing dates:

Click or tap here to enter text.

Does the person currently require admission to hospital under Section 2 or 3 of the Mental Health Act 1983? **Yes ☐** **No ☐**

If yes, please provide details and dates:

Click or tap here to enter text.

RELEVANT PERSON'S WISHES AND FEELINGS

Is the person objecting to care and treatment, if so, what are they objecting to? What are the relevant person's wishes, feelings, beliefs and values (present and past) so far as they can be ascertained and have, they/have not been met?

Click or tap here to enter text.

Note:(If a deprivation of liberty has been identified for a mental health patient accommodated for the purpose of treatment for a mental disorder and they are objecting to care and treatment for their mental disorder only the Mental Health Act 1983 can be used to deprive the person of their liberty).

Is the person asking to leave? **Yes ☐** **No ☐**

Is the person trying to leave? **Yes ☐** **No ☐**

Is the person concordant with care? **Yes ☐** **No ☐**

Please record the wishes and views of the person:

Click or tap here to enter text.

PLEASE SIGN AND DATE THIS FORM

Name: Click or tap here to enter text.	**Position:** Click or tap here to enter text.
Date: Click or tap to enter a date.	**Time:** Click or tap here to enter text.

PLEASE ENSURE THE FORM IS FULLY COMPLETED OTHERWISE THE FORM WILL BE RETURNED

Please note the Urgent Authorisation is on the last page

RACIAL, ETHNIC OR NATIONAL ORIGIN *Place a cross in one box only*		
White: ☐	**Mixed / Multiple Ethnic groups:** ☐	**Asian / Asian British:** ☐
Black / Black British: ☐	**Not Stated:** ☐	**Undeclared / Not Known:** ☐
Other Ethnic Origin: *(please state)* Click or tap here to enter text.		

THE PERSON'S SEXUAL ORIENTATION *Place a cross in one box only*		
Heterosexual: ☐	**Homosexual:** ☐	**Bisexual:** ☐
Undeclared: ☐	**Not Known:** ☐	**Other:** ☐

OTHER DISABILITY *Place a cross in one box only*

While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.

To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of "other disability" may be unrelated to an assessment of mental disorder or lack of capacity. Place a cross in one box only

Physical Disability: Hearing Impairment ☐	**Physical Disability: Visual Impairment** ☐
Physical Disability: Dual Sensory Loss ☐	**Physical Disability: Other** ☐
Mental Health needs: Dementia ☐	**Mental Health needs: Other** ☐
Learning Disability ☐	**Other Disability:** *(none of the above)* Click or tap here to enter text.
No Disability ☐	

RELIGION OR BELIEF *Place a cross in one box only*	
None ☐	**Not stated** ☐
Buddhist ☐	**Hindu** ☐
Jewish ☐	**Muslim** ☐
Sikh ☐	**Any other religion** ☐
Christian *(includes Church of Wales, Catholic, Protestant and all other Christian denominations)*	

ONLY COMPLETE THIS SECTION IF YOU ARE GRANTING AN URGENT AUTHORISATION

MANAGING AUTHORITY'S URGENT AUTHORISATION

Place a cross in EACH box to confirm that the person appears to meet the particular condition

The person is aged 18 or over. **Please note:** If the person is 16-17years of age and is deprived of their liberty you must seek legal advice.	☐
The person is suffering from a mental disorder.	☐
The person is being accommodated here for the purpose of being given care or treatment.	☐
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment.	☐
The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment.	☐
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Deputy for Health and Welfare appointed by the Court of Protection under the Mental Capacity Act 2005.	☐
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty.	☐
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise.	☐
The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given.	☐
The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately.	☐

AN URGENT AUTHORISATION IS MADE

This Urgent Authorisation comes into force immediately.

It is to be in force from Click or tap here to enter text. *(time)* **on** Click or tap to enter a date. *(date)* **a period of** Click or tap here to enter text. **Days**

The maximum period allowed is seven days.

This Urgent Authorisation will expire at Click or tap here to enter text.*(time)* **on** Click or tap to enter a date. *(date)*

PLEASE NOW SIGN AND DATE THIS FORM
(to be signed on behalf of the Managing Authority)

Name: Click or tap here to enter text.	**Position:** Click or tap here to enter text.
Date: Click or tap to enter a date.	**Time:** Click or tap here to enter text.

IF THE PATIENT IS EXPECTED TO BE IN HOSPITAL LONGER THAN 7 DAYS AND YOU WISH TO APPLY FOR AN EXTENSION TO THE EXISTING URGENT AUTHORISATION PLEASE COMPLETE THE SECTION BELOW

A REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION CAN BE CONSIDERED IF IT IS LIKELY THE EXISTING URGENT AUTHORISATION WILL EXPIRE BEFORE THE SUPERVISORY BODY IS ABLE TO ASSESS THE PERSON

An Urgent Authorisation is in force and a Standard Authorisation has been requested for this person.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of Click or tap here to enter text. DAYS **(up to a maximum of 7 days)**.

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows *(please record your reasons):*
Click or tap here to enter text.

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature: Click or tap here to enter text.	**Date:** Click or tap to enter a date.

14. THIS SECTION IS TO BE COMPLETED BY THE SUPERVISORY BODY ONLY

This part of the form must be completed by the SUPERVISORY BODY if the duration of the Urgent Authorisation is extended. The Managing Authority does not complete this part of the form.

The duration of this Urgent Authorisation has been extended by the Supervisory Body.

It is now in force for a further Click or tap here to enter text. **days**

Important note: The period specified must not exceed seven days.

This Urgent Authorisation will now expire at Click or tap here to enter text. *(time)* on Click or tap to enter a date. *(date)*

SIGNED (on behalf of the Supervisory Body) Click or tap here to enter text.	**Signature:** Click or tap here to enter text.	
	Print Name: Click or tap here to enter text.	
	Date: Click or tap to enter a date.	**Time:** Click or tap here to enter text.

Appendix 3: Role of the Relevant Persons Representative

Once a DoLS Standard Authorisation has been granted, the Supervisory Body (DoLS Team) must appoint the 'relevant person' (patient) a representative as soon as possible to protect the persons interests throughout the process.

The representative is called a Relevant Persons Representative (RPR) and is appointed to support and represent individuals who are deprived of their liberty under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS). The RPR's role is to act in the best interest of the relevant person and ensure their rights are upheld.

The RPR must be over the age of 18 years, must be able to maintain regular contact with the relevant person and be independent of the commissioners and providers of the services they are receiving. The RPR must have no financial interest in the relevant persons managing authority and not be employed by the any of the service providers.

As part of the assessment process, the Best Interest's Assessor (BIA) must identify if there is anyone, they would recommend to become the RPR. A suitable family member, close friend or partner can be appointed as the RPR if all of the above applies and they are acting in the relevant persons best interests, as per the best interest's principle of the MCA.

The BIA must be satisfied that the appointed person has a good understanding of their responsibilities and must be willing to undertake the role. If the relevant person has no one suitable to fulfil this role the BIA can recommend a paid RPR be appointed via the Independent Mental Capacity Advocacy (IMCA) Service.

Once the RPR has been appointed their role is:

- To maintain sufficient contact with the relevant person, including face-to-face contact.
- To represent and support the relevant person in all matters relating to the deprivation of liberty safeguards.
- Request a review of the authorisation if required.
- Raise a complaint on the persons behalf.
- Make an application to the Court of Protection to raise a challenge to the deprivation.

Prior to raising a challenge, it would be important to consider whether it is possible to resolve any concerns informally first. All unpaid RPR's and relevant persons have a statutory right to be supported by a specialist IMCA through the court process.

The RPR must have an adequate understanding of the role and what this entails. The RPR should work closely with the Managing Authority (MA) and be fully aware of the following:

- the effect of the authorisation.
- Their right to request a review.
- The formal and informal complaints procedures that are available to them.
- Their right to make an application to the Court of Protection to seek variation or termination of the authorisation.
- Their right, where the relevant person does not have a paid 'professional' representative, to request the support of an Independent Mental Capacity Advocate.

It is crucial when acting on behalf of or making decisions for individuals who lack capacity that the RPR is fully involved in any decision making and attends all relevant meetings, ensuring the relevant persons views and wishes are heard and respected. The RPR should consult with carers and anyone who has an interest in the relevant person's welfare to ensure that all decisions are made in their best interests.

Teitl adroddiad: ***Report title:***	Healthcare Inspectorate Wales (HIW) Assurance Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	08 May 2025			
Crynodeb Gweithredol: ***Executive Summary:***	HIW is the independent inspectorate and regulator of all health care in Wales. HIW conduct announced and unannounced visits to services offered by the Health Board, considering how the services are meeting the Quality Health and Care Standards 2023 and the Mental Health Act. This report provides assurance that recommendations relating to the Mental Health Act arising from HIW inspections have agreed actions in place, and the progress of those actions, to ensure continued compliance. The report also includes the HIW Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2023-24 which was published on 31 January 2025.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Erika Dennis, Quality Lead Manager Clare Jones, Quality Assurance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Health Board's Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is around the quality of patient experience, the delivery of safe and, the effective care and, the quality of management and leadership. The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo *N*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	N/A
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act) require no financial consideration at present.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	N/A

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** N/A	
Rhestr o Atodiadau: **List of Appendices:** Appendix 1 - Inspection and Action Progress Report Appendix 2 - Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring Annual Report 2023-24	

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

Healthcare Inspectorate Wales (HIW)

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

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

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

Inspections

1 Unannounced Visit: Gwanwyn and Hydref Wards, Heddfan Unit

Inspection Date: 21st to the 23rd October 2024
Publication Date: 23rd January 2025
Responsible Director: – Iain Wilkie, Director of MHLD

HIW Recommendation (1)
The Health Board must ensure that the MHA legal status of patients is recorded within their Medicine Administration Record (MAR) charts to provide clear guidance to staff.

Service Improvement Actions

Action Reference MD12/1
MHLD Clinical Director to communicate importance of medical staff filling in MHA legal status on MAR charts.

Progress Status
MD12/1: Fully complete (approved)

HIW Recommendation (2)
The Health Board must implement robust governance oversight to ensure unnecessary or duplicate documentation is removed from patient MHA records, to avoid confusion for staff.

Service Improvement Actions

Action Reference MD21/1
Ensure duplicate and outdated documentation is removed from files.

Action Reference MD21/2
Local audit to be undertaken aligned to Good Record Keeping, outcome brought through weekly managers meeting for discussion and support.

Progress Status
MS21/2: Fully complete (approved)
MD21/2: Fully complete (approved)

HIW Recommendation (3)
The Health Board must ensure patient Section 17 leave forms are fully completed and signed as appropriate.

Service Improvement Actions

Action Reference MD22/1
Clinical Director to remind medical staff of their responsibility and accountability.

Action Reference MD22/2
To discuss Section 17 Leave form completion in the consultant forums.

Action Reference MD22/3
Audit to be carried out to ensure compliance

Progress Status
MD22/1: Fully complete (approved)
MD22/2: Fully complete (approved)
MD22/3: Partially complete (overdue)

2. Unannounced Visit: Carreg Fawr

Inspection Date: 21st to the 23rd January 2025
Publication Date: 1st 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
In Progress

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

Inspection Date: 13th to the 15th January 2025
Publication Date: 17th 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: Partially complete (overdue)
MD12/2: Fully complete (approved)
MD12/3: In Progress

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: Partially complete (overdue)
MD13/2: In Progress
MD13/3: Fully complete (approved)
MD13/4: In Progress

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: In progress

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: In Progress
MD18/2: In Progress
MD18/3: In Progress

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: In Progress

MD19/2: In Progress
MD19/3: Fully Complete (approved)
MD19/4: In Progress

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: In Progress
MD20/2: Fully Complete (approved)
MD20/3: In Progress

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: In Progress
MD22/2: In Progress
MD22/3: In Progress

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: In Progress
MD22/3: In Progress
MD22/4: In Progress

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: In Progress
MD23/2: In Progress
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: In Progress
MD24/2: In Progress
MD24/3: In Progress

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Gwirio bod pobl yng Nghymru yn derbyn gofal da

Checking people in Wales are receiving good care

Mental Health, Learning Disability Hospitals and Mental Health Act Monitoring

Annual Report 2023-24

This report is also available in Welsh. If you would like a copy in an alternative language or format, please contact us.

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

In writing:

Healthcare Inspectorate Wales
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via:

Phone: 0300 062 8163

Email: **hiw@gov.wales**

Website: **www.hiw.org.uk**

To aid readers, a list and explanation of technical terms used in this report is included as Appendix B.

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

Our purpose

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

Our values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective – we are reasoned, fair and evidence driven.

Decisive – we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive – we value and encourage equality and diversity through our work.

Proportionate – we are agile and we carry out our work where it matters most.

Our goal

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

Our priorities

We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.

We will adapt our approach to ensure we are responsive to emerging risks to patient safety.

We will work collaboratively to drive system and service improvement within healthcare.

We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

1. Executive Summary

This report sets out the activity and findings for mental health and learning disability services during the period April 2023 to March 2024.

The report provides an insight into the challenges faced by mental health and learning disability services including community services. However, in spite of these challenges, there are many positive findings and it is clear that the workforce is appreciated by patients and others, in their endeavour to continue to deliver care and treatment in a changing landscape.

We continue, in the majority of our inspections, to receive feedback from patients who are complimentary about the care provided and about their interactions with staff. HIW staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many examples of good practice within the monitoring and implementation of the Mental Health Act (MHA) including documentation which was well organised, easy to navigate and securely stored, and MHA administrators demonstrating good governance and oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful. On our inspections, there was good evidence that patients were aware of their rights, and this was well recorded. There had also been improvements with patient observations, with very few issues being identified within our individual reports.

