

Bundle Mental Health Legislation Committee 1 August 2024

- 1 PRELIMINARY MATTERS
 - 1.1 MH24.16 – Welcome and Apologies – Verbal – Chair
 - 1.2 MH24.17 – Declarations of Interest relating the the agenda – Verbal – Chair
 - 1.3 MH24.18 – Unconfirmed Minutes of the Mental Health Legislation Committee 2 May 2024 – Attached – Chair
 - MH24.18 – Unconfirmed Minutes of the Mental Health Legislation Committee 2 May 2024
 - 1.4 MH24.19 – Matters Arising & Table of Actions – Attached – Chair
 - Public Session – MHLC Committee – Action Log
- 2 FOR ASSURANCE
 - 2.1 MH24.20 – Mental Health Act Assurance Report – Attached – Deputy Director Of Quality
 - MH24.20 – Mental Health Act Assurance Report – Cover Paper – August 2024
 - MH24.20a – Mental Health Act Assurance ReportAppendix 1 Assurance Report – August 2024
 - MH24.20b – Mental Health Act Assurance Report– Appendix 2 S136 Gender Report – August 2024
 - MH24.20c – Mental Health Act Assurance Report– Appendix 3 Audit Report – August 2024
 - 2.2 MH24.21 – Mental Capacity Assurance Report – Attached – Director of Safeguarding and Public Protection
 - MH24.21 – Mental Capacity Assurance Report and Action Plan V1.00 Q1 2024–25
 - 2.3 MH24.22 – HIW Assurance Report – Attached – Deputy Director Of Quality
 - MH24.22 – HIW Assurance Report – August 2024
 - 2.4 MH24.23 – Associate Hospital Managers Update Report
 - MH24.23 – Associate Hospital Managers Update Report – August 2024
 - 2.5 MH24.24 – Report from the Power of Discharge (Associate Managers) Group
 - MH24.24 – Report from the Power of Discharge (Associate Managers) Group – August 2024
- 3 CLOSING BUSINESS
 - 3.1 MH24.25 – Agree Items for referral to Board / other Committees – Verbal – Chair
 - 3.2 MH24.26 – Agree items for Chairs Assurance Report – Verbal – Chair
 - 3.3 MH24.27 – Review of Meeting Effectiveness – Verbal – Chair
 - 3.4 MH24.31 – Date of Next Meeting – 7 November 2024

Mental Health Legislation Committee (MHLC)

Unconfirmed Minutes of the Mental Health Legislation Committee meeting
held on 2nd May 2024
Via Teams / Boardroom, Carlton Court

Committee Members Present	
Name	Title
Gareth Williams	Health Board Vice Chair (Chair)
Dyfed Jones	Independent Member
Rhian Watcyn Jones	Independent Member
In Attendance:	
Emma J Hosking (EJH)	IHC Medical Director (East)
Matthew Joyes (MJ)	Deputy Director of Quality
Hayley Lloyd (HL)	Regional Manager, Safeguarding
Chris Lynes (CL)	Area Nurse Director (West), Representing Angela Wood
Ceri McGaugie (CM)	Senior Secretary
Teresa Owen (TO)	Executive Director of Public Health
Philippa Peake-Jones (PPJ)	Head of Corporate Affairs
Mat Phillips (MP)	Regional Safeguarding Specialist
Alberto Saimoiraghi (AS)	Consultant Psychiatrist/Medical Director, Mental Health and Learning Disabilities
Pam Wenger (PW)	Director of Corporate Governance
Iain Wilkie (IW)	Interim Director, Mental Health & Learning Disabilities

Agenda item	Action
MH24.5 – Apologies	
MH24.5.1 The Chair welcomed everyone to the meeting and thanked all in attendance. It was noted that the meeting was being recorded.	
MH24.5.1 Apologies were received from Angela Wood, Nick Lyons, Carol Shillabeer.	
MH24.6 - Declarations of Interest	
There were no declarations of interest made in respect of items on the agenda	

<p>MH24.7 - Minutes from the Previous Meeting</p> <p>MH24.7.1 GW asked if there were any issues of accuracy. It was noted that Louise Bell's title needed to be corrected. PPJ noted that due to the changes in the Terms of Reference some regular attendees had not received a timely invitation. GW noted that representatives of the Associate Hospital Managers should have a standing invitation and that new nominations from the group would be invited moving forward.</p> <p>MH24.7.2 The draft minutes of meeting held on 11 January 2024 were approved.</p>	PPJ
<p>MH24.8 - Matters Arising & Table of Actions</p> <p>MH24.8.1 The updates provided within the action log were agreed.</p>	
<p>MH24.9 - Mental Health Assurance Report</p> <p>MH24.9.1 MJ introduced the paper noting that it had been produced by Wendy Lappin and her team.</p> <p>MH24.9.2 MJ highlighted key points particularly around rectifiable errors, noting these were from typographical errors, for example, inputting the incorrect hospital. The Committee noted that the report was sent to AS and his Team monthly and cascaded through the organisation, giving the Committee some assurance of learning. Currently there were no fundamental errors, but there continued to be minor ones mostly as a result of the paper based system.</p> <p>MH24.9.3 Appendix 5 provided some information around training and e-learning awareness: the paper captured feedback and gave assurance as to how any issues were managed as they arise.</p> <p>MH24.9.4 The Committee discussed the data, noting that the percentages could be somewhat misleading given what were often very low absolute numbers. The sample inspected would be clarified on each page going forwards. No significant issues were raised other than areas where improvement was needed and it was noted that these were within smaller units. The Committee noted that all Audit reports were shared with other services for reflection and sharing of learning, there were no significant issues reported.</p> <p>MH24.9.5 The Committee noted that the Health Board was fully compliant, although there was currently a lack of consistent data on the use of Section 136 Suites across Wales. It was expected that the NHS Executive would be collating this data in future. The Committee noted ongoing work between the police and the team and the importance of reducing the use of the Suites in cases which proved not to merit admission or further support from the Division, noting that there was a lot of medical hours and other resources committed to each person brought to the 136 suites. It was agreed that this would be discussed at a future meeting and the police invited to attend to share their experience around Right Care Right Place.</p>	IW

MH24.9.6 In relation to Section 12 (2) Doctors, the Committee were advised that it was difficult to employ them as doctors needed to have a number of years in psychiatry and be approved by the Secretary of State in order for them to undertake Sections 2 and 3. Funding has been received for social work with work ongoing on piloting a phone app in North Wales with the list of Section 12 (2) Doctors. AS noted not all wish to be part of the list although the app does allow for those listed to be clear about when they are and are not available.

MH24.9.6 A further discussion took place around Right Care Right Place with IW noting that a Crisis Care Concordat commenced in January 2024 and that the Together 4 Mental Health Partnership received updates on this work as well. IW advised that he was happy to present a paper on this. DJ noted the comprehensive report and supported moves to reduce out of area placements. A discussion took place around the quality of care for patients placed out of area, with AS noting that in terms of legal responsibility, once a patient was placed out of area legal responsibility for ensuring the requirements of the Act were respected rested with the care provider: similarly, where a patient from out of area was admitted to BCUHB facilities, legal responsibility for compliance rested with BCUHB. The matter of repatriation was highlighted noting that the Health Board was responsible for seeking repatriation of its patients wherever possible: this was however, complex, with the pressure on community services impacting on the capacity to discharge from acute care, but this was something being seen across the whole of the Country

MH24.9.7 TO spoke about crisis care and 136 Suites and the importance of ensuring the quality of such care was kept under review by the QSE Committee.

MH24.9.8 Clarification around Hospital Managers titles and responsibilities were discussed. RWJ thanked MJ for the briefing at the Development Session, highlighting the discussion about how much work was involved in ensuring compliance. It was noted that the Health Board was meeting statutory obligations and that there was a clear picture of learning and measuring impact and trends, but that the work was onerous, not least because so much of it was necessarily paper based given the lack of acceptance of electronic signatures.. GW agreed, noting that it had long been recognised that a significant overhaul of the legislation was required.

MH24.9.9 It was noted that the requirement for 'wet signatures' was laid down in Statute and could not be waived by the Health Board. AS also confirmed that patients had to be seen face to face as a matter of human rights: the courts had ruled that virtual interviews (i.e. by Teams or Zoom) were not acceptable AS did however believe that the system was working well: there was no unnecessary deprivation of human rights and appeals processes were fully operational.

MH24.9.10 A discussion took place around the need for patients to be able to communicate in their primary language. TO agreed to look into examples of this happening to share with the Committee.

MH24.9.11 To conclude GW agreed that the report was good noting that it was work in progress and the content was really valuable.

IW

TO

<p>MH24.10 - Mental Capacity Assurance Report</p> <p>MH24.10.1 MP presented the report to the Committee, advising that it was a joint approach providing assurance of an improving picture at the Health Board around the safeguarding of liberty. Information was shared around valuable learning under NPS and that as national network there was a focus on implementing learning from DOLS paperwork, noting digitalisation of paperwork, and that a working group for this and developing to a digital system had been set up.</p> <p>MH24.10.2 The Committee noted that Welsh Government wanted a continued focus on MCA training and that improved awareness had resulted in an increase in applications for DOLS. Progress was highlighted on the ability to address the application backlog by improving systems and timescales for completion and thanks to ring-fenced funding from the Welsh Government. RWJ queried that if Welsh Government were to stop funding would the progress in reducing the backlog be reversed, the response being that it would, given the 200+ applications per month.</p> <p>MH24.10.3 It was discussed that further assurance would be gained through an Audit and Action Plan which would form the basis of future reports. The Committee discussed training and the improvement of compliance for some wards and that ESR was being redeveloped to align with statutory requirements in respect of MCA training.</p> <p>MH24.10.4 AS advised that Court of Protection cases were becoming more common for a number of reasons, and that they were very time consuming, often complex cases, with high costs associated due to legal fees etc. It was noted that in future more of this work would be handled within the Health Board and that there would need to be discussions around who should lead on this, perhaps with a view to looking at it being centrally managed. GW asked if the Committee could focus on this at a future meeting.</p>	<p>PPJ</p>
<p>MH24.11 - HIW Assurance Report</p> <p>MH24.11.1 MJ introduced the report advising that only issues relating to the Mental Health Legislation Committee were being shared. The Committee noted that there was an inspection report on CMHT Nant y Glyn which had been published that week: there were some improvements required but these were not significant in terms of the Act. More generally, every action in response to HIW recommendations was tracked and evidence collated before being signed off and submitted to HIW.</p>	
<p>MH24.12 - Associate Hospital Managers Update Report</p> <p>MH24.12.1 MJ presented the report noting that Hospital Managers act independently from the organisation as lay people, that they sit as a panel supported by WL and MJ. The Committee were advised that summary notes were of a good standard, and that although there was no mandated timeframe, patients had access to appropriate rights and potential for redress.</p>	

<p>MH24.12.2 GW queried if Associate Managers overturned decisions and was advised that it was rare and hadn't occurred that quarter. The Committee were updated on the training and the appraisal process, noting that there were 15 active Hospital Managers currently in place with an ongoing recruitment process being promoted through social media and with the Welsh Language team, with the aim to increase diversity of the cohort.</p>	
<p>MH24.13 - Report from the Power of Discharge (Associate Managers) Group</p> <p>MH24.13.1 The Committee noted that the last meeting of the group was held on 23 April 2024 and that no issues were being escalated. The Committee were informed that the group were very active and the only issue to highlight was that timely receipt from approved mental health practitioners could be something the Committee could be sighted on, that the delay was likely due to capacity issues which IW and TO would pick up with Local Authorities.</p> <p>It was resolved that the Committee:</p> <ul style="list-style-type: none"> • Ratified the Terms of Reference for the Power of Discharge Group noting that there were now 8 Hospital Mangers on the Group whereas before there had been 10. • Noted the expression of interest from colleagues who would like to come to the Committee meetings, viz. Phil Williams, Jenny Gilmour and Louise Cunliffe • Agreed that Louise Cunliffe should attend as the formal member with Phil Williams and Jenny Gilmour attending as an observer for six months each. 	TO
<p>MH24.14 - Closing Business</p> <p>MH24.14.1 GW asked for feedback on the meeting. It was felt that there had been a good discussion, and that it was helpful it had been focussed on providing assurance to the Board on the operation of the legislation rather than wider issues of the service provided by the Mental Health and Learning Disability Division which were properly the responsibility of other committees, notably QSE and PFIG.</p> <p>There were positive comments on how the different Committees were working together and that this would be further improved with the introduction of the Integrated Governance Advisory Group which would be the Chair of each Committee meeting in attendance.</p>	
<p>MH24.15 - Date of Next Meeting</p> <p>1 August 2024, Boardroom, Carlton Court</p>	



Mental Health Legislation Committee - Public - Action Log

Open Actions

Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH24.9.5	2/5/24	Invite the police to attend to share their experience around Right Care Right Place and draft a paper on this area.	IW		Open to return to the next MHLC
2	MH24.9.10	2/5/24	Look into examples patients being able to communicate in their language of choice of this happening to share with the Committee.	TO		
3	MH24.10.4	2/5/24	Review how Court of Protection cases would be handled within the Health Board	PPJ		Open to return to a future meeting as appropriate
4	MH24.13.1	2/5/24	IW and To to pick up with the Local Authorities on capacity issues around Approved Mental Health Practitioners	IW/TO		



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Closed Actions

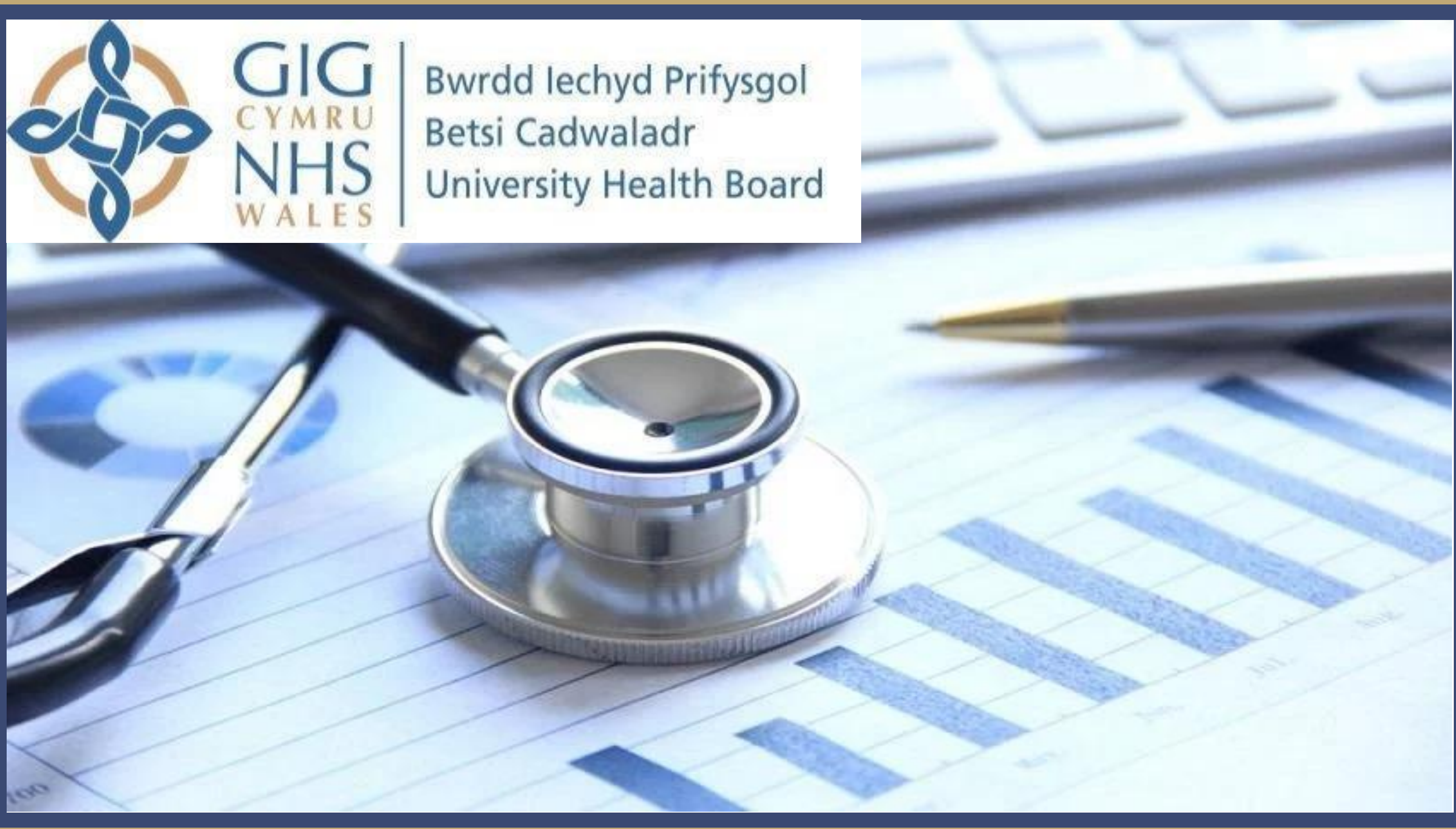
Action No.	Minute Ref.	Date	Agreed Action	Lead	Timescale	Status
1	MH24.7.1	2/5/24	Update Invitations to include Associate Hospital Managers	PPJ		Completed. The agenda invitations have now been amended



