Bundle Mental Health Act Committee 12 March 2021

Agenda attachments

Agenda_Mental_Health_Act_Committee_-12_March_2021 V1.0.docx

1 OPENING BUSINESS

1.1 10:30 - MHAC21/1 Welcome and apologies

Apologies received from:

** Jo Whitehead, Chief Executive Officer.*
** Teresa Owen, Executive Director of Public Health.*
** Chris Stockport, Executive Director Primary & Community Care, Corporate Office.*
** Rachel Turner, Ward Manager - RCN Steward, Adult Mental Health & Social Care.*

1.2 10:31 - MHAC21/2 Declaration of Interests

1.3 10:32 - MHAC21/3 Draft minutes of the meeting held on 8.12.20

1\. To confirm as a correct record the minutes of the previous meeting\.

MHAC21.3 Draft MHAC draft mins 8.12.20 v0.6 TAO LR.docx

1.4 10:37 - MHAC21/4 MHAC Matters arising and Review of Summary Action Log

1. To review the Summary Action Log.
2. To deal with any matters arising not dealt with elsewhere on the agenda.
3. Simon Evans-Evans, Interim Director of Governance, to provide a verbal update regarding the Committee Governance Review.

MHAC21.4 MHAC Summary Action Plan live version v1.1.doc

1.5 10:47 - MHAC21/5 Draft minutes of Power of Discharge Sub-Committee meeting held on 8.12.20 and verbal update from the earlier meeting

MHAC21.5 Draft PODSub C draft mins 8.12.2020 v0.5 TAO IW LR.docx

2 10:51 - MHAC21/6 Items circulated since the previous meeting

** Detail (*via email)* circulated to members only on the 1/3/21 with regards to:- Devon Partnership NHS Trust v Secretary of State for Health and Social Care [2021] EWHC 101 (Admin).*

3 FOR DISCUSSION

3.1 10:52 - MHAC21/7 Patient Story

Mike Smith, Director of Nursing, Mental Health and Learning Disabilities (Interim).
Recommendation:
The Committee is asked to note the patient story and the lessons learnt.

MHAC21.7 a Patient Story - Coversheet.docx

MHAC21.7 b Appendix 1 Patient Story v0.2.doc

3.2 11:06 - MHAC21/8 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales

Heulwen Hughes, All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors.
Recommendation:
To note for assurance purposes that appropriate governance arrangements, processes and activities are in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.

MHAC21.8 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales.docx

3.3 11:20 - MHAC 21/9 Update on Section 12 (2) Recruitment – update with regards to the current situation.

Alberto Salmoiraghi, Medical Director of Mental Health and Learning Disabilities.
Recommendation:
The Committee is asked to note the report and progress on the matter.

MHAC21.9 Report on Section 12(2) Doctors Dr Alberto Salmoiraghi 3 March 2021 v0.3.docx

3.4 11:34 - COMFORT BREAK

3.5 11:39 - MHAC21/10 Mental Health Act Performance Report

Hilary Owen, Head of Governance.
Wendy Lappin, Mental Health Act Manager.
Recommendation:
The Committee is asked to note the report.

MHAC21.10 a Coversheet MHA Performance Report v0.2.docx

MHAC21.10 b Appendix 1 - MHAct Report V2.pdf

MHAC21.10 c Appendix 2 Divisional S136 Report February 2021.pdf

MHAC21.10 d Appendix 3 - CAMHS S136 Report Feb 21.pdf

3.6 11:53 - MHAC21/11 Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meeting's remit

Hilary Owen, Head of Governance
Wendy Lappin, Mental Health Act Manager
• Healthcare Inspectorate Wales (HIW) Monitoring Report
Recommendation:
The Committee is asked to note the report.

MHAC21.11 a HIW Monitoring Report - Hilary Owen v0.2.docx

MHAC21.11 b Appendix 2 - Quality Inspection Summary Ablett Unit Appendix 2.pdf

3.7 12:07 - MHAC21/12 Hospital Manager's Update Report

Wendy Lappin, Mental Health Act Manager
Verbal summary, based on feedback from earlier Power of Discharge Sub-Committee meeting.

3.8 12:15 - MHAC21/13 Draft Committee Annual Report 2020/21, which also incorporates the Draft Cycle of Business 2021/22 and current Terms of Reference

Matthew Joyes, Acting Associate Director of Quality Assurance
Recommendation:
The Committee is asked to:
• Consider the draft Committee Annual Report for 2020/21 (in particular, confirming agreement for the proposed RAG scores).
• Agree that Chair's Action can be taken to approve the final Committee Annual Report for submission to the Audit Committee meeting on 25th May.

MHAC21.13 a MHAC Draft Annual Report and review of TOR inc POD Terms of Reference v1.0.docx

MHAC21.13 b Draft POD MHA Committee Annual Report 2020-21 v0.5.docx

4 CLOSING BUSINESS

4.1 12:25 - MHAC21/14 Any Other Business

4.2 12:27 - MHAC21/15 Issues of significance to inform the Chair's assurance report

4.3 12:29 - MHAC21/16 Date of next meeting - 25th June, 2021

Agenda Mental Health Act Committee

Subtitle	DRAFT AGENDA
Date	12/03/2021
Time	10:30 - 12:30
Location	Virtual Microsoft Teams
Chair	Lucy Reid

1	**OPENING BUSINESS**
1.1	**MHAC21/1 Welcome and apologies**
10:30	Apologies received from: • Jo Whitehead, Chief Executive Officer. • Teresa Owen, Executive Director of Public Health. • Chris Stockport, Executive Director Primary & Community Care, Corporate Office. • Rachel Turner, Ward Manager - RCN Steward, Adult Mental Health & Social Care.
1.2	**MHAC21/2 Declaration of Interests**
10:31	
1.3	**MHAC21/3 Draft minutes of the meeting held on 8.12.20**
10:32	1. To confirm as a correct record the minutes of the previous meeting.
1.4	**MHAC21/4 MHAC Matters arising and Review of Summary Action Log**
10:37	• To review the Summary Action Log. • To deal with any matters arising not dealt with elsewhere on the agenda. • Simon Evans-Evans, Interim Director of Governance to provide a verbal update regarding the Committee Governance Review.
1.5	**MHAC21/5 Draft minutes of Power of Discharge Sub-Committee meeting held**
10:47	**on 8.12.20 and verbal update from the earlier meeting**
2	**MHAC21/6 Items circulated since the previous meeting**
10:51	• Detail (*via email)* circulated to members only on the 1/3/21 with regards to:- Devon Partnership NHS Trust v Secretary of State for Health and Social Care [2021] EWHC 101 (Admin).

3	**FOR DISCUSSION**
3.1	**MHAC21/7 Patient Story**
10:52	Mike Smith, Director of Nursing, Mental Health and Learning Disabilities (Interim). Recommendation: The Committee is asked to note the patient story and the lessons learnt.
3.2	**MHAC21/8 Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales**
11:06	Heulwen Hughes, All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors. Recommendation: To note for assurance purposes that appropriate governance arrangements, processes and activities are in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.
3.3	**MHAC 21/9 Update on Section 12 (2) Recruitment – update with regards to the current situation.**
11:20	Alberto Salmoiraghi, Medical Director of Mental Health and Learning Disabilities. Recommendation: The Committee is asked to note the report and progress on the matter.
3.4	**COMFORT BREAK**
11:34	
3.5	**MHAC21/10 Mental Health Act Performance Report**
11:39	Hilary Owen, Head of Governance. Wendy Lappin, Mental Health Act Manager. Recommendation: The Committee is asked to note the report.
3.6	**MHAC21/11 Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit**
11:53	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager • Healthcare Inspectorate Wales (HIW) Monitoring Report Recommendation: The Committee is asked to note the report.

3.7	**MHAC21/12 Hospital Manager's Update Report**	
12:07	Wendy Lappin, Mental Health Act Manager Verbal summary, based on feedback from earlier Power of Discharge Sub-Committee meeting.	
3.8	**MHAC21/13 Draft Committee Annual Report 2020/21, which also incorporates the Draft Cycle of Business 2021/22 and current Terms of Reference**	
12:15	Matthew Joyes, Acting Associate Director of Quality Assurance Recommendation: The Committee is asked to: • Consider the draft Committee Annual Report for 2020/21 (in particular, confirming agreement for the proposed RAG scores). • Agree that Chair's Action can be taken to approve the final Committee Annual Report for submission to the Audit Committee meeting on 25th May.	
4	**CLOSING BUSINESS**	
4.1	**MHAC21/14 Any Other Business**	
12:25		
4.2	**MHAC21/15 Issues of significance to inform the Chair's assurance report**	
12:27		
4.3	**MHAC21/16 Date of next meeting - 25th June, 2021**	
12:29		

Mental Health Act Committee (MHAC)

DRAFT Minutes of the Meeting Held on 8.12.20 via Webex

Present:

Lucy Reid	Health Board Vice Chair (Chair)
Jackie Hughes	Independent Member (*Co-opted member)*

In Attendance:

Dr Alberto Salmoiraghi	Consultant Psychiatrist/Medical Director, Mental Health & Learning Disabilities (MHLD)
Alison Cowell	Assistant Area Director Central Area – Child & Adolescent Health Services (CAMHS)
Frank Brown	Associate Hospital Manager
Heulwen Hughes	All Wales Approval Manager for Approved Clinicians & Section 12(2) Doctors
Iain Wilkie	Interim Director, MHLD
Jody Evans	Secretariat
Liz Jones	Assistant Director, Corporate Governance
Lynda King	All Wales Project Support Manager
Marilyn Wells	Regional Child and Adolescent Mental Health Services Clinical Lead
Mark Jones	Interim Senior Head of Service, Adult Social Care, Wrexham Council
Matthew Joyes	Acting Associate Director of Quality Assurance & Assistant Director Of Patient Safety & Experience
Michael Openshaw	Unison Health & Safety Officer
Michelle Denwood	Associate Director of Safeguarding
Mike Smith	Interim Director of Nursing, MHLD
Rachel Turner	Royal College of Nursing, Accredited Steward
Simon Evans-Evans	Interim Director of Governance
Susan Hamilton	Consultant in Child & Adolescent Psychiatry
Teresa Owen	Executive Director, Public Health & Acting Deputy Chief Executive
Wendy Lappin	Mental Health Act Manager, Administration

AGENDA ITEM DISCUSSED	ACTION BY
MHAC20/19 Welcome, opening remarks and apologies **MHAC20/19.1** The Chair welcomed everyone to the meeting and confirmed that apologies had been received from Cheryl Carlisle, Independent Member, Eifion Jones, Independent Member, Hilary Owen, Head of Governance & Compliance, Chris Pearson - Safeguarding Specialist Practitioner/Deprivation of Liberty Safeguarding Manager, Dr Chris Stockport, Executive Director Primary & Community Care, Ben Thomas, Consultant Nephrologist, and Debra Hickman, Acting Executive Director of Nursing & Midwifery.	

MHAC20/19.2 The Committee welcomed Jackie Hughes - co-opted Independent Member to the Committee, in the absence of Eifion Hughes - Independent Member. The Chair thanked everyone for making themselves available at the rescheduled meeting. **MHAC20/19.3** The Chair welcomed two additional attendees to the Committee namely Dr Susan Hamilton - Consultant In Child & Adolescent Psychiatry and Marilyn Wells - Regional Child and Adolescent Mental Health Services Clinical Lead. **MHAC20/19.3** The Chair informed members that subject to a wider governance review being undertaken, it was envisaged that the Power of Discharge (POD) Sub-Committee and Mental Health Act Committee would form a combined Committee. The Chair informed members that their input and suggestions relating to the Terms of Reference, would be welcomed.	ALL
MHAC20/20 Declarations of Interest **MHAC20/20.1** None noted.	
MHAC20/21 Previous minutes of the meeting held on 19.10.20 **MHAC20/21.1** The minutes were confirmed as an accurate record of the previous meeting.	
MHAC20/22 Matters arising and Review of Summary Action Log **MHAC20/22.1** The Summary Action Log was reviewed and updated accordingly.	
MHAC20/23 Draft minutes of the Power of Discharge Sub-Committee meeting held on 19.10.20 and verbal update from the earlier meeting **MHAC20/23.1** The Mental Health Act Manager presented a verbal account of relevant feedback from the Sub-Committee meeting, held earlier that day.	
MHAC20/24 Action Plan item/update - Regarding under 15's detentions and of emergency assessments being undertaken by adult psychiatrists. Action plan item:MHAC20/9.4 **MHAC20/24.1** The Assistant Area Director - Central Area, Childrens Services provided the update to the Committee. The update included annual data and attendance detail, in relation to sections by age profile. The report overview also included progress on the development of the action plan in place with MHLD, along with the successful position of the Welsh Government (WG) crisis bid. The Assistant Area Director confirmed that a meeting had taken place to discuss the forward plan of actions required, along with the identification of the key elements, in order to continue to develop the crisis pathway management.	