However, as mentioned above some areas continue to cause concern for us, particularly where there has been little or no improvement since our previous report. Workforce challenges in relation to recruitment and retention of staff was a finding in a significant number of inspections and there were vacancies across a wide range of disciplines. Medicines management also continues to be a theme, and the specific issues identified are discussed within section 5 of this report.

Risk assessments and care planning also continue to be a significant finding in our inspections and one very worrying example was of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan which had only been partially completed.

In two of our inspections this year, we identified issues with the seclusion of patients and the provision of meaningful and therapeutic activities. The environment of care provision was also concerning and in a number of our visits, we identified patient and staff safety issues. In one example, patient call bells were not easily accessible which meant that patients who required assistance were not easily able to summon staff.

We have also detailed, within this report, specific findings in relation to our learning disability and Children & Adolescent Mental Health Services (CAMHS) inspections.

We also identified, in some of our inspections, a lack of a robust system of audit and governance in our mental health and learning disability inspections. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider.

In seven of our visits, we identified very serious issues which led us to issue immediate assurance letters for health boards, or non-compliance notices for independent providers. The health board/independent provider responds to these letters or notices with an immediate improvement plan that HIW must agree. We made use of these processes following three health board inspections and four inspections of independent providers.

Chapter 6 of this report identifies the process and areas we focus on to be assured that services discharge their powers and duties correctly under the Mental Health Act 1983 in Wales.

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues
- Older persons
- Learning Disabilities
- CAMHS

Within the total of 26 we jointly visited one Community Learning Disability Team (CLDT) with Care Inspectorate Wales (CIW). We also undertook one visit to a Community Mental Health Team (CMHT). Our findings are drawn from these inspections.

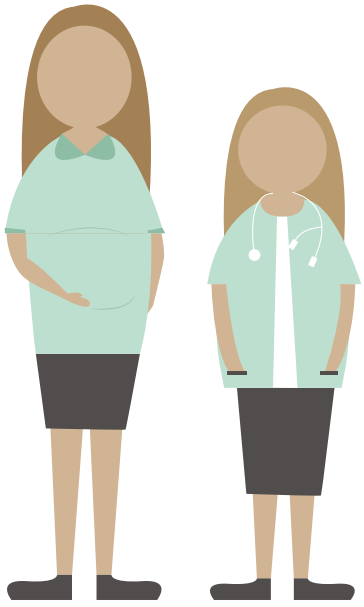
Overall, there were 199 complaints and concerns about mental health and learning disability healthcare services. This is an increase on the previous year from 164.

In addition, during the period April 2023 to March 2024, the Review Service for Mental Health (RSMH) received 733 requests for a visit by a Second Opinion Appointed Doctor (SOAD). This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

665	requests related to the certification of medication
44	requests related to the certification of ECT
24	requests related to medication and ECT.

In conclusion, whilst we continue to identify areas of good practice the issues identified within this report are concerning and health boards and independent providers of healthcare need to improve upon their audit and governance processes to ensure that the areas identified are addressed.



2. Context

Throughout 2023-24 mental health and learning disability hospitals and community services faced many challenges in delivering services. Workforce challenges in the recruitment and retention of appropriately skilled, knowledgeable and trained staff in key disciplines continue to have a detrimental impact on the ability of health boards and independent providers to meet the needs of increasing numbers of patients who require care and treatment.

Patients continue to experience a lack of mental health support in a timely manner and when they are admitted to in-patient wards these are very busy places with extreme pressure on beds. Patients do not always have sufficient time with staff due to staffing pressures as outlined above.

In addition, in September 2023 we published the Improvement Plan – review of discharge arrangements for adult patients from inpatient health services in Cwm Taf Morgannwg University Health Board (CTMUHB). This followed the report itself which was published in March 2023 and contained a significant number of recommendations for the health board.

We continue to monitor the implementation of some key pieces of guidance and the Mental Health Act 1983 Code of Practice for Wales (revised 2016) and the Code of practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. The Mental Health Act 1983 Code of Practice for Wales is a key document to ensure patients' rights are promoted and protected. The Code provides a support framework that helps to ensure the delivery of care is evidenced-based and promotes effective care and treatment with the detained person at the centre of the decision-making process.

The SOAD service remains a hybrid model with a mixture of remote and face to face contact with patients who require a second medical opinion under the Act. However, our preference is for patients to be seen face to face but sometimes this is not possible. When a request for a SOAD is made there is still the requirement for health boards and independent providers to send key documentation to us to enable the SOAD to have access to key information in relation to the history and treatment for the patient.

We continue to work with a number of stakeholders for mental health and these stakeholders are listed within section 3 of this report. Following the end of Welsh Government's Together for Mental Health Delivery Plan in 2022, a new mental health strategy is expected from the Welsh Government to be in 2024.

3. Our role in mental health and learning disability care

HIW has a number of key roles within healthcare in Wales which are outlined below:

- we inspect all NHS mental health and learning disability services
- we are the regulator and inspectorate of all independent mental health and learning disability healthcare services
- we work with a number of key stakeholders
- we have a statutory responsibility to monitor the use of the Mental Health Act on behalf of the Welsh Ministers
- we provide a SOAD service
- we monitor parts 2 and 4 of the Mental Health (Wales) Measure 2010
- we monitor the implementation of the Deprivation of Liberty Safeguards (DoLS).

Inspection and regulation

NHS and Independent Healthcare

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 introduced a duty of quality. The Act places an overarching duty of quality on the Welsh Ministers regarding their health-related functions. The purpose of the duty of quality is to ensure that Welsh Ministers and NHS bodies secure improvements in the quality of services they provide. Furthermore, HIW, on behalf of Welsh Ministers, considers the Health and Care Quality Standards when conducting reviews of, and investigation into, the provision of health care by and for NHS bodies under section 70 of the Health and Social Care (Community Health and Standards) Act 2003.

HIW is the registering body for all independent healthcare providers in Wales. We register, inspect, consider intelligence on complaints and concerns and enforce in accordance with the Care Standards Act 2000, the Independent Health Care (Wales) Regulations 2011 and the 25 National Minimum Standards for Independent Health Care Services in Wales.

We made use of a combination of routine unannounced on-site hospital and focused inspections during 2023-24. The findings from these inspections are summarised in section 5 of this report. In addition, a list of the activity we undertook and links to the reports for individual settings is included as Appendix A.

Monitoring use of the Mental Health Act 1983

The Welsh Ministers have a duty to monitor how services discharge their powers and duties in relation to the Mental Health Act (MHA) 1983. This duty is undertaken by HIW on their behalf. We have a number of knowledgeable and experienced MHA reviewers who form part of the on-site inspection team. These reviewers monitor how the health boards and independent providers discharge their duties under the Act. Our MHA reviewers examine detention paperwork to ensure legal compliance and consult with the MHA administrators employed by Health Boards and independent providers, to gain an insight into how the Act is administered and the governance processes in place. We also have a specific role in relation to the investigation of complaints, specifically in regard to legal detention and compliance with the MHA and the associated Code of Practice. During our inspections we routinely review a number of key areas as outlined below:

MHA detention paperwork ensures patients are lawfully detained and well cared for.

The legal status of patients is appropriately recorded on documentation including on individual drug administration records.

Consent to treatment forms are completed in a timely manner.

patients are given respect for their qualities, abilities, and diverse backgrounds as individuals, and that their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds are taken into account.

Section 17 leave documentation contains conditions and outcomes and is routinely utilised when appropriate and to assist patients in their care/rehabilitation pathway.

The MHA Code of Practice for Wales (Revised 2016), that has been prepared and issued under section 118 of the MHA 1983 is being followed.

Detailed plans are made for patients before they are discharged from hospital and consider key area such as relapse indicators.

In general, the findings from our inspections of the processes and application of the MHA were positive, however, we did find a number of areas for improvement. Our findings for the period April 2023 to March 2024 are summarised in section 6 of this report.

Review Service for Mental Health

HIW's Review Service for Mental Health (RSMH) covers a number of key areas of the Mental Health Act including:

The SOAD service for Wales. The SOAD service safeguards the rights of people who, whilst detained under the MHA, have refused prescribed treatment, or have been assessed as unable to consent to the treatment.

A review of treatment under Section 61 of the MHA. When a SOAD has authorised a treatment plan, the doctor responsible for the patient's care and treatment (the Responsible Clinician) must provide a report on the patient's condition and treatment to the RSMH for review.

The RSMH is also notified of all deaths of detained patients receiving treatment within the NHS. We consider the notifications and the details of events that led up to the death of the patient.

A summary of work undertaken by SOADs and the findings from our section 61 reviews between April 2023 and March 2024 is provided in section 7 of this report.

Monitoring the Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 consists of four distinct parts:

Part 1 – Primary mental health support services

Part 2 – Coordination of, and care planning for, secondary mental health service users

Part 3 – Assessment of former users of secondary mental health services

Part 4 – Mental health advocacy.

During our inspections we routinely focus on individual patients' care and treatment plans and the areas as set out within section 18 of the Measure, namely:

- finance and money
- accommodation
- personal care and physical wellbeing
- education and training
- work and occupation
- parenting or caring relationships
- social, cultural or spiritual
- medical and other forms of treatment including psychological interventions ensure it for patients.

We also consider the role of the Care Coordinator and their level of engagement with the patients. Within section 5 of this report, we have detailed our findings on risk assessment and care planning where we consider various aspects of the Measure. We also consider the role and access for patients to advocacy services.

Monitoring use of the Deprivation of Liberty Safeguards

Each year, we jointly publish, with CIW, an annual report on the use of the Deprivation of Liberty Safeguards (DoLS). DoLS is a part of the Mental Capacity Act 2005. The Liberty Protection Safeguards (LPS) was scheduled to replace DoLS in 2024, but this did not happen and there is no revised date for its implementation. DoLS can be used when detention under the Mental Health Act 1983 is not appropriate. The DoLS annual monitoring reports are available on the HIW website.

UK National Preventive Mechanism

HIW is one of 21 designated bodies of the UK's National Preventative Mechanism (NPM) which was established in March 2009 following the UK ratification of the United Nations Optional Protocol to the Convention against Torture (OPCAT) in 2003. Membership of the NPM comprises of organisations from the four nations that make -up the United Kingdom, namely, Wales, England, Scotland and Northern Ireland. The other inspectorate in Wales that is also a member of the NPM is CIW. Other organisations that form the NPM include the Care Quality Commission (CQC), and His Majesty's Inspectorate of Constabulary in Scotland. Other members that HIW undertakes joint work with include, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Prisons (HMI Prisons).

HIW is a designated body of the UK's NPM because of its role in monitoring places where patients may be detained under the Mental Health Act. This role is further explored within section 6 of this report.

The UK's NPM liaises directly with the United Nations Committee Against Torture (CAT) and the Subcommittee on Prevention of Torture (SPT) which is an international body established by OPCAT.

We attend NPM business meetings and HIW's representative is a member of the steering committee.

Youth Justice Services

In January and February 2024, HIW joined His Majesty's Inspectorate of Probation (HMI Probation) on the joint inspection of Conwy & Denbighshire Youth Justice Services (YJS). Key areas identified for improvement were for Betsi Cadwaladr University Health Board (BCUHB). Other inspectorates that participated in the joint inspection include, CIW, Estyn and HMICFRS. HIW's specific remit was to consider the services received by the YJS from a healthcare perspective. Key members of staff employed by the health board were interviewed as part of this process.

The improvements included for BCUHB to provide a designated number of hours of a CAMHS nurse and other CAMHS specialists available to the YJS. Clear delays were identified in young people having access to timely and an appropriate level of CAMHS support. In addition, there was lack of timely access to Speech and Language Therapy (SALT) services and the health board needed to undertake a governance and quality review of the support required for the YJS.