Teitl adroddiad:	Mental Health Act Assurance Report		
Report title:			
Adrodd i:	Mental Health Legislation Committee (MHLC)		
Report to:			
Dyddiad y Cyfarfod:	Thursday, 01 August 2024		
Date of Meeting:			
Crynodeb Gweithredol: Executive Summary:	<p>The Mental Health Act Performance Report provides an update in relation to Mental Health Act (MHA) activity across the Health Board during April – June 2024.</p> <p>The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This is completed on a monthly, quarterly and annual basis. This report includes comparison figures for the previous month and quarter to highlight the activity and use of the Mental Health Act sections.</p> <p>Activity is recorded in table and chart format, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included, as is information regarding transfers in and out for specialist services and repatriation.</p> <p>Lapsed sections are reported as ‘exceptions’ throughout the report, and invalid detentions recorded as ‘fundamentally defective’. Any lapses or fundamentally defective sections are Datix reported and investigated.</p> <p>Up to date S136 reports are submitted to the Committee along with any ad hoc requests for information.</p> <p>A monthly report is submitted to the Deputy Director of Quality and the Medical Director for MHLD to ensure that the MHA is monitored with the exceptions highlighted including any mitigation and learning that has occurred.</p> <p>Appendices are included to support the report.</p>		
Argymhellion: Recommendations:	The Committee is asked to discuss and note the report and appendices.		
Arweinydd Gweithredol: Executive Lead:	Teresa Owen, Lead for Mental Health		
Awdur yr Adroddiad: Report Author:	Wendy Lappin, Mental Health Act Manager – <i>author</i> Matthew Joyes, Deputy Director – <i>presenting</i>		
Pwrpas yr adroddiad: Purpose of report:	I’w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>

Lefel sicrwydd: Assurance level:	Arwyddocaol Significant <input type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol Acceptable <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol Partial <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
<p>Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:</p> <p><i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i></p>				
Cyswllt ag Amcan/Amcanion Strategol: <i>Link to Strategic Objective(s):</i>	Outcome 4 - Improved access, outcomes and experience for citizens			
Goblygiadau rheoleiddio a lleol: <i>Regulatory and legal implications:</i>	This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</i>	The use of the Mental Health Act Sections apply to all persons All policies in relation to the use of the Mental Health Act have been equality impact assessed.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i>	N/A			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i>	<p>The patient information recorded to produce the reports required for the Health Board, Welsh Government, and North Wales Police also assists the Health Board in the management of the Mental Health Act functions such as expiry dates, consent to treatment, patient history, movements and deadlines. This data is currently recorded within excel databases which have been identified as unsustainable and difficult to future proof due to the amount of data held and detentions the Health Board experiences. This was previously raised as a concern. Discussions are ongoing as to a more safe and robust way of storing and reporting data with a Digital Steering Group taking this forward as part of a wider improvement for the whole health board.</p> <p>The Mental Health Act detentions fall into categories of being either legal or illegal</p>			

	(invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked for validity, and any invalid detentions are reported through Datix, investigated and escalated as appropriate. These are reported as exceptions within the report.
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith Financial implications as a result of implementing the recommendations	The increase in Mental Health Act detentions has financial implications.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith Workforce implications as a result of implementing the recommendations	None required
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori Feedback, response, and follow up summary following consultation	<p>A monthly report is produced and the data submitted monthly to Alberto Salmoiraghi, Medical Director of Mental Health & Learning Disability Service and Matthew Joyes, Deputy Director of Quality.</p> <p>Reports are also shared with the Power of Discharge Group which is held in advance of the MHLC.</p>
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) Links to BAF risks: <i>(or links to the Corporate Risk Register)</i>	N/A
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) Reason for submission of report to confidential board (where relevant)	N/A
Camau Nesaf: Gweithredu argymhellion Next Steps: Implementation of recommendations	
Rhestr o Atodiadau: List of Appendices: Appendix 1 – MHA Committee Assurance Report April - June 2024 Appendix 2 – Section 136 gender detentions Appendix 3 – Compliance with the Mental Health Act Quarterly Audit Report: Q2	



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Report to Mental Health Legislation Committee Additional Appendices will be included as requested.

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

NHS Wales Performance Framework 2024-2025

The NHS Performance Framework is a key measurement tool for 'A Healthier Wales' outcomes, and reflects the National Programme areas as outlined in the NHS Wales Planning Framework 2024-2027.

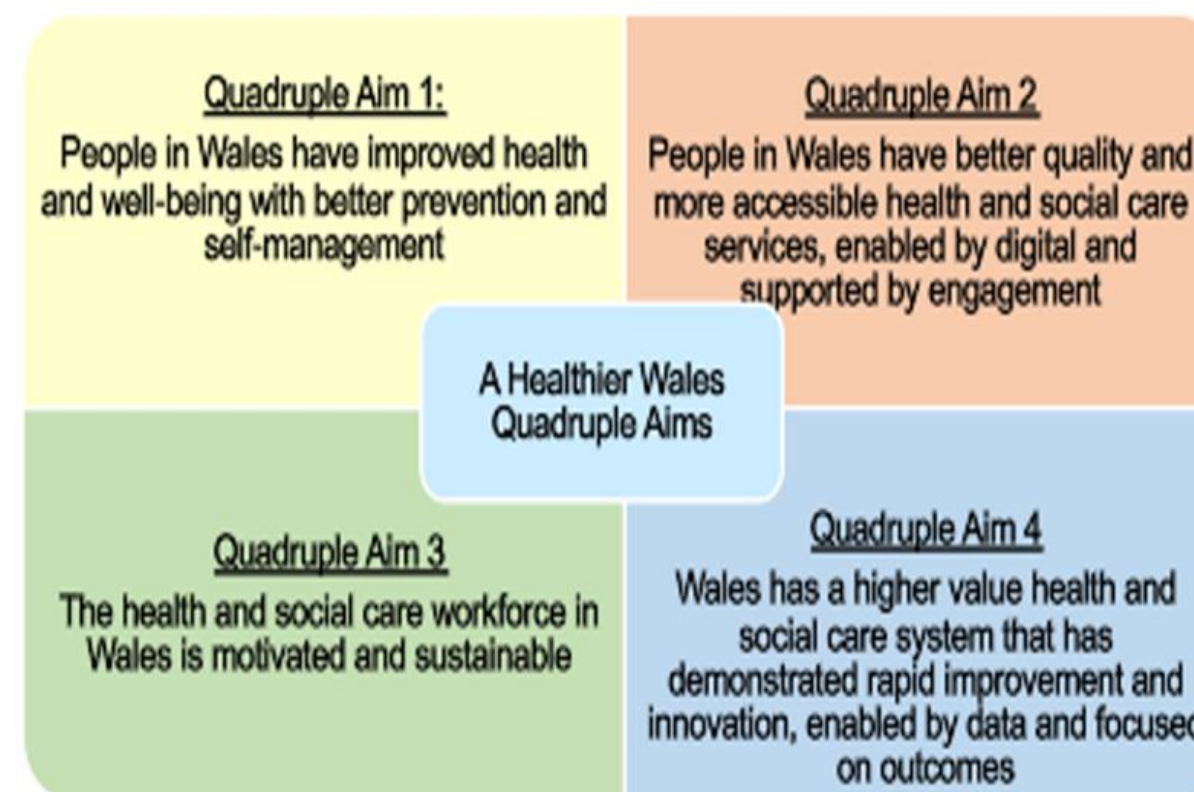
These are:

1. Enhanced care in the community, with a focus on reducing delayed pathways of care
2. Primary and community care, with a focus on improving access and shifting resources into primary and community care.
3. Urgent and emergency care, with a focus on delivery of the 6 goals programme.
4. Planned care and cancer, with a focus on reducing longest waits.
5. Mental health, including CAMHS, with a focus on the delivery of the national programme.

In addition, a small set of measures focusing on enablers, health prevention and the delivery of quality and safe services has been included.

To support the performance measures, NHS organisations will also be required to complete Policy Assurance Assessments. These assessments provide further assurance on some of the Minister's key areas of focus and key Welsh Government strategies and pathways that cannot be monitored via traditional quantitative measurement.

All of the performance measures and policy assurance assessments in the NHS Performance Framework have been mapped to 'A Healthier Wales' quadruple aim:



Executive Summary:

Exceptions are noted throughout the report within this quarterly period (April - June) the Health Board has experienced no fundamentally defective detentions and one lapsed detention.

Exceptions are detentions that are deemed fundamentally defective which cannot be rectified under Section 15 of the Mental Health Act and those detentions that are not managed correctly and lapse. All fundamentally defective and lapsed detentions managed by the Health Board will be datixed, investigated and mitigation and learning considered to ensure that recurrent instances do not occur.

CENTRAL AREA

A CTO was discovered to have lapsed INC 98320. This was discovered on review of the database and a request for the detention to be updated to the office, the office confirmed that they had missed this renewal as had the Responsible Clinician and the Care Coordinator. **Outcome:** The patient was informed by the RC and reviewed along with the Care Coordinator to ensure there was not a need for a further detention and to clarify that the patient understands. **Learning/Mitigation:** The level of work demands can play a huge part in staff missing dates, the Care Coordinators are to add review/expiry dates to their diaries, the Consultants are to request the same from their administrators and the MHA office will be carrying out weekly data checks within the database.

EVIDENCE OF EFFICIENT WORKING

The Health Board experienced an admission that was due to expire that evening following a transfer in from a hospital in England. It was communicated that the plan was for a DOLS application which had not been completed prior to transfer, the unit staff ensured that an urgent DOLS was put in place at the point of the Section 2 expiry. DATIX 93847. The efficiency of the staff ensured that the patient was not held in hospital without any legal framework.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

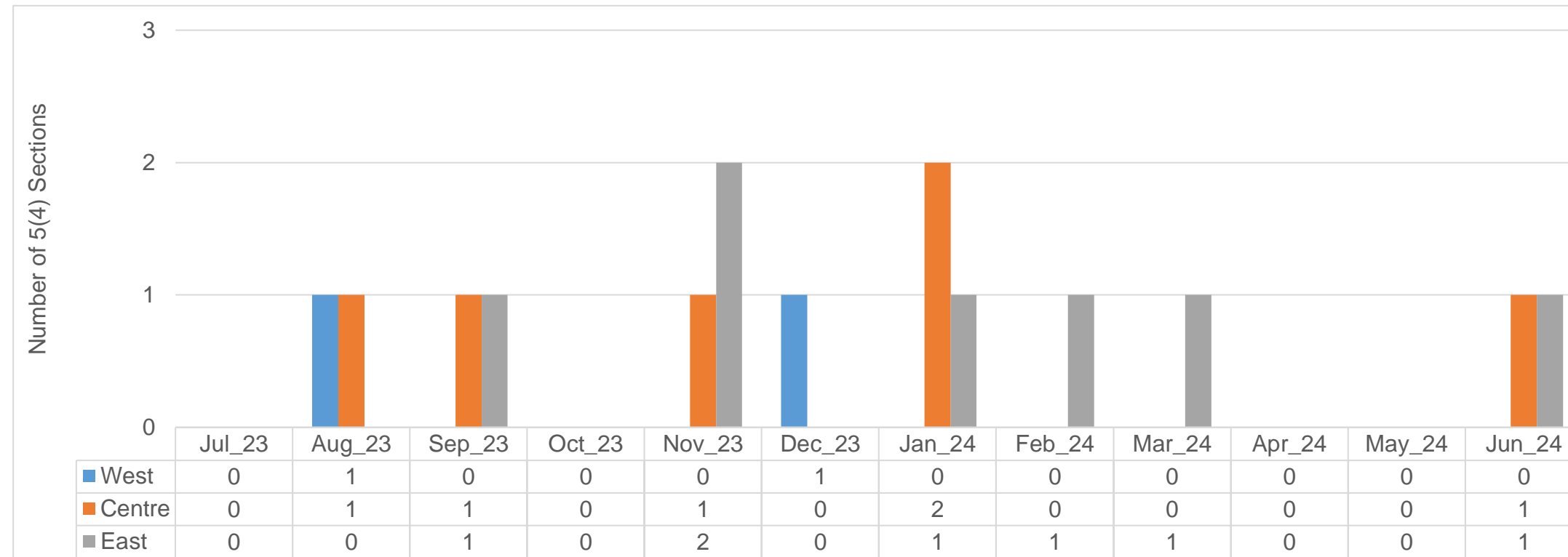
Section 62: Emergency Treatment of a detained patient regardless of section status

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

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

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

Section 5(4) - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(4) during Quarter	Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	2	0	↑	2	5	↓	4	1 Centre	1
								1 East	1
								3 West	0



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

There were no S5(4) detentions in April or May.

LAPSES

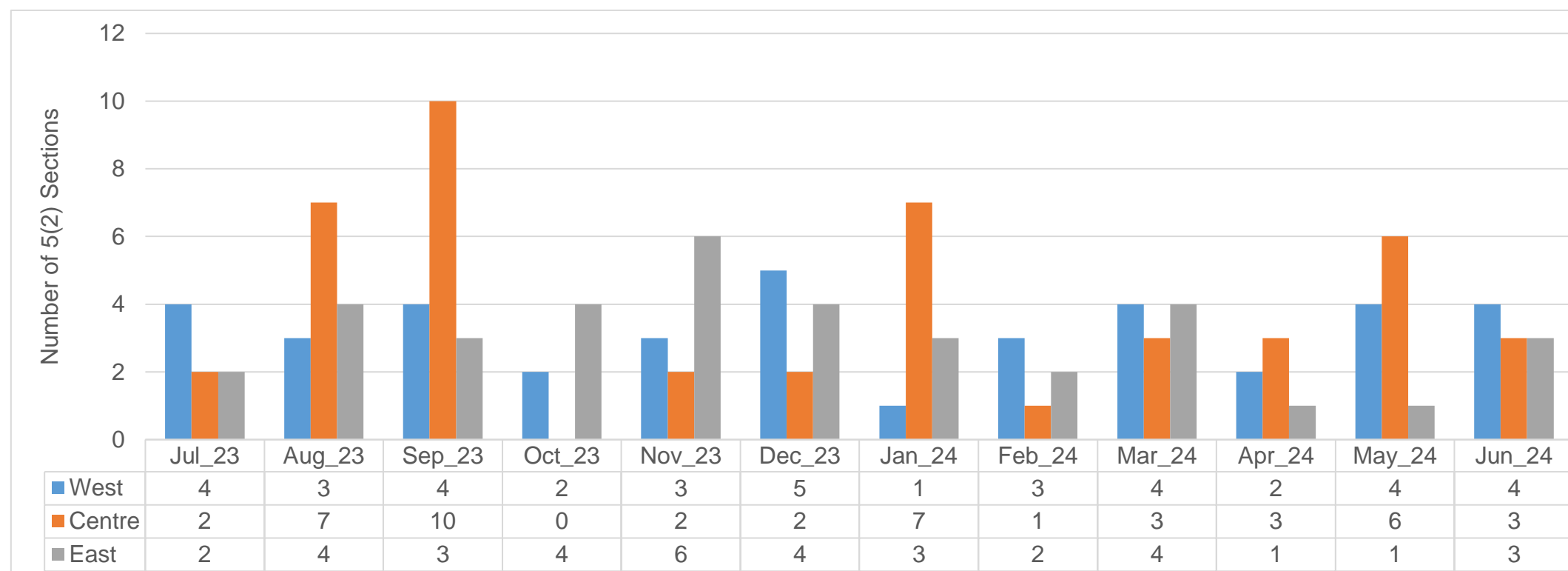
No exceptions to report.

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

CENTRE		
Month	Duration (hh:mm)	Outcome
Jun_24	02:33	Section 5(2)

EAST		
Month	Duration (hh:mm)	Outcome
Jun-24	02:40	Informal

Section 5(2) - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 5(2) during Quarter	Quarter 5(4) Sections
Section 5: Application in respect of patients already in hospital	10	11	↓	27	28	↓	31	1 Centre 2 West 3 East	12 10 5



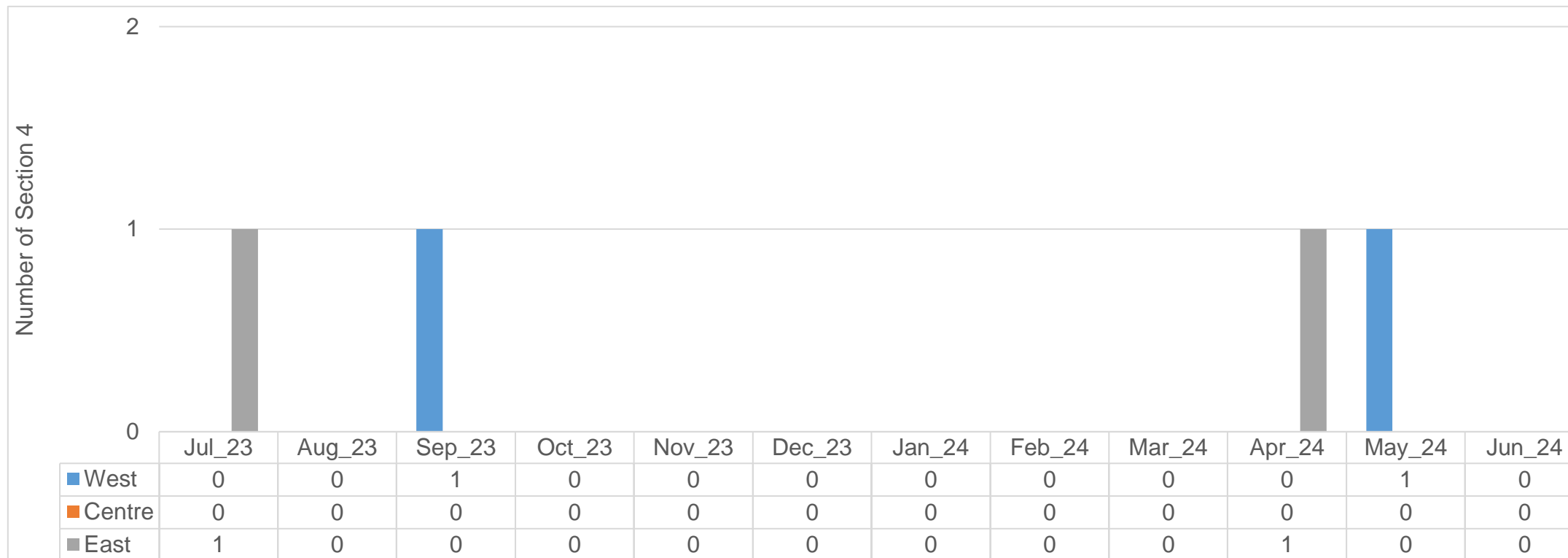
Section 5(2) Outcomes			
	Apr 2024	May 2024	Jun 2024
Section 2:	1	4	1
Section 3:	2	2	5
Informal:	4	5	1
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	0	0	1
Other:	0	0	0

A Section 5(2) on occasions will be enacted within the acute hospital wards, during this period there were two detentions in an acute hospital.