MHAC20/24.2 The Chair then invited questions. The surge in activity as a direct impact of Covid restrictions was highlighted. The Assistant Area Director confirmed that the backup plan was initiated and the team was working closely with WG and Welsh Health Specialised Services, with regards to the national bed capacity challenges. It was noted that the community and inpatient child and adolsecent teams are working closely together to provide care in the community to young people requiring admissions, in order to manage the risks while waiting for bed capacity. **MHAC20/24.3** The Committee recognised the key importance and impact of the contributions from the Local Authority, along with staff shortages with regards to Child Psychiatrists. It was confirmed that the Consultant Psychiatrist/Medical Director MHLD was meeting with the CAMHS Leads, to develop the Workforce Strategy and to continue to establish good governance between Children's Services and Adult Mental Health. **MHAC20/24.4** The Committee noted the robust plan and the update regarding the children and young people's crisis pathway, number of section 136 attendances, and the plans to improve services.	
MHAC20/25 Action Plan item/update - Approved Clinicians & Section 12(2) Doctors (Action plan items MHAC19.08 and MHAC20/14.2) **MHAC20/25.1** The Consultant Psychiatrist/Medical Director MHLD presented the status update to the Committee. The detail included information in relation to Health Boards in Wales and doctor provisions, along with the number of approved Section 12(2) medics being available to facilitate assessments under the Mental Health Act, along with the current practices and mitigations. **MHAC20/25.2** The Chair thanked the Consultant Psychiatrist/Medical Director for the update and referred to the original action points, as stated within the historical MHAC Action Plan. It was agreed that the action had still not been answered in its entirety to date. The Chair expressed disappointment that this issue remains unresolved despite repeated requests for it to be addressed and that she was concerned about the apparent lack of progress and ownership between the relevant departments. **MHAC20/25.3** It was acknowledged and agreed by the Committee that the issues were not solely the responsibility of one area and that the action was a Health Board wide issue. The Lead Executive stated that the action requirements would therefore be taken via the Executive Team, in order to work through the recommendations and issues previously raised and fed back collectively.	TO
MHAC20/26 Approval for All Wales Approved Clinicians and Section 12(2) Doctors) **MHAC20/26.1** The All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors presented the report and asked the Committee to note the governance arrangements, processes and activities in place that underpin the	

approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales. **MHAC20/26.2** The Committee received the report and questions were raised with regards to training and development. It was confirmed that the All Wales Approval Manager had continued to advertise when and where the training takes place. It was raised by the Chair that mixed messages had been received in relation to the communication surrounding training and availability. The All Wales Approvals Manager agreed to address the miscommunication issue accordingly. **MHAC20/26.3** A discussion took place in relation to GP applicants and on applications to date. It was also agreed that GP recruitment was not the sole resolution. The All Wales Manager informed the Committee of the support offered to applicants and the Committee thanked the All Wales Manager for the update. **MHAC20/26.4** The Committee noted the report for information.	HH
MHAC20/27 Deprivation of Liberty Safeguards (DoLS) Update Report **MHAC20/27.1** The Associate Director of Safeguarding presented the update report to the Committee. Particular clarification was provided in relation to accountability and the managing authorities within the key domains in the report. The Quarter one and two report report focused upon the DoLS activity across the organisation, which evidenced at 8% of the DoLS activity being within the MHLD Division. Assurance and evidence was provided to highlight the activities that was in place to support clinical practice and mitigate against unlawful detention of service users. A discussion also took place regarding the findings of the documentation audit, which reviewed the MHLD DoLS applications, and it was noted that the full circle approach highlighted the actions in place, to provide assurance and to support improved practice. **MHAC20/27.2** It was also stated that the Quality, Safety and Experience Committee, (along with the four safeguarding forums), also receive regular DoLS updates. The Chair suggested that the reporting arrangements should be reviewed to ensure there is not any duplication and that responsibilities are clear. The Interim Director of Governance agreed to review and take forwards. **MHAC20/27.3** The Executive Lead and Committee Chair thanked the Associate Director for the clarification presented to the Committee. **MHAC20/27.4** The Committee received and accepted the report	SEE
MHAC20/28 Mental Health Act Performance Report **MHAC20/28.1** The Mental Health Act (MHA) Manager presented the report and referred to the earlier presentation, at the POD Sub-Committee meeting that day. The MHA Manager explained that the data included compliance with the Mental Health Act requirements within the division for the period from July to October 2020, due to a change in the reporting schedule, to ensure that the most up to date	

information was provided to both the Sub-Committee and MHAC. It was recognised within the report that there had been an overall reduction of reported errors within the reporting period. **MHAC20/28.2** It was agreed to include within future reports a caveat to cover any statistical variances**.** **MHAC20/28.3** The Committee noted the report for the four month period.	
MHAC20/29 Healthcare Inspectorate Wales (HIW) Monitoring Report **MHAC20/29.1** The MHA Manager provided an update against the action plans in the HIW report, and clarified that the findings were detailed within the appendices covering the twelve month period. A discussion took place and the Interim Divisional Director for MHLD confirmed that changes had been made at the Heddfan Unit, via the specific action plan and that sustained improvements would be implemented going forward. **MHAC20/29.2** The Committee noted the report.	
MHAC20/30 Hospital Manager's Update Report **MHAC20/30.1** The MHA Manager provided a verbal summary update, based on feedback from the earlier PoD Sub-Committee meeting regarding the activities of the Associate Hospital Managers during the quarter July to October 2020. The verbal update included details in relation to hearings, scrutiny, training, recruitment, forums and Key Performance Indicators. **MHAC20/30.2** The Committee noted the verbal update.	
MHAC20/31 Any other business **MHAC20/31.1** An Associate Hospital Manager (AHM) stated that the AHMs had held a virtual meeting where several felt that their remuneration was overdue for an increase. It was confirmed that the Mental Health Act Manager and the Interim Director, Mental Health & Learning Disabilities were reviewing this issue.	
MHAC20/32 Issues of significance to inform the Chair's assurance report **MHAC20/32.1** To be agreed by the Chair.	
MHAC20/33 Date of next meeting: 12th March 2021 (It was noted that the North Wales Regional Partnership Board meeting was to take place on the same date in March, therefore the Chair and Lead Executive would discuss availability in due course).	TO/LR

BCUHB MENTAL HEALTH ACT COMMITTEE Summary Action Plan – Live Document – last updated 11/03/2021 15:26				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
JT	**MHAC19.08** – Approved Clinicians & Section 12(2) Doctors – JT & AS do discuss with Chris Stockport re taking discussions to Cluster Leads meeting	March 2019	HJ to provide detailed report on number of approved clinicians in North Wales. Formal letter from Gwynedd expressing their concern on lack of doctors. Agreement that we do need to look at a different strategy with EMD, meeting to be held with Chris Stockport to look at how this can be moved forward, propose, it needs to be escalated to Board – paper will be provided in September with proposed plan, actions previously approved have not been successful. This is a national problem. **September 2019 update** – AS to meet with CS. AS and CS to provide an update following their meeting. **27.9.19 update**: The meeting between JT, AS and CS had been re-arranged. It was noted that the item is ongoing and an update would be provided at the December meeting. **December 2019 update:** AS provided (*via email)* a report to the MHAC Members, outlining that a Task & Finish group was composed and included the following:- • Medical Director for Mental Health and Learning Disabilities • Head of Office of the Medical Director • All Wales Approval Manager for Approved	

LS/AS AS WL			Clinicians and Section 12(2) Doctors • Mental Health Act Lead Administrator for Mental Health and Learning Disabilities There were a number of issues noted within the report, and proposals put forward to improve the current situations in North Wales. This report will go through the relevant governance processes within the Health Board. **Actions :** • The paper would be presented to the relevant Committee of the Health Board for further consideration in accordance with the delegated authorities. • The question of indemnity for GPs should be discussed and clarified with Welsh Risk Pool and Welsh Government as the provision of Section 12(2) doctors are core services • Other options relating to MHA assessments would be explored as a way to manage the geographical challenges faced in North Wales. Update to be deferred to October Meeting **October 2020 -** Update noted via MH Team – Action plan to be developed for December meeting. Please also see item ref: MHAC20/14.2. (Committee to confirm if the action is to be now referred to as action ref: MHAC20/14.2 upon the action log).	December 2020

TO			**December 2020 - Update received 8.12.2020** as Agenda Item Ref: MHAC20/25. **8.12.2020 Agenda Item - MHAC20/25.3** It was acknowledged and agreed by the Committee that the issues were not solely the responsibility of one area and that the action was a Health Board wide issue. The Lead Executive stated that the action requirements would therefore be taken via the Executive Team, in order to work through the recommendations and issues previously raised and fed back collectively. **4.3.2021 Update –** Agenda item at the March MHAC Meeting - It was agreed that an update report be received with regards to the current situation and to update the Committee on progress to date.	Timescale to be confirmed Agenda Item – March
27th September 2019				
JE	**MHAC19.51 – Membership and Terms of Reference** **MHAC19.51.1** – JE agreed to re-issue expressions of interest communication via email to replace the Associate Hospital Manager upon the Committee.	December 2020	**October 2020 update** – Email re-issued for expressions of interest. December meeting agenda item. **March 2020 update** – Email re-issued for expressions of interest. Update at March meeting. Deferred to October Meeting due to zero expressions received. (Agenda Item at the PoD) **October 2020 update:** Action to be closed. Item discussed and expressions of interest to be sought - deadline of 13th November 2020 to be applied. **Update received 8.12.2020:** It was agreed to keep	

SEE / IW SEE			the item open pending the Governance Framework Review which will include a terms of reference review. The Committee decided to defer a decision on future membership until this is completed. **Update received 19.01.21**: Review still underway. **Update 3.3.2021:** SEE to provide a verbal update regarding the Committee Governance Review at the March MHAC meeting.	Verbal update - March
20th December 2019				
SEE/MJ	**MHAC19/63.5** Corporate Governance Officer to liaise with the Acting Board Secretary to establish opportunities to streamline the agendas of the Committees.	March 2020	**January 2020 Update** – Complete. Supporting information provided to the Chair regarding the decision to remove the reporting of the Mental Health Act Measure from the MHAC Agenda, to reduce duplication with the Quality, Safety Experience Committee. **October 2020** – It was agreed to revisit the action in order for Matthew Joyes and Simon Evans- Evans to provide support, in order to review the overlaps throughout the POD and MHA Committee agenda items. **Update received as at 27.11.2020 via SEE**: MJ/SEE recommend that these committees are combined – subject to wider governance review. **Update received as at 8.12.2020** – It was confirmed that a meeting has been arranged, in order for the governance review to take place. **Update received as at 19/01/21**: Review still underway	Timescale to be confirmed

SEE			**Update 3.3.2021:** SEE to provide a verbal update regarding the Committee Governance Review at the March MHAC meeting.	Verbal update - March
AS	**MHAC19.66.2** Briefing note on recruitment and medical staffing vacancies would be provided by the Medical Director to the next PoD Sub Committee.	March	**Agenda Item** – PoD Sub Committee – March 2020. Deferred to September Meeting. Deferred to October Meeting (**PoD Agenda**). **October 2020 update** – Work is ongoing with the Work Force and Organisation Development Team. Issues are not unique to the mental health division. **Update received as at 8.12.2020:** Concerns continue to be raised within the Committee by members and it was suggested to close the item. However, TO stated that the item would be reviewed at a later date and it was agreed to discuss in a future meeting. (Date of meeting to be agreed). It was agreed to add the issue to the cycle of business as a future agenda item.	Action to be closed.
19th October 2020				
RJ/SR	**MHAC20/6.3 Patient Story -** It was agreed for the Clinical Justice Liaison Nurse to liaise with the Consultant Nurse for CAMHS to link in at locality meetings.	December 2020	**Update as at 8.12.2020** – Update at the meeting not received. AC agreed to contact RJ and SR for updates. **Update as at 8.12.2020 following the MHAC** - RJ confirmed that an invite would be received to attend the appropriate Clinical Advisory Group to update in regard to the service provision within CJLS. The possibility of bespoke training has been discussed with regards to the CJLS practitioners to assist police in interactions with children and young people in mental distress.	