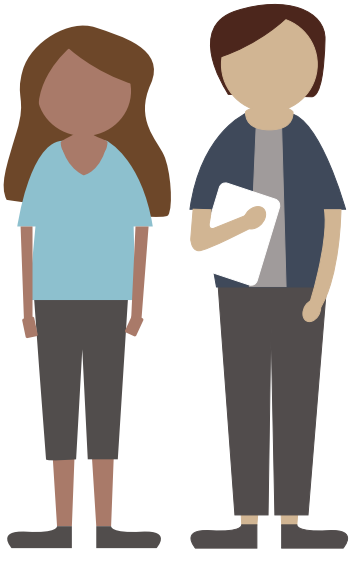
Prison Healthcare

In February 2024, HIW undertook a joint inspection of HMP Cardiff with HMI Prisons and other inspectorates including Estyn. The focus of these visits, from an HIW perspective, is to support the inspection of health services from a Welsh perspective. Generally, health services had improved since the last inspection, with 41% of prisoners telling the inspection team that the quality of the service was now good. In addition, services for prisoners with mental health problems had improved, with better access and a wider range of therapies than at the previous inspection. However, a number of key areas for improvement were identified as outlined below;

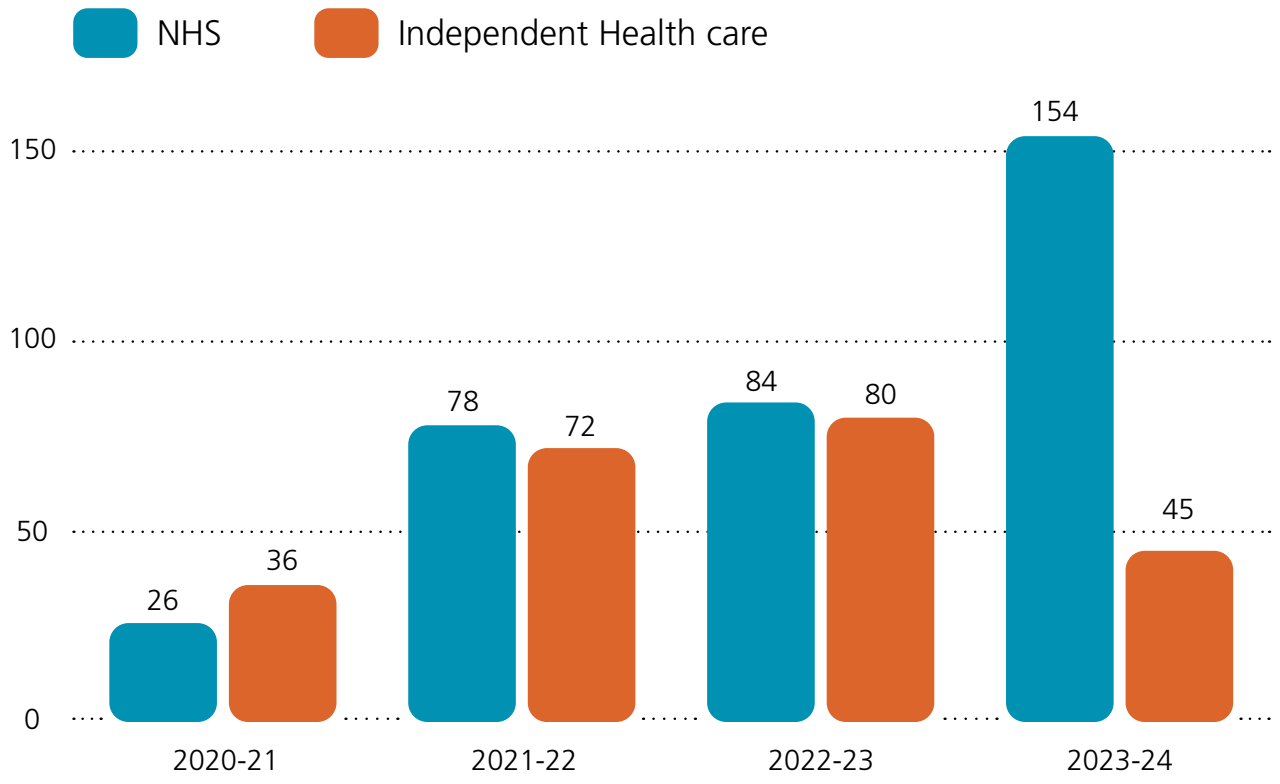
- There was inadequate oversight and planning of care for patients with long term conditions.
- Dental waits for urgent and emergency care were too long.
- Some pharmacy practices were not in line with good practice such as the management and use of stock medicines, secondary dispensing, and the lack of restrictions to drug storage areas.

Dementia Partners National Steering Group.

We continue to attend the Dementia Partners National Steering Group which has direct links to the Welsh Government Dementia Oversight of Implementation and Impact Group (DOIIG). Within this group good practice initiatives are shared and the positive outcome for patients with a dementia and their significant others are identified. The health boards provide regional updates, within the group.



Number of patients contacting HIW with concerns and complaints about mental health care



4. Listening to concerns

During the period 1 April 2023 – 31 March 2024 we received:

614 complaints and concerns about healthcare providers in Wales, this is a reduction of 45

199 of these were about mental health and learning disability healthcare services. This is an increase on the previous year from 164

154 were in relation to NHS mental health and learning disability services and increase of 70

45 were in relation to independent mental health and learning disability services and this represents a decrease of 35.

The table below for 2023/24 shows a breakdown of concerns and complaints by their subject

Subject of Concerns and Complaints	NHS Settings	Independent Healthcare Settings
Access, Admission, Transfer, Discharge (including missing patient)	12	2
Clinical Assessment (Including Diagnosis, scans, tests, assessments)	15	3
Communication	9	2
Complaints Management	5	3
Consent & Confidentiality	5	0
Infrastructure (including staff facilities, environment)	19	11
Medication Management	16	4
Mental Health Act	12	4
Other	9	3
Records Management	13	0
Safeguarding	8	7
Self-harming Behaviour	5	3
Treatment/Procedure	16	2
Whistleblowing	6	5
Total	**150**	**49**

The highest number of concerns and complaints for the NHS was in relation to:

- Infrastructure (including staff facilities and the, environment). This concurs with our inspection findings in section 5 where infrastructure was identified in a considerable number of our on-site inspections.
- Medication management was also a key finding in our inspections and a range of issues were identified and these again can be located within section 5 of this report Treatment was also amongst the top concerns and again we have a considerable number of findings detailed within this report.
- The highest category of concerns and complaints for the Independent Healthcare providers was in relation to Infrastructure (including staff facilities and the environment). This demonstrates that both the NHS and independent providers of healthcare are having similar issues that can impact on patient care.

- Patients complain when there is a poor level of communication about their care and treatment pathway. Whilst it is acknowledged that there were only 11 concerns and complaints in relation to communication, elements of inadequate communication was also a theme in many of the other areas identified above.

Staff concerns

Whistleblowing is different to making a complaint or a grievance. A 'whistleblower' is somebody who makes a 'qualifying disclosure' about a concern at work. HIW is a 'prescribed body' under whistleblowing laws. This means that a whistleblower can make a 'qualifying disclosure' to us and will have certain employment protections under the Employment Rights Act 1996, which was amended by the Public Interest Disclosure Act (PIDA) 1998.

PIDA protects the public interest by providing a remedy for individuals who suffer workplace reprisal for raising a genuine concern, whether it is a concern about patient safety, safeguarding, financial malpractice, danger, illegality, or other wrongdoing.

Additional information in relation to whistleblowing can be found at **www.hiw.org.uk**.

This year we have seen a significant decrease (as outlined below) in the number of whistleblowers raising concerns with HIW compared to previous years It is difficult to explain this trend but maybe one explanation is that the health boards and independent providers have in place more effective whistleblowing procedures that has resulted in whistleblowers not contacting HIW because their whistleblowing concerns have adequately been addressed within the health boards and independent providers.

- 42 in 2020-21
- 15 in relation to NHS services
- 27 in relation to independent services
- 28 in 2021-22
- 10 in relation to NHS services
- 18 in relation to independent services
- 28 in 2022-23
- 18 in relation to NHS services
- 20 in relation to independent services
- 11 in 2023-24
- 6 in relation to NHS services
- 5 in relation to independent services.

Regulation 30 and 31 Notifications

The table below reflects the number of Regulation 30 and 31 notifications received between 1 April 2023 – 31 March 2024.
The registered person of an independent hospital, independent clinic, or independent medical agency is required by Regulations 30 and 31 of the Independent Health Care (Wales) Regulations 2011 to notify us of specific patient safety-related events.

This is required by law and includes:

- Death of a patient.
- Unauthorised absence of a patient who is detained or liable to be detained under the Mental Health Act 1983.
- Serious injury.
- Outbreak of an infectious disease.
- Alleged staff misconduct.
- Any request to a supervisory body, by the registered person, for a standard authorisation of a Deprivation of Liberty.

During the reporting period, we received 821 notifications of incidents that occurred within independent mental health and learning disability healthcare settings. This was 81 less than the notifications received in 2022-23. The classification of the notifications were themed as shown in chart below.

Table of notification type for Regulation 30/31s

Notification Type	Total
Death of a Patient	9
Unauthorised Absence	140
Serious Injury	462
Outbreak of an Infectious Disease	22
Allegation of Staff Misconduct	161
Deprivation of Liberty	27
Total	**821**

There was a decrease in the number of serious injuries reported to us from the previous year, however, there was an increase from 100 to 140 of unauthorised absence notifications, for patients detained under the MHA, when compared to the previous year. We continue to identify an increase in the numbers of patients self-harming and this illustrates the level of complexity and acuity of patients accommodated within the independent sector. The range of issues identified within this report, such as a lack of staff, poor risk management plans and care and treatment plans as well as issues with patient observation may be contributory factors in relation to serious injury. HIW has increased communication with the independent sector around the completion of these notifications and there has been increased engagement from providers.

5. Inspecting mental health and learning disability healthcare services

In 2023-24 we undertook a total of 26 onsite inspections of a range of healthcare settings of both NHS and independent hospitals. The wards inspected accommodated a range of patients that included:

- Adults with mental health issues.
- Older persons.
- Learning Disabilities.
- CAMHS.

Within the total of 26 we visited one CMHT and jointly visited one CLDT with CIW.

During our onsite inspections we:

- Spoke with a number of patients and visitors to ascertain their thoughts on the quality of care and treatment provided.
- Spoke with a range of staff from multi-disciplinary teams to ascertain their thoughts on the effectiveness of their roles and how any challenges were overcome.
- Examined a range of care documentation, including risk assessments and how part 2 of the Mental Health (Wales) Measure 2010 was implemented and reviewed and considered the role of the Care Coordinators and other members of the multi-disciplinary team.
- We also examined a range of other patient documentation including, observational records, any records of restraints, and records of any seclusion undertaken.
- Considered if there was an effective discharge pathway in place and the arrangements put in place to ensure there was a crises management plan considered as part of the discharge process.
- Examined audit findings and governance processes.
- Considered the appropriateness of the environments of care, and ensured that risks had been identified and appropriate action taken to mitigate against those risks.
- Reviewed administration of the Mental Health Act and compliance with the Mental Health Code of Practice for Wales (2016).

A list of the health boards and independent registered providers we inspected is included as Appendix A, along with links to the reports of findings.

Our findings

Within this section our findings are broken down into three specific areas:

Findings specific to mental health, including older and younger persons and the CMHTs.

Findings specific to Learning Disabilities.

Findings specific to CAMHS.

The detailed findings are drawn from our reports following our onsite inspections carried out in 2023-24. Where HIW identifies significant issues we send immediate assurance letters for health boards, and non-compliance notices for the independent providers. These letters or notices are sent within two days of the inspections being undertaken. The health board/ independent provider responds to these with an immediate improvement plan that HIW must agree. We issued a total of seven letters or notices between the period 1 April 2023 and the 31 March 2024. This comprised of three for health boards and four for the independent providers.

Findings specific to mental health, including older and younger persons and the CMHTs

A positive finding in the vast majority of our inspections was the feedback from patients who were complimentary about the care provided and about their interactions with staff. Our staff continue to observe patients being engaged in a positive manner and this is in line with last year's findings. In addition, there were many areas of good practice with the monitoring and implementation of the Mental Health Act (MHA) and these will be further explored within section 6 of this report.

Least restrictive care

This part of the report covers three distinct areas, restraint, seclusion and segregation. During our inspections we were not assured that the least form of restrictive practice was always being utilised and our findings are identified within the sections below.

Use of restraint

The MHA 1983 - Code of Practice for Wales 2016 has a section dedicated to restraint and managing challenging behaviour. Section 26.7 states that "when making decisions about any interventions undertaken during the management of a patient's care and treatment, the principles set out in Chapter 1 of the Code must be taken into consideration. Decisions about interventions should be discussed and agreed with the patient as far as possible. Interventions may include prevention, observation, restraint and/or seclusion".

The guiding principles of the Code are:

- Dignity and respect.
- Least restrictive option and maximising independence.
- Fairness, equality and equity.
- Empowerment and involvement.
- Keeping people safe.
- Effectiveness and efficiency.

Restraint covers a number of key areas including, whether it is physical, chemical, environmental, or mechanical. Any form of restraint should always be a last resort when all other interventions have failed, a risk assessment and a comprehensive care and treatment plan must be in place for all incidents of restraint. Risk assessments must consider all triggers and alternative strategies to a restraint being undertaken.

In terms of mechanical restraint, the Code stipulates that HIW must be consulted if this is being considered. The use of mechanical restraint in hospitals is very rare but in the event it is being considered, our role is to check that this form of restraint has been thoroughly risk assessed and care planned, and that it is the last option available in managing a patients' extreme challenging behaviour, whether that is violence directed at others or self-injury. This form of restraint, as with all restraints, must be regularly reviewed and be in place for the shortest possible period of time.

Any restraints undertaken must follow national guidelines and local policies and procedures and this area is considered within our inspection process. The Welsh Government published **guidance** (October 2022) on a framework for reducing restrictive practices in childcare, education, health and social care settings is a key document that covers the use of physical, chemical, environmental and mechanical restraint.

This guidance is considered within our inspection process.

In six of our inspections, we found issues with restraint, these issues included staff undertaking restraint who were untrained or non-compliant with their mandatory Restrictive Physical Intervention (RPI) training. Staff who have not received training in restraint pose a significant risk to patients and fellow staff and they should not be used in restraint until they have received the necessary training.

In addition, 'Use of Restrictive Physical Intervention' policies had not been reviewed in two of our inspections and were out of date. Also, on two inspections, we found that restraint incidents were not correctly recorded or could not be filtered to produce specific restraint data. Therefore, as a result, accurate restraint data was not available. and posed considerable difficulty for supervisory staff to provide robust governance oversight of restraint incidents. We were not, therefore, assured that patients and staff were being fully protected from harm within these hospitals.

One patient record reviewed contained no descriptive details on what positions the patient and staff were in when utilising a safehold. In addition, there was nothing recorded for post intervention observations after the patient had received intramuscular medication.