EXCEPTIONS

There are no exceptions to report this quarter.

Section 4 - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 4 during Quarter	Quarter Section 4
Section 4: Admission for assessment: Cases of emergency	0	1	↓	2	0	↑	1	1 East	1
								1 West	1
								3 Centre	0



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

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

There are no exceptions to report.

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

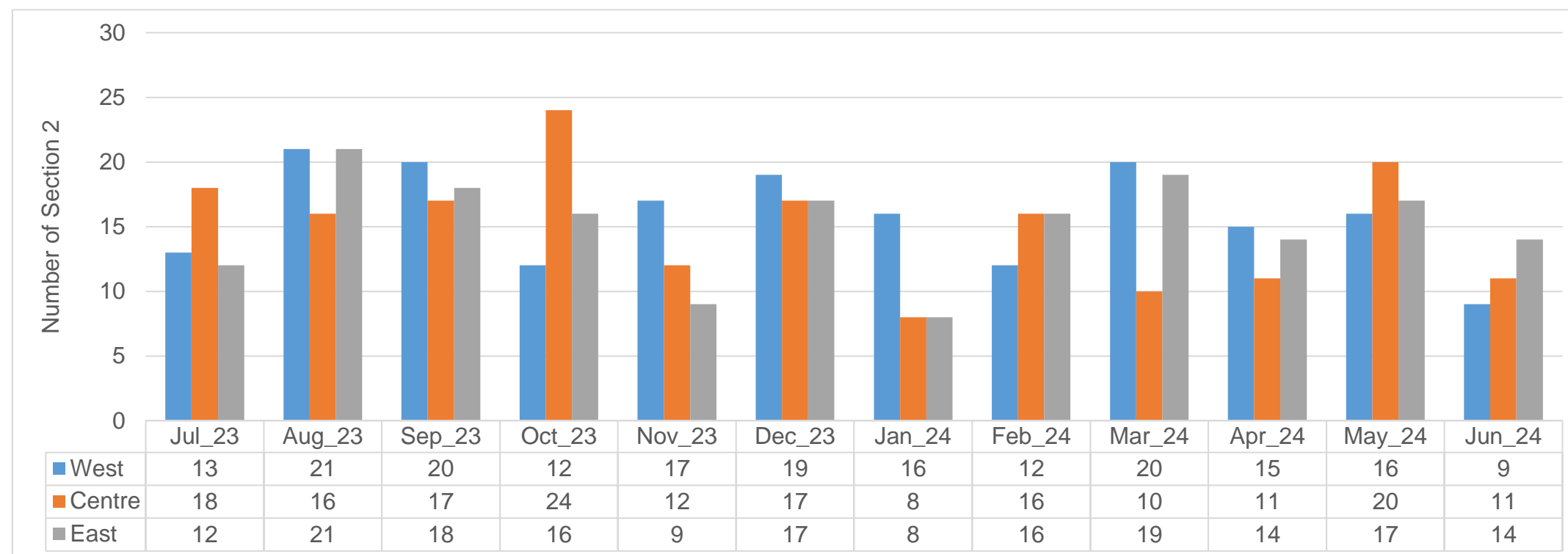
There were two section 4's this quarter used due to the necessity of hospital admission for health and risk reasons for both patients.

WEST		
Month	Duration (hh:mm)	Outcome
May_24	10:25	Section 2

CENTRE		
Month	Duration (hh:mm)	Outcome

EAST		
Month	Duration (hh:mm)	Outcome
April	01:35	Section 2

Section 2 - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 2 during Quarter	Quarter Section 2
Section 2: Admission for assessment	34	53	↓	127	125	↑	138	1 East	45
								2 Centre	42
								3 West	40



Section 2 Outcomes			
	Apr 2024	May 2024	Jun 2024
Section 3:	16	12	9
Informal:	7	19	9
Lapsed:	0	0	0
Pending:	0	0	0
Discharged:	6	5	7
Transferred:	13	17	10
Invalid and Other:	0	0	0

* data is as at position and is subject to change

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

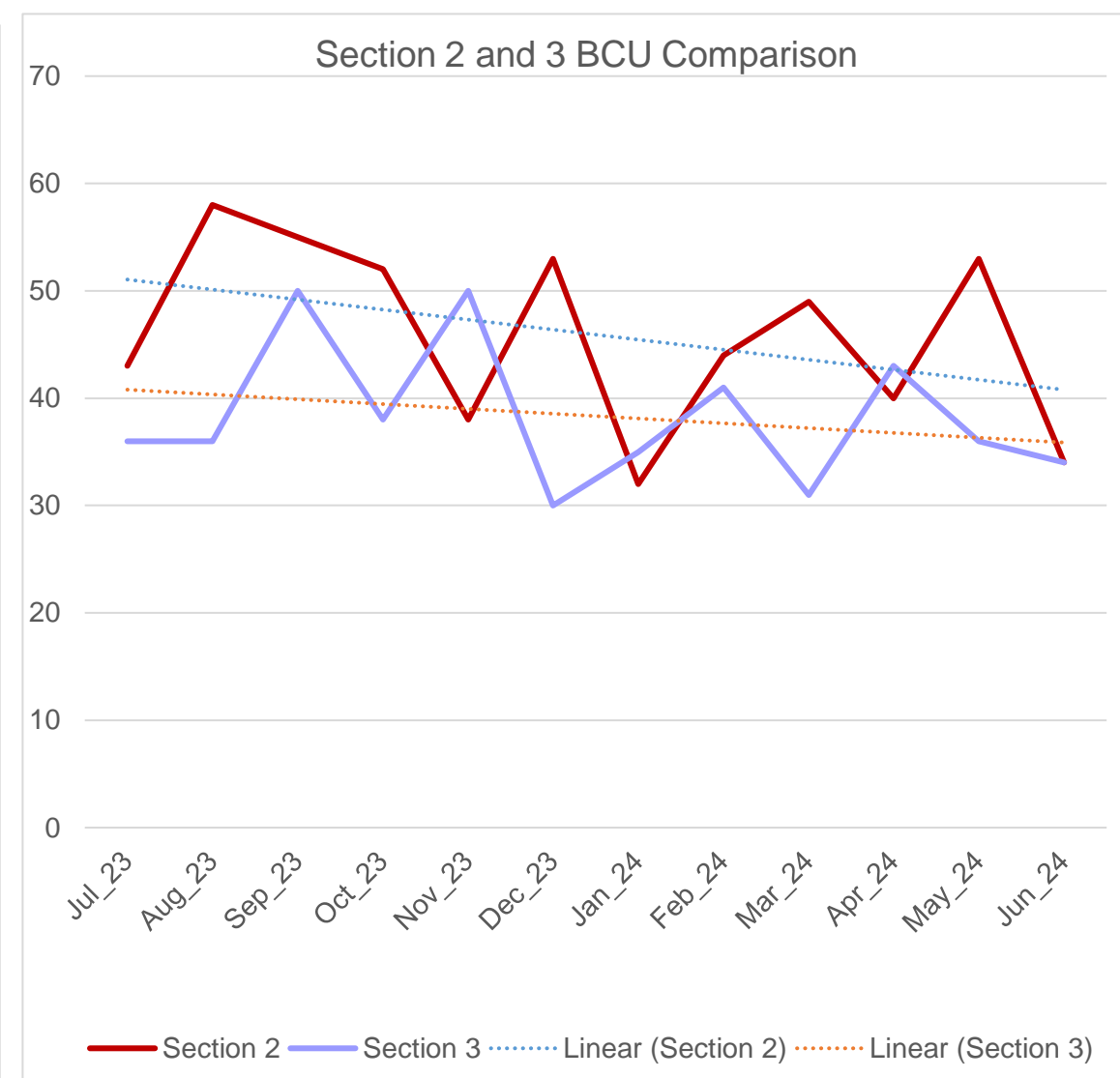
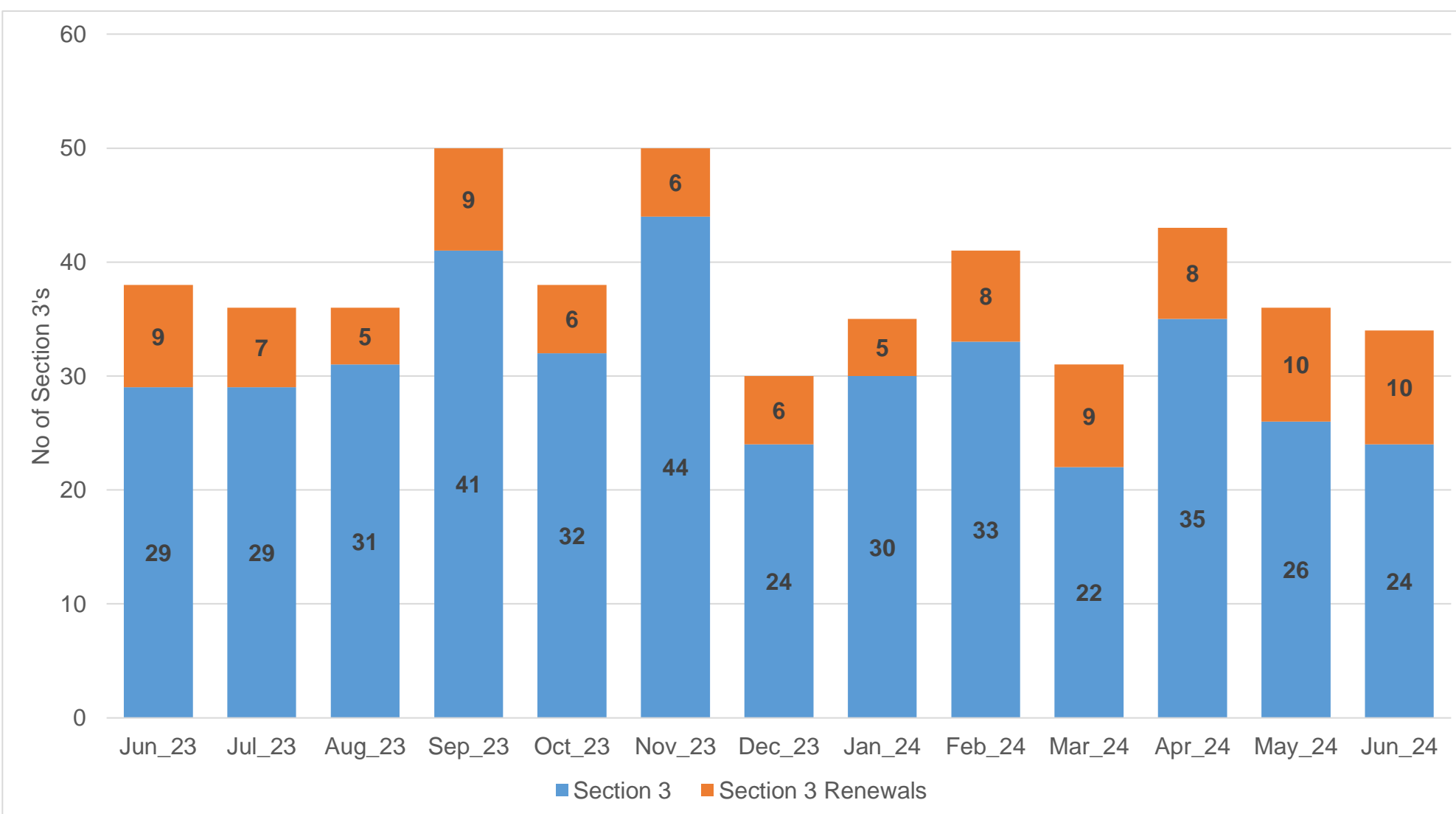
Section 2 is also used as a direct admission detention.

There was one young person placed on a Section 2 this period regraded from informal.

EXCEPTIONS:

There are no exceptions noted this period.

Section 3 - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 3 during Quarter	Quarter Section 3
Section 3 (Including Renewals): Admission for treatment	34	36	↓	113	107	↑	115	1 Centre	43
								2 East	36
								3 West	34



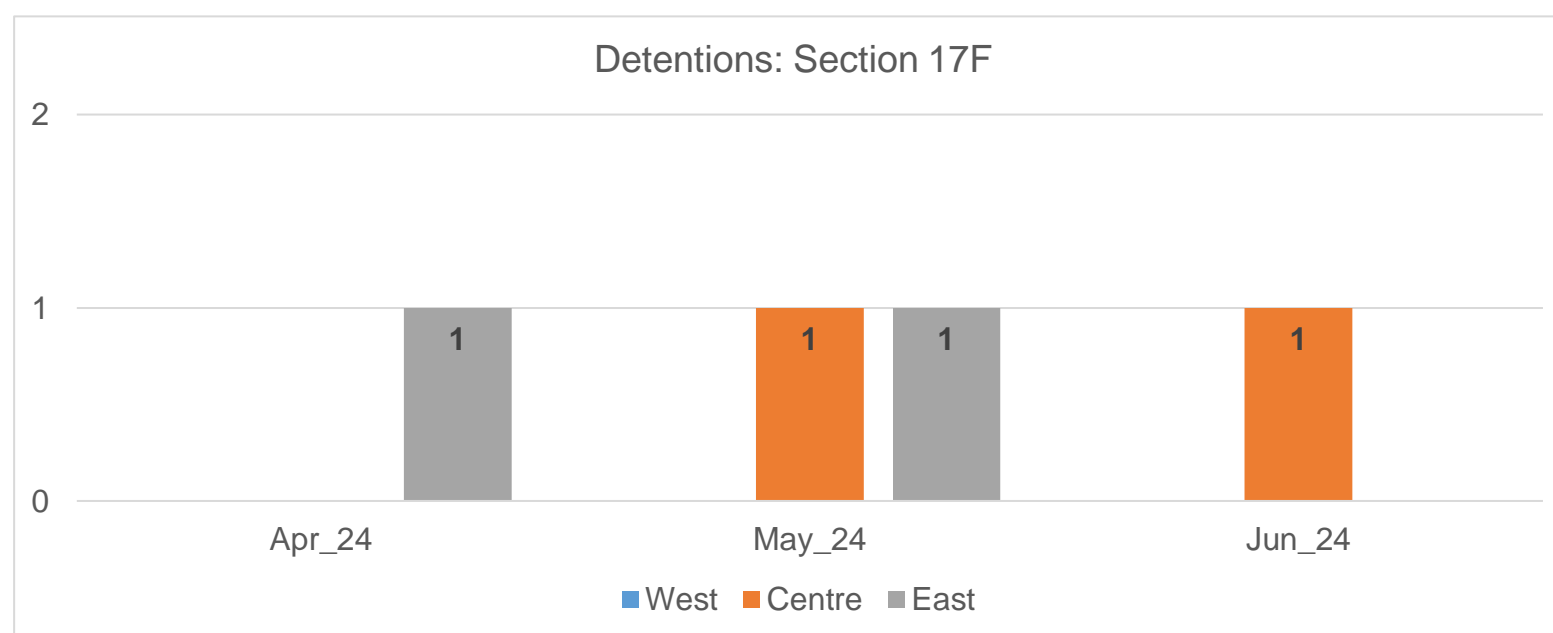
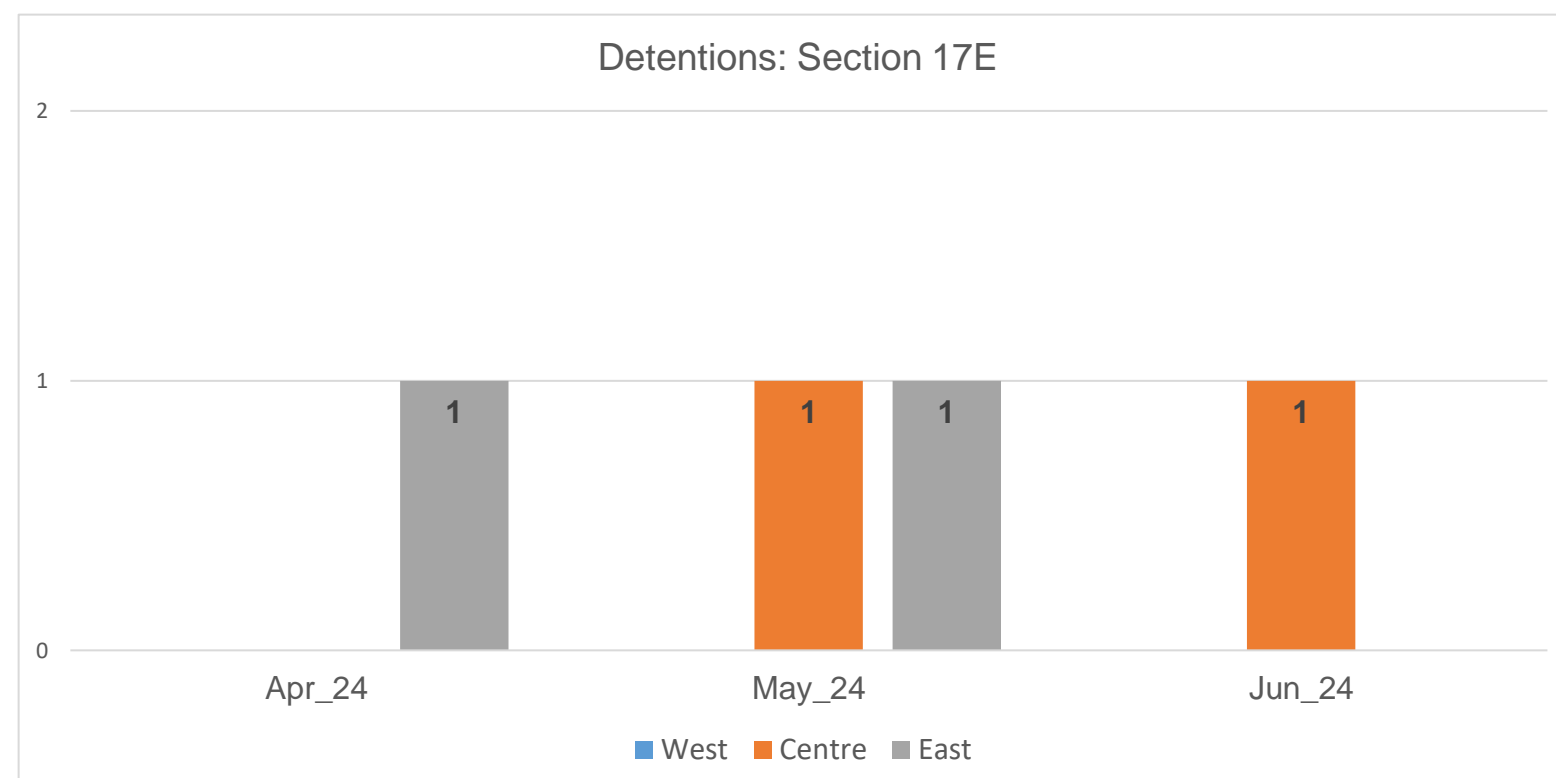
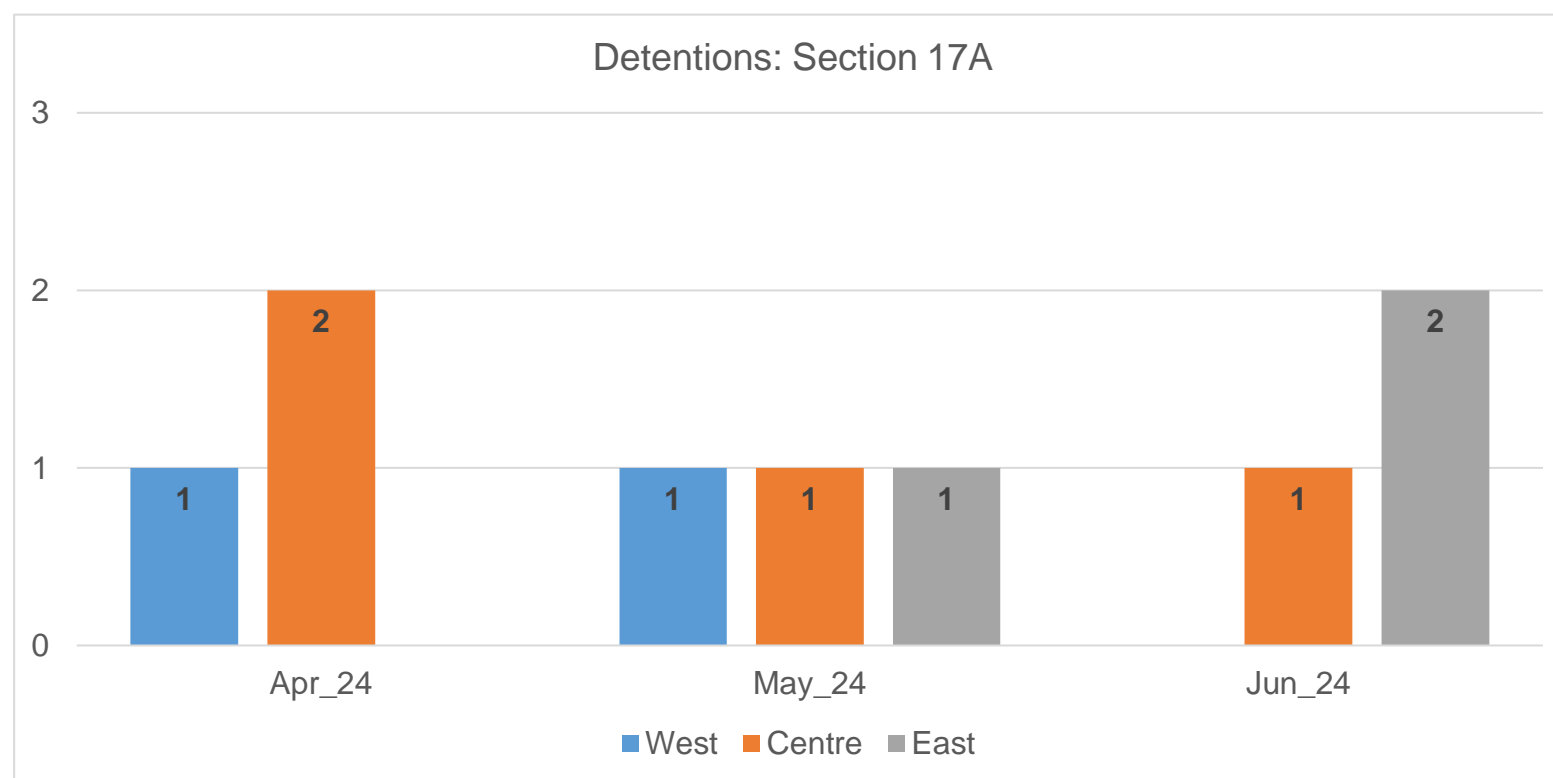
* data is as at position and is subject to change