			Update also received as at 9.12.2020 - SJ confirmed that there is now a plan to take forwards the relationship between the CJLS within the police headquarters and CAMHS.	
SR/AC	**Use of Section 136 for Young People under the age of 18 years** **MHAC20/9.4** Concern raised regarding under 15's detentions and of emergency assessments being undertaken by adult psychiatrists. It was agreed that CAMHS, MHLDS and primary care leads should work collectively to pull together an action plan. It was agreed that the Consultant Nurse, CAMHS, would liaise with the appropriate senior individuals in the first instance and report back to the next meeting.	December 2020	**Update as at 8.12.2020 -** Agenda Item at the meeting held on 8.12 2020. Agenda Item Ref: MHAC20/24. The agenda item update provided an overview (which included progress on the development of the action plan).	Action to be closed.
CP/TO	**Deprivation of Liberty Safeguards (DoLS)** **MHAC20/10.2** The Safeguarding Specialist/DoLS Manager to work with the Executive Lead to improve the quality and clarity of future reports. **MHAC20/10.4** It was confirmed that a Standard Operating Procedure for DoLS had been created and that further review of the procedure would be undertaken.	December 2020 ~~December~~ **April 2021**	**Update received as at 30.11.2020** - DoLS Manager has a meeting scheduled with Teresa Owen to formulate the agreed criteria and scope for future DoLS reports which meet the requirements of the MHA Committee. Meeting tabled 22nd December 2020. **Update received as at 30.11.2020 via CP** - CP confirmed that this is a corporate safeguarding document that covers all services, not just mental health. It is due for review April 2021. **Update also received 30.11.2020 via WL** –	

			Mental Health Act Manager and Assistant Director of Nursing have highlighted the SOP, training and information to MHLD staff. (*This communication has been sent out recently by way of a memo*).	
TO/AS/MS/IW **TO**	**MHAC20/14.2 Approval for All Wales Approved Clinicians and Section 12(2) Doctors)** It was agreed that a wider piece of work was required, and a further paper and action plan would be presented for the next meeting. ***This action is linked to MHAC19.08 above.**	December 2020	**Update received as at 8.12.2020** as Agenda Item Ref: MHAC20/25. **MHAC20/25.3** It was acknowledged and agreed by the Committee that the issues were not solely the responsibility of one area and that the action was a Health Board wide issue. The Lead Executive stated that the action requirements would therefore be taken via the Executive Team, in order to work through the recommendations and issues previously raised and fed back collectively. **4.3.2021 Update –** Agenda item at the March MHAC Meeting - It was agreed that an update report be received with regards to the current situation and to update the Committee on progress to date.	**Agenda Item - March**
December 2020 - The following actions are taken from the Draft Minutes				
All SEE	**MHAC20/19.3** The Chair informed members that subject to a wider governance review being undertaken, it was envisaged that the Power of Discharge (POD) Sub-Committee and Mental Health Act Committee would form a combined Committee. The Chair informed members that their input and suggestions relating to the Terms of Reference, would be welcomed. ***This action is linked to: MHAC19/63.5 and MHAC19.51 above, relating to the outcome of the Governance Review.**	March 2021	**Update received as at 22.1.21:** Comments received from Wendy Lappin and sent to the Chair for consideration. **Update received as at 15.2.21**: Governance Review being undertaken. Outcome of the governance and terms of reference review awaited. **Update 3.3.2021:** SEE to provide a verbal update regarding the Committee Governance Review at the March MHAC meeting.	Verbal update – March

HH	**MHAC20/26.2** It was confirmed that the All Wales Approval Manager had continued to advertise when and where the training takes place. It was raised by the Chair that mixed messages had been received in relation to the communication surrounding training and availability. The All Wales Approvals Manager agreed to address the miscommunication issue accordingly.	March 2021	**Update received as at 23.2.21**: The Interim Director for Mental Health contacted the All Wales Approval Manager on 15/02/2021 requesting details regarding Section 12(2) training and availability. The All Wales Approval Manager advised how the training is advertised, how often training takes place and the arrangements within BCUHB for payment of the attendance fee for BCUHB clinicians and North Wales GPs.	Action to be closed.
SEE	**MHAC20/27.2** It was stated that the Quality, Safety and Experience Committee, (along with the four safeguarding forums), also receive regular DoLS updates. The Chair suggested that the reporting arrangements should be reviewed to ensure there is not any duplication and that responsibilities are clear. The Interim Director of Governance agreed to review and take forwards.	Date to be confirmed	**Update received as at 19/01/21**: Review still underway.	
TO/LR	**MHAC20/18 Date of next meeting:** 12th March 2021 (It was noted that the North Wales Regional Partnership Board meeting was to take place on the same date in March, therefore the Chair and Lead Executive would discuss availability in due course).	January 2021	**Update received as at 23.2.21**: It was agreed to accept TO's apologies for the March MHAC meeting.	Action to be closed.

Power of Discharge (PoD) Sub Committee

DRAFT Minutes of the Meeting Held on 08.12.20 via Webex

Present:

Lucy Reid	Vice Chair (Chair)
Eifion Jones	Independent Member (IM) (*part meeting*)
Jackie Hughes	Independent Member (*co-opted member*)
Frank Brown	Associate Hospital Manager (AHM)
Diane Arbabi	Associate Hospital Manager
Shirley Davies	Associate Hospital Manager
Jackie Parry	Associate Hospital Manager
Helena Thomas	Associate Hospital Manager
Satya Schofield	Associate Hospital Manager
John Williams	Associate Hospital Manager

In Attendance:

Mike Smith	Interim Director of Nursing, Mental Health & Learning Disabilities (MHLD)
Iain Wilkie	Interim Director, MHLD
Jody Evans	Secretariat, Corporate Governance Officer
Liz Jones	Assistant Director, Corporate Office
Simon Evans-Evans	Interim Director of Governance
Teresa Owen	Executive Director, Public Health & Acting Deputy Chief Executive
Wendy Lappin	Mental Health Act Manager, MHLD

AGENDA ITEM DISCUSSED	ACTION BY
POD20/9 Welcome and apologies **POD20/9.1** The Chair welcomed everyone to the meeting and explained the virtual meeting etiquette standards to those present. **POD20/9.2** The Chair confirmed that apologies had been received from Cheryl Carlisle - Independent Member, Hilary Owen - Head of Governance and Compliance, Hugh Jones - Associate Hospital Manager (AHM), Matthew Joyes - Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety & Experience. **POD20/9.3** The Chair welcomed Jackie Hughes as the Independent (co-opted) Member to the Sub-Committee, attending in place of Cheryl Carlisle – Independent Member. **POD20/9.4** The newly appointed Interim Director of Governance also introduced himself to the Sub-Committee and an overview of the Interim Director responsibilities was noted by the attendees.	

POD20/10 Update on Sub-Committee Membership **POD20/10.1** The Chair informed members that the Health Board were looking at the governance arrangements for the Committees and one consideration is that this Sub-Committee and the Mental Health Act Committee (MHAC) could form a combined Committee, subject to a wider governance review being undertaken. The Chair informed members and attendees that their input and suggestions regarding revised terms of reference would be welcomed. It was agreed for LR, WL and JE to meet to discuss and review the current membership. **POD20/10.2 Expressions of interest received - Vacancies on the POD and MHAC** The Chair confirmed that there had been 3 expressions of interest received regarding the Associate Hospital Manager (AHM) vacancies on the Sub-Committee. It was also noted that there had been one expression of interest received regarding the AHM position on the MHAC. It was agreed that in light of the terms of reference and wider governance review, there would not be any immediate appointments made until the review had concluded.	ALL LR/WL/JE
POD20/11 Previous minutes of the meeting held on 19th October 2020 and matters arising **POD20/11.1** The minutes were confirmed as an accurate record, apart from the need to record the attendance at the last meeting of Diane Arbabi – AHM and Simon Evans-Evans - Interim Director of Governance.	JE
POD20/12 Items circulated to members since the previous meeting: **POD20/20.12.1** The summary action log was reviewed and updated accordingly.	
POD20/13 Associate Hospital Managers Update **POD20/13.1** The Mental Health Act Manager provided an update on the activities of the AHMs during the quarter July to October 2020. The reporting period detailed four months of activity, given the request to bring the most up to date information to the committee wherever possible. The update report included details in relation to hearings, scrutiny, training, recruitment, forums and key performance indicators (KPIs) - as referred to within Appendix 1. **POD20/13.2** The Mental Health Act Manager explained that all hearings had continued to be held remotely via Skype, due to the Covid 19 pandemic. It was noted that hearings would be held via Microsoft Teams in the future, due to the changeover to Microsoft Office 360. Training was received by the AHMs during November. It was also noted that technical challenges with video conferencing had been experienced at the outset of the pandemic, but overall it was agreed that the system had worked well. It was also noted that holding hearings remotely had enabled managers from across the Health Board to support the work, as many may not have been able to travel such distances in the pre-Covid period. It was further stated that telephone hearings were being resisted, in favour of the video sessions, due to concerns raised. WL confirmed that feedback questionnaires would be distributed in order to improve the service going forwards.	