Use of seclusion

The MHA1983, Code of Practice for Wales 2016, has a section dedicated to the use of seclusion. Seclusion is described within the Code as "the supervised confinement of a patient in a room which may be locked". It is interesting to note that the Code uses the term "may be locked", implying that it is possible for a patient to be secluded within a room behind a door that is closed but not locked. The Code also sets out timeframes for when continued seclusion should be reviewed, these are, "every two hours by two nurses" and "every four hours by a doctor, or a suitably qualified approved clinician". The Code also states that seclusion is used as a last resort and for the shortest possible time. Policies and procedures must be in place for the use of seclusion and should reflect the National Institute for Health and Care Excellence (NICE) and other guidelines.

In two of our inspections, we identified issues with seclusion including, a patient being secluded in a separate area of the ward. We looked at the arrangements in place to manage this patient and identified a number of concerns:

- The area being used to seclude the patient did not conform to best practice standards or to the health board policy and procedures for the use of seclusion. Notably, a clock was not visible and there was no temperature control outside the area.
- The separate toilet facility being used by the patient had not been adapted for high risk patients.
- We were concerned that the patient was not having access to regular periods of fresh air.
- There was no seclusion care plan in place for the patient which contravened the health board policy.
- We were informed that there were not enough resources available for patients in seclusion to participate in activities.

In another inspection, the policy on seclusion had not been reviewed within the identified timescales and was out of date.

Meaningful and therapeutic activities

Activities play an important part in the treatment process, and during our inspections we routinely review this area to ensure a range of meaningful and therapeutic activities are available. There is an abundance of published research that confirms

the importance of meaningful therapeutic, social and recreational activity and the positive impact this has on patient wellbeing and their recovery pathway.

In many of our inspections we found examples of appropriate and meaningful therapeutic activities available for the patients. However, in six of our inspections we found a range of issues including no evidence of a dedicated therapeutic patient activity programmes on wards, and no dedicated staff available to support and supervise off-ward patient activities. In one inspection we found that the gym equipment and exercise machines in the activities room were cordoned off with signs forbidding their use. Other issues identified included little evidence that the activities on offer were being delivered in the hospital nor recorded prominently within patient records, and a lack of funding for patient occupational activities and equipment. There were also issues with the outside spaces and their utilisation to provide additional therapeutic activities for patients.

We continued to identify issues with section 17 leave under the Mental Health Act, but these will be addressed within section 6, Monitoring the Mental Health Act, of this report.

Medication Management

Again, this year we continued to identify issues with the safe and effective administration, storage and ordering of medication. This area continues to be a recurring theme in the majority of our inspections. Out of 19 hospitals and one CMHT we identified issues with medicines management in 16 hospitals and the one CMHT. This is a reoccurring theme in our inspections and it is increasingly disappointing to note that there has been no improvement on this area since our last annual report. Issues identified covered many different aspects of medicines management with the most significant being:

- The Mental Health Act legal status section of the Medicine Administration Record (MAR) was consistently left blank.
- A lack of Consent to Treatments forms attached to MAR charts and a lack of regular reviews.
- Limited pharmacy input and audit activity undertaken.
- A lack of governance of medicines management.
- Medication trolleys were not locked and secure when not in use.
- Unused medical equipment including wound care equipment and syringes had been removed from their original boxes/containers and placed in plastic baskets that prevented the expiry date of each item being viewed.
- Multiply missing signatures on the MAR charts.
- Out of date controlled drugs in the controlled drugs cabinet.
- Medication policies out of date and a lack of staff access to policies.

The issues listed above are only examples of the issues identified within our visits; many more were identified. The range of findings do not demonstrate effective oversight, audit and governance of medicines management for both health boards and independent providers.

Risk assessment and care planning

Out of 19 hospitals and one CMHT we identified issues in 16 of the 20. A robust risk management process and a clear and accurate care planning process is key to ensure patients' care and treatment needs are identified and any risks identified and a strategy in place to address these risks. In terms of care and treatment plans, HIW has a specific responsibility in monitoring part 2 of

the Mental Health (Wales) Measure 2010. Part 2 of the Measure requires all patients receiving secondary mental health care to have a care and treatment plan in place. Care and treatment plans) should be comprehensive, holistic, and patient focused.

The role of the Care Coordinator is outlined within the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

In chapter 3 of the Code of Practice the responsibilities of the care coordinator is set out for the following areas:

- working collaboratively with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
- ensuring that a care and treatment plan is developed and written;
- ensuring care and treatment plans are reviewed and revised;
- providing advice to service providers on the effective coordination of the care which is delivered;
- keeping in touch with the relevant patient. The are coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

As identified above, care coordinators are key individuals, and their input is central to assisting the patient with their journey through secondary mental health services. This is another area that is assessed within our inspections.

During our inspections we also interview patients and staff to get an understanding of the effectiveness of the care and treatment plans. It was good to note some good practice examples for the care and treatment plans and risk assessments we considered as part of the inspection process. Some examples of good practice identified included, seeing evidence that care plans were person centred with support provided in a structured way to enable patients to achieve individual goals. Care plans were very detailed and personalised, helping to support hospitals in being able to deliver comprehensive care to the patients. In addition, we found examples of well-organised records completed, which were easy to navigate through clearly marked sections. Information was being captured comprehensively within the records and they were appropriately and securely stored. We also found examples of patients being involved in the planning and provision of their own care, as far as possible, and where patients were unable to make decisions for themselves, we saw evidence that relatives were consulted. However, we also identified many areas that required improvement in many of the inspections that we undertook. Issues we identified included:

- We saw an example of a patient who had been admitted for over three weeks but only had a seventy-two-hour pathway plan and that had only been partially completed.
- We were not assured that appropriate arrangements were in place to meet the physical health care needs of patients.
- We were not assured that the care and treatment arrangements in place were in line with the Mental Health (Wales) Measure 2010.
- We did not find evidence within patient records that patients were being supported to meet their individual dietary needs.
- In one of our inspections, we found incorrect information on the current care and treatment plans for two patients.
- Care and treatment plans had not always been signed by the staff member undertaking the review and were not always dated.

- The electronic system (WICCIS) had limited recorded entries for the patient.
- There was no evidence of a Wales Applied Risk Research Network (WARRN) risk assessment being updated to reflect the patient's admission.
- No evidence of current care planning to address the risks and needs of the individual.
- The patients' voice was not always reflected in all of the care and treatment plans viewed. There was also a tendency for plans to be risk and needs focused rather than strengths based.
- A lack of a review of patient care and treatment plans to ensure that all relevant information is included in accordance with guidance and legislation.
- START risk assessments were not fully completed to ensure the safety of patients, staff and visitors and to plan future care.

The issues identified above cover a wide range of patient documentation and risk assessments. HIW is not assured that the risk and care and treatment plans are always effective in mitigating the risks associated with acutely unwell patients who may display challenging behaviour. It is vital that the individual health boards and independent health providers develop effective audits and governance processes to ensure all care and treatment plans and risk assessments are robust and assist in an effective care pathway for all patients.

Environment of care

We routinely undertake a tour of the wards to consider the appropriateness and safety of the areas that patients are accommodated within. We identified issues with the environment of care during seventeen of our nineteen hospital and one CMHT inspections. The issue of ligature risk assessments and availability of ligature cutters will be addressed within the staff and patient safety section below.

A range of other environmental issues were identified including, a lack of maintenance, redecoration and replacement of broken items. In addition, during one inspection, there were insufficient rooms available for Consultant Psychiatrists to hold confidential conversations with patients and in another inspection, there was mould and poor ventilation in shower rooms and toilets on all three wards. In another inspection there was a lack of handrails in the ward area and in bathrooms and in another inspection we were not assured there was an efficient process in place which ensured that outstanding estates issues were being identified, addressed and signed off as complete for the awareness of all staff.

Staff and patient safety

In all of our twenty inspections (nineteen hospitals and one CMHT) we identified a range of patient and staff safety issues. The issues identified covered a wide range of areas and some of the significant findings include:

- We noted throughout the inspection that staff were not wearing personal alarms or radios.
- No policy on the use of personal alarms was in place.
- Patient call bells were not easily accessible.
- We saw environmental examples of potential risks to patient safety as follows: glass damaged and boarded up and the electronic security of the door had been compromised.
- Ligature cutters were not available/easily accessible to all staff.
- Patient adverse reactions and venous thrombosis assessments were not being appropriately completed.

- Some ligature risks had been recommended for anti-ligature work in 2020 but still hadn't been completed.

Privacy and dignity of patients

Within this area we identified a number of issues including no privacy and dignity policy in place and patients could not freely access their bedrooms during the day. Significantly, during one inspection, we observed two instances compromising patient privacy: personal care given with bedroom doors open and a patient's room with a clear glass window and broken blinds. The window overlooked the nursing station of the ward and allowed light into the bedroom even with the blinds closed. This compromised patient privacy and dignity and posed a risk of potentially disturbing the patient.

Workforce

Significant workforce challenges persist across Wales. The picture is very mixed with some health boards and independent providers having more success than others with recruiting and retaining sufficient and well-trained staff. Staff shortages were affecting a range of disciplines including, medical staff, registered nurses, psychologists and occupational therapists. Staff shortages were having a detrimental effect on staff, and during one inspection, we were told that they felt that the current staffing template was not sufficient to support safe and effective care. In another inspection the comments from staff, and the difficulties we observed, raised doubts about whether the current staffing establishments were sufficient to provide safe and effective care to patients at all times.

In spite of extensive workforce challenges we continue to receive positive feedback from patients on staff attitudes and their willingness to assist patients on their care pathway. In addition, we continue to observe many positive interactions by a very busy workforce under pressure.

Workforce issues were identified in fourteen of the twenty inspections across a range of disciplines and some of these are outlined below:

- There were staffing vacancies for a range of disciplines including an activity coordinator. OT support worker, a dedicated consultant psychiatrist, a psychologist and a registered nurse.
- Staff told us that staffing levels had not been reviewed for some time and the environment, they were working in was becoming more challenging and complex. Some staff members felt that in general, their job was detrimental to their health.
- The Speech and Language Therapist (SALT) was completing telephone consultations with patients and had not visited the patients on the ward.
- We were told that staffing resources had not been reviewed to meet this increase in workload resulting from the number of service users diagnosed with ADHD being referred to the team and there was no workload management policy in place to support this.
- Staff told us that there was a lack of administrative support within the team to enable an effective service.

The above findings are only a sample of the range of issues that we identified during our inspection visits. The healthcare sector continues to experience significant challenges in the recruitment and retention of a sufficient number of knowledgeable and trained staff to deliver an effective service for some of the most vulnerable patients in mental health hospitals. It is therefore imperative that health boards and independent providers have a range of strategies to ensure the recruitment and retention of staff.

Governance

The issues identified within this report suggest that governance processes within health boards and independent providers of care are not effective. There also appears to be a lack of shared learning within health boards and independent providers where issues identified in one area are replicated in another hospital within the same health board or independent provider. Robust governance and audit processes are key to identifying, at an early stage, where the delivery of a service needs to improve to meet the needs of the patient group more effectively. In addition, lessons learnt do not appear to be embedded sufficiently to prevent issues reoccurring. Unfortunately, in nineteen out of twenty of our visits, we identified issues in relation to audit and governance, this is very worrying. Some of the areas include,

- A lack of a robust system of governance oversight which ensures that the hospital's medications management processes support patient safety.
- During one inspection we identified a lack of governance oversight and communication between senior staff and ward staff in relation to ward-based systems, audit processes and opportunities for shared learning. Therefore, we were not assured that key issues were being effectively investigated, escalated, supervised and scrutinised to prevent reoccurrence and drive quality improvement.
- In one visit we identified that there was no formal process in place to obtain patient or family carer feedback.
- In another visit we did not see any evidence of changes that had been made as a result of formal patient feedback,
- There was no dedicated formal staff meeting process to engage staff, discuss issues and encourage staff feedback,
- Policies were found to be out of date.
- Record keeping audits were generic health board audits, which were inappropriate for the mental health setting.
- A lack of ongoing senior management scrutiny of the hospital's systems and audit processes to ensure they are completed in a timely and effective manner and drive quality improvement.
- A lack of quality governance and leadership to ensure effective communication between senior management and ward staff.
- In one visit we identified that the registered provider should undertake measures to strengthen its leadership and governance systems and provide additional training to ensure that staff are compliant with administrative hospital procedures.
- The service must standardise systems and processes throughout the hospital in order to share best practice and drive quality improvement.

The above issues were identified within our health boards and independent provider inspections and must be addressed as a matter of priority. Many of the issues above can be easily addressed with strengthened governance processes. In one of the most significant failures of governance, a health board did not ensure that robust processes were in place to correctly record restraint incidents within Datix to support effective investigation, supervision and governance oversight.

Findings specific to Learning Disabilities

During 2023/24 we undertook three inspections of learning disability establishments and one assurance check to a CLDT jointly with CIW. Within these inspections, we noted some positive findings including, patients having access to advocacy services, and we observed staff interacting with patients in a proactive and engaging manner, and staff we spoke with demonstrated a genuine patient focus. Patients were also happy to engage with the inspection team and the views expressed to us were overall supportive of the care they receive.

In all four inspections no immediate assurances actions were requested, however, there were a number of areas for improvement identified.

Patient and staff safety

Patient and staff safety is an important issue and central to any care and treatment delivered. If patients feel safe, they will respond much better to any treatment and will feel empowered to maximise their full potential. If staff feel safe, then they will be better equipped to care and empower patients in their care.