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

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

There are no exceptions to report this period.

Section 17 A-F - BCUHB	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Section 17 during Quarter	Quarter Section 17
Section 17A (Including Renewals)-17F: Community Treatment Orders	5	7	↓	17	18	↓	19	1 Centre	8
								2 East	7
								3 West	2

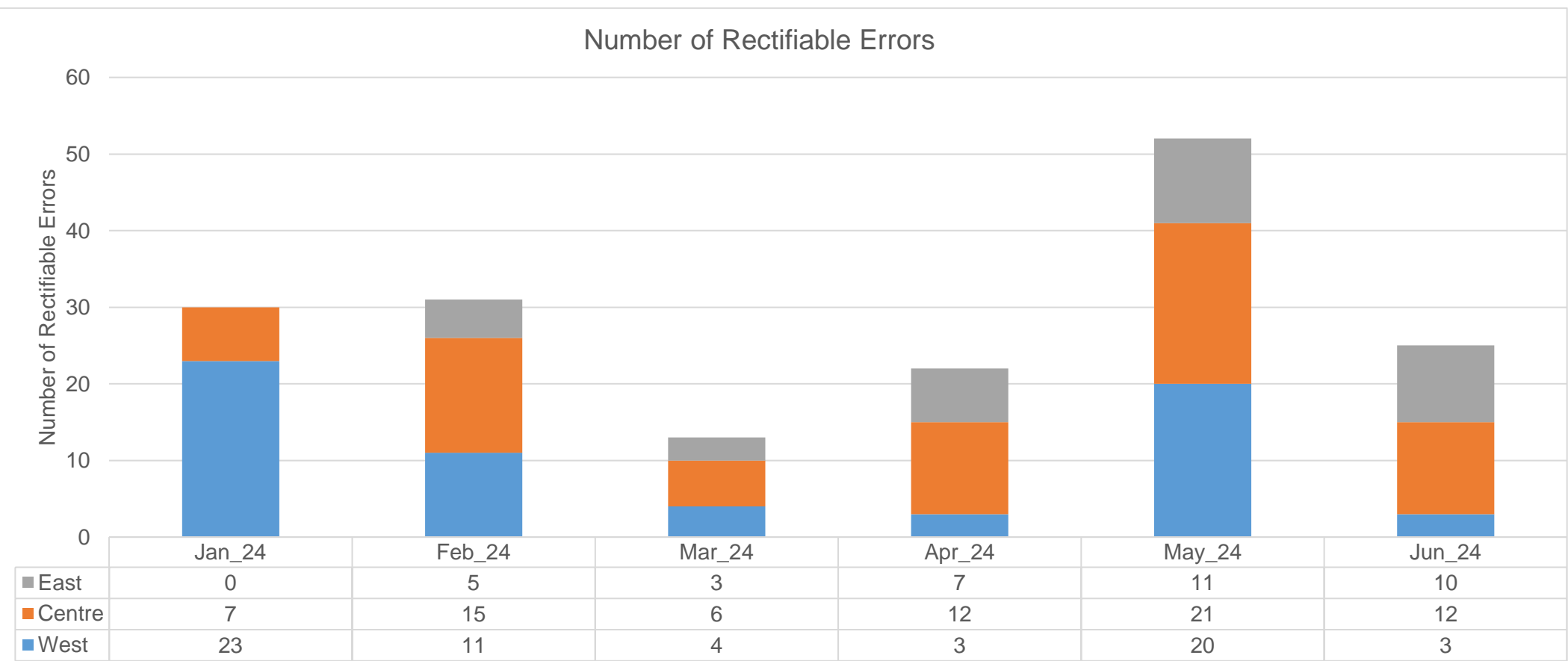


This quarterly data 17A shows the numbers of patients who are being placed on a CTO for the first time, as well as any renewals within the month. 17E data shows those who have been recalled to hospital from their CTO and 17F data shows those who have had their CTO revoked and become subject to a Section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

The number of patients subject to a CTO at the end of June West: 7, Central: 9 and East: 8. There has been a decline in the number of patients subject to a CTO for all areas compared to the last quarterly report in March.

Exceptions: One CTO lapsed this quarter within the month of April, Datix ref 98320. The MHA office, Responsible Clinician and Care Coordinator did not pick up that this was due to expire. Additional recording and diary and database management has been identified as part of the learning process.

Fundamental and Rectifiable Errors	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter	Quarter Errors
Fundamental and Rectifiable Errors in line with Health Boards in Wales	25	52	↓	76	80	↓	107	1 Centre	45
								2 East	28
								3 West	26



Rectifiable Errors

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

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

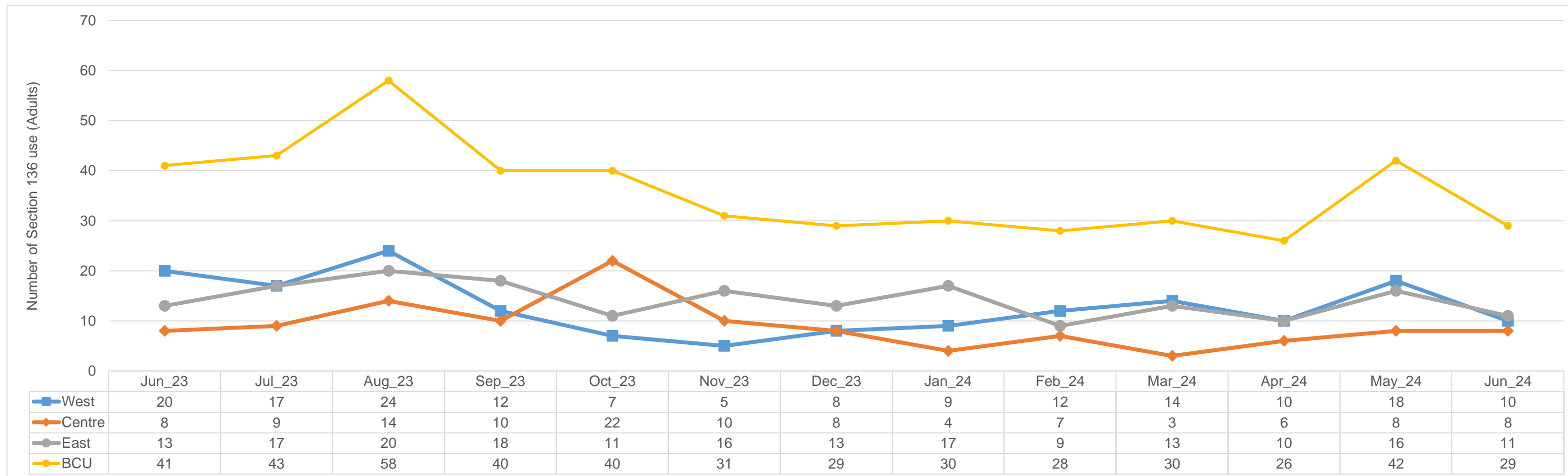
It is important to note that rectifiable errors can be amended under Section 15 of the Mental Health Act and do not render the detention invalid.

Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report information regarding these are reported as part of the executive summary (P.4) to include learning and mitigation.

To date there have been no fundamentally defective and one lapsed detention following the Health Boards use of the Mental Health Act.

Lapsed - Section 17A(CTO).

Section 135 - 136	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 135 and 136: Patient transfers to a place of safety (Adults)	29	42	↓	97	88	↑	107	1 West	38
								2 East	37
								3 Centre	22



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

There were eight under 18 S136s this period, six discharged with follow up from CAMHS, one discharged and referred and one S2 admission.

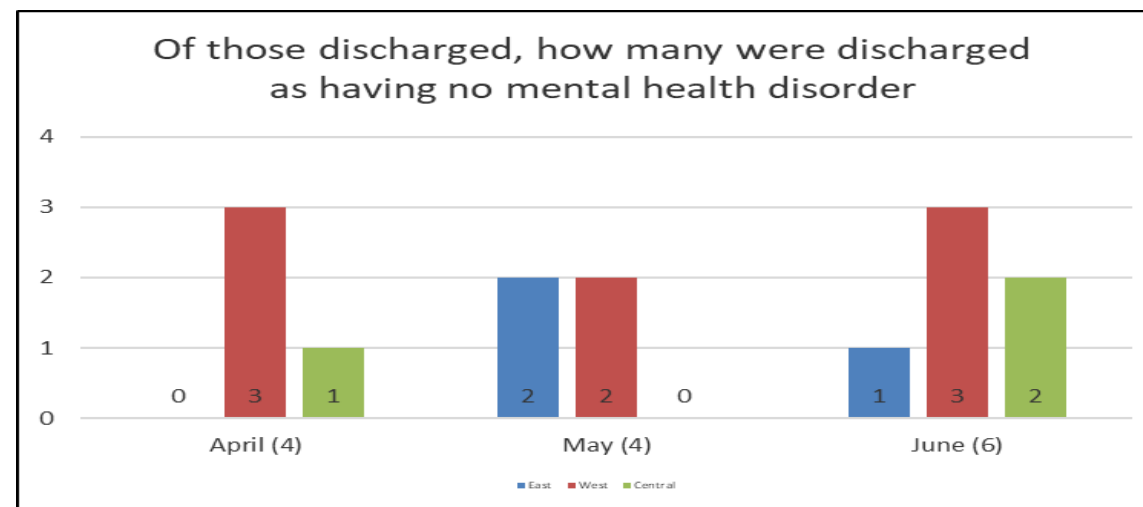
There has been four S135 detention this period resulting in three admissions under S3 and a CTO recall.

During this period there were three custody detention noted as the first place of safety resulting in two S2 admissions and one discharge referred to services.

Two requests for an extension were made this period resulting in a S2 admission and a discharge no mental disorder. No detentions lapsed this period.

Section 136	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter	Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	29	42	↓	97	88	↑	107	1 West	38
								2 East	37
								3 Centre	22

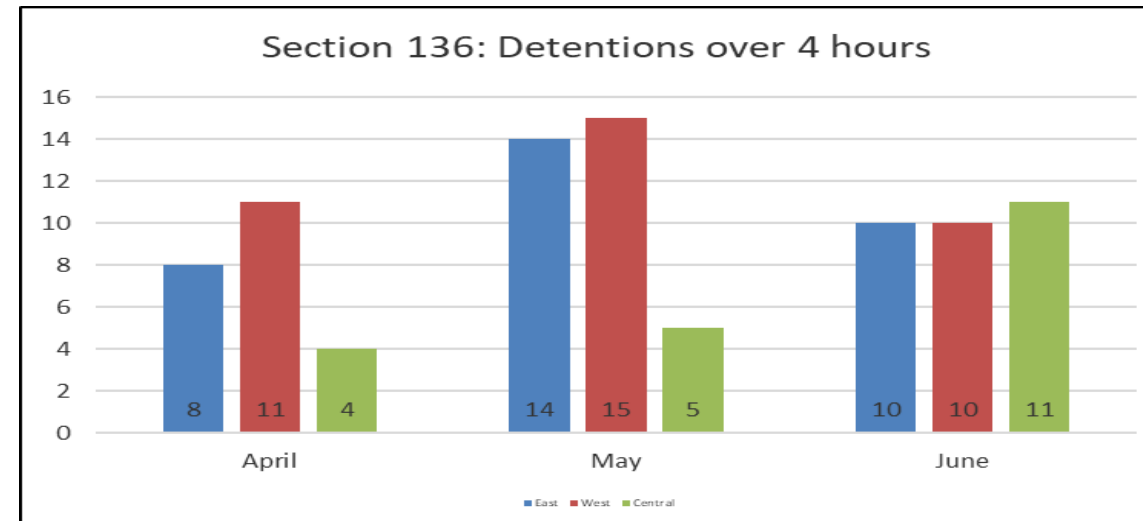
Section 136 Outcomes			
	Apr 2024	May 2024	Jun 2024
Discharged:	16 57.14%	33 73.33%	22 62.86%
Informal Admission:	5 17.86%	1 2.22%	6 17.14%
Section 2:	6 21.43%	10 22.23%	6 17.14%
Section 3:	1 3.57%	1 2.22%	1 2.86%
Other:	0 0.00%	0 0.00%	0 0.00%



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

Total percentages of all detentions for those discharged with no mental disorder (rounded up) are:
April 14%
May 9%
June 17%

Section 136 - Known to Service			
	Apr 2024	May 2024	Jun 2024
Yes	18	26	24
Yes (percentage)	64.28%	57.77%	68.57%



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.