POD20/13.3 The breakdown of activity was presented to the Sub-Committee. It was confirmed that since the previous reporting period, fifteen hearings were held during the months of July – October 2020. It was confirmed that there were no discharges and that twelve were section renewals and three had been appeals. **POD20/13.4** It was noted that the KPI target set for the hearings was at 73% which demonstrated an improvement from the previous report. The structure of the hearings and limited IT equipment had meant that only one hearing could take place at any one time. It was confirmed that during December there would be additional equipment secured along with the move to Microsoft Teams. **POD20/13.5** It was confirmed that on-site scrutiny visits by AHMs was suspended and sessions would be reinstated once it was safe for the AHMs to physically attend in the Health Board units. It was confirmed that all other HB scrutiny had continued, as per policy for all detentions. **POD20/13.6** The Mental Health Act Manager clarified the number of current vacancies of AHMs to date, following the sad passing of Mrs Susan Roberts and three recent resignations from Shirley Cox, Delia Fellowes and Ann Owens. It was expressed that the Managers concerned were all very experienced and their input would be greatly missed. It was confirmed that shadowing was taking place and interviews had been arranged for the month of January 2021, in order to recruit to the vacant positions. **POD20/13.7** The Chair then invited questions from Independent Members and none were received. The Chair therefore expressed her sincere thanks to the team for their ongoing commitment, recognising the flexibility and adaptability of the virtual systems in place. The Sub-Committee noted the report and update. It was agreed for future meetings to be conducted via Microsoft Teams, in light of the AHMs now utilising the system. JE to arrange via calendar invitations accordingly.	JE
6. FOR INFORMATION	
POD20/14 Mental Health Act Committee Performance Report **POD20/14.1** The Mental Health Act Manager presented the performance report for information, assurance and discussion and explained that it included an update regarding compliance with the Mental Health Act requirements within the division during the four month period from July to October 2020. It was confirmed that additional appendices had been included which detailed the four month reporting period, due to the change in the reporting schedule to ensure that the most up to date information was provided to both the Sub-Committee and MHAC. **POD20/14.2** The Mental Health Act Manager confirmed that during the reporting period there had been five lapsed sections and two fundamentally defective. It was confirmed that all had been Datix reported and investigations had taken place. It was confirmed that the narrative relating to each section had been fully provided. It was noted that benchmark data was not received from Cardiff and Vale at the time of reporting in relation to reportable errors rates. It was confirmed that there had been further reductions regarding the number of errors that the BCUHB had reported and it was confirmed that the figure was 28% for the quarter. It was also confirmed that the Central area had identified as having the highest number of errors compared to the	

East and West areas for the period. It was explained that the Central area had seen the rise in reportable errors due to it being the admissions area. It was also confirmed that the number of section 136s being reported had reduced, with an initial rise within July. Reporting statistics in relation to under 18s had seen two children repeatedly detained under the section 136 status in the month of November. An overview of the numbers of patients being detained in independent hospitals in and out of Wales was also included in the report; and it was further confirmed that they are monitored by the Continuing Healthcare team. **POD20/14.3** A discussion took place with regards to the Criminal Justice Liaison Service (CJLS) due to the report highlighting that there had been consultations which resulted in detentions. It was confirmed that the number of section fours had been reviewed and issues around obtaining two doctors were raised along with the themes regarding the sourcing of a second doctor. The rarity of the incidents was discussed and no concerns had been raised. Following a further discussion and query raised by an AHM, it was agreed to review data where possible and include within future reports with regards to the use of Approved Mental Health Professionals on an exception basis only. Comparisons of area data were also noted and pathways were commented upon, which had affected activity throughout the pandemic. The sudden variances in data in relation to demographics were discussed and it was agreed to supply the future reporting template with the caveat to cover the variances raised in relation to the statistics, situation and demographics**.** **POD20/14.4** Members also asked a range of questions regarding the information relating to Section 136 data. A question was asked regarding non-detainees and the risks associated with possible self-harm, following non-detentions. A discussion took place and it was agreed that an opportunity to review and potentially conduct a clinical audit relating to joint working with the CJLS would be beneficial in the future. It was agreed to follow up once the CJLS service had matured over time. **POD20/14.5** The Sub-Committee noted the report for information.	WL WL
POD20/15 Issues of Significance to inform the Chair's Report to the Mental Health Act Committee - Nothing to report at present.	
POD20/16 Any other business **POD20/16.1** An AHM raised that the AHMs had held a virtual meeting where several felt that their remuneration was overdue for an increase. It was confirmed that the Mental Health Act Manager and the Interim Director, MHLD were reviewing this issue.	
POD20/17 Date of next meeting **POD10/17.1** 12th March 2021. (It was noted that the North Wales Regional Partnership Board meeting is to take place on the same date in March, therefore the Chair and Lead Executive would discuss their availability in due course).	

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 12.03.2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Patient Story
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Mike Smith, Director of Nursing, Mental Health and Learning Disabilities (Interim)
Craffu blaenorol: Prior Scrutiny:	Mental Health & Learning Disabilities - Quality, Safety and Experience Group Meeting
Atodiadau Appendices:	Appendix 1

Argymhelliad / Recommendation:

The Mental Health Act Committee (MHAC) is asked to note the patient story and the lessons learnt.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

Patient stories are an important feature in the MHAC agenda (as per the Terms of Reference). This is one example, and provides an opportunity for the MHAC members to listen and reflect on a recent patient story/experience.

Cefndir / Background:

As per patient story in Appendix 1.

Asesiad / Assessment & Analysis

Strategy Implications
The Terms of Reference of the MHAC clearly identify the importance of patient stories.

Options considered
Not Applicable.

Financial Implications
Not Applicable.

Risk Analysis
Not Applicable.

Legal and Compliance
The Health Board has a duty to ensure appropriate services are available for its patients.

Impact Assessment
Not Applicable.

Appendix 1

Betsi Cadwaladr University Health Board
Patient's Stories Transcript Form

Who took the patient's story:	Denise Charles, CANIAD
Reason for taking the story and areas covered:	• Experience of attending A&E in crisis. • Experience of detention under section 2 of the Mental Health Act. • Experience of in-patient treatment and discharge back to community. • Experience of tier zero support in the community (post discharge).
Brief summary of the story:	The story below is captured verbatim to reflect the patient's true experience: "*I was on the waiting list to see someone as my Doctor referred me. At the beginning of lockdown I got a letter to say that I wouldn't be able to see anyone because of Covid. I understand this as people are really busy, but I wasn't well.* *I could not go back to my Doctor as they stopped doing appointments, and I'm not very good on the phone.* *About a month into lockdown I got to feel even worse, I was on my own and couldn't see anyone. This made me even more depressed, and I thought no one will miss me at all. No one will care if I'm not here, so what is the point of carrying on?* *I got so bad one night that I went to A&E as I was so scared, I knew I was going to do something to myself, and all that stopped me was my dog, what would happen to him?* *I waited in A&E hours and hours, I felt like even they didn't care, I was invisible.* *I don't know how long I waited but a lovely nurse came to see me, she was the first person who sat and listened to me. She understood that I was on my own and felt like I had no one, and she believed me when I said I didn't want to live anymore.* *I said I wanted to go home, but she said that I really need to have another assessment and that she felt I was a danger to myself.* *She explained everything to me, but I couldn't take it in, my mind was all over the place, I just wanted to end it all.*

	I got really anxious and I started kicking off, and now I know that I wasn't being reasonable, but at the time all I could think of was I need to not be here. *The next few hours went by and I can't remember them at all, the next thing I knew I was at the Ablett Unit, and I had been sectioned. I couldn't believe it and was so angry and upset, I kept kicking off and shouting, banging my head, my feelings were all over the place.* *The nurses were so kind to me and spent time with me, they spoke in a nice way and didn't shout.* *I was in for about a week I think, it was all a blur, I now have tablets and I have a worker, this has helped me so much. I understand that I need the help, and I also know what is wrong with me.* *I have linked in with Caniad and do their Zoom sessions, which is great; I can join in from my living room, and don't have to go out. I know that my story doesn't give much details but that is because I can't remember them, but I do know that everyone was so caring and lovely to me. No one treated me like I was a pain, they understood that I was hurting inside.* *Caniad have also been great, and make sure that they involve me in things, they ring me and remind me about things, and they don't judge me. Through Zoom I made friends with other people who have been through the same thing. At first, I was ashamed that I had been sectioned, some of the other patients in the Ablett bragged about how many times they have been sectioned, like a badge of honour, to me I was ashamed, but now I know that there is nothing to be ashamed of, I was just getting the help that I needed, I also know that I need to be open and honest and not play things down like I did before. I am so grateful to everyone who helped me, I know that I wouldn't be here without them.* *Caniad have promised that they won't give my name, I know I say I'm not ashamed but I don't really want everyone to know about it, I need to get my head around it, but writing this had helped me, and I have been able to understand, I don't know if it's a good or bad thing that I can't remember things clearly, but I'm not going to dwell on it. I hope that this story is good enough, and that you don't think that I am daft."*
Key themes emerging:	• The Covid-19 pandemic has been an exceptional experience for all – patients, staff and organisations. The scale of the pandemic has been significant and the Mental Health & Learning Disabilities (MHLD) division

	acknowledge the traditional ways of working pre-Covid-19, and the requirements to work very differently during the pandemic i.e. working without direct face-to-face contact in many instances. Teams have been required to work differently • It is widely recognised that lock-down and the effects of isolation have had a negative impact on many individuals who are already disconnected, and with existing mental health issues. • The division notes that people could and did choose to escalate their health needs via the emergency services route, however some of these instances may have been avoidable. The narrative above is one example of how individuals can become overwhelmed in such situations. This in turn can mean that they are a danger unto themselves, and it is vital that there are sufficient MHLD service functions to support them, supported with the appropriate lawful processes. • In this patient's story, there is evidence that psychiatric liaison in the Emergency Department were empathetic. They listened to the patient, qualified the risk and admitted the person to an in-patient care environment using a detention order, under the Mental Health Act. • The MHLD division reflect often on the importance of kindness and humanity in our actions. These are often more important than technique and therapy for individuals. We note the kindness of the nurses within the in-patient unit in this patient's story, and how this was valued by the individual. • The MHLD division is reminded through this story of how people want and need to be heard. This is a key function in the healing process. • This patient's story highlights the need for good, robust patient pathways. The importance of linking a person rapidly back to the community with safe and secure connections, were important. On this occasion the acute pathway proved beneficial for the individual. We note that the combination of a kind and understanding approach, appropriate treatment, a rapid return to a familiar community, alongside community connectivity provided a positive intervention. A key element was the community connectivity, the absence of which was related to the initial episode. • This story emphasises that CANIAD and the wider Third Sector provision is critical. They are acting as connecters within our communities, and can support individuals, prevent escalation and support health restoration.

Lessons learnt:	This patient's story has provided the division with an opportunity to reflect on the holistic needs of our patients. Key lessons learned include: • Face to face contacts are key components of our service offer. As we continue through the pandemic, attention to this element remains an important element of our service restoration activity. In addition, the service must ensure that a range of "connection" opportunities/choices are available (telephone, video, zoom, face to face). • Being heard is important for people who feel overwhelmed. • The MHLD division have reflected on whether an earlier intervention, or a primary care contact could have helped this situation be avoided, and have come to the conclusion that this is possibly so. However it is difficult to ascertain this fully, as the division also notes people sometimes have to reach an overwhelmed state as a turning point. This patient's story touches on this aspect. • On this occasion the short stay intervention was appropriate with a stay of only one week. This suggests that our acute pathway work is appropriate, even with the context of a Covid-19 pandemic. • People have adapted to new communication platforms (we are currently using zoom for tier zero connections). • The division reflects that acute and community pathway elements are mutually important, and can support restoration for individuals and prevent further breakdowns. • The division are constantly learning about the value of connecting appropriately with patients. Face to face contact remains important within the health system, and new ways of working can also provide positive experiences for many. • This patient's story highlights the importance of informal and voluntary sector connectedness.
Shared with:	Patient Carer Experience sub-group of MHLD QSE

Proposed action:	• The themes from this patient's story will support the MHLD division's service planning and organisational development activity. This will build on good practise and ensure a constant learning approach going forward. *(Owner: Divisional Director of Nursing and the Deputy Director of Partnerships).* • Continue to enhance and invest in the tier zero approach and ensure sufficient attention is given to community capacity activity in the strategic planning arena. *(Owner: Deputy Director of Strategy & Partnerships).* • As part of the organisational development activity, ensure there is a focus on human values; the importance of patients being heard and the choice agenda. *(Owner: Divisional Director of MHLD).* • Continue to develop and enhance the adult mental health pathway. *(Owner: Divisional Medical Director, Divisional Nursing Director).*
Responsibility:	Chair and Vice-Chair of Patient & Care Experience – MHLD: Deputy Director Strategy Partnerships – MHLD

Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **12th March 2021**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Update on the approval functions of Approved Clinicians and Section 12(2) Doctors in Wales
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Professor Arpan Guha Executive Medical Director (acting)
Awdur yr Adroddiad **Report Author:**	Mrs Heulwen Hughes All Wales Approval Manager for Approved Clinicians and Section 12(2) Doctors
Craffu blaenorol: **Prior Scrutiny:**	The report has been scrutinised by Professor Arpan Guha prior to submitting to the Committee.
Atodiadau **Appendices:**	Appendix 1 – Additions and Removals to the All Wales register of Approved Clinicians. Appendix 2 – Additions and Removals to the All Wales register of Section 12(2) Doctors. Appendix 3 - Breakdown of Section 12(2) GPs currently approved in Wales as at 23rd February 2021.