In our CLDT inspection we identified delays in allocating, assessing and authorisation of the Deprivation of Liberty Safeguards (DoLS) applications to both Rhondda Cynon Taf County Borough Council (RCT) and CTMUHB. This delay continues to result in many people being deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. Further work is required to ensure people rights are protected and care and support/treatment arrangements amounting to deprivation of liberty are appropriately authorised. Senior Managers must ensure there is sufficient capacity to meet statutory responsibilities.

In an inpatient hospital we found that the call bells in patient bedrooms were not easily accessible for patients.

Medicine management

The safe and effective administration, storage and ordering of medication is a very important area of focus for our inspections. It was pleasing to note that we only identified issues with the management of medication in one of our four inspections; this being in an independent hospital where the registered manager must ensure that medication stock reconciliation processes are always adhered to.

Training

In terms of training, we identified one issue in the CLDT assurance review in relation to specific training related to the Mental Health Act. The training was not routinely delivered to all health board practitioners. We asked the health board to review and ensure that those practitioners delivering care to people subject to the Mental Health Act receive up to date knowledge of the act and its implications for the people supported. In another of our inspections we identified that the health board continues to utilise the expertise held within the Multidisciplinary Team (MDT) to provide person specific Positive Behavioural Support (PBS) training and supports staff to attend as required.

Care plans and risk assessments

Care plans, in particular PBS plans, are an important component in delivering effective care and ensuring the patient is at the centre of all care and treatment delivered. In addition, any patient risks must be fully described with triggers identified and a range of strategies identified to mitigate against identified risks. We routinely examine care and risk documentation as part of the inspection process. In all four of our visits,

we identified issues with the care documentation including;

- a health board did not have an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board did not ensure that the latest behaviour support plan was available in the active file used by staff.
- We recommended additional information was documented relating to the reason(s) for why a particular intervention was implemented and what was done to justify that intervention as last resort.

Patient information

Patient information should be in a suitable format to assist individuals in making informed choices. In one of our inspections the patient information board was not up to date and therefore did not ensure that patients had access to appropriate information.

Use of seclusion

The Mental Health Act and information position on seclusion is documented earlier in this section of the report. In one of our inspections the documentation relating to the use of seclusion was not completed accurately.

Workforce

Workforce and the recruitment and retention of suitably qualified and experienced staff continues as an issue. In one of our inspections the health board did not ensure that staff were supported in any changes to their roles aligned with the service change from assessment and treatment to that of rehabilitation.

Environment of care

In all three of our visits to in-patient settings we identified issues with the environment of care, environmental improvements were required in relation to the refurbishment, redecoration and repairs on wards and in one of our inspections the health board was required to ensure that the physical environment meets the needs of patients in receipt of rehabilitative care. Other specific environmental issues included heating problems and the lack of the development of a patient kitchen as part of a life skills programme of therapy. Lastly the registered manager needed to ensure that maintenance issues were resolved according to their level of priority and risk.

Governance

A range of governance issues were identified in three of our four visits. These included:

- a health board needing to set up an auditing and review process for care and support records to ensure accuracy and consistency.
- A health board needing to place emphasis on ensuring that issues relating to service change continue to be explored and acted upon in a timely and robust manner.
- The registered provider making sure that all policies are updated and reviewed.
- Health boards must establish and communicate timely and effective processes to ensure people who are supported by the CLDT, do not experience lengthy delays and bureaucracy in accessing medical equipment.

Findings specific to CAMHS

During 2023-24 we inspected two of the three in-patient CAMHS units in Wales. Some positive findings were identified including, the environments of care was generally well maintained internally and care plans were generally of a good standard, but with some areas for improvement required. However, our inspections also identified a range of issues and following one of our inspections an immediate assurance letter was issued in relation to ensuring that the governance of restraints was appropriately reported and investigated including details on:

- triggers and build up to the restraint
- Accurate recording of the length of time of restraint.
- Subsequent analysis and investigation of the restraints to ensure lessons are learnt and that the restraints are analysed to identify any themes and whether the restraint could have been avoided and whether the type of restraint used was appropriate.

Other issues identified included, a number of vacant posts of educator, psychologist and occupational therapist that resulted in young people not having access to the education and therapies that they needed. In addition, we identified a range of issues with medicines management including:

- The medicines management policy was out of date.
- Gaps on the fridge temperature recording sheet in the clinic room.
- The temperature inside the clinic room was very hot and no room temperature checks were being undertaken to ensure that the temperature remained below the advised storage temperatures for the medication in the room.
- Staff we spoke with during the inspection were unclear about what to do in the event of an adverse drug reaction.

Lastly, on one of our visits we saw that a treatment pathway had not been put in place for a young person with a diagnosed condition on admission.

6. Monitoring the Mental Health Act, 1983

HIW monitors how health boards and independent providers discharge their powers and duties under the Mental Health Act (MHA) 1983 and amended in 2007, on behalf of Welsh Ministers. Part of our statutory responsibilities is to provide the public with assurance about the quality, safety, and effectiveness of mental healthcare services in Wales.

Individuals who access mental health and learning disability services do so either as an informal patient, liable to be detained, or as a detained patient. Informal patients receive treatment on a voluntarily basis, detained patients are assessed and/or receive treatment through the provisions set out in the MHA1983.

The MHA is the legal framework that provides authority for the detention and treatment of people who have a mental illness and need protection for their own health or safety, or for the safety of others. The MHA provides a legal framework to protect the rights of patients, and requires that an appropriate level of care, effective treatment, and an environment that promotes recovery is provided.

How the Mental Health Act, 1983 is monitored

HIW is one of several individuals and organisations with powers and responsibilities under the MHA. Other individuals and organisations include, officers and the staff of health boards, social services and independent hospitals, Welsh Ministers, courts, police officers, advocates, and relatives of people who are detained. HIW undertakes a number of inspection visits where we consider how healthcare organisations discharge their powers and responsibilities under The Act. This section of the annual report details how the MHA is being implemented and how the powers granted are being exercised and monitored in Wales. HIW also operates the SOAD service and consider how health boards and independent providers investigate complaints. In some circumstances, where HIW is not satisfied with an investigation, it can undertake its own investigation.

During our inspection visits in 2023-24 we focused on a number of key areas including:

- Are patients lawfully detained and is the detention under the Act the most appropriate.
- Under section 132 are patients informed about their rights, at the point of detention, and then at regular intervals. Is it recorded if patients have understood the detention or not.
- Is there a care and treatment plan in place that considers aftercare of the patient

We consider the detention of patients through a number of methodologies including interviews with patients and members of the multi-disciplinary team. We also use observation and we examine the detention paperwork to ensure patients are lawfully detained. In addition, we consult with the MHA administrators.

Mental Health Act Reviewers

During our inspections we utilise the skills and knowledge of our MHA Reviewers whose purpose is to consider the detention of patients under the MHA. They make a judgement on the application of the MHA and whether it was being lawfully applied and the MHA 1983 Code of Practice was being adhered too. A number of key sections are scrutinised including section 132 which ensures detained patients are informed of their rights at the point of detention and that there is an on-going process of continuing to ensure patients are aware of their right. The reviewers also consider the documentation for section 17 leave and whether any leave takes account of the

patient's wishes and those of carers, relatives, and friends. Leave must also take into consideration any risks to the patient's and others health and safety. Any conditions for the leave are also scrutinised.

Our reviewers also consider access to legal services and advocacy to assist in the protection of the rights of detained patients. In addition, they consider if patients are aware of their rights to apply to the Mental Health Review Tribunal for Wales (MHRT). They also consider hospital managers' duty to refer cases to the MHRT for Wales.

Our Findings

Mental Capacity

A range of good practice was identified and, on many of our inspections, there was evidence that capacity assessments for consenting to treatment were completed upon admission and the mental capacity of each patient had been assessed and clearly documented.

However, on one of our visits, we identified that patient capacity and capacity to consent was not routinely assessed and recorded during the first three months of treatment and proformas were not routinely used in relation to patients that lacked capacity to make specific decisions about aspects of their care and treatment that were outside of the provisions of the act during their stay on the ward. In another of our visits we noted that mental capacity assessments were not fully completed and regularly reviewed and updated

In one case, the capacity to consent to treatment for patients was not regularly assessed using the framework set out in the Mental Capacity Act and guidance set out in the MHA Code of Practice for Wales (13.8) and recorded within their patient records.

Lawful detention/treatment

HIW has a duty to monitor the MHA to ensure that the detention of patients is lawful and there are systems and processes in place to ensure audits and effective governance of the Act. A key component of our inspection process is the review of statutory detention documentation to ensure the patients were legally detained. We found many examples of good practice including the MHA documentation was well organised, easy to navigate and securely stored and MHA administrators demonstrated good governance oversight of patient MHA records to monitor compliance with national guidelines and review upcoming deadlines to ensure patient detentions remained lawful.

However, during one of our visits, we identified that a review of the hospital's use of urgent treatment under Section 62 of the MHA was required, in order to ensure full compliance with the Act and full completion of relevant documentation.

In addition, we also identified in one of our visits that implementation of a robust system of audit and governance oversight in respect of the MHA was required.

In addition, Consent to Treatment forms must be completed and stored with corresponding patient medication records for staff awareness and the statutory certificate of consent forms must always state the correct type and dosage of medication that has been prescribed to patients.

Section 17 (leave)

Section 17 leave is an important part of a patients journey to discharge from their section and back into the community. This process must be carefully managed with clear conditions of leave taking into account any risk factors and balances the needs of the patient with these risks. A number of areas of concern were identified during our inspections including:

- A review of patient s17 leave to ensure leave is personalised and tailored to the needs of individual patients, and that patients, family and carers are involved in the decision-making process in relation to the leave process.
- Insufficient numbers of staff available to ensure patients are able to take their Section 17 leave.
- We saw examples where the patient Section 17 leave forms had been signed but not dated. The 'circulation list' tick boxes within the Section 17 leave forms were not fully completed to indicate who had been provided with a copy of the form.
- Incomplete Section 17 leave forms that did not include the date and details of all recipients, as a matter of good practice.
- We noted the conditions and outcomes of the section 17 leave for some patients could be strengthened to provide more clarity to staff on the expectations of the leave arrangements.
- We found that Section 17 leave arrangements were not in place for all patients to authorise unexpected or emergency leave from the hospital.
- The health board must ensure that when leave is granted for more than 7 days the responsible clinician considers whether the Community Treatment Order (CTO) might be more suitable option in accordance with paragraph 27.8-27.9 of the Code of Practice.

Managers hearings

In terms of managers hearings, we identified two issues during our inspections, one was to ensure Hospital Managers Hearings are held in a timely manner as in one record we reviewed, we noted a delay of five months. Another area was that action must be taken to ensure the routine appraisal of hospital managers in respect of MHA administration.

Ensuring patients' rights

Section 132 and 132A of the MHA places a duty upon hospital manager to ensure detained patients understand how the MHA applies to them and what their rights are. Information must be given to the detained patient both verbally and in writing in accessible formats as a matter of urgency. Accessible formats include, easy read, a language the patient understands, and Braille.

On our inspections there was good evidence that patients were aware of their right and this was well recorded. Only on one of our inspections we did not find evidence that patient rights were re-presented on a regular basis and there was no indication that copies of the documentation had been provided to relevant parties as required.

Statutory consultees

Our SOADs are required to consult two people, called statutory consultees, before issuing any certificates approving treatment. When section 57, 58 or 58A applies, one of the consultees must be a nurse and the other must not be a nurse or a medical doctor. A patient's care coordinator will be particularly well placed to act in the role of a statutory consultee.

In two of our visits we identified that that the views of the statutory consultees were not being routinely captured to support the medical treatment of patients authorised by the SOAD.

Audit and governance arrangements

Throughout our visits we consider the audit and governance arrangements for the monitoring of the MHA by the health boards and independent providers of healthcare. During three of our monitoring visits we identified issues in the audit and governance oversight in respect of the

The findings within this section of the report demonstrate that health boards and independent providers need to ensure a robust audit and governance process is in place.

7. Review Service Mental Health

The Review Service for Mental Health (RSMH) has a number of key functions that this section of the report will consider. The key role of the RSMH is to monitor how services discharged their powers and duties under the Mental Health Act 1983, and the administration of the Second Opinion Appointed Doctor SOAD service. We undertake this work on behalf of Welsh Ministers, to protect the interests of people whose rights were restricted under the Act.

Our RSMH also undertake a review of section 61 and any deaths that occur of detained patients within the NHS. We can also investigate certain types of complaints, and can talk to detained patients, hospital managers and other staff about matters that affect care and treatment of detained individuals.

Second Opinion Appointed Doctor Service

The SOAD is a key service to protect the rights of patients who are detained under the Act and who either do not consent or are assessed as unable to consent to the treatment that has been prescribed for their mental illness.

A SOAD is an independent registered medical practitioner, appointed by HIW, who can approve certain forms of treatment. The role of the SOAD, under parts 4 and 4A of the Act is to provide an additional safeguard to protect individual patient's rights.

Certain treatments require patient consent and a second opinion under section 57 of the Act. Section 57 applies to invasive treatments such as psychosurgery or surgical implements for the purpose of reducing male sex drive.

In addition, detained patients of any age who do not consent, or do not have capacity to consent, to medication (section 58) and electroconvulsive therapy (ECT) (section 58A) prescribed for mental disorder, also require a second opinion. All patients under 18 years of age, including those who are not detained and for whom ECT is proposed, also require a second opinion from a SOAD.

SOADs have a responsibility to ensure that the proposed treatment is appropriate, is in the patient's best interests, and that the patient's views and rights have been taken into consideration. If the SOAD is satisfied, he/she will issue a statutory certificate that provides the legal authority for the treatment to be given.