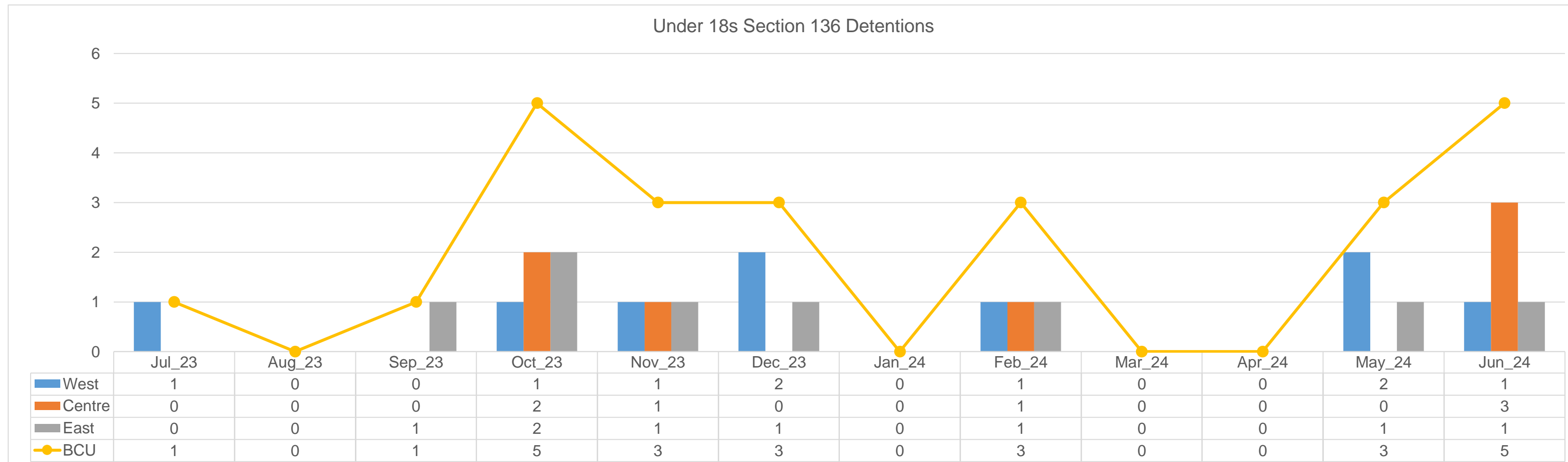
Data below shows the percentage of the detentions discharged that are followed up by services or new referrals into services these figures are rounded up/down as appropriate:

April 63% discharged follow up, 13% referred to services.
May 64% discharged follow up, 24% referred to services.
June 55% discharged follow up, 18% referred to services.

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.

During this period 18 people were diverted to other avenues and 22 people were detained on a S136 following consultation.

Section 135 - 136 (Under 18)	June 2024	May 2024	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 (<18) during Quarter	Quarter <18 S.136 use
Section 135 and 136: Patient transfers to a place of safety (<18)	5	3	↑	8	3	↑	6	1 Centre 1 West 3 East	3 3 2



There were eight under 18s assessed under a S136 this period resulting in one detention under the Mental Health Act.

The tables below shows the ages of young persons assessed and the outcomes for the year period April 24 - March 25. In comparison to the last year 2023/2024 this is 11 less.

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)	

5

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
May	YG	Discharged	CAMHS	16:05	17
May	YG	Discharged	CAMHS	18:30	15
May	Heddfan	Discharged	CAMHS	02:55	17
June	Heddfan	Discharged	CAMHS	20:55	17
June	YGC	Discharged	CAMHS	12:50	16
June	Ablett	Discharged	CAMHS	11:00	16
June	Hergest	Discharged	CAMHS	10:40	17
June	Ablett	Admission	CAMHS	16:40	15

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

Average PoS hours: 13:41hrs the previous quarter figures were 14:13 hrs.

Under 18's admitted to Adult Psychiatric Wards

There has been one admission this reporting period where a young person remained in the S136 suite or was admitted to an adult ward prior to transfer to an age appropriate unit.

The table below shows the county that the young persons originated from and where they were assessed for the period April 24 - March 25

County Originated from and where assessed:

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

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

Ty Llywelyn Medium Secure Unit is a 25 bedded all male facility. The nature of the forensic sections does not always generate rapid activity.

There are times when section 3 patients will be detained within the unit and the unit is responsible for one CTO patient in the community.

There are no exceptions to report.

Total Transfers for the Quarter

	Apr 2024	May 2024	Jun 2024
Internal Transfers	10	15	11
External Transfers (Total)	25	20	15
External Transfers (In)	10	7	10
External Transfers (Out)	15	13	5

Internal Transfers

This data only includes detained patient transfers between BCU facilities, including the transfer of rehab patients which will be part of their patient pathway. 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.

Transfers In

APRIL 2024

West = four patients
Central = five patients
East = one patient
All patient were returning to BCU from out of area hospitals to the respective area that covers their local authority.

There were 10 internal transfers: four patients were returning to units within their home area, one patient was due to a need for higher security, three due to transfers between DGH and psychiatric units and two due to step down/up pathway needs.

MAY 2024

West = four patients
Central = one patient
East = two patients
Five patients were returning to BCU from out of area hospitals to the respective area that covers their local authority. Two patients were transfers from HMP Berwyn to the forensic unit.

There were 14 internal transfers: six patients returning to units within their home area, three transferred between DGH and psychiatric units and five due to step down/up or pathway needs.

JUNE 2024

West = seven patients
Central = three patients

All patient were returning to BCU from out of area hospitals to the respective area that covers their local authority.

There were 11 internal transfers: four patients returning to units within their home area, six transferred due to step down/up pathway needs and one transferred between S136 suites.

Transfers Out

APRIL 2024

West = nine patients
Central = three patients
East = three patients.

Two patients were out of area patient who were being repatriated to their home area.

Seven patients were within the S136 suite on a detention prior to transfer, three within the DGH and three within the psychiatric units.

MAY 2024

West = five patients
Central = five patients
East = three patients.

One patient was an out of area patient being repatriated to their home area.

Four patients were within the S136 suite on a detention prior to transfer, two within the DGH and six within the psychiatric units.

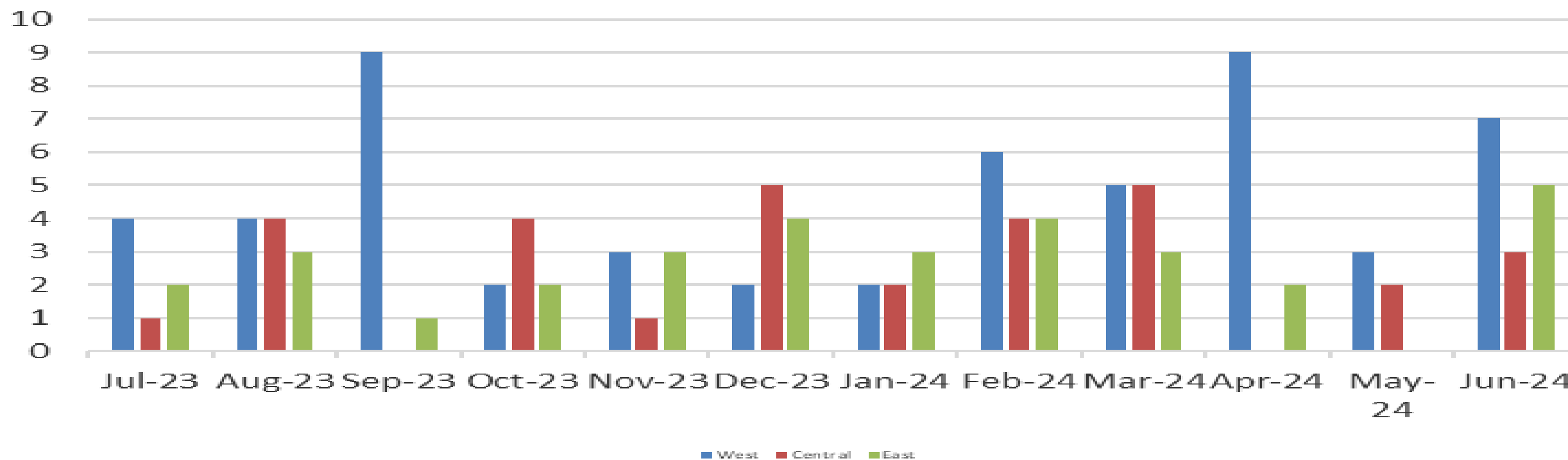
JUNE 2024

West = five patients

One patient was an out of area patient being repatriated to their home area.

Two patients were within the S136 suite on a detention prior to transfer, one within the DGH and one within the psychiatric unit.

Use of Section 62 by area



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

Reason for S62 use:

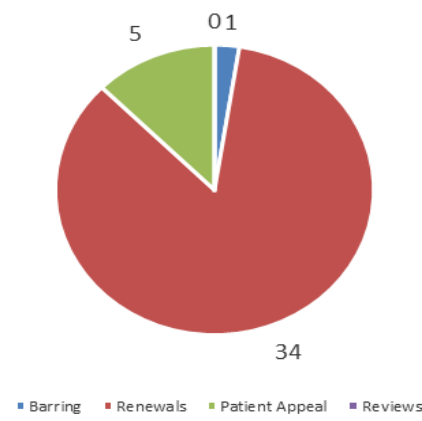
Medication changes

Patient no longer able to give consent to treatment or refusing consent

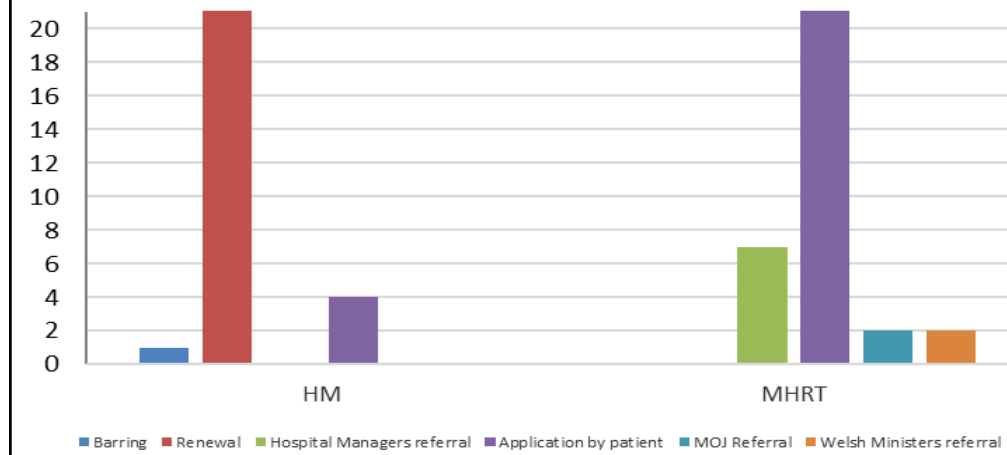
ECT

Awaiting a Second Opinion Appointed Doctor (SOAD) to arrive and three month consent to treatment has expired.

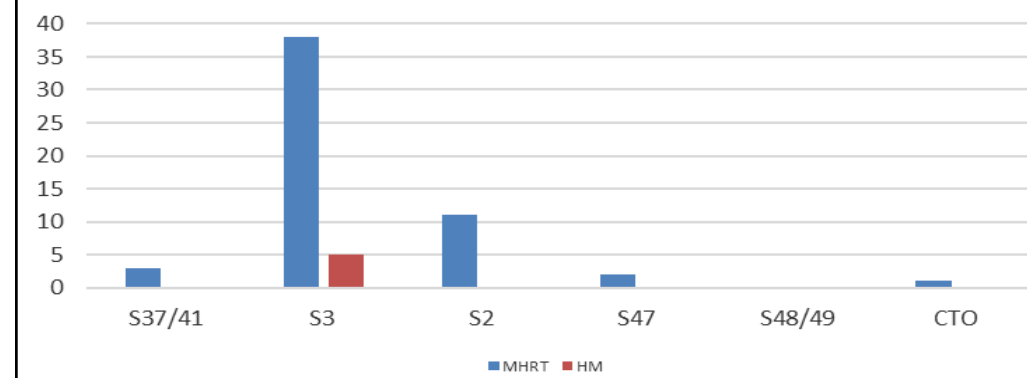
Hospital Managers Panel Hearings scheduled April - June 2024 (n40)



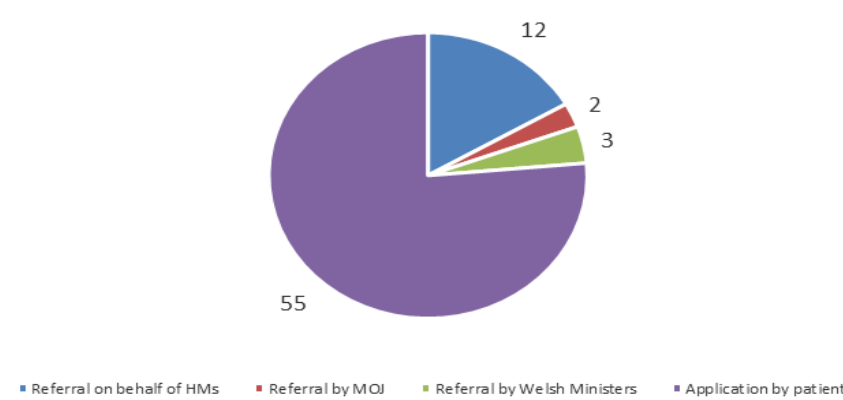
70 Hearings Held April - June 2024 by type



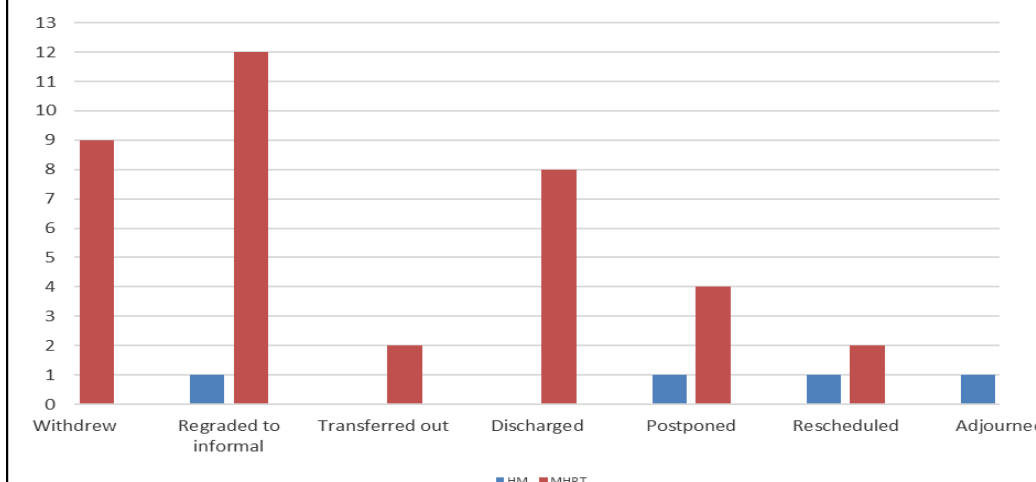
Type of patient appeals received April - June 2024
55 MHRT and 5 Hospital Managers



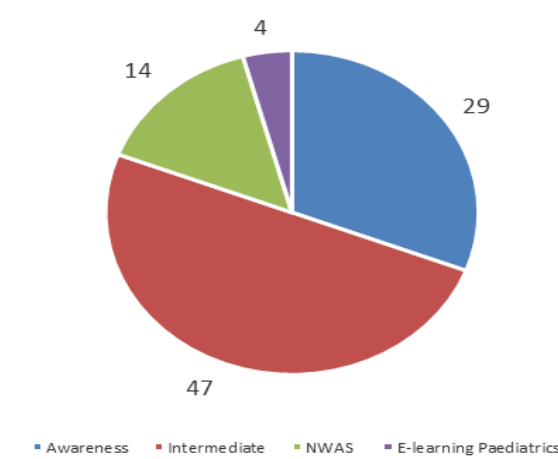
Mental Health Review Tribunals scheduled April - June 2024 (n72)



42 Hearings not held April - June 2024



MHA Training attendance 2024 to June (n94)



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

There were 112 hearing scheduled this period which included 60 applications from patients. 70 hearings took place of which 27 were patient applications.

The MHRT discharged three patients this quarter from S2, S3 and S37/41, all other hearings held resulted in the patients remaining detained.

Training under the MHA is now recorded and an initial analysis report of the attendees for 2023 has been produced.

There were 213 staff members trained in 2023 through Teams sessions, face to face and via a new e-learning developed for the paediatrics department. To date 94 people have been trained in 2024.

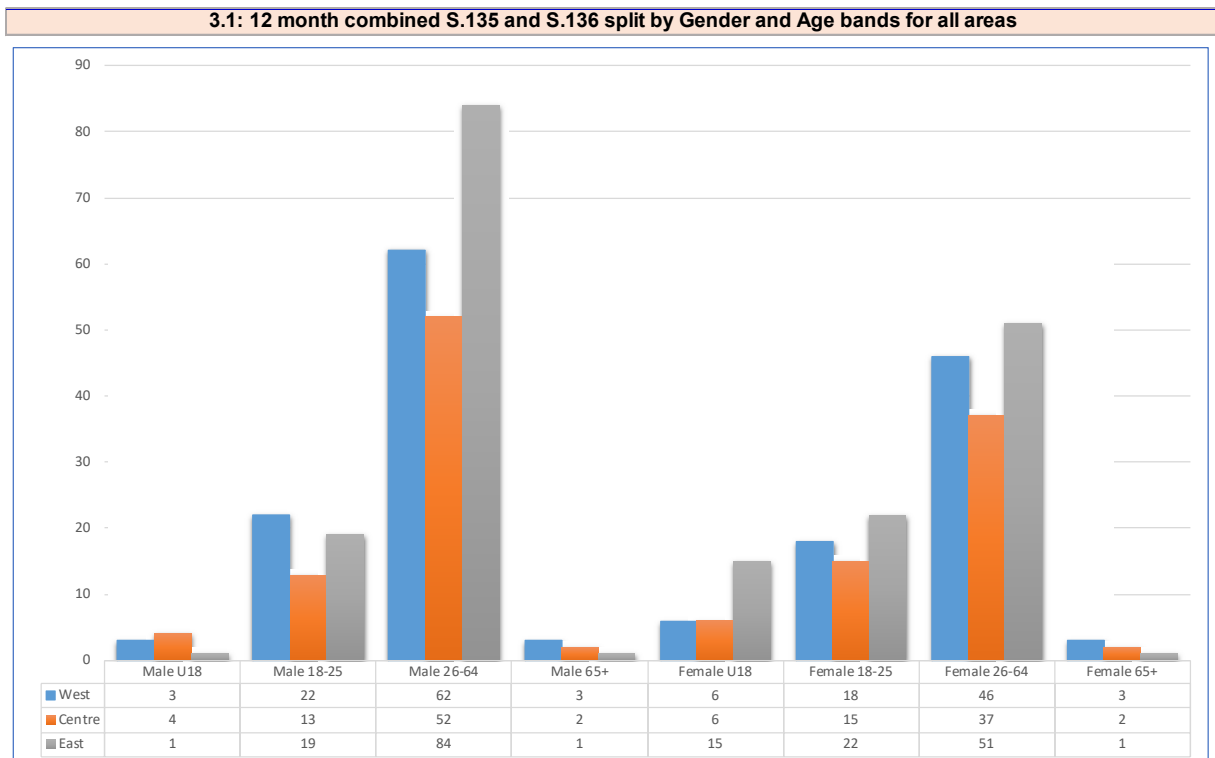
Training is advertised through Health Board publications and on the Mental Health Act sharepoint page. A new Awareness e-learning training was added to the MHA training page in June.