Argymhelliad / Recommendation:

To note for assurance purposes that appropriate governance arrangements, processes and activities are in place to underpin the approval and re-approval of Approved Clinicians and Section 12(2) Doctors in Wales.

Please tick as appropriate

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

Sefyllfa / Situation:

Betsi Cadwaladr University Health Board is responsible for the initial approval, re-approval, suspension and termination of approval of Approved Clinicians and Section 12(2) Doctors in Wales.

Cefndir / Background:

The change introduced to the Mental Health Act 1983 was the abolishing of Responsible Medical Officers (RMOs) and Community Responsible Medical Officers (CRMOs) and the introduction of Approved/Responsible Clinicians (ACs and RCs) in their place.

The Minister for Health and Social Services agreed that as of the 3rd November 2008, Wrexham Local Health Board (LHB) would act as the Approval Body for Approved Clinicians and section 12(2) Doctors on behalf of the LHBs in Wales. The transfer of function from Wrexham Local Health Board to Betsi Cadwaladr University Health Board took place on 1st October 2009.

Asesiad / Assessment & Analysis

Strategy Implications
It is important to ensure the highest standards of governance for approving and re-approving practitioners who are granted these additional responsibilities, which apply when people are mentally disordered.

Options considered
This is a factual report on the numbers of applications and therefore, options are not considered relevant for this purpose.

Financial Implications
The Approvals Team receive a ring-fenced budget from Welsh Government to support the monitoring and approvals of Clinicians in Wales.

Risk Analysis
To ensure that all Clinicians are approved and reapproved within the agreed timescales, the All Wales Approval Panel assesses applications according to the Procedural Arrangements agreed with Welsh Government.

Legal and Compliance
The Approval Process meets the legislative requirements of the Mental Health Act 1983 (as amended 2007) and the Mental Health Act 1983 (Approved Clinicians)(Wales) Directions 2018

Impact Assessment
An impact assessment is considered unnecessary for this update paper. The Approval Process is part of the legislative process

Service Developments

1. Approved Clinician/Section 12(2) Induction and Refresher Training

The February Induction and Refresher training was held via Webinar. The next induction and refresher training will take place in June 2021 this will be via Webinar also.

2. Temporary Arrangements for the re-approval of Approved Clinicians and Section 12(2) Doctors during Covid-19

Following discussions with Welsh Government, a letter was sent via email in June 2020 to all ACs and S12(2) doctors informing of and clarifying details for a temporary variation in the arrangements for re-approval during the Covid19 pandemic. The variation applied to ACs/S12(2) doctors who were due to apply for re-approval during the pandemic advising that the team were able to continue to offer Webinar-based refresher training compliant with social distancing requirements during Covid-19. This would enable clinicians to meet the extant requirements of re-approval. Welsh Government agreed that it would also be prudent to make a temporary and minor variation in the event that the refresher training could not be delivered or where a clinician had been unable to attend due to Covid-19 related reasons

In that exceptional circumstance, the Approving Board may grant approval, on condition that the clinician attends refresher training within 12 months of the start date of the new approval period.

To date all applicants have attended refresher training and there has, therefore, been no need to use the temporary arrangements.

3. Approved Clinician/Section 12(2) Induction and Refresher Training

The February 2021 Induction and Refresher training took place via Webinar and received excellent feedback. The next induction and refresher training will take place in June 2021.

APPENDIX 1

Additions and Removals to the all Wales register of Approved Clinicians

17th November 2020 – 23rd February 2021

New Applications Received	**17**
Number of applications from professions other than Psychiatrists	
Mental Health/Learning Disability Nurse	1
Social Worker	0
Occupational Therapist	0
Psychologist	0
Number of applications approved	17
Number of ACs already approved in England	8
Number of applications with panel (including portfolios)	0
Number of applications not approved	0
Re-approval Applications Received (5 Yearly)	
Number of applications with panel	2
Number of applications approved	11
Number of applications not approved	0
Number of ACs reinstated	3
Number of re-approvals which have come to an end	**9**
Expired	3
Retirement	1
No longer working in Wales	3
No longer registered with professional body	0
AC requested	0
Registered without a licence to practise	0
Awaiting CCT	1
Suspended	1
Total Number of Approved Clinicians	**387**
Total Number of Approved Clinicians from previous report	**376**

APPENDIX 2

Additions and Removals to the all Wales register of section 12(2) Doctors

17th November 2020 – 23rd February 2021

New Applications Received	**5**
Applications from GPs	0
Applications from Psychiatrists	4
Application from Forensic Medical Examiner	0
Number of Applications Approved	4
Number of Applications Not Approved	0
Number of Applications with Panel	1
Re-approval Applications (5 years)	3
Applications from GPs	1
Applications from Psychiatrists	2
Applications from Forensic Medical Examiners	0
Number of Applications Approved	2
Number of Applications Not Approved	0
Number of Applications with Panel	1
Transferred from AC register	**0**
Number of Approvals which have come to an end:	**1**
Expired	0
Become an Approved Clinician	6
No longer working in Wales	0
No longer registered	1
Registered without a licence to practise	0
Retired	0
Under Police Investigation	0
RIP	0
Suspended from Medical Practitioners List	0
Total Number of S12(2) Doctors currently approved	**162**
Total Number of S12(2) Doctors from previous report	**164**

APPENDIX 3

Breakdown of Section 12(2) GPs currently approved in Wales

As at 23rd February 2021

	Anglesey	Conwy	Denbighshire	Flintshire	Gwynedd	Wrexham	TOTAL
Section 12(2) GPs	3	5	0	0	2	3	**13**
Section 12(2) Psychiatrists	1	5	4	2	3	4	**19**
Approved Clinicians	3	12	21	9	16	20	**81**

Number of 12(2) GPs per Health Board

BCUHB	13
ANEURIN BEVAN	7
CARDIFF & VALE	5
CWM TAF	0
HYWEL DDA	1
POWYS	2
SWANSEA BAY	1

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 12.03.2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Section 12(2) Doctors Update
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Alberto Salmoiraghi, Medical Director of Mental Health and Learning Disabilities
Craffu blaenorol: Prior Scrutiny:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (Interim)
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Mental Health Act Committee (MHAC) is asked to note the report and progress on the matter.

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**	

Sefyllfa / Situation:

The MHAC asked colleagues from across the Health Board to produce a plan to mitigate the risk of insufficient Section 12(2) Doctors. A number of reports have been produced and discussed in the past; however concerns remain. The current report is an update on the actions taken after the last Committee meeting.

Cefndir / Background:

Following the last meeting, the MHAC Chair indicated that the issue required Executive leads attention.

A meeting was organised and attended by Professor Arpan Guha, Interim Executive Medical Director; Teresa Owen, Executive Director of Public Health, Iain Wilkie, Interim Director of Mental Health and Learning Disabilities (MHLD); Professor Alberto Salmoiraghi, Medical Director MHLD and Hilary Owen, Head of Governance MHLD.

The discussion focussed on the next steps and the possible solutions that can be realistically implemented. Due to the interdependencies with other Divisions, Corporate and Executive Board, it has been agreed to form a Task and Finish (T&F) Group to write a detailed proposal to be discussed at an Executive Board Meeting. The T&F group will be led by Teresa Owen, Executive Director of Public Health.

Asesiad / Assessment & Analysis

Strategy Implications
The Health Board has a responsibility to comply with the requirement of the law, hence it is essential to have a strategy for a sustainable Section 12(2) Doctors workforce.

Options considered
N/A

Financial Implications
Some of the solutions proposed in this preliminary discussion may incur extra costs for the Health Board.

Risk Analysis
The lack of Section 12(2) Doctors may pose a risk to people in need of urgent assessments under the Mental Health Act.

Legal and Compliance
Insufficient Section 12(2) Doctors has significant legal implications for the Health Board.

Impact Assessment

N/A

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 12.03.2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mental Health Act Committee Performance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (Interim)
Awdur yr Adroddiad Report Author:	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: Prior Scrutiny:	Gold Command meeting on behalf of MHLD Senior Leadership Team Quality Safety and Experience Group 20.02.2021
Atodiadau Appendices:	Appendix 1 MHA Committee Performance Report November 2020 – January 2021 Appendix 2 S136 Divisional Report – February 2021 Appendix 3 S136 CAMHS Report – February 2021

Argymhelliad / Recommendation:

The Mental Health Act Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The Mental Health Act Committee Performance Report provides an update in relation to the Mental Health Act Activity within the division for the detailed period. (Additional appendices are included as determined by the Mental Health Act Committee when assurance is required for specific use of certain sections under the Mental Health Act).

During the Covid 19 pandemic the service followed an alternate pathway approach for admissions. The Ablett Unit became the admissions unit regardless of the demographics of the patient origin. This has affected admission and transfer statistics from March 2020 to January 2021.

Cefndir / Background:

The Health Board has a duty to monitor and report the number of persons placed under a section of the Mental Health Act. This reporting is undertaken monthly, quarterly and annually. This report is therefore presented as an advisory report to the Mental Health Act Committee. The report also includes comparison figures for the previous month and quarter, to highlight the activity and use of the Mental Health Act sections.

Within the report the section activity is recorded in tables and charts, detailing outcomes and timeframes of the section use for adults and young persons. Forensic data is also included. Additionally information regarding transfers in and out for specialist services and repatriation.

Lapsed sections are reported as 'exceptions' throughout the report and Invalid detentions recorded as Fundamentally Defective.

Up to date S136 reports are submitted to the Committee.

Asesiad / Assessment & Analysis

Strategy Implications
The use of the Mental Health Act is determined by patient needs, and the priority is always to aim for the least restrictive options. In line with the Health Board strategy, the MHLD division gives consideration to care closer to home wherever possible, and in line with the wellbeing objectives, is increasingly focused on early intervention where possible.

Options considered
Not Applicable

Financial Implications
The rise in Mental Health Act detentions, and also legal advice requirements in general have financial implications.

Risk Analysis
The Mental Health Act detentions fall into a category of being legal or illegal (invalid) which may result in challenges from legal representatives on behalf of their clients. All detentions are checked, and any invalid detentions are reported through Datix, investigated and escalated as appropriate.

Within this reporting period one section was deemed 'fundamentally defective', and there have been three sections which lapsed. These are reported as exceptions within the report and all have been datixed.