The SOAD service operates as a Hybrid service. Our methodology is set out in detail in our guidance to all SOADs and provided to all MHA Administrators on our website. In addition, we produce a patient information leaflet, also available on our website, for all patients to understand their rights and the role of the SOAD service.

This year we amended our methodology to fully incorporate and utilise the benefits of hybrid methodology that has been in use since 2021. One of the main changes we have implemented is that whilst all SOAD visits should occur in person for the purposes of interviewing the patient for most cases. However, in specific cases, namely Community Treatment Order (CTO cases), we have opted for a remote first methodology. All patients are to be consulted by their clinical team prior to the submission of requests if they are content for their CTO case to be dealt with on a remote first basis. Patients retain the right in all cases to specifically request an onsite visit from a SOAD. Our forms are being updated to

reflect these changes and will be published in the summer of 2024. In addition, we are refreshing and redrafting our suite of guidance toolkits on all matters relating to the RSMH services, including the SOAD service. We are currently in the process of consulting with external stakeholders on these revisions and intend to publish our refreshed guidance toolkit suite on our website later in the year.

In all cases, the SOAD must and will use their professional opinion and discretion to consider whether they can safely and confidently certify in remote cases, and the method of interviewing the patient should always be recorded as part of their reasoning on their certificate of consent CO forms.

Full advice on our methodology is available on our website and is currently being updated to reflect the changes we have made in 2023-24 this year.

SOAD Recruitment

We have now recruited into the role of a Lead SOAD and plan to recruit to the role of Deputy Lead SOAD in early 2025. We continue to recruit additional SOADs to provide further resilience to the service.

SOAD activity

During the period April 2023 to March 2024, the RSMH received 733 requests for a visit by a SOAD. This figure is an increase from the April 2022 to March 2023 requests.

These figures can be broken down as follows:

- 665 requests related to the certification of medication.
- 44 requests related to the certification of ECT.
- 24 requests related to medication and ECT.

In the table below the number of requests for a SOAD visit appears to have stabilised from the peak of 954 visits in 2019-20.

Requests for visits by a SOAD, 2006-07 to 2023-24[1]

Year	Medication	ECT	Medication & ECT	Total
2006-07	428	106	3	537
2007-08	427	79	5	511
2008-09	545	60	2	607
2009-10	743	57	11	811
2010-11	823	61	17	901
2011-12	880	63	1	944
2012-13	691	59	8	758
2013-14	625	60	5	690
2014-15	739	68	5	812
2015-16	793	60	16	869
2016-17	841	71	2	914
2017-18	830	52	25	907
2018-19	834	51	25	910
2019-20	877	51	26	954
2020-21	693	43	20	756
2021-22	657	66	36	759
2022-23	640	42	12	694
2023-24	665	44	24	733

1 Source: SOAD requests to HIW

Timely SOAD assessment

To ensure patients receive appropriate care and treatment it is very important that the SOAD assessment is completed in a timely manner. Therefore, three key performance indicators, with precise timescales, were developed to ensure the assessment is completed as soon as possible, and within:

- Two working days for a referral in relation to ECT.
- Five working days for referrals about prescribed medication when the patient is in hospital.
- Ten working days when the referral is in relation to someone subject to a Community Treatment Order.

There are a number of reasons when on occasions we do not meet the above timescales including, the availability of the Responsible Clinician or Statutory Consultees to be consulted with by the SOAD. In addition, the requirement for all relevant documentation to be provided to the SOAD in advance of the consultations, has continued to maintain the improved timeliness of the assessment process. However, sometimes delays occur because of the availability of the patient, or it was not clear whether the patient wished to be interviewed or not by the SOAD.

It must be reiterated that our guidance is first and foremost that all patients should be offered interview on a face to face basis, unless the patient indicates they are content or would indeed prefer a remote consultation. There remain difficulties in assessing the preferences of patients and we intend to consult with relevant stakeholders, notably the MHA Administrators for all settings to try and ensure improvements in this process next year.

Review of treatment (Section 61)

Following the authorisation of a treatment plan by an authorised medical practitioner (SOAD) that has been appointed by HIW, a report on the treatment and the patient's condition must be provided by the responsible clinician in charge of the patient's treatment and given to HIW. The designated form is provided to the MHA administrators office for all local health boards and independent settings for the Responsible Clinician to complete. For the eight consecutive year HIW undertook an audit of these forms to ensure that adequate patient safeguards were in place. The treatments are routinely reviewed by our lead SOAD for Wales on a monthly basis. We categorise and identify any compliance issues and use this to identify trends and discrepancies in administration of the Mental Health Act 1983. This process is designed to add an additional layer of patient safety to those being treated under the Act and is in compliance with requirements placed upon HIW as outlined in the Code of Practice (for Wales) revised 2016.

There remain very few instances where discrepancies are identified by the reviewer. Further improvements from our previous report continue in relation to the following areas:

- There continues to be minimal occasions where more medication is listed under the treatment description than is authorised on the CO3[1] form. In these instances, the reviewer highlights the need for a SOAD request to be submitted by the setting and this resulted in several new SOAD certification requests.
- There remain minor discrepancies in relation to complex issues relating to the patient address as listed on the CO forms. This relates to patients mainly who have no fixed abode. HIW has produced guidance to MHA administrator in relation to this subject to minimise these instances.

8. Our Data

To prepare this report we analysed data from our work between April 2022 and March 2023, including our Mental Health Act monitoring activities and inspection of mental healthcare services and services for people with learning disability and autism. We also analysed concerns raised with us by patients, relatives, staff, and members of the public, and statutory notification data submitted by independent providers of mental healthcare and learning disability services.

Feedback on this report

If you have any comments or queries regarding this publication, please contact us

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Appendix A

Relevant work 2022-23

	Hospital	Date	Type
Health Boards			
1	Assessment and Treatment Unit, Swansea Bay University Health Board	17 - 19 April 2023	Inspection
2	Hergest Unit Betsi Cadwaladr University Health Board	15 - 17 May 2023	Inspection
3	Ward F, Neath Port Talbot Hospital, Swansea Bay University Health Board	22 - 24 May 2023	Inspection
4	Ty Llewelyn, Bryn Y Neuadd Hospital, Betsi Cadwaladr University Health Board	3 - 5 July 2023	Inspection
5	Ablett Unit, Glan Clwyd Hospital, Betsi Cadwaladr University Health Board	17 - 19 July 2023	Inspection
6	Cedar Parc Ward, Ysbyty'r Tri Chwm, Aneurin Bevan University Health Board	7 - 9 August 2023	Inspection
7	Tŷ Llidiard Cwm Taf Morgannwg University Health Board	11 - 13 September 2023	Inspection
8	Caswell Clinic, Swansea University Health Board	11 - 13 September 2023	Inspection
9	Canolfan Bro Cerwyn, Withybush Hospital, Hywel Dda University Health Board	16 - 18 October 2023	Inspection
10	Angelton Clinic, Glanrhyd Hospital, Cwm Taf Morgannwg University Health Board	13 - 15 November 2023	Inspection
11	Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board	20 - 22 November 2023	Inspection

Hospital		Date	Type
12	Community Mental Health Team Nant y Glyn Team, Betsi Cadwaladr University Health Board	23 and 24 January 2024	Inspection
13	Talygarn Ward, County Hospital, Aneurin Bevan University Health Board	5 - 7 February 2024	Inspection
14	Care Inspectorate Wales (CIW) & Healthcare Inspectorate Wales (HIW) – Inspection of Rhondda Cynon Taf County Borough Council/ Cwm Taf Morgannwg University Health Board/Swansea Bay University Health Board Community Learning Disability Team (CLDT)	13-15 February 2024	Inspection
Independent Healthcare Providers			
15	Ty Cwm Rhondda	17 - 19 April 2023	Inspection
16	Hillview Hospital	9 and 10 May 2023	Inspection
17	St David's Independent Hospital	19 - 21 June 2023	Inspection
18	Aberbeeg Hospital	10 - 12 July 2023	Inspection
19	Rushcliffe Mental Health Hospital Aberdare	25 - 27 September 2023	Inspection
20	Ty Gwyn Hall Hospital	2 - 4 October 2023	Inspection
21	New Hall Independent Hospital	24 - 26 October 2023	Inspection
22	Tŷ Grosvenor	6 - 8 November 2023	Inspection
23	Heatherwood Court Hospital Llantrisant Road, Pontypridd	4 - 06 December 2023	Inspection
24	Priory Hospital Cardiff	8 - 10 January 2024	Inspection
25	St Peter's Hospital	26 - 28 February 2024	Inspection
26	Coed Du Hall Hospital	25 - 27 March 2024	Inspection

Appendix B: Glossary

Advocacy	Independent help and support with understanding issues and assistance in putting forward one's own views, feelings and ideas. See also independent mental health advocate.
Approved Clinician	A mental health professional approved by the Welsh Ministers (or the Secretary of State) to act as an approved clinician for the purposes of the Act. In practice, Local health boards take these decisions on behalf of the Welsh Ministers. Some decisions under the Act can only be undertaken by people who are approved clinicians. A responsible clinician must be an approved clinician.
Assessment	Examining a patient to establish whether the patient has a mental disorder and, if they do, what treatment and care they need. It is also used to mean examining or interviewing a patient to decide whether an application for detention or guardianship should be made.
Capacity	The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack mental capacity to take a particular decision because they cannot understand, retain or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in Section 2 of the Mental Capacity Act 2005.
Care Standards Act 2000	An Act of Parliament that provides a legislative framework for independent care providers.
CO2 form	Certificate of consent to treatment (Section 58(3) (a)).
CO3 form	Certificate of second opinion (Section 58(3) (b)).
CO7 form	Certificate of appropriateness of treatment to be given to a community patient.
CO8 form	Certificate of consent to treatment for a community patient.

Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto supervised community treatment. They are a mechanism to enable individuals detained in hospital for treatment (under section three of the Act or an equivalent part three power without restrictions) to be discharged from hospital to be cared for and treated more appropriately at home or in a community setting. When an individual is subject to a CTO the discharging hospital has the power to recall the patient to hospital for up to 72 hours, which can be followed by release back into the community, an informal admission or revoking the CTO in place and re-imposing the previous detention.
Compulsory Treatment	Medical treatment for mental disorder given under the Act.
Consent	Agreeing to allow someone else to do something to or for you, particularly consent to treatment.
Deprivation of Liberty	A term used in Article 5 of the European Convention on Human Rights to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
Detained patient	Unless otherwise stated, a patient who is detained in hospital under the Act, or who is liable to be detained in hospital but who is (for any reason) currently out of hospital.
Detention/detained	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment for mental disorder. Sometimes referred to as "sectioning" or "sectioned".
Discharge	Unless otherwise stated, a decision that a patient should no longer be subject to detention, supervised community treatment, guardianship or conditional discharge. Discharge from detention is not the same thing as being discharged from hospital. The patient may already have left hospital or might agree to remain in hospital as an informal patient.
Doctor	A registered medical practitioner.

Electro-Convulsive Therapy (ECT)	A form of medical treatment for mental disorder in which seizures are induced by passing electricity through the brain of an anaesthetised patient; generally used as a treatment for severe depression.
Guardianship	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local social services authority (LSSA) or someone else approved by the LSSA (a private guardian).
HIW	Healthcare Inspectorate Wales is the independent inspectorate and regulator of healthcare in Wales.
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (e.g., an NHS Trust or Health Board). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service is established under the Mental Capacity Act. It is not the same as an ordinary advocacy service or an independent mental health advocacy (IMHA) service.
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act; also, sometimes known as a voluntary patient.
Learning disability	In the Act, a learning disability means a state of arrested or incomplete development of the mind which includes a significant impairment of intelligence and social functioning. It is a form of mental disorder for the purposes of the Act.
Leave of absence (section 17 leave)	Formal permission for a patient who is detained in hospital to be absent from the hospital for a period of time; patients remain under the powers of the Act when they are on leave and can be recalled to hospital, if necessary, in the interests of their health or safety or for the protection of others. Sometimes referred to as 'Section 17 leave'.

Liable to be detained	This term refers to individuals who could lawfully be detained but who, for some reason, are not at the present time.
Ligature	A ligature is an item or items that can be used to cause compression of airways, resulting in asphyxiation and death. A Ligature (Point) Risk Assessment identifies potential ligature points and what actions should be undertaken by the healthcare provider to remove or manage these points for patient safety.
Mental Health Review Tribunal	The Mental Health Review Tribunal (MHRT) for Wales safeguards patients who have had their liberty restricted under the Mental Health Act. The MHRT for Wales review the cases of patients who are detained in hospital or living in the community subject to a conditional discharge, community treatment or guardianship order.
Medical treatment	In the Act this covers a wide range of services. As well as the kind of care and treatment given by doctors, it also includes nursing, psychological therapies, and specialist mental health intervention, rehabilitation, and care.
Medical treatment for mental disorder	Medical treatment, which is for the purpose of alleviating, or preventing a worsening of the mental disorder or one or more its symptoms or manifestations.
Mental Capacity Act 2005	An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives and where the incapacitating condition has been present since birth.
Mental illness	An illness of the mind. It includes common conditions like depression and anxiety and less common conditions like schizophrenia, bipolar disorder, anorexia nervosa and dementia.
Multidisciplinary Team	A Multidisciplinary Team (MDT) is a group of professionals from one or more clinical disciplines who together make decisions about recommended treatments.
Patient	A person who is, or appears to be, suffering from mental disorder. The use of the term is not a recommendation that the term ‘patient’ should be used in practice in preference to other terms such as ‘service user’, ‘client’ or similar. It is simply a reflection of the terminology used in the Act itself.