S136 data in relation to male and female detentions and discharge proportions.

S136 data is recorded on a monthly basis and individual reports provided for each area East, West and Central, a combined BCU S136 report is produced for the Mental Health and Learning Disabilities Division and a separate S136 report is produced for North Wales Police.

Each report details information that was deemed important to the Health Board and Police service on the initial production of these reports, some have been expanded over time. Within the reports the number of male and female detentions are included.

The graph below details gender and ages of patients detained April 2023 – March 2024.



The data shows there were 46 more males detained under a S136 than females.

The below table shows the number of detentions and those discharged with the % for 2023/24.

Gender	Number detained	Number discharged	% of those detained discharged
Male	266	109	40.97%
Female	222	134	60.36%

For 2024 within the first quarter (April – June) there have been two more males detained than females with one more female being discharged than males.

Gender	Number detained	Number discharged	% of those detained discharged
Male	55	35	63.63%
Female	53	36	67.92%

This information was provided following a query on the last bundle submitted to the Mental Health Legislation Committee in regards to if discharges of males from s135/136 was a higher proportion of those detained than is true for females.

For the year 2023-2024 this would appear to be so with 59.03% of males detained compared to 39.64% female.

If useful this information can be further monitored going forward or historic data gathered.



Quality Directorate / Healthcare Law Department

Compliance with the Mental Health Act Quarterly Audit Quarter 2 - 2024

Audits conducted by: Mental Health Act Department Staff
Report produced by: Carlie Swingle, Mental Health Act Administrator, validated by Wendy Lappin Mental Health Act Legislation Manager
July 2024

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SUMMARY

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

In quarter 2 of 2024, nine units were audited reviewing a total of 54 files. Standards in relation to Care and Treatment Plans and medication charts were previously added and are now part of the regular audit. Nine files were also audited for the patients detained on a Community treatment order (CTO).

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

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

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

Considering the combined results, at the end of the audit all standards (apart from standard 7.3) ended with a better compliance than they began.

The lowest compliance was 24.1% for standard 7.3 which was impacted by the patients that lack capacity to sign the CTP. The highest was 100% for standard 8 followed closely by standard 6 at 92.6%.

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

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

INTRODUCTION AND STANDARDS

For 2024 each unit is detailed within the audit in relation to the standards below. Additional standards have been added, Care and Treatment Plans and Medication Charts. It is noted that Care and Treatment Plans state they MUST be signed by a Care Coordinator and the patient MAY sign. Within some units the lack of capacity may also affect if the patient signs the Care and Treatment Plan.

When considering standard 7 if there is a lack of up to date CTPs the following questions regarding date and signatures will be measured against those that were compliant with the initial question.

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

NUMBER	STANDARD
1	Section papers The correspondence file and case notes should contain the same detention paperwork.
2	Section 17 Leave documentation The correspondence file and case notes should contain the same information.
3	Explanation of Rights The correspondence file and case notes should contain the same document.
4	Explanation of Rights The patient should be made aware of their rights in their primary language
5	Explanation of Rights The patient should be offered a referral to IMHA services
6	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.
7	Care and Treatment Plan The integrated file should contain an up to date Care and Treatment Plan. <ul style="list-style-type: none">• Is the CTP dated on the last page?• Has the CTP been signed by the Care Coordinator?• Has the CTP been signed by the patient?
8	Mental Health Act Divider The integrated file should contain a Mental Health Act divider.
9	Paperwork The documentation should confirm that the Mental Health Act documentation is filed correctly.
10	Medication Charts The legal status should be recorded on the medication chart.

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

The below table shows the number of files scrutinised during quarter 2 of 2024 for each unit.

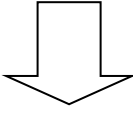

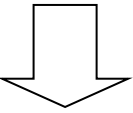
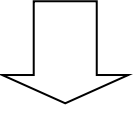
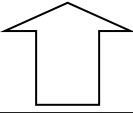
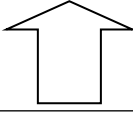
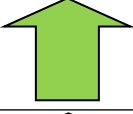

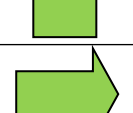
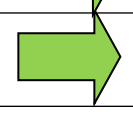
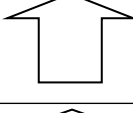
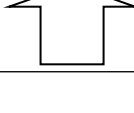
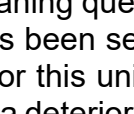
Specialism and Unit	Number of files scrutinised	Specialism and Unit	Number of files scrutinised
Older Persons		Learning Disability	
Cefni Hospital	11	Villas	
Bryn Hesketh	9	Tan Y Coed	0
Rehabilitation		Foelas	1
Tan Y Castell	4	Mesen Fach	3
Coed Celyn	3	CAMHS	
Carreg Fawr	4	North Wales	
Forensic		Adolescent Service	2
Ty Llywelyn	17	CTO patients	
		Patients within the community under a Community Treatment Order	9

RESULTS

Each unit's results are reported within a table detailing the result of the previous audit at the beginning of 2024 the starting position being Quarter 1 audit aside from Foelas which did not have any detained patients in the first quarter of 2024, confirmation of an upward, downward or no change result is then included. For those standards that the unit met 100% the arrow is shaded green.

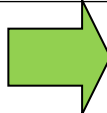
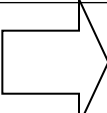



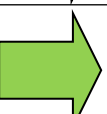
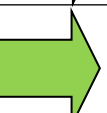
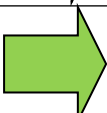
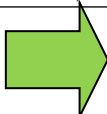
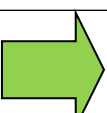
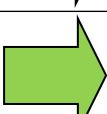
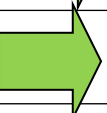
For each unit any notes of concern or good practice are recorded along with any immediate actions taken at the time of the audit.

Cefni

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	70%	54.5%	45.5%	
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	90%	100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	60%	54.5%	45.5%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	50%	27.3%	72.7%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	60%	63.6%	36.4%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	80%	81.8%	18.2%	
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	70%	100%		
	Care and Treatment Plan Is the CTP dated on the last page	70%	90.9%	9.1%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	70%	100%		
	Care and Treatment Plan Has the CTP been signed by the patient			100%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	50%	72.7%	27.3%	
10	Medication Charts Is the legal status correct on the medication chart	50%	81.8%	18.2%	


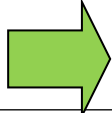



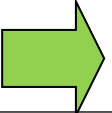
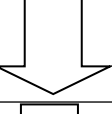
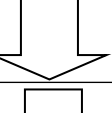
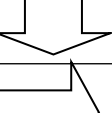
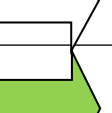

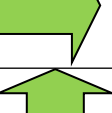

Notes: In this quarter a number of files appeared to have old rights forms meaning question 4 was not answered. This has impacted the result heavily. The new form has been sent to the ward manager, deputy' and the ward clerk. In regards to standard 7.3 for this unit the patients are likely to lack capacity so this will not be achieved. There has been a deterioration in the section papers being present within the files which may be due to the lack of a ward clerk.

Bryn Hesketh

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	100%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	66.6%	66.6%	33.3%	
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	100%	100%		
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	100%	100%		
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	100%	100%		
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	100%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	100%	100%		
	Care and Treatment Plan Is the CTP dated on the last page	100%	100%		
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	100%	100%		
	Care and Treatment Plan Has the CTP been signed by the patient			100%	New measure
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	100%	100%		
10	Medication Charts Is the legal status correct on the medication chart	100%	100%		








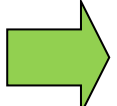
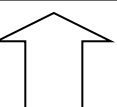
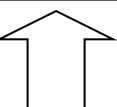
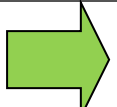
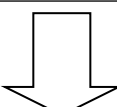
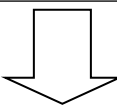
Notes: In regards to the standard 'has the CTP been signed by the patient?' for this unit the patients are likely to not have capacity so this will not be achieved. This unit always has a high compliance for the standards and is well ran and documentation monitored efficiently.

Tan Y Castell

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	100%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	100%	100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	75%	100%		
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	75%	100%		
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	75%	100%		
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	100%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	75%	50%	50%	
	Care and Treatment Plan Is the CTP dated on the last page	75%	50%	50%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	75%	25%	75%	
	Care and Treatment Plan Has the CTP been signed by the patient			100%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	100%	100%		
10	Medication Charts Is the legal status correct on the medication chart	-	100%		


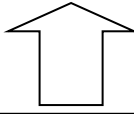
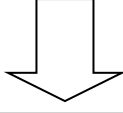
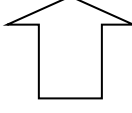
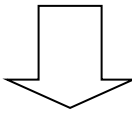
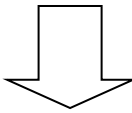
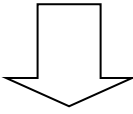
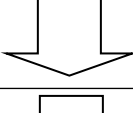
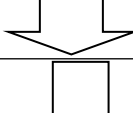
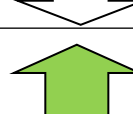

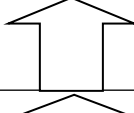
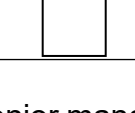
Notes: This unit always has a high compliance for the standards and is well ran and documentation monitored efficiently. The explanation of rights compliance is now back at 100% for this quarter.

Carreg Fawr

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	40%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	100%	100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	60%	100%		
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	60%	100%		
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	60%	100%		
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	100%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	60%	100%		
	Care and Treatment Plan Is the CTP dated on the last page	100%	100%		
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	66.7%	75%	25%	
	Care and Treatment Plan Has the CTP been signed by the patient	33.3%	75%	25%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	100%	50%	50%	
10	Medication Charts Is the legal status correct on the medication chart	100%	25%	75%	


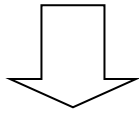




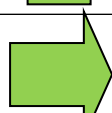




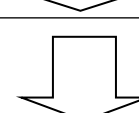
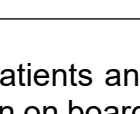
NOTE: The unit has received support in relation to documentation and additional training and has made significant progress this quarter.

Ty Llywelyn

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	100%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	73.7%	82.4%	26.6%	
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	100%	76.5%	23.5%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	78.9%	88.2%	11.8%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	94.7%	88.2%	11.8%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	94.7%	94.1%	5.9%	
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes	94.7%	70.6%	29.4%	
	Care and Treatment Plan Is the CTP dated on the last page	89.5%	82.4%	17.6%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	78.9	76.5%	23.5%	
	Care and Treatment Plan Has the CTP been signed by the patient	63.2%	52.9%	47.1%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes	89.5%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	84.2%	94.1%	5.9%	
10	Medication Charts Is the legal status correct on the medication chart	84.2%	94.1%	5.9%	



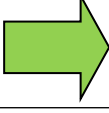



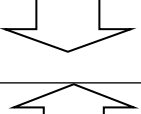
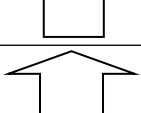
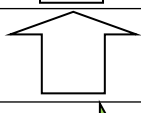


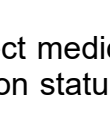

NOTE: The unit has seen a fall in compliance this has been shared with all senior managers and the scrutiny standards shared with the ward managers to assist going forward.

Mesen Fach

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	80%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	100%	66.6%	33.3%	
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	60%	100%		
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	60%	100%		
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	60%	100%		
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	40%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	100%	100%		
	Care and Treatment Plan Is the CTP dated on the last page	100%	100%		
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	100%	100%		
	Care and Treatment Plan Has the CTP been signed by the patient			100%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	100%	33.3%	66.6%	
10	Medication Charts Is the legal status correct on the medication chart	80%	66.6%	33.3%	

NOTE: The unit was reminded in regards to the explanation of rights for patients and the need for the documentation to be completed fully. This has clearly been taken on board with standard 4 achieving 100%. In regards to the standard 'has the CTP been signed by the patient?' for this unit the patients are likely to not have capacity so this will not be achieved.

CAMHS – North Wales Adolescent Service

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	100%	100%		
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	100%	100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	100%	100%		
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	100%	100%		
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	100%	100%		
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	100%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	100%	50%	50%	
	Care and Treatment Plan Is the CTP dated on the last page	-	50%	50%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	-	50%	50%	
	Care and Treatment Plan Has the CTP been signed by the patient	-	50%	50%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	100%	100%		
10	Medication Charts Is the legal status correct on the medication chart		100%		

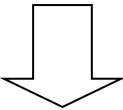

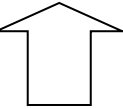
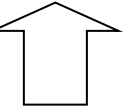
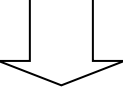



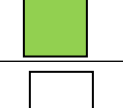
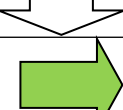
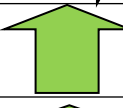


NOTE: The staff have been informed that they should be using the correct medication chart which has a dedicated question on the front in regards to the section status of a patient this appears to have had an impact.

Foelas

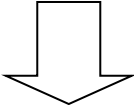
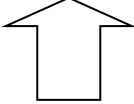
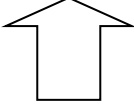
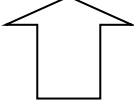
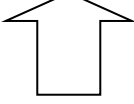
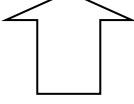
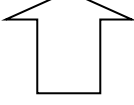
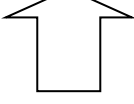
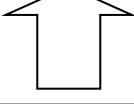
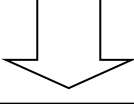
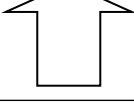
No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.		100%		There were no detained patients at Foelas last quarter for comparison
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.		100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.			100%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language			100%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services			100%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.			100%	
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.		100%		
	Care and Treatment Plan Is the CTP dated on the last page		100%		
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator		100%		
	Care and Treatment Plan Has the CTP been signed by the patient			100%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes		100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly			100%	
10	Medication Charts Is the legal status correct on the medication chart		100%		

NOTE: Comparison will be followed through for the year if patients remain detained within the Foelas unit.

Coed Celyn

No	Standard	2024 (starting Position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	100%	66.6%	33.3%	
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	60%	100%		
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	60%	66.6%	33.3%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	40%	66.6%	33.3%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	40%	33.3%	66.6%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	100%	100%		
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes	50%	100%		
	Care and Treatment Plan Is the CTP dated on the last page	60%	100%		
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	60%	100%		
	Care and Treatment Plan Has the CTP been signed by the patient	40%		100%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes.	100%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly.	66.7%	100%		
10	Medication Charts Is the legal status correct on the medication chart	60%	100%		

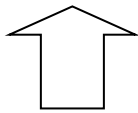
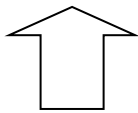
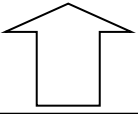
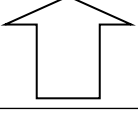
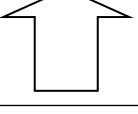
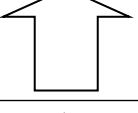
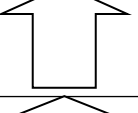
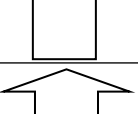
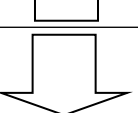

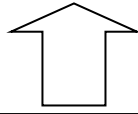
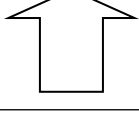

CTO Patient Files (Patients currently on a Community Treatment Order)

No	Standard	2024 (Starting position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	50%	33.3%	66.6%	
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	0%	44.4%	55.6%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	0%	33.3%	66.6%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	0%	33.3%	66.6%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	0%	88.9%	11.1%	
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes.	50%	77.8%	22.2%	
	Care and Treatment Plan Is the CTP dated on the last page	50%	77.8%	22.2%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	0%	77.8%	22.2%	
	Care and Treatment Plan Has the CTP been signed by the patient	0%	44.4%	55.6%	
8	Mental Health Act Divider Was there a Mental Health Act divider in the case notes	100%	77.8%	22.2%	
9	Paperwork Was the Mental Health Act documentation filed correctly	0%	44.4%	55.6%	

NOTE: Not all of the standards can be reported against for CTO patients as they will not have section 17s and there is no access to the medication charts.

All documents that are missing from CTO files are forwarded from the MHA office for filing. Staff are also reminded about carrying forward documents when new files are created.