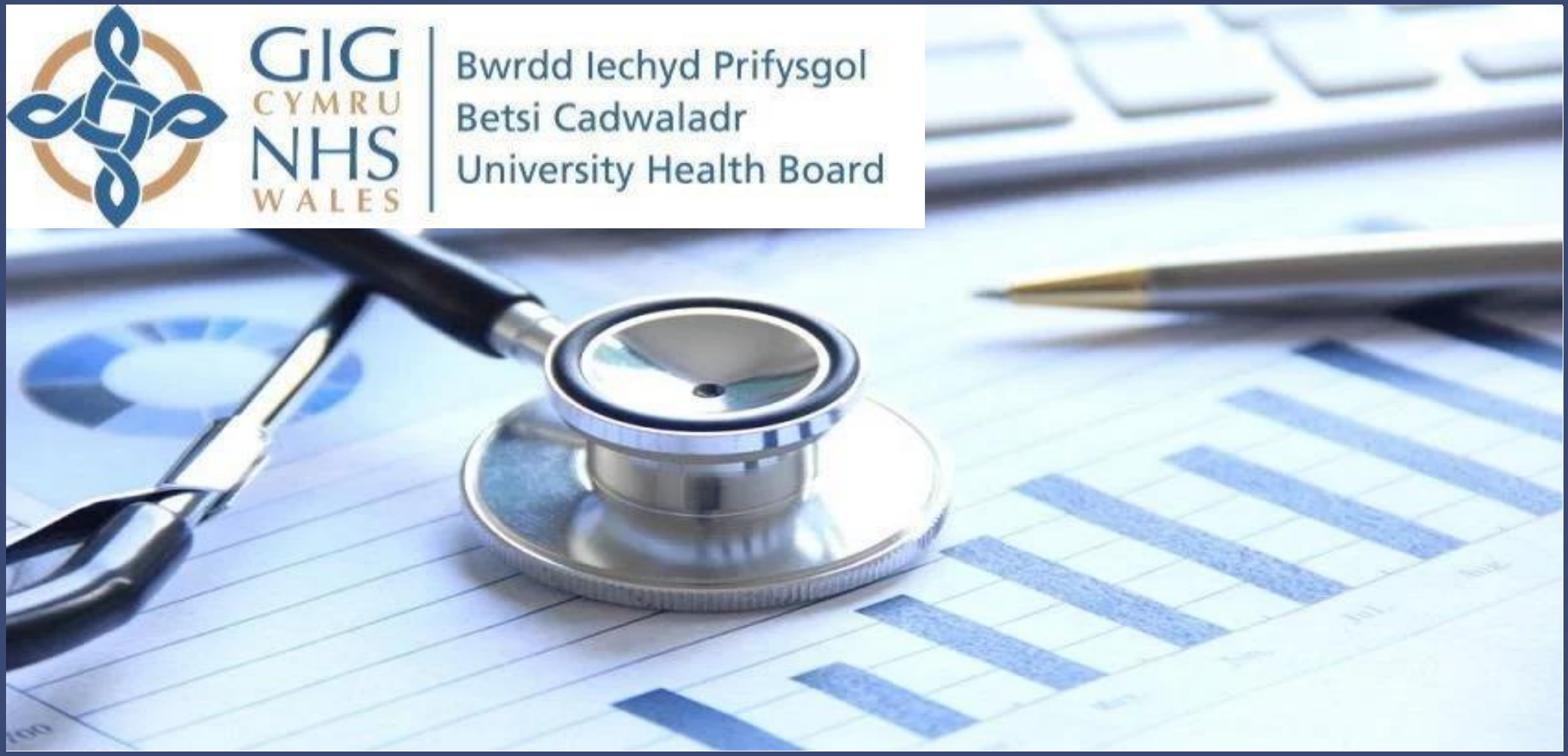
Legal and Compliance
This report is generated quarterly. The Mental Health Act sections are monitored, to ensure they are legal and the Health Board is operating in compliance with the Mental Health Act 1983 (amended 2007), and the Code of Practice for Wales 2016.

Impact Assessment
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.

Mental Health Act Committee Performance Report

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board



Mental Health Act Committee Performance Report

January 2021

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Mental Health Act Committee Performance Report - Foreword

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

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

Seven Domains

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

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

Advisory Reports & Exception reports

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

Exceptions are noted throughout the report within this period three sections lapsed: 1 x S2 - INC249407 following a decision to allow the section to lapse and 2 x S136s INC 252876 and INC247549 both due to the detainees being unfit for assessment.

One section was fundamentally defective - the person was admitted to a hospital not named on the documents.

Advisory Report Definitions

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

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

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

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

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

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

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

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

Advisory Report Definitions

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

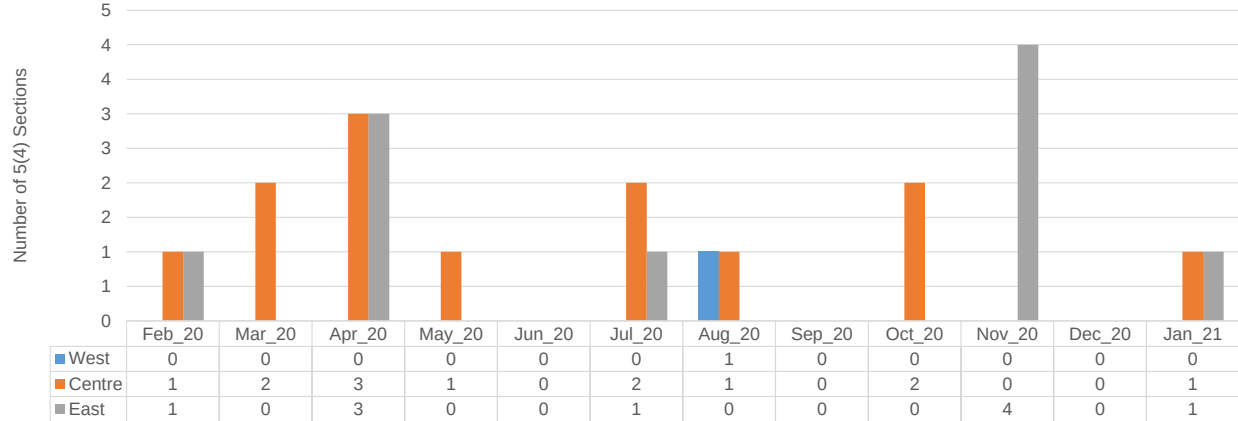
Fundamentally Defective Errors: concerned with errors which cannot be rectified under section 15

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	Latest Month	Previous Month	Monthly Trend
Section 5: Application in respect of patients already in hospital	2	0	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)
6	4	↑	6

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



	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	0	0	0	0	0	0	1	0	0	0	0	0
Centre	1	2	3	1	0	2	1	0	2	0	0	1
East	1	0	3	0	0	1	0	0	0	4	0	1

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

All of the patients this quarter were assessed within the 6 hour timeframe. The highlighted episodes denote when there is multiple detentions for a patient. Four instances relate to the same person who is currently detained on a Section 3. Investigation of the documentation has shown that on assessment the person was agreeing to stay initially this being the least restrictive pathway they returned to informal on three occasions.

LAPSES

There are no lapses to report this period.

WEST

Duration (hh:mm)	Outcome

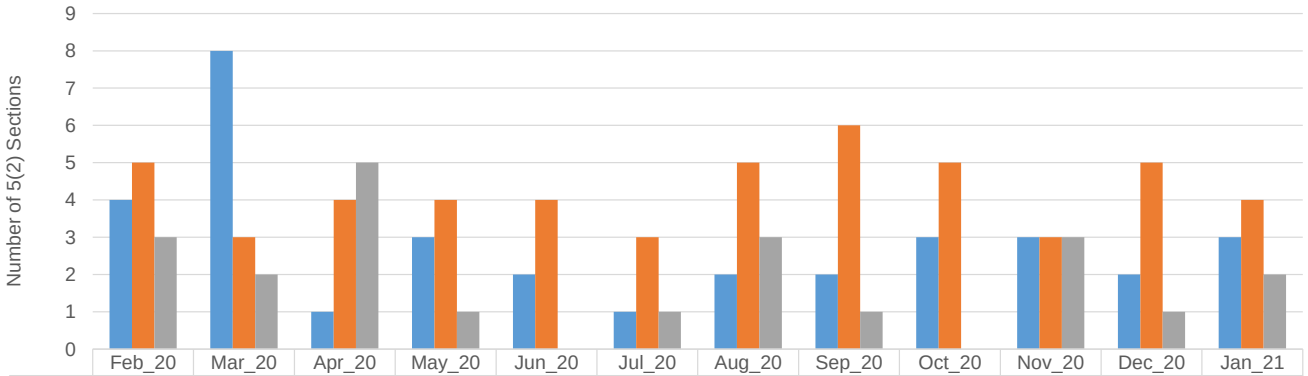
CENTRE

Month	Duration (hh:mm)	Outcome
Jan_21	01:00	Section 5(2)

EAST

Month	Duration (hh:mm)	Outcome
Nov_20	00:20	Informal
Nov_20	00:45	Section 5(2)
Nov_20	03:07	Section 5(2)
Nov_20	05:25	Informal
Jan_21	00:30	Section 5(2)

Section 5(2) - BCUHB	Latest Month	Previous Month	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	9	8	↑	26	27	↓	27	1	Centre	12
								2	West	8
								3	East	6



	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	4	8	1	3	2	1	2	2	3	3	2	3
Centre	5	3	4	4	4	3	5	6	5	3	5	4
East	3	2	5	1	0	1	3	1	0	3	1	2

Section 5(2) Outcomes

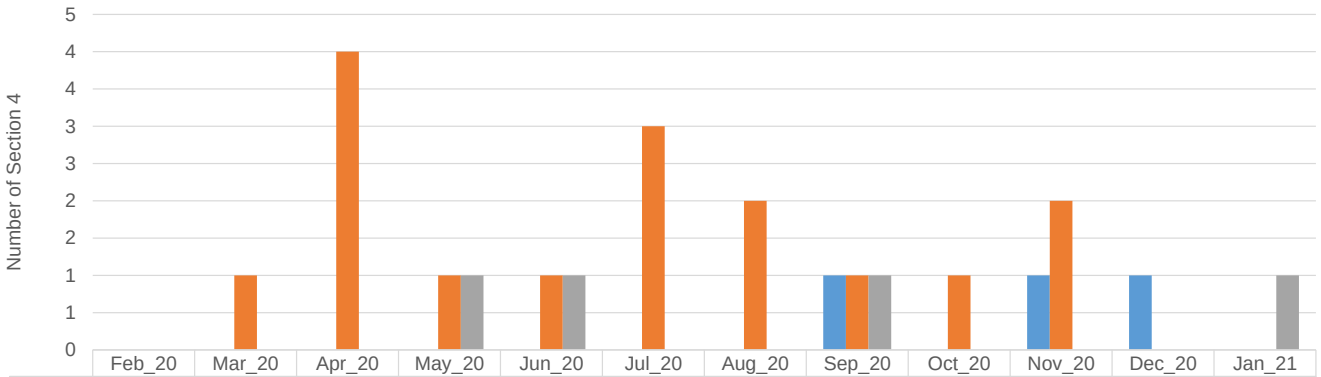
	Nov 2020	Dec 2020	Jan 2021
Section 2:	4	3	3
Section 3:	1	2	1
Informal:	5	3	3
Lapsed:	0	0	0
Invalid:	0	0	0
Discharged:	0	0	1
Other:	0	0	0

The data above does not include

A Section 5(2) on occasions will be enacted within the acute hospital wards, during November - January there were three instances none of which progressed to a further detention.

There are no exceptions to report for this period

Section 4 - BCUHB	Latest Month	Previous Month	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	1	1	→	5	6	↓	6	1	Centre	2
								1	West	2
								3	East	1



	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	0	0	0	0	0	0	0	1	0	1	1	0
Centre	0	1	4	1	1	3	2	1	1	2	0	0
East	0	0	0	1	1	0	0	1	0	0	0	1

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 have been considered to reveal if the S4 was used for emergency purposes or due to a lack of doctor availability.

WEST

	Duration (hh:mm)	Outcome
Nov_20	20:00	Section 2
Dec_20	44:00	Informal

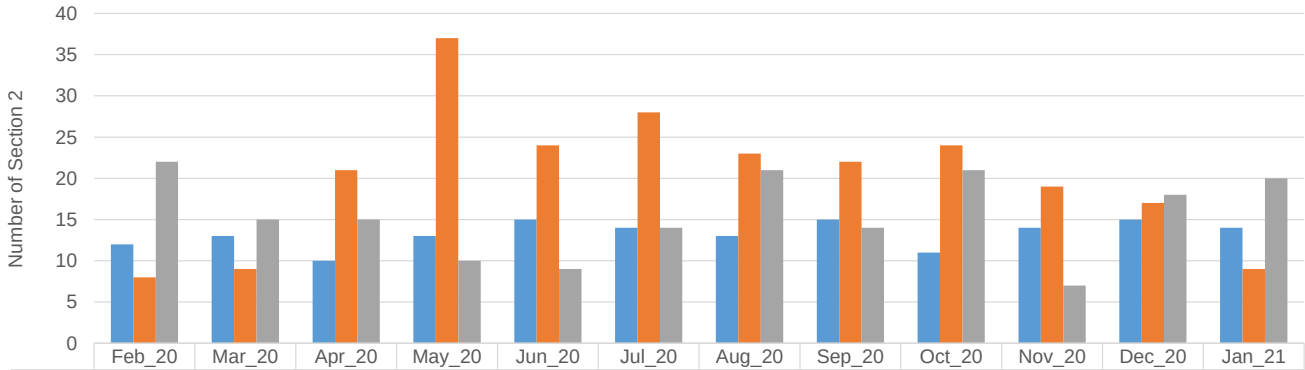
CENTRE

Month	Duration (hh:mm)	Outcome
Nov_20	20:00	Section 2
Nov_20	07:20	Section 2

EAST

Month	Duration (hh:mm)	Outcome
Jan_21	38:25	Section 2

Section 2 - BCUHB	Latest Month	Previous Month	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 5: Admission for assessment	43	50	↓	133	164	↓	147	1	Centre	45
								2	East	45
								3	West	43



	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	12	13	10	13	15	14	13	15	11	14	15	14
Centre	8	9	21	37	24	28	23	22	24	19	17	9
East	22	15	15	10	9	14	21	14	21	7	18	20

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

Section 2 Outcomes

	Nov 2020	Dec 2020	Jan 2021
Section 3:	16	10	17
Informal:	18	22	6
Lapsed:	0	0	1
Pending:	0	0	0
Discharged:	4	5	6
Transferred:	11	12	12
Invalid and Other:	0	0	0

It is hard to interpret these figures in isolation. It must be noted from April the Ablett Unit has been used as the admissions unit for adults and Heddfan for older persons.