Prescribed body	The role of a prescribed person or body is to provide workers with a mechanism to make their public interest disclosure to an independent body where the worker does not feel able to disclose directly to their employer and the body might be in a position to take some form of further action on the disclosure.
Public Interest Disclosure Act	The Public Interest Disclosure Act 1998 provides protection to "workers" making disclosures in the public interest and allows such individuals to claim compensation for victimisation following such disclosures. Further protection was afforded by The Enterprise and Regulatory Reform Act 2013 (ERRA) which came into force in July 2013.
Recall (and recalled)	A requirement that a patient who is subject to the Act return to hospital. It can apply to patients who are on leave of absence, who are on supervised community treatment, or who have been given a conditional discharge from hospital.
Regulations	Secondary legislation made under the Act. In most cases, it means the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008.
Revocation	This term is used to describe the rescinding of a CTO when a supervised community treatment patient needs further treatment in hospital. If a patient's CTO is revoked, the patient is detained under the same powers of the Act before the CTO was made.
Responsible Clinician	The approved clinician with overall responsibility for the patient's case.
Restricted patient	A Part 3 patient who, following criminal proceedings, is made subject to a restriction order under Section 41 of the Act, to a limitation direction under Section 45A or to a restriction direction under Section 49. The order or direction will be imposed on an offender where it appears necessary to protect the public from serious harm. One of the effects of the restrictions imposed by these sections is that such patients cannot be given leave of absence or be transferred to another hospital without the consent of the Secretary of State for Justice, and only the Mental Health Review Tribunal for Wales can discharge them without the Secretary of State's agreement.

Second Opinion Appointed Doctor (SOAD)	An independent doctor appointed by the Mental Health Act Commission who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient's consent.
Section 3	Section 3 of the Mental Health Act allows for the detention of a patient for treatment in a hospital and initially for a period of up to 6 months. This can be renewed for a further 6 months and then annually.
Section 12 doctor	See doctor approved under Section 12.
Section 17A	This is a Community Treatment Order.
Section 37	This is a hospital order, which is an alternative to a prison sentence.
Section 41	This is accompanied by a section 37 and only a Crown Court can use a section 37 (41). The patient must have a mental illness that needs treatment in hospital and the patient. Section 41 is a restriction order and is used if a patient is considered a risk to the public.
Section 57 treatment	Section 57 treatments mean psychosurgery or surgical implants to alter male sexual function.
Section 58 & 58A	Section 58 treatments refer to medication for mental disorder and section 58A treatments electroconvulsive therapy for mental disorder. Part 4A of the Act regulates the Section 58 and 58A type treatments of those on community treatment.
Section 61	This provides for reports to be given in relation to treatments given under section 57, 58, 58A or 62B.
Section 132	This provides a responsibility on the hospital managers to take al responsible steps to ensure all detained patients are given information about their rights.
Section 135	Section 135 allows a police officer the powers of entry using a warrant obtained from a Justice of the Peace. This is used to gain access to a person believed to be mentally disordered who is not in a public place and if necessary, remove them to a place of safety.

Section 136	Section 136 of the Act allows for any person to be removed to a place of safety (section 136 suites) if they are found in a public place and appear to be police officer to be suffering from a mental disorder and in immediate need of care and control.
SOAD certificate	A certificate issued by a second opinion appointed doctor (SOAD) approving particular forms of medical treatment for a patient.
Statutory Consultees	A SOAD is required to consult two people (statutory consultees) before issuing certificates approving treatment. One of the statutory consultees must be a nurse and the other must have been professionally concerned with the patient's medical treatment and neither maybe the clinician in charge of the proposed treatment or the responsible clinician.
The Mental Health (Wales) Measure 2010	Legislation that consists of 4 distinct parts: Part 1 – Primary mental health support services. Part 2 – Co-ordination of and care planning for secondary mental health service users. Part 3 – Assessment of former users of secondary mental health services. Part 4 – Mental health advocacy.
Voluntary patient	See informal patient.
Welsh Ministers	Ministers in the Welsh Government.

Teitl adroddiad: ***Report title:***	Mental Health Act (MHA) Associate Hospital Manager Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	08 May 2025			
Crynodeb Gweithredol: ***Executive Summary:***	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. 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. 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.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Because of significant capacity pressures in the MHA Team, some data in this report cannot be produced for this quarter. Subject to capacity being restored to the team, the aim would be to include this in the next report.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report is generated quarterly. The Mental Health Act requires that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	The use of the Mental Health Act sections apply to all persons and all policies in relation to the use of the Mental Health Act have been equality impact assessed.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board 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. Hearings for patients should be conducted as close to the renewal date as possible. If a patient requests a hearing this should be given priority. Risks associated with not conducting a hearing as close as possible to the relevant date, would be:

	• Transfers impacting on hearings with the potential for a hearing to be missed or rearranged. • The Associate Hospital Managers Discharge Panel may not agree with the professionals and feel that patient should be discharged any delay in the hearing may result in the patient being detained for longer than necessary.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed by Matthew Joyes, Deputy Director for Legal Services. Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** N/A	
Rhestr o Atodiadau: **List of Appendices:** AHM Report	

1 Hearings

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

31 hearings were held during the months January-March 2025 (up from 26 in the previous quarter).

9 held face to face and 22 via Teams. The hearings consisted of twenty one section 3 renewals, six Community Treatment Orders (CTO) renewals, three section 47 renewals, and one Section 2 Appeal.

There have been no discharges to date for this period.

A breakdown of the hearing activity is below:

January

- **10 hearings arranged (eight held); one held face to face and seven via Microsoft Teams.**
  Seven hearings were in relation to renewals and one appeal.

  Two of the ten hearings were postponed
  - One was postponed due to the patient being unwell.
  - One was postponed due to the patient being regraded to informal by the Responsible Clinician.

  Outcomes of hearings held
  - All detentions were upheld.

February

- **20 hearings arranged (seventeen held); four held face to face and thirteen via Microsoft Teams.**
  All hearings were in relation to patient renewals.

  Two of the hearings were adjourned
  - Unsure as to why due to not recorded from East MHA Office

  One hearing was postponed
  - Due to having no Legal Representation.

  Outcomes of hearings held
  - All detentions were upheld

March

- **8 hearings arranged (Six held); Four held face to face and two held via Microsoft Teams.**
  All six hearings were relating to renewals.

One hearing was cancelled
The patients HO15 was not lawful due to the same professionals completing the form, it should have been a different professional alongside the Responsible Clinician.

One hearing was moved to a later date
- The patient decided at a later date to want Legal Representation, a later date had to be arranged to facilitate availability.

Outcomes of hearings held
- All detentions were upheld

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

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

Hearing Quality Standard

Following a renewal, there is no timeframe specified within the Mental Health Act of when a hearing is to be held, only the confirmation that one 'must' be held. Good practice suggests this should be undertaken as close to a renewal date as possible. The internal 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 internal quality standard is set at a week (the same as a Mental Health Review Tribunal).

Currently 71.3% of hearings were held within the set quality standard (up from 69.5% in the previous quarter).

Renewal Date	**Hearing Date**	**Quality Standard (6 weeks = 42 days)**	
03/01/2025	09/01/2025	6	
16/11/2024	10/01/2025	55	*1
17/01/2025	13/01/2025	0	
06/01/2025	20/01/2025	14	
16/11/2024	23/01/2025	68	*2
14/12/2024	23/01/2025	40	*3
10/01/2025	31/01/2025	21	
05/01/2025	03/02/2025	29	
11/10/2024	04/02/2025	116	*6
03/10/2024	06/02/2025	126	*3
13/12/2024	10/02/2025	59	*3
10/01/2025	10/02/2025	31	
09/01/2025	11/02/2025	33	
11/01/2025	13/02/2025	33	
25/12/2024	18/02/2025	55	*4

24/01/2025	18/02/2025	25
24/01/2025	20/02/2025	27
12/01/2025	21/02/2025	40
26/01/2025	24/02/2025	29
25/01/2025	25/02/2025	31
03/12/2024	26/02/2025	85 *7
15/02/2025	27/02/2025	12
24/01/2025	28/02/2025	35
20/01/2025	28/02/2025	39
28/02/2025	11/03/2025	11
12/12/2024	13/03/2025	91 *4
14/02/2025	13/03/2025	27
28/02/2025	14/03/2025	14
01/03/2025	18/03/2025	18
26/02/2025	20/03/2025	22
Appeal By Patient	**Hearing Date and Section**	**Quality Standard (7 days for a Section 2)**
13/01/2025	20/01/2025 S2	7

***1** This hearing was scheduled 13/12/2024 but was postponed due to Responsible Clinician on sick leave.
***2** Delay due to lack of Responsible Clinician availability.
***3** Delay due to lack of staff covering the East MHA office
***4** Delay due to lack of staff covering the West MHA office.
***5** Delay due to lack of staff covering the Central MHA office.
***6** The patient's section was renewed whilst inpatient at Heddfan unit (East). However, the hearing was not held prior to the patient's transfer to the Ablett (Central), resulting in a delay. The hearing was then organised with the new clinical team.
***7** This hearing was rescheduled in order for the Legal Representative to confer with the patient.

Teitl adroddiad: ***Report title:***	Power of Discharge Group Chair's Assurance Report			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	08 May 2025			
Crynodeb Gweithredol: ***Executive Summary:***	The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director for Legal Services.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services (Chair of the PoD Group)			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
N/A				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report is generated quarterly. The Mental Health Act (MHA) and MHA Code of Practice for Wales (CoPW) requires that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated			

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

Chair's Report

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

Purpose of the group	Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'. In Wales, NHS hospitals are managed by Local Health Boards. The Local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'. Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4) In practice, most of the decisions the Hospital Managers take, are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5) In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels, 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) 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.

Summary of business conducted	The most recent Power of Discharge Group meeting was held on 29 April 2025. A summary of the business is as follows: • The group reviewed the MHA Assurance Report. • The group reviewed the Associate Hospital Managers Update Report. • The group reviewed the HIW Assurance Report - discussion took place on the recommendation for photographs on MAR charts and Section 17 leave forms. Concerns raised about the statutory requirement and practicality of this recommendation. • The group received an update on progress of the new Mental Health Bill. • The group noted the continued staffing pressures within the MHA Team. • Discussion took place on the time period for report delivery prior to panels: confirmed the aim was for submissions a week before hearings and the Chair's retain discretion to postpone if there is insufficient time to review all papers.

Teitl adroddiad: ***Report title:***	CAMHS Legal Case Study			
Adrodd i: ***Report to:***	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	08 May 2025			
Crynodeb Gweithredol: ***Executive Summary:***	This short paper provides an overview of a CAMHS legal case.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Allied Health Professionals and Health Science Pam Wenger, Director of Corporate Governance			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director for Legal Services			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/ tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
N/A				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Objective 4 - Improving quality, outcomes and experience Objective 5 - Establishing an effective environment for learning			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This short paper provides an overview of a CAMHS legal case.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

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

CAMHS Legal Case Study

Re SB [2024] EWHC 2964 (Fam)

Factual background

This was a case in the Family Division of the High Court of Justice in a matter relating to inherent jurisdiction.

The case concerned a 15-year-old girl (SB). Care proceedings had been brought by the Local Authority and two days later, the Local Authority applied for a deprivation of liberty (DoL) order due to the extremely challenging behaviour that SB was exhibiting, which often involved weapons or assault on the police and professionals.

SB was eventually placed in the Health Board's General Adolescent Unit (GAU) subject to a DoL.

The Health Board was responsible for her care during her admission to the GAU. SB had been subject to 6 assessments in the past four months as to whether she met the statutory conditions to be detained to a psychiatric unit under section 3 of the Mental Health Act 1983. All of the assessment concluded that that she was not detainable and that it would not be in her best interests to be detained in hospital.

As part of the care proceedings, the Local Authority instructed an independent consultant psychiatrist to prepare a report. The conclusions of this psychiatrist were that having considered the possible options, an outcome under the Mental Health Act was the best option and that SB satisfied the section 3 criteria.

Legal Principles

The issue arose between the Local Authority and Health Board as to which statutory body was responsible for the care and treatment of SB and under what legal framework she should/could be detained. As such, the Local Authority sought declarations and ancillary orders at the High Court on the basis that because SB was detainable under the Mental Health Act 1983, the court did not have jurisdiction to grant a DoL under the inherent jurisdiction.

The Health Board opposed the Local Authority on the following grounds:

- The court did not have jurisdiction to determine whether SB was detainable in a hospital under the MHA 1983.
- The court had no jurisdiction to exercise a reviewing or supervisory role of the decisions made by clinicians under the MHA 1983.

- That the court making a finding as to whether SB was detainable under the MHA 1983 put pressure on the Health Board to change its position or otherwise was an abuse of process.

Section 3 of the 1983 Act sets out the following criteria for detention in hospital under section 3:

1. *A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as "an application for admission for treatment") made in accordance with this section.*
2. *An application for admission for treatment may be made in respect of a patient on the grounds that—*
    a. *he is suffering from [F1mental disorder] of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*
    b. *. . . . . .*
    c. *it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and*
    d. *appropriate medical treatment is available for him.*
3. *An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—*
    a. *such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and (d) of that subsection; and*
    b. *a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether other methods of dealing with the patient are available and, if so, why they are not appropriate.*

An application may only be made by an Approved Mental Health Professional or a nearest relative.