Combined results from the inpatient units

No	Standard	2024 (starting position)	% achieved	% not achieved	Comparison to previous audit
1.	Section papers The correspondence file and case notes should contain the same detention paperwork.	86.9%	88.9%	11.1%	
2.	Section 17 Leave documentation The correspondence file and case notes should contain the same information.	77%	87.1%	12.9%	
3.	Explanation of Rights The correspondence file and case notes should contain the same document.	78.7%	79.6%	20.4%	
4.	Explanation of Rights Was the patient made aware of their rights in their primary language	68.9%	75.9%	24.1%	
5.	Explanation of Rights Was the patient offered a referral to the IMHA services	75.4%	81.5%	18.5%	
6.	Medication Certificates The correspondence file and case notes should contain the same documents, certificate and consent.	86.9%	92.6%	7.4%	
7.	Care and Treatment Plan Is there an up to date Care and Treatment Plan within the case notes	81.9%	85.2%	14.8%	
	Care and Treatment Plan Is the CTP dated on the last page	72.1%	87.1%	12.9%	
	Care and Treatment Plan Has the CTP been signed by the Care Coordinator	72.1%	83.3%	16.7%	
	Care and Treatment Plan Has the CTP been signed by the patient	36.1%	24.1%	75.9%	
8.	Mental Health Act Divider Was there a Mental Health Act divider in the case notes	95.1%	100%		
9.	Paperwork Was the Mental Health Act documentation filed correctly	81.9%	83.3%	16.7%	
10	Medication Charts Is the legal status correct on the medication chart	73.8%	87.1%	12.9%	

ACTIONS TAKEN

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

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

ACTION PLAN FROM THE YEARLY AUDIT AND PROGRESS

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

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

RECOMMENDATIONS / SHARING OF INFORMATION

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

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

The audit will be shared with the Business Support Managers in relation to filing so that this can be shared in admin meetings with administration staff. The importance of documentation and audits undertaken is to be highlighted within the MHA training sessions provided to the MHLD staff.

Cyfarfod a dyddiad: Meeting and date:	Mental Health Legislation Committee 1 st August 2024						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) Q1 2024-25 Update						
Cyfarwyddwr Cyfrifol: Responsible Director:	Michelle Denwood, Director of Safeguarding and Public Protection Angela Wood, Executive Director of Nursing and Midwifery						
Awdur yr Adroddiad Report Author:	Hayley Lloyd, DoLS and MCA Regional Team Manager Mat Phillips, Safeguarding Adults/Adults with Dementia Lead Chris Walker, Head of Safeguarding Adults, DoLS and MCA						
Craffu blaenorol: Prior Scrutiny:	Due to the non-alignment of the cycles of business, this quarterly report is submitted directly to the Committee. Deprivation of Liberty Safeguards is held within the portfolio of the Executive Director of Nursing and Midwifery, this update has been reviewed by Angela Wood, Executive Director of Nursing and Midwifery.						
Atodiadau Appendices:	Appendix 1: DoLS and MCA Audit Action Plan						
Argymhelliad / Recommendation:							
The Committee is asked to:							
<ol style="list-style-type: none"> 1. Accept the DoLS and MCA Report and the identified activity for the period of Q1 2024-25 2. Receive the DoLS and MCA Audit Action Plan and recorded progress. 							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	x	Er gwybodaeth For Information	x
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable					No		
Sefyllfa / Situation:							
Governance The activity recorded provides oversight and organisational assurance in relation to the Health Board's statutory duty under The Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA 2005) for the period of Q1 2024-25. The activity includes key actions to ensure that DoLS and the MCA as part of the wider Safeguarding and Public Protection agenda remains paramount to service delivery across the Health Board.							

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

Legislation Activity

The implementation of the Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards (LPS) was placed on hold by UK Government prior to the General Election in July 2024. The new elected Government have appointed MP Stephen Kinnock as Care Minister with responsibility for the MCA, DoLS and the LPS. However, it was announced within the Kings Speech (July 2024) that the priority for the Minister would be the reform of the Mental Health Act prior to any work in addressing the current DoLS process and the proposed/delayed implementation of the LPS.

Welsh Government (WG) continue to ensure additional funding is available to strengthen the current DoLS system and implement elements of the LPS. We follow WG directives by promoting MCA awareness and delivering MCA training whilst addressing the DoLS backlog (legal term for applications awaiting authorisation). The MCA/DoLS National Workforce Group continues to focus on the MCA and DoLS enabling stakeholders to jointly consider issues of local concern that may have a wider or national relevance and provide a forum for joint working on national projects.

Current Health Board Position (Q1)

In partnership with other Health Boards, the National Workforce Group continues to meet every quarter. The action plan continues to address the following:

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

Addressing each action in turn.

- Action 1 will support an improvement in the current compliance of the completion of the DoLS and MCA documentation. The Health Board Chair this sub-group on behalf of the National Workforce Group. A reduction in the amount of statutory paperwork and repetitiveness of the documentation would support an improvement in compliance.
- Action 2 is a key activity for the Health Board with progress on MCA training compliance having been achieved during 2023-24. National training programmes will offer a standardised approach to MCA awareness and understanding, providing staff with the necessary skills to confidently support patients in their care and uphold their rights under the legislation.
- Action 3 relates to the DoLS Backlog. As of the 18/07/2024 the DoLS Backlog for the Health Board stands at 44 (see Table 1 below). It is important to note, applications received can differ significantly from month to month and the backlog will fluctuate.

Table 1

Urgent Applications (1-7 Days)	44
Extended Applications (8 - 14 days)	24
Backlog	44
Applications Allocated to BIA	18
Applications Allocated to Section 12(2) Doctors	16
Applications Pending Authorisation	2

Utilising the additional WG funding we have been able to continue to offer Secondment opportunities in order to strengthen the current DoLS/MCA system. WG have recently confirmed that temporary funding will become permanent funding, a further review of the service is underway to strengthen the Health Boards provision of DoLS and MCA support. All activities are closely monitored by the Welsh Government to monitor performance and improvements to support the implementation of this legislation and improve patient care.

Cefndir / Background:

Performance and Activity

The annual trend for DoLS applications is an upward trajectory within the Health Board. This is in line with the National picture. During Q1 2024-25 a total of 563 DoLS applications were submitted, this is a 28.2% increase in comparison to last year's figure. Although the increase places pressure on the service it also demonstrates learning and compliance with the statutory legislation.

We are currently reporting an average of a four to 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 are in a similar position. WG have responded to organisational challenges and the financial support offered to address the DoLS Backlog has resulted in a reduction in authorisation times that were historically recorded as anything up to a ten to twelve week delay.

An internal Audit of the MCA and DoLS commenced during Q4 2023-24. This included a review of the processes in place for the management of DoLS activity within the Health Board, including procedures, staff training, and the monitoring and escalation of cases. Recommendations have been received and a management response, approved by the Executive Director of Nursing and Midwifery was completed. The overall outcome reported a position of Assurance and Limited Assurance.

There are three actions to note:

- Action 1 relates to a key activity to the Health Board and is in relation to the Mandatory MCA training Level 1 and 2 compliance figures for Bank, Locum and Honorary staff due to low compliance. A review of the training data has commenced to identify staff who have not undertaken training. Following the review, details will be shared with respective services regarding the agreed requirement to complete MCA training and will be reported and monitored for compliance within Safeguarding Forums (MCA and DoLS are a standard item agenda at all Safeguarding Forums). Where action is not taken to improve this will be escalated through appropriate governance channels, following the Safeguarding Reporting Framework and BCUHBS Governance Cycle of Business.

- Action 2 notes that Standard Authorisations are not being granted within the legal timeframe. There has already been a significant improvement in reducing the DoLS Backlog due to the additional work by the MCA/DoLS Team. However, the Supervisory Body (MCA/DoLS Team) will continue addressing quality issues with relevant areas and continue to review the workload of BIAs and Mental Health Assessors (a s12(2) Approved Doctor) to improve timescales. Utilising the WG money, additional internal staff will have the opportunity to undertake the Masters level Best Interest Assessor Course during 2024-25 as this will improve Health Board capacity to undertake additional assessments.
- Action 3 relates directly to the DoLS documentation and the inaccuracies to the applications by front line practitioners. Again, this is a key target for the Health Board and we already have additional support in place to improve the quality of the information and reduce inaccuracies. There has been a significant improvement due to the additional support sessions that have been provided to the Managing Authorities (Hospital Wards/Front line practitioners). It should be noted that the errors do not result in the delay of an Authorised DoLS. Errors in paperwork are predominantly minor but to ensure good governance and compliance with legislation and potential challenges within the Court of Protection improvement is needed. Every application is quality assured and audited on receipt by the MCA/DoLS Team, with feedback on the quality of paperwork provided within 24 hours.

Welsh Government (WG) Monies

WG confirmed that additional funding will be made permanent in line with a bidding process. 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.

Asesu a Dadansoddi / Assessment & Analysis

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 internal audit undertaken in Q1 2024-25 included 563 DoLS applications. Although the findings demonstrated continued errors in the quality of the paperwork resulting in applications having to be initially returned to the Managing Authority (Hospital Wards). The issues were minor and required minimal input and time to rectify. Returned applications did not result in a delay in the authorisation of a DoLS, but importantly they support reflection and improvement in practice.

Analysis

Of the 352 applications that recorded issues during Q1, 43.5% (n=153) applications were rectified within the Urgent application timeframe. The majority of the issues from the applications were minor with minimal amendments required. The submitted applications continue to identify four (4) main themes:

- No inclusion of the Mental Capacity Assessment Form. The findings from the audit reported 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.
- Some details were included, however to fully adhere to the legal framework the Managing Authority must provide all necessary information. This issue is usually addressed immediately by the Managing Authority and we plan to include enhanced monitoring of timescales.

Training

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

Competency	Q4 2023-24	Q1 2024-25	Trend
Mental Capacity Act Level 1	80.4%	80.7%	↑
Mental Capacity Act Level 2	79.6%	79.8%	↑

Q1 2024-25 has already seen a small overall improvement in MCA training compliance. An identified priority for 2024-25 is to review and action training provision and compliance to students, bank, agency and non-substantive staff. There are a number of individual Divisions and Services that have a compliance rate above the organisational target of 85%. Training compliance is shared monthly with respective services to ensure compliance is reviewed and actions taken as appropriate with monitoring taking place in the Safeguarding Forums. The MCA lead reviews the DoLS data and targets areas of low compliance.

Analysis

Training compliance and an understanding of DoLS and the MCA is a key target so the approach taken is to ensure all areas or departments with a reduced compliance are afforded extra training and support. A revised virtual training programme is also available and remains in place to encourage ongoing training. MCA training is also included within the mandatory Adult Level 2 Safeguarding Module to utilise all available opportunities. Work is ongoing to secure offices for BIA's at the three DGH's. This will provide each IHC with on-site support to address any immediate MCA/DoLS concerns or issues.

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)

A Standard Operating Procedure (SOP) for 16-17 year olds within the CoP DoL process to reflect the legislative policy and to ensure good practice and governance is in the final stages of development and approval. This includes the application of the MCA for 16-17 year olds.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

There are no financial implications for this report.

Risk Analysis

Risk CRR 24-03. There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients. Following review at the Health Board Risk Management Group and the Formal Executive Group in Q1 the current risk score is recorded as 16.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

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

Asesiad Effaith / Impact Assessment

N/A

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

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

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

	Recommendations	Action Required	Lead	Evidence of completion	Target Date	RAG
1.0	Welsh Government funding, actions and objectives.	<ul style="list-style-type: none"> Fund additional Best Interest Assessments to reduce the DoLS Backlog. Embed MCA training across BCUHB. Prepare for the implementation of LPS. Improve MCA training compliance for Locum and temporary staff. 	CW HL	<p><u>Update Q1 2024-25:</u></p> <p>This action will be ongoing until March 2025 following confirmation from WG that funding is available for 2024-25.</p> <p>The MCA training lead will provide targeted sessions for our temporary staffing establishment within the Health Board. In conjunction with this the health boards temporary staffing team have been requested to assure competency of agency staff being utilised in this area parable with substantive staff.</p>	31.03.2025 On Track	Amber

Appendix 1

<p>2.0</p>	<p>Development of a Standard Operating Protocol (SOP) for assessing existing patients and for assessing future funded patients.</p>	<ul style="list-style-type: none"> • Further engagement with commissioning services. • Development of a Standard Operating Procedure (SOP) for assessing existing patients and for assessing future funded patients. • Support the development of a protocol to help manage the complex interface between the Mental Health Act and the Mental Capacity Act and review service users accessing Mental Health services (individuals who are not objecting to their care and treatment as defined under the Mental Health Act). 	<p>CW HL</p>	<p><u>Q1 2024-25 update:</u></p> <p>A secondment opportunity has been made available to continue to progress this activity.</p> <p>Engagement has taken place with L&R Services to establish the legislative position, accountability and responsibility.</p> <p>Engagement with Commissioning Services to support the development of a SOP is ongoing.</p> <p>A draft SOP has been developed and is currently progressing through the governance process for ratification and approval.</p>	<p>30.09.2023</p>	<p>Amber</p>
<p>3.0</p>	<p>DoLS Internal Audit Actions and Objectives</p>	<ul style="list-style-type: none"> • Improve MCA Level 1 and 2 compliance for Bank Locum and Honorary staff: Review training data to identify those staff that have not undertaken training. Once identified, confirm with staff the requirement to complete the training. Where this is not undertaken, escalate as appropriate. 	<p>CW HL</p>	<p><u>Q1 2024-25 Update:</u></p> <p>Mapping exercise completed. Reviewed training compliance and trend for MCA Level 1 and 2.</p> <p>Data collection methods are being reviewed and progress is shared at the IHCs and MHLD Safeguarding Forum.</p>	<p>30/09/2024</p>	<p>Amber</p>

Appendix 1

			<p>Reporting follows the Safeguarding Governance and Reporting Framework to ensure reporting and escalation and monitoring.</p> <p>Training data and the escalation of low compliance is reported via IHC/MHLD Safeguarding Forums and follows the Safeguarding Governance and Reporting Framework (SGPG, QDG, and QSE) is reported via the newly formed Quality Performance Reviews by IHCs and DoN.</p> <p>We have completed a scoping exercise and engaged with temporary staffing teams in relation to those staff being provided by agency having competency in Mental Capacity Act.</p> <p>The All Wales Recruitment Framework which is due to go to tender from September 2024.</p> <p>This framework requires that all staff must hold the Mental Capacity Act competency to work within the Health Board. A plan is in place to prioritise implementation and identify workforce groupings to support this action.</p>		
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Appendix 1

<p>4.0</p>	<p>DoLS Internal Audit Actions and Objectives</p>	<ul style="list-style-type: none"> DoLS Authorisations: Address quality issues with relevant areas and review capacity of BIAs and Mental Health Assessor (a s12(2) Approved Doctor) to improve the authorisation process ensuring Standard Authorisations are completed within the 2 week timeframe 	<p>CW HL</p>	<p><u>Q1 2024-25 Update:</u></p> <p>Work underway with Data Analysis support to develop a modelling process and is identify high referral areas, to be monitored monthly.</p> <p>Two staff members have already completed the BIA course and following an expression of interest a further 6 Health Board employees have registered an interest in completing the course thus increasing the capacity of the BIA's to compete additional assessments over the weekends.</p> <p>The MCA Lead (seconded position) is in place and undertakes weekly visits and daily contact within high risk areas. Authoriser training to be sourced to train additional employees to be able to grant DoLS Authorisations.</p>	<p>31/03/2025</p>	<p>Amber</p>
<p>5.0</p>	<p>DoLS Internal Audit Actions and Objectives</p>	<ul style="list-style-type: none"> DoLS Documentation: Managing Authorities to ensure that the applications are completed appropriately and returned in a timely manner. Where issues are identified with quality or 	<p>CW HL</p>	<p><u>Q1 2024-25 Update:</u></p> <p>A review of the process is currently underway. The administration Team has been strengthened (seconded position) to provide support and feedback to the DGH and Community</p>	<p>31/03/2025</p>	<p>Amber</p>

Appendix 1

		<p>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.</p>	<p>hospitals regarding the applications. Support sessions are currently being rolled out to provide QA sessions.</p> <p>Progress is reported via the Safeguarding Governance and Reporting Framework. Formal documentation, schedule of activities for MCA/DoLS Supervision sessions are under development. To support and inform this activity BIA's are present on the wards throughout all DGH and Community hospitals and provide advice and support.</p> <p>Escalation process under review. Current safety mechanisms include immediate reporting of non-compliance to senior staff within respective services.</p>		
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Teitl adroddiad: <i>Report title:</i>	Healthcare Inspectorate Wales (HIW) Assurance Report			
Adrodd i: <i>Report to:</i>	Mental Health Legislation Committee			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 01 August 2024			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>HIW is the independent inspectorate and regulator of all health care in Wales.</p> <p>HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board, considering how the services are meeting the Quality Health and Care Standards 2023 and the Mental Health Act.</p> <p>This report provides assurance that following inspections, recommendations/actions in relation to the Mental Health Act.</p>			
Argymhellion: <i>Recommendations:</i>	The Committee is asked to note the report			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: <i>Report Author:</i>	Erika Dennis, Quality Lead Manager Clare Jones, Quality Assurance Manager Matthew Joyes, Deputy Director – <i>presenting</i>			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	I'w Nodi <i>For Noting</i> <input checked="" type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>	
Lefel sicrwydd: <i>Assurance level:</i>	Arwyddocaol <i>Significant</i> <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol <i>Acceptable</i> <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol <i>Partial</i> <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd <i>No Assurance</i> <input type="checkbox"/> Dim hyder/tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: <i>Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:</i>				

<p>Cyswllt ag Amcan/Amcanion Strategol:</p> <p>Link to Strategic Objective(s):</p>	<p>Outcome 4 - Improved access, outcomes and experience for citizens</p>
<p>Goblygiadau rheoleiddio a lleol:</p> <p>Regulatory and legal implications:</p>	<p>The Health Board's Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is around the quality of patient experience, the delivery of safe and, the effective care and, the quality of management and leadership.</p> <p>The Health Board has a legal obligation under the Mental Health Act to keep people safe and ensure that they are being detained and cared for with least restrictive options being at the forefront of professional's practices. There are obligations under the Mental Health Measure to ensure that all persons have a care and treatment plan that is appropriate.</p>
<p>Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP7 has an EqIA been identified as necessary and undertaken?</p>	<p>This is a retrospective report, and therefore no EQIA required. All policies which link in with HIW actions will be Equality Impact Assessed.</p>
<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?</p> <p>In accordance with WP68, has an SEIA identified as necessary been undertaken?</p>	<p>N/A</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR)</p> <p>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</p>	<p>N/A</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p>Financial implications as a result of implementing the recommendations</p>	<p>Issues highlighted by HIW may have financial implications. However the aspects covered by this document (namely the Mental Health Act and Mental Health Measure) require no financial consideration at present.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p>Workforce implications as a result of implementing the recommendations</p>	<p>N/A</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p>Feedback, response, and follow up summary following consultation</p>	<p>This report has been reviewed by:</p> <ul style="list-style-type: none"> - Mental Health & Learning Disability Service Quality Delivery Group - Matthew Joyes, Deputy Director of Quality

<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p>Links to BAF risks: (or links to the Corporate Risk Register)</p>	N/A
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p>Reason for submission of report to confidential board (where relevant)</p>	N/A
<p>Camau Nesaf: Gweithredu argymhellion</p> <p>Next Steps: Implementation of recommendations</p>	
<p>Rhestr o Atodiadau: List of Appendices: Appendix 1 – Inspections</p>	

Inspections within the last 6 months (1)

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

Announced Visit: Nant Y Glyn Community Mental Health

Inspection Date: 23rd and 24th January 2024
Publication Date: 25th April 2024
Inspection Report: [HIW Nant y Glyn Inspection Report](#)

HIW Recommendation

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

Service Improvement Actions

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

Responsible Lead – Iain Wilkie

Progress Status – **Fully Complete (Approved)**

Audit completed on 11th April 2024 and shared with Service and Team Managers on 15th April 2024

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

Responsible Lead – Iain Wilkie

Progress Status – **Fully Complete (Approved)**

Audit report completed and improvements required noted. Action plan to be formulated to address recommendations from the audit report.