There were five under 18s placed on a Section 2 this period.
Two young persons were in the general hospital prior to transfer to an age appropriate bed.
One young person was transferred in from an out of area placement to an age appropriate bed in CAMHS.
Two detentions were following assessments under S136.

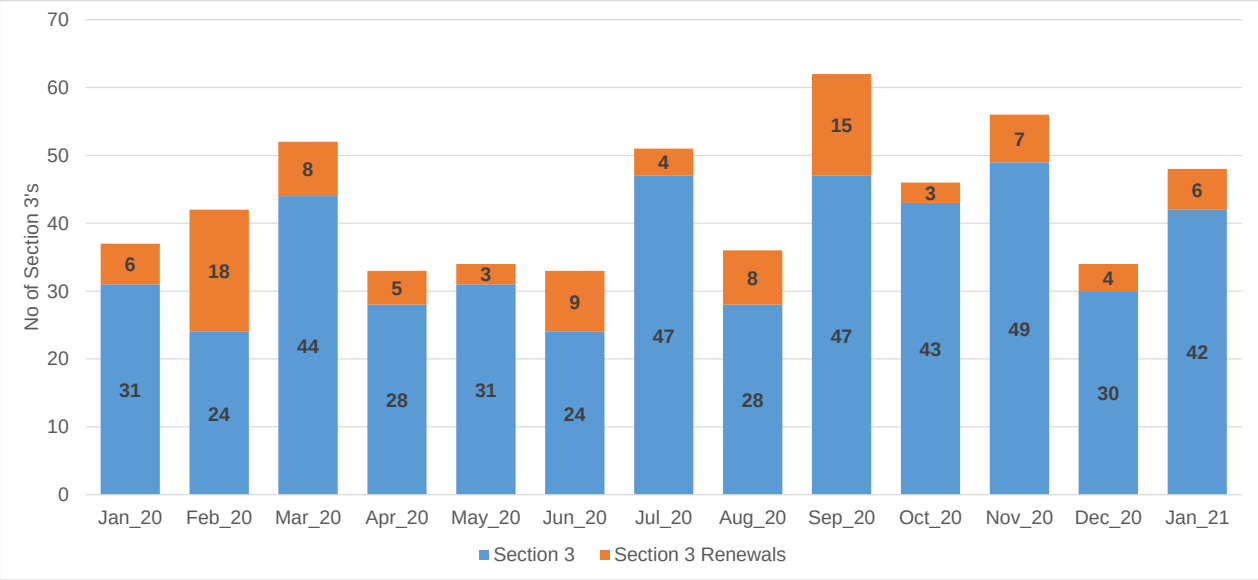
EXCEPTIONS:

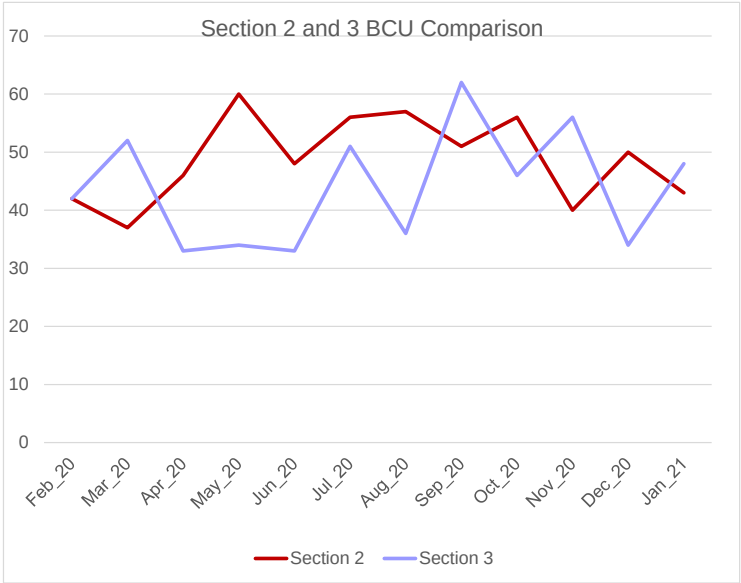
There is one exception to report this period.

EAST: (January) A Section 2 expired as the reviewing Consultant was asked by the treating team to allow the section to lapse rather than discharging following a decision not to convert to a Section 3. INC249407

Advisory Report - Section 3

Section 3 - BCUHB	Latest Month	Previous Month	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	48	34	↑	138	144	↓	132	1	East	46
								2	West	46
								3	Centre	46





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

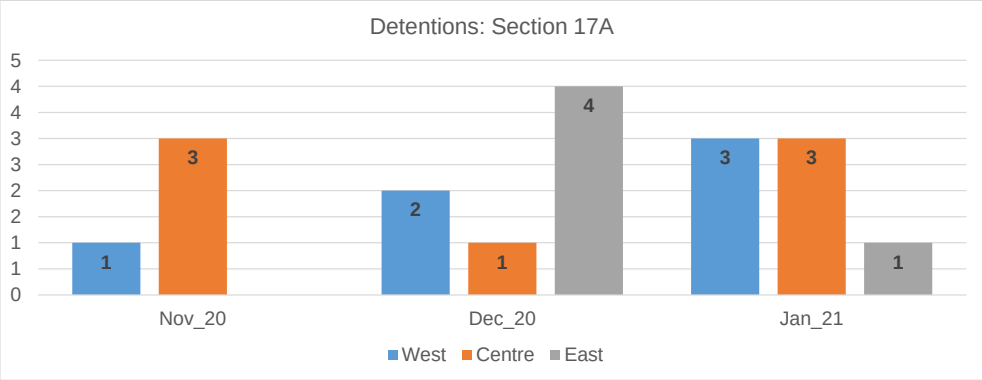
These numbers also include any renewal sections undertaken within the month. As with the data for section 2 it is hard to interpret these figures in isolation and previous months figures are prone to change due to admissions into the Health Board.

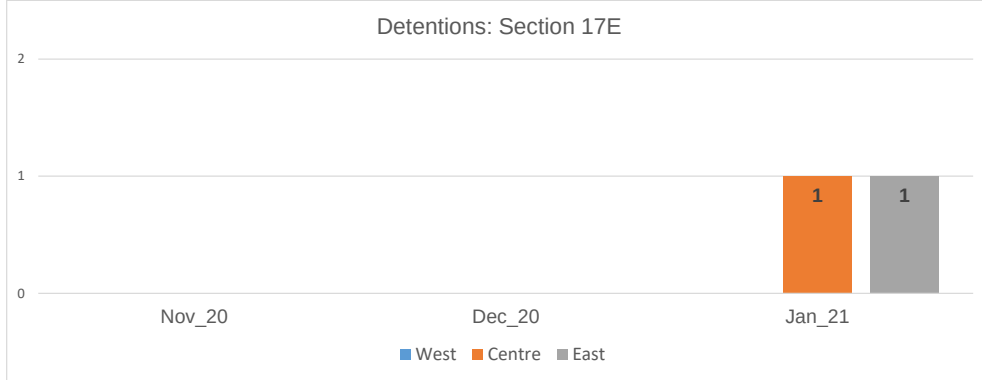
This period there were four under 18s made subject to a section 3, two were in the general hospitals prior to transfer to an age approprate bed . The trend for use of S2 and S3 over the 12 months at the end of January continues to remain upward despite the quarterly trend reporting as downward.

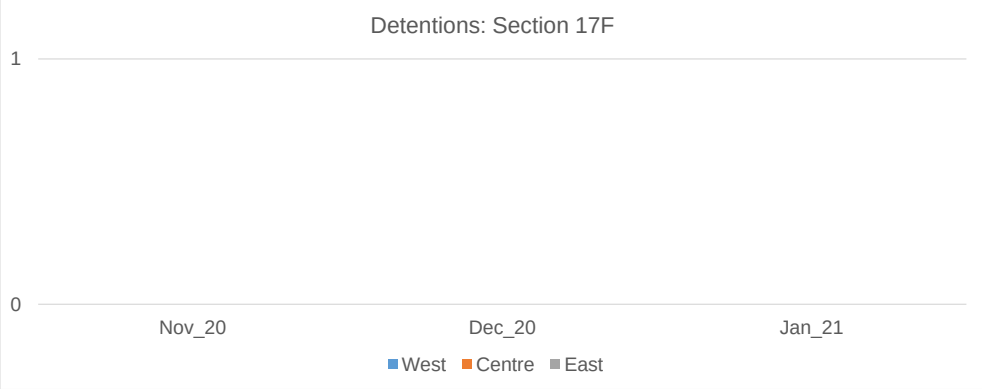
There are no exceptions to report.

Advisory Report - Section 17A - F

Section 17 A-F - BCUHB	Latest Month	Previous Month	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	9	7	↑	20	27	↓	19	1	Centre	8
								2	East	6
								2	West	6







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

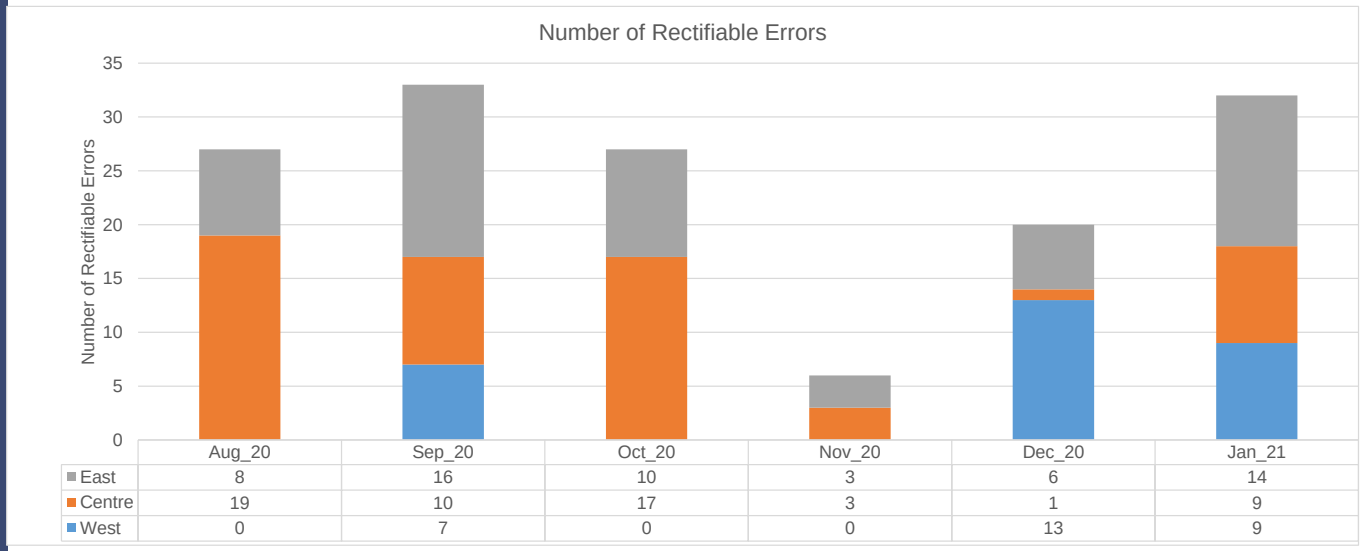
The number of patients subject to a CTO at the end of January West:13, Central: 11 and East: 12.

There has been an Increase in the number of patients subject to a CTO for each area this quarter.

Exceptions: There are no exceptions to report.

Fundamental and Rectifiable Errors	Latest Month	Previous Month	Monthly Trend
Fundamental and Rectifiable Errors in line with Health Boards in Wales	32	20	↑

Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of Errors during Quarter		Quarter Errors
76	80	↓	107	1	East	23
				2	West	22
				3	Centre	13



	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
East	8	16	10	3	6	14
Centre	19	10	17	3	1	9
West	0	7	0	0	13	9

Rectifiable Errors

Rectifiable errors are reported on a quarterly basis and benchmarked with the other health boards throughout Wales. Due to coronavirus we have not received any benchmarking reports for the year 2020 onwards so are not aware of our current position. data from BCUHB has been submitted at the required times.

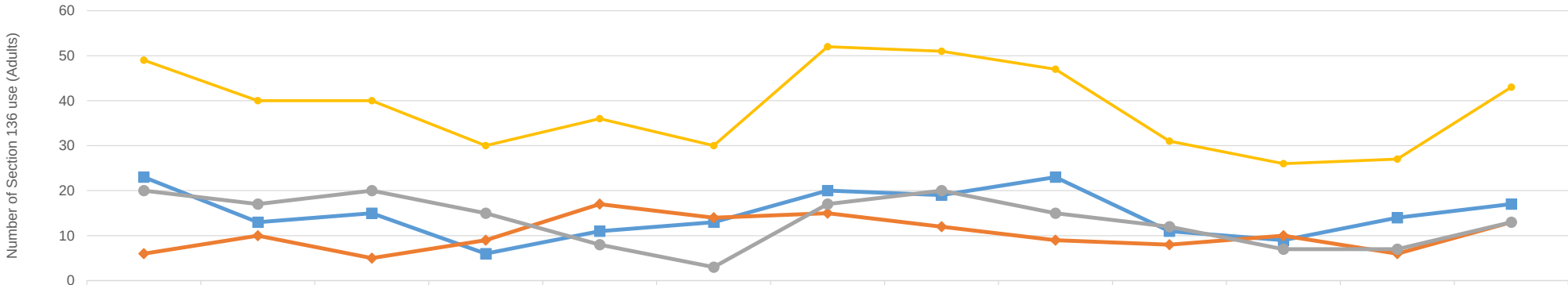
The reporting period that is benchmarked shows 13% of the total detentions contained errors compared to 28% last quarter. This improvement has continued to be seen each quarter.

Exceptions are reported as lapses and fundamentally defective (invalid sections) throughout the report.

This period there was one section deemed fundamentally defective due to a decision made to transfer paperwork was not completed correctly resulting in the person being admitted out of hours not under a detention for a period of 4 hours until reassessment could be completed.

This period there has been 3 lapsed Sections:- 1 x Section 2 and 2 x Section 136s.

Section 135 - 136	Latest Month	Previous Month	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)	43	27	↑	96	129	↓	113	1	West	40
								2	Centre	29
								3	East	27



	Jan_20	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	23	13	15	6	11	13	20	19	23	11	9	14	17
Centre	6	10	5	9	17	14	15	12	9	8	10	6	13
East	20	17	20	15	8	3	17	20	15	12	7	7	13
BCU	49	40	40	30	36	30	52	51	47	31	26	27	43

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

There have been six S135 detentions this period all resulting in detention under S2 or S3.
Two Section 136s lapsed this quarter, INC247549 and INC252876. Both instances were due to the detainees being unfit for assesmsent and no extension was requested, in one instance it was recorded that the Consultant had made the decision not to extend as the person would still not be fit for assessment following an additional 12 hours.

There were two people noted to be in custody as their first place of safety, one in December and one in January.
One S136 12 hour extension was granted due to the person not being fit for assessment, on assessment they were discharged and referred to services.

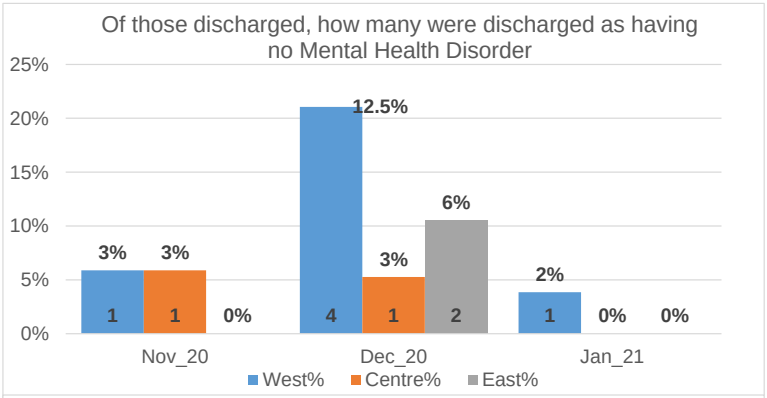
Section 136	Latest Month	Previous Month	Monthly Trend	Latest Quarter	Previous Quarter	Quarter Trend	Quarter Average (last 4 quarters)	Area Rank by numbers of S.136 during Quarter		Quarter S.136 detentions
Section 136: Patient transfers to a place of safety (Adults)	43	27	↑	96	129	↓	113	1	West	40
								2	Centre	29
								3	East	27

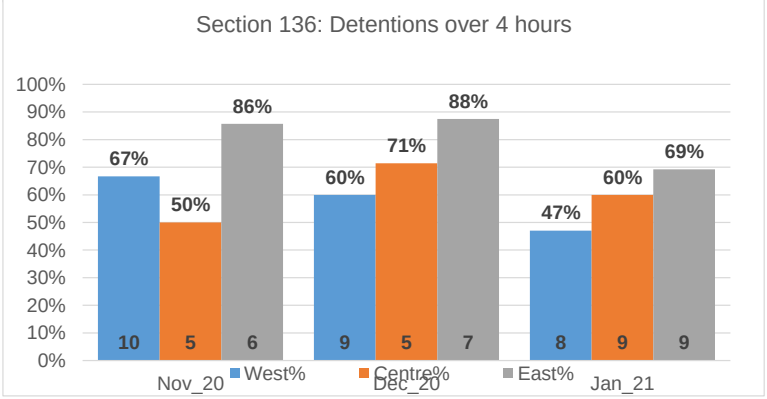
Section 136 Outcomes

	Nov 2020	Dec 2020	Jan 2021
Discharged:	17 54.84%	19 65.52%	26 56.52%
Informal Admission:	6 19.35%	3 10.34%	9 19.57%
Section 2:	7 22.58%	6 20.69%	8 17.39%
Section 3:	1 3.23%	1 3.45%	3 6.52%
Other:	0 0.00%	0 0.00%	0 0.00%

Section 136 - Known to Service

	Nov 2020	Dec 2020	Jan 2021
Yes	21	20	25
Yes (percentage)	65.63%	66.67%	55.56%





The data shows figures from outcomes recorded and whether a patient is known to service. Whilst a large proportion of 136's are discharged those with no mental disorder has historically been around 20% This quarter has seen two months considerably lower.

Total percentages for the months for those discharged with no mental disorder are:
November 6%
December 21.5%
January 2%

Data below shows the percentage of the remaining discharges that are followed up by services or new referrals into services:

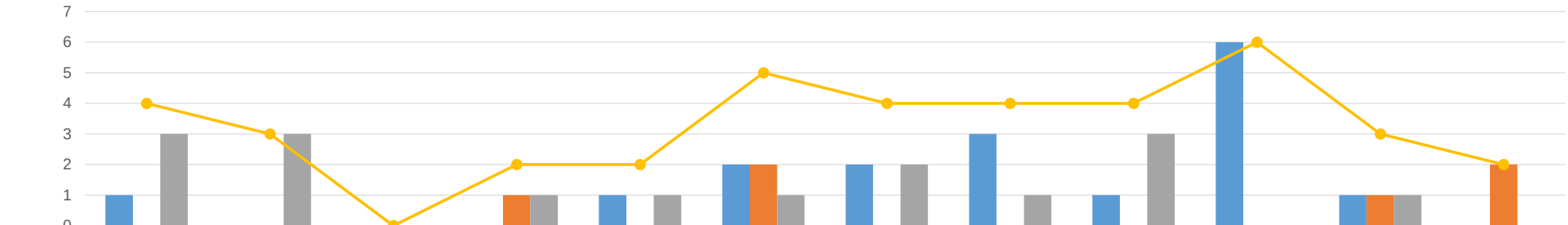
November 22% discharged with follow up and 9% referred to services.
December 9% discharged with follow up and 18% referred to services.
January 17% discharged with follow up and 19% referred to services.

The Criminal Justice Liaison Service has been working out of North Wales Police Headquarters and in the community since January 2020. The service has been actively involved in assisting the police and signposting people in crisis to other avenues rather than the police using the S136 power. Since January this has been recorded and 111 people have not become detained on a S136 due to CJLS intervention. This period accounts for 22 of those figures.

Data is now being recorded in relation to those that do progress to being detained on a S136 following consultation, since September 2020 there have been 27 instances.

Advisory Report - Section 136: Under 18 detentions

Section 135 - 136 (Under 18)	Latest Month	Previous Month	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)	2	3	↓	11	12	↓	10	1	West	7
								2	Centre	3
								3	East	1



	Feb_20	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21
West	1	0	0	0	1	2	2	3	1	6	1	0
Centre	0	0	0	1	0	2	0	0	0	0	1	2
East	3	3	0	1	1	1	2	1	3	0	1	0
BCU	4	3	0	2	2	5	4	4	4	6	3	2

A total of eleven under 18's were assessed this period between the ages of 16 and 17 years. Five assessments resulted in discharge with follow up to services, , one young person was discharged recorded as no mental discorder, four resulted in admissions, three to the childrens wards two without the restriction of a detention and one under section 2. There was one admission to the Psychiatric Unit under a section 2 and one S136 lapsed due to the young person not being fit for assessment.

The tables below shows the ages of young persons assessed and the outcomes for the year period April 20 - March 21.

Under 18 Assessments

AGE	No of Assessments
12	0
13	0
14	3
15	1
16	11
17	17

Outcome of Assessments

Outcome	Number
Returned Home	16
Returned to Care Facility	3
Admission to childrens ward	5
Admission to Adult ward / S136 suite	2
Admission NWAS/CAMHS	3
Admission OOA	1
Other (Friends, Hotel, B&B)	2

Month of Admission	Place of Assessment	Outcome	Assessing Clinician	Total Hours	Age
November	Hergest	Discharged	CAMHS	9:50:00	17
November	Hergest	Admission	CAMHS	11:00:00	16
November	Hergest	Admission	CAMHS	17:41	16
November	Hergest	Discharged	CAMHS	13:00:00	16
November	Hergest	Admission	CAMHS	17:10	16
November	Hergest	Admission	CAMHS	04:40	16
December	Hergest	Lapsed	CAMHS	24:01:00	16
December	Heddfan	Discharged	CAMHS	17:25	17
December	Ablett	Discharged	CAMHS	14:21	17
January	Ablett	Discharged	Adult	03:25	17
January	Ablett	Discharged	CAMHS	22:53	17

Out of the 11 young persons assessed all originated from their own home.

8 of the detentions were initiated out of hours.

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

Average PoS hours: 14:07 hrs this is an increase on the previous quarter figures of (10:17 hrs).

Under 18's admitted to Adult Psychiatric Wards

There was one admission to an Adult Psychiatric