The court was also referred to the case of *A v Liverpool City Council* [1982] AC 363:

'The High Court cannot exercise its powers, however wide they may be, so as to intervene on the merits in an area of concern entrusted by Parliament to another public authority.'

It was held on this basis that it is not open to the Court in this matter to intervene in the decision under section 3 of the 1983 act as the statute confers the power to registered medical practitioners alone.

The court was also referred by the Local Authority to the observations of MacDonald J in respect of the Supreme Court decision in *Re T* (A Child) [2021] UKSC 35 in the case of *MBC v AM and Others (DoL Orders for Children under 16)* [2021] EWHC 2472 (Fam) where he said at paragraph 69 and 70:

"69. In Re T the Supreme Court restated the seminal importance of the inherent jurisdiction of the High Court in respect to children. In particular, the Court emphasised its protective nature. As Lady Arden pointed out at [192]:

"The inherent jurisdiction plays an essential role in meeting the need as a matter of public policy for children to be properly safeguarded. As this case demonstrates, it provides an important means of securing children's interests when other solutions are not available".

As noted above, Lady Black further highlighted the need for the protective jurisdiction to be deployed in a manner that anticipates and prevents harm, rather than seeking to repair harm already suffered.

Within this context, the Supreme Court further reiterated that, particularly in the context of the protective purpose of the inherent jurisdiction in relation to children, the Courts should be slow to hold that an inherent power had been abrogated or restricted by Parliament and should only do so when it is clear that Parliament so intended".

The Decision

The Local Authority decided not to pursue its application following an indication from the court.

Nonetheless the court held that it has no role to supervise or review decisions that have been entrusted to another public authority by parliament.

Schedule 1a of the Mental Capacity Act 2005 dictates that a person is ineligible for a deprivation of liberty where they are detained under the MHA 1983 provisions.

Therefore, the court held that it has no jurisdiction to make findings or orders regarding whether SB was detainable under s3 of the 1983 act.

Even if those findings were made, it would not of itself lead to SB being detained under the MHA 1983. To make such orders would be an abuse of process.

Applications refused and the court continued to authorise SB's DoL under the inherent jurisdiction.

This briefing is taken from the public record of the Court hearing, available at:

SB, Re [2024] EWHC 2964 (Fam) (19 November 2024)

Mental Health Legislation Committee – Annual Cycle of Committee Business

(1st April 2024 to the 31st March 2025)

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

The role of the Committee is set out in the Health Board's standing orders and the Terms of Reference, both of which are available here:

The **Quality Safety and Experience Committee** meets bi-monthly

Committee Chair:	**Members**	**In Attendance**	**Preliminary matters to be included on agenda:**
• Gareth Williams **Committee Vice Chair**	Dyfed Jones Rhian Watcyn Jones	• 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) • Imran Devji (Interim Chief Operating Officer) • Alberto Salmoiraghi (Medical Director for Mental Health and Learning Disabilities) • Iain Wilkie (Medical Director for Mental Health and Learning Disabilities) • Matt Joyes (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)	Welcome & Apologies Declarations of Interest Unconfirmed minutes of meeting held on xxxx Matters Arising & Action Log

AGENDA ITEM	MAY (Q1)	AUGUST (Q1)	NOVEMBER (Q3)	FEBRUARY (Q4)
PRELIMINARY MATTERS				
ROUTINE REPORTING FOR ASSURANCE				
Mental Health Act Assurance Report				
Mental Capacity Assurance Report				
HIW Assurance Report				
Associate Hospital Managers Update Report				
Report from the Power of Discharge Group (Associate Managers)				
ANNUAL REPORTING				
Committee Annual Report to Board				
FOR INFORMATION				
Review Committee Workplan				
Review Committee Cycle of Business				
CLOSING BUSINESS				
Agree Items for Referral to Board / Other Committees				
Meeting Effectiveness				
Date of the Next Meeting				
Resolution to Exclude the Press and Public				

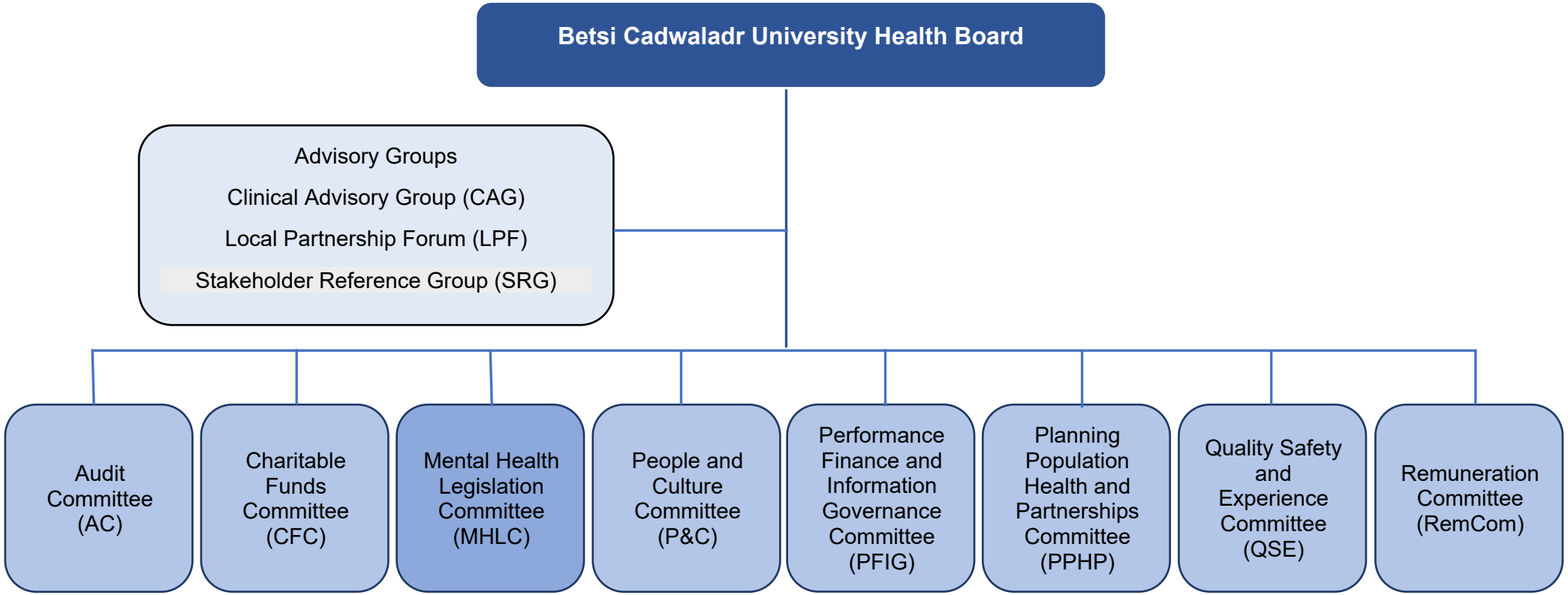
Note 1

MENTAL HEALTH LEGISLATION COMMITTEE

Terms of Reference & Operating Arrangements

(Schedule 3.5 of the Standing Orders)

Date approved by Health Board :



Version Control

Version	Issued to	Date	Comments
V0.01			

TERMS OF REFERENCE

1 INTRODUCTION

1.1 The Betsi Cadwaladr University Health Board (BCUHB) Standing Orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Board either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees

1.2 In accordance with Standing Orders (and the BCUHB scheme of delegation), the Board shall nominate annually a committee to be known as the Mental Health Legislation Committee. The detailed terms of reference and operating arrangements set by the Board in respect of this committee are set in this document.

1.3 Due to the nature of the business being considered at the RC these meetings will be held in private and papers/minutes will not be made publically available. A summary highlight report will be received at the Public Board meeting that follows.

2 PURPOSE

The 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 DELEGATED POWERS

With regard to its role in acting on behalf of the Board, and in providing advice and assurance to the Board, the Mental Health Legislation Committee will comment specifically upon:

3.1 The Committee shall provide advice, assurance and support to the Board in ensuring the provision of high quality, safe healthcare for its citizens of all ages, as follows:

3.2 Review reports in relation to the two Acts from Healthcare Inspectorate Wales visits, NHS Wales

Executive and other external scrutiny bodies and approve the action plans for monitoring.

3.3 Consider issues arising from related Committees or Health Board Groups.

3.4 Receive Mental Health Legislation Assurance Reports to ensure compliance with the Codes of Practice. In respect of its provision of assurance to the Board, the Mental Health Legislation Committee will seek assurances that:

3.5 The operation of mental health legislation is exercised fairly and lawfully and that specific issues related to compliance are managed through its Committee and Group structures.

3.6 The powers provided by the Mental Health Act 1983 (notably the Board's delegated functions as Hospital Managers) are being exercised reasonably, fairly and lawfully and that specific issues related to compliance are managed through the Board's Committee and Group structure.

3.7 The powers provided by the Mental Capacity Act 2005 (notably in regard to the Deprivation of Liberty) are being exercised reasonably, fairly and lawfully and that decisions by the Court of Protection are implemented appropriately.

3.8 Identified matters of risk relating to compliance with mental health legislation are being appropriately mitigated.

3.9 Ensure that Associate Hospital Managers are being appointed, trained and appraised effectively to ensure the proper discharge of their duties and that there is appropriate access to mental health advocates; and draw on the experience of both Associate Hospital Managers and mental health advocates to receive assurance on the quality of care provided to patients.

3.10 Ensure policies and procedures are in place to facilitate compliance with the Mental Health Act 1983 and the Mental Capacity Act 2005.

3.11 Ensure that those staff who exercise the functions of mental health legislation have access to, and undertake, appropriate training to provide them with the requisite skills and competencies to discharge the Board's responsibilities.

3.12 Ensure adherence to the relevant legislation, in particular, the Human Rights Act 1998, the Equality Act 2010, and the Data Protection Act 1998.

3.13 Assure the Board in relation to its compliance with relevant national practice, mandatory guidance, healthcare standards and duties, including Duty of Quality, Duty of Candour, Quality Standards and Quality Management ensuring the Board is supported to make strategic decisions from a quality perspective.

4 AUTHORITY

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

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

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

5 SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to perform specific aspects of Committee business.

6 MEMBERSHIP

6.1 Formal membership of the Committee shall comprise of the following:

MEMBERS
Independent Member (Chair)
2 x Independent Members (one of whom will be designated as Vice Chair)

6.2 The following should attend Committee meetings:

IN ATTENDANCE
Executive Director with responsibility for Mental Health and Learning Disabilities (Executive Lead)
Executive Director of Nursing and Midwifery
Executive Medical Director
Medical Director for Mental Health and Learning Disabilities
At least one of the Medical Directors of the Integrated Health Communities
Chief Operating Officer
Deputy Director for Legal Services
Senior Manager for Mental Health Act
Senior Manager for Mental Capacity Act
At least one Director of Operations from the Integrated Health Communities
Head of Safeguarding
Other Attendees
The Chair can if required, invite Hospital Managers to attend Committee
The Chair can if required, invite representatives of partner agencies to attend Committees.

6.3

6.3 The attendance of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair, taking into account the balance of skills and expertise necessary to deliver the Committee's remit, and subject to any specific requirements or directions made by the Welsh Government.

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

5. COMMITTEE MEETINGS

5.1 Quorum

- A quorum shall consist of no less than two of the membership, and must include as a minimum the Chair or Vice Chair of the Committee.

5.2 Frequency of meetings

- The Committee will meet quarterly and an annual schedule of meetings will be determined by the corporate calendar.

- Any additional meetings will be arranged under exceptional circumstance and shall be determined by the Chair of the Committee in discussion with the Executive Lead.

5.2 Withdrawal of individuals in attendance

- The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5.3 Meeting arrangements

- The agenda and papers will be distributed/published seven days in advance of the meeting.

- The Director of Corporate Governance is to hold an agenda setting meeting with the Chair and/or Vice Chair and the Executive Director of Allied Health Professionals and health Science at least six weeks before the meeting date.

- The agenda will be based on the Committee work plan, identified risks, matters arising from previous meetings, issues emerging throughout the year, and requests from Committee members.

6. REPORTING AND ASSURANCE ARRANGEMENTS

The Committee, through its Chair and members, shall work closely with the other Committees to provide advice and assurance to the Board through joint planning and co-ordination of Board and Committee business including sharing information.

6.1 The Committee Chair, supported by the Committee Secretary, shall:
- Report formally, regularly and on a timely basis to the Board on the Committee's activities;
- Bring to the Board's specific attention any significant matter under consideration by the Committee; and
- Ensure appropriate escalation arrangements are in place to alert the Health Board's Chair, Chief Executive and/or Chairs of other relevant Committee, of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

6.2 The Committee will undertake an annual review on the effectiveness of its arrangements and responsibilities. The Director of Corporate Governance will oversee this review.

7. RELATIONSHIP WITH THE BOARD AND ITS COMMITTEES/GROUPS

Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for these matters.

7.1 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference.

7,2 The Committee, through its Chair and members, shall work closely with the Board's other committees, including joint (sub) committees and groups to provide advice and assurance to the Board through the:

~ Joint planning and co-ordination of Board and Committee business and
~ Sharing of information

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

7,3 The Committee will consider the assurance provided through the work of the Board's other committees and sub groups to meet its responsibilities for advising the Board on the adequacy of the Health Board's overall system of assurance.

7.4 The Committee shall embed the Health Board's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

9. REVIEW

These Terms of Reference and operating arrangements shall be reviewed on at least an annual basis by the Committee for approval by the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board – after first consulting with **all** Members of the Committee. The Secretariat must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

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