Status updates for all service improvement actions have been reported to the monthly Regulatory Assurance Group, chaired by the Deputy Director of Quality Governance.



Teitl adroddiad: <i>Report title:</i>	Associate Hospital Managers Update Report (April - June 2024)			
Adrodd i: <i>Report to:</i>	Mental Health Legislation Committee (MHLC)			
Dyddiad y Cyfarfod: <i>Date of Meeting:</i>	Thursday, 01 August 2024			
Crynodeb Gweithredol: <i>Executive Summary:</i>	<p>The Associate Hospital Managers update report provides details regarding the Associate Hospital Managers activity within the Health Board for the detailed period. The report describes activities in the following areas: Hearings, Scrutiny, Training, Recruitment, Forums and Meetings.</p> <p>This report provides assurance that the individuals who form the Hospital Manager Discharge Panels (namely Mental Health Act Associate Hospital Managers (MHA AHM)) are in receipt of adequate training and conform to the Health Board standards.</p> <p>The report details the activity of the Associate Hospital Managers in relation to hearings and activity undertaken, concerns raised and improvements to the division or service to which they have input for the period April - June 2024.</p>			
Argymhellion: <i>Recommendations:</i>	The committee is asked to note the report.			
Arweinydd Gweithredol: <i>Executive Lead:</i>	Teresa Owen, Lead for Mental Health			
Awdur yr Adroddiad: <i>Report Author:</i>	Wendy Lappin, Mental Health Act Manager – <i>author</i> Matthew Joyes, Deputy Director – <i>presenting</i>			
Pwrpas yr adroddiad: <i>Purpose of report:</i>	<p>I'w Nodi <i>For Noting</i></p> <p><input checked="" type="checkbox"/></p>	<p>I Benderfynu arno <i>For Decision</i></p> <p><input type="checkbox"/></p>	<p>Am sicrwydd <i>For Assurance</i></p> <p><input checked="" type="checkbox"/></p>	
Lefel sicrwydd: <i>Assurance level:</i>	<p>Arwyddocaol <i>Significant</i></p> <p><input type="checkbox"/></p> <p>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i></p>	<p>Derbyniol <i>Acceptable</i></p> <p><input checked="" type="checkbox"/></p> <p>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>General confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Rhannol <i>Partial</i></p> <p><input type="checkbox"/></p> <p>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol</p> <p><i>Some confidence / evidence in delivery of existing mechanisms / objectives</i></p>	<p>Dim Sicrwydd <i>No Assurance</i></p> <p><input type="checkbox"/></p> <p>Dim hyder/tystiolaeth o ran y ddarpariaeth</p> <p><i>No confidence / evidence in delivery</i></p>
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

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:	Outcome 4 - Improved access, outcomes and experience for citizens
Link to Strategic Objective(s):	
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:	Mental Health Act 1983 (amended 2007) The Mental Health Act determines that the Health Board must ensure that there are Associate Hospital Managers available to conduct panels for the patients on their request or at the time of a renewal. These Managers cannot be employees of the Health Board to ensure that an independent view is taken when reviewing the detention. Conflicts of interest require consideration and can include any work undertaken for associated agencies which may have contact with patients or influence on the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? In accordance with WP68, has an SEIA identified as necessary been undertaken?	N/A - This report does not inform strategic decisions, it relates to the day to day operations of the Associate Hospital Managers who have delegated functions under the Mental Health Act. Strategic change would only need considering if the Mental Health Act was amended to detail a different course of action for Hospital Managers.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	The number of Associate Hospital Managers must be kept at a reasonable levels to ensure the availability of persons for this activity. The Health Board addressed this by having an open direct hire advert to ensure that the cohort is kept at an adequate level. 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

	<p>given priority. Risks associated with not conducting a hearing as close as possible to the relevant date, would be:</p> <ul style="list-style-type: none"> • Transfers impacting on hearings with the potential for a hearing to be missed or rearranged. • The Associate Hospital Managers Discharge Panel may not agree with the professionals and feel that patient should be discharged any delay in the hearing may result in the patient being detained for longer than necessary.
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Financial implications as a result of implementing the recommendations</i></p>	<p>The Associate Hospital Managers are paid a sessional fee for each activity. The Associate Hospital Managers are now provided with devices to ensure that costs in relation to posting reports are minimised along with ensuring protection and confidentiality of patient's personal information.</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith</p> <p><i>Workforce implications as a result of implementing the recommendations</i></p>	N/A
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori</p> <p><i>Feedback, response, and follow up summary following consultation</i></p>	<p>Matthew Joyes, Deputy Director of Quality and Alberto Salmoiraghi, Medical Director, Mental Health & Learning Disability Division have seen the report prior to submission.</p> <p>The Power of Discharge Group is held prior to the MHLC to discuss the activity.</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)</p> <p><i>Links to BAF risks:</i> (or links to the Corporate Risk Register)</p>	None
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)</p> <p><i>Reason for submission of report to confidential board (where relevant)</i></p>	N/A
<p>Camau Nesaf: Gweithredu argymhellion <i>Next Steps: Implementation of recommendations</i></p> <p>N/A</p>	
<p>Rhestr o Atodiadau: <i>List of Appendices:</i></p> <p>Appendix 1 – Associate Hospital Managers Update Report</p>	

Appendix 1



Associate Hospital Managers (AHM) Update Report April – June 2024

Quarterly Activity

1 Hearings

At the time of writing (05.07.2024) hearings are held both remotely via Microsoft Teams and face to face.

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

17 held face to face and 20 via Teams. The hearings consisted of 28 section 3 renewals, four CTO renewals, one section 47 renewal, one section 3 Barring and four section 3 appeals.

There have been no discharges to date for this period.

A breakdown of the hearing activity is below:

April

- ***Nine hearings arranged (all held); Five held face to face and four via Microsoft Teams.***

Seven hearings were in relation to renewals and two were patient appeals.

Outcomes of hearings held

- All detentions were upheld.

May

- ***15 hearings arranged (13 held); Seven held face to face and six via Microsoft Teams.***

12 hearings were in relation to renewals and two were patient appeals.

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

One hearing was postponed – The reports were not produced on time by the RC the hearing proceeded two weeks later and the patient remained detained.

One appeal hearing was adjourned on the day – The patient was physically unwell this hearing is still to be arranged.

Outcomes of hearings held

- All detentions were upheld

- There was indication that a review was required for two patients, one due to no clear discharge plan being in place and a change in consultant initiated (request form waiting to be received) and one due to accommodation being sought and leave being progressed (patient has since been discharged).

June

- **16 hearings arranged (15 held); Five held face to face and ten via Microsoft Teams.** 14 hearings were in relation to renewals and one was a barring hearing.

One hearing was cancelled and rearranged – The solicitor had double booked, the hearing was face to face and the patient requested their attendance. This took place within the month and the patient remained detained.

Outcomes of hearings held

- All detentions were upheld
- One hearing was initially adjourned as the patient attended and stated they wished to contest the hearing and have representation this was held within the month.

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

Patients with capacity are asked regarding the venue of their hearing, this is now a routine procedure.

Hearing Quality Standard

Following a renewal, there is no timeframe specified within the Mental Health Act of when a hearing is to be held, only the confirmation that one 'must' be held. Good practice suggests this should be undertaken as close to a renewal date as possible. The quality standard is set at 6 weeks following the renewal date. An analysis of the hearings held this quarter is detailed below.

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

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

Currently 62% of hearings were held within the set quality standard.

Renewal Date	Hearing Date	Quality Standard (6 weeks = 42 days)
12/01/2024	12/04/2024	90 days *1
21/01/2024	19/04/2024	88 days *2
09/02/2024	04/04/2024	54 days *3
19/03/2024	09/04/2024	20 days
19/03/2024	22/05/2024	63 days *5
22/03/2024	29/04/2024	37 days
29/03/2024	22/05/2024	53 days *6
06/04/2024	30/04/2024	24 days

09/04/2024	13/06/2024	65 days	*8
11/04/2024	24/04/2024	13 days	
11/04/2024	03/05/2024	22 days	
13/04/2024	16/05/2024	33 days	
16/04/2024	15/05/2024	29 days	
24/02/2024 (23/04/2024)	29/05/2024	36 days	*4
27/04/2024	24/05/2024	27 days	
28/04/2024	20/05/2024	22 days	
29/04/2024	03/06/2024	35 days	
01/05/2024	22/05/2024	21 days	
04/05/2024	31/05/2024	27 days	
07/05/2024	26/06/2024	50 days	
07/05/2024	19/06/2024	43 days	
11/05/2024	03/06/2024	23 days	
13/05/2024	24/05/2024	11 days	
14/05/2024	20/06/2024	41 days	
15/05/2024	07/06/2024	29 days	
15/05/2024	24/06/2024	46 days	
24/05/2024	27/06/2024	35 days	
28/05/2024	17/06/2024	20 days	
30/05/2024	14/06/2024	15 days	
05/06/2024	24/06/2024	19 days	
10/06/2024	28/06/2024	18 days	
11/06/2024	27/06/2024	16 days	
Barring Hearing			
30/04/2024	07/06/2024	38 days	
Appeal by Patient Date	Hearing Date and section	Quality Standard (7 days for a section 2)	
08/03/2024	04/04/2024 S3	26 days	
13/03/2024	02/04/2024 S3	18 days	
18/04/2024	24/05/2024 S3	36 days	
27/03/2024	01/05/2024 S3	34 days	
05/04/2024	15/05/2024 S3	41 days	*7

*1-3 and 5-6 were all in the East and had significant delays.

*1 and *5 were due to the office waiting for the proforma this was prior to the decision being made that if the document is not returned within two weeks a date will be set for a Teams hearing which can be changed if the patient requests.

*2 the RC was off sick.

*3 the original date was set at the 28th day of the Quality standard but due to the RC taking leave the covering RC was unable to facilitate this date it was therefore changed on the RC return from leave.

*4 the patient arrived with the Health Board on the 23/04/2024 the section had been renewed on the 24/02/2024 but no hearing had been held, this was subsequently arranged when discovered.

*6 was due to the RC not providing the report on time this meant the hearing had to be rescheduled at short notice.

*7 the patient was physically unwell on the day of the hearing this is still to be rearranged.

*8 the solicitor was waiting for instruction from the patient to be able to proceed with the contested renewal hearing.

2 Scrutiny

Scrutiny has been undertaken with the first being held at the beginning of February, this is conducted on a monthly basis within the three psychiatric units, Heddfan, Ablett and Hergest. Issues raised via scrutiny are also reported within the AHMs newsletter. The scrutiny form was reviewed at the last Forum meeting, all agreed this was an improvement.

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

3 Training

The training compliance now includes MHA training, all managers have completed this and any new appointments are booked onto the next available date. There are ten AHMs who are 100% compliant with the 16 training sessions.

The compliance for the sessions is recorded on 16 managers this includes one new appointment and has therefore affected the previous compliance.

Compliance is as below:

Training	Compliance	Training	Compliance
Environmental Waste and Energy	88%	Violence and Aggression	88%
Equality Diversity and Human Rights	88%	Welsh Language Awareness	81%
Fire Safety	94%	Dementia Awareness	94%
Health, Safety and Welfare	94%	Fraud Awareness	88%
Infection Prevention and Control	100%	Violence against women, domestic abuse	88%
Information Governance	100%	Mental Capacity Act	100%
Safeguarding Adults	100%	Paul Ridd LD training	75%
Safeguarding Children	100%	Mental Health Act	100%

4 Recruitment

The Associate Hospital Manager cohort at the time of writing this report consists of:

17 persons, 16 are actively involved with hearings. The active cohort consists of five male and 11 female members, of which three are Welsh speakers.

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

The advertised role has generated a number of enquiries with two applications received to date. Interviews will be held shortly.

5 Forums and Meetings

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

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

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

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:	August 2024		
Crynodeb Gweithredol: Executive Summary:	<p>Section 23 of the Mental Health Act (the Act) gives certain powers and responsibilities to 'Hospital Managers'.</p> <p>In Wales, NHS hospitals are managed by Local Health Boards. The Local Health Board is therefore for the purposes of the Act defined as the 'Hospital Managers'.</p> <p>Hospital Managers have the authority to detain patients under the Act. They have responsibility for ensuring the requirements of the Act are followed. In particular, they must ensure patients are detained and treated only as the Act allows and that patients are fully informed of, and are supported in, exercising their statutory rights. Hospital Managers have equivalent responsibilities towards Community Treatment Order (CTO) patients. (CoPW 37.4)</p> <p>In practice, most of the decisions the Hospital Managers take, are undertaken by individuals (or groups of individuals) on their behalf by means of the formal delegation of specified powers and duties. (CoPW 37.5)</p> <p>In particular, decision about discharge from detention and CTOs are taken by Hospital Manager Discharge Panels, made up of Associate Hospital Managers who are not employees. They are directly accountable to the Board in the execution of their delegated functions via the Mental Health Legislation Committee. (CoPW 37.6)</p> <p>The Power of Discharge Group is held on a quarterly basis to provide a forum for Associate Hospital Managers to discuss matters related to their role, chaired by the Deputy Director of Quality; reports are produced and presented by the Mental Health Act Manager to the group.</p> <p>The Power of Discharge Group meeting was held on 23 July 2024.</p> <p>There are no issues for escalation from the group.</p> <p>The group reviewed the MHA Assurance Report, including the Quarterly MHA Compliance Audit, and the Associate Hospital Managers Update Report. These papers are being submitted to the Committee.</p> <p>The group noted that the two newly nominated Associate Hospital Managers had received the invite for the Mental Health Legislation Committee. This allows Associate Hospital Managers direct access to the Board.</p>		
Argymhellion: Recommendations:	The Committee is asked to note this report.		
Arweinydd Gweithredol: Executive Lead:	Teresa Owen, Lead for Mental Health		
Awdur yr Adroddiad: Report Author:	Matthew Joyes, Deputy Director for Quality (Chair of the PoD Group)		
Pwrpas yr adroddiad: Purpose of report:	I'w Nodi <i>For Noting</i> <input type="checkbox"/>	I Benderfynu arno <i>For Decision</i> <input type="checkbox"/>	Am sicrwydd <i>For Assurance</i> <input checked="" type="checkbox"/>

Lefel sicrwydd: Assurance level:	Arwyddocaol Significant <input checked="" type="checkbox"/> Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>High level of confidence/evidence in delivery of existing mechanisms/objectives</i>	Derbyniol Acceptable <input type="checkbox"/> Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>General confidence / evidence in delivery of existing mechanisms / objectives</i>	Rhannol Partial <input type="checkbox"/> Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol <i>Some confidence / evidence in delivery of existing mechanisms / objectives</i>	Dim Sicrwydd No Assurance <input type="checkbox"/> Dim hyder/ tystiolaeth o ran y ddarpariaeth <i>No confidence / evidence in delivery</i>
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):		Outcome 4 - Improved access, outcomes and experience for citizens Outcome 5 - Recognition of BCU as a learning and self-improving organisation		
Goblygiadau rheoleiddio a lleol: Regulatory and legal implications:		Hospital Managers have the authority to detain patients under the Mental Health 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. The Duty of Quality is a statutory requirement under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The statutory duty of quality requires the decision-making processes by the Health Board take into account the improvement of health services and outcomes for the people of Wales – the duty also includes new Health and Care Quality Standards. Instances of harm to patients may indicate failures to comply with the NHS Wales standards or safety legislation.		
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		

<p>Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? <i>In accordance with WP68, has an SEIA identified as necessary been undertaken?</i></p>	<p>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.</p>
<p>Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) <i>Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)</i></p>	<p>BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<p>Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith <i>Financial implications as a result of implementing the recommendations</i></p>	<p>N/A</p>
<p>Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith <i>Workforce implications as a result of implementing the recommendations</i></p>	<p>N/A</p>
<p>Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori <i>Feedback, response, and follow up summary following consultation</i></p>	<p>N/A</p>
<p>Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) <i>Links to BAF risks:</i> <i>(or links to the Corporate Risk Register)</i></p>	<p>BAF-SP18 and CRR-24-04 – Quality, Innovation and Improvement</p>
<p>Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) <i>Reason for submission of report to confidential board (where relevant)</i></p>	<p>N/A</p>
<p>Camau Nesaf: Gweithredu argymhellion <i>Next Steps: Implementation of recommendations</i> N/A</p>	
<p>Rhestr o Atodiadau: <i>List of Appendices:</i> N/A</p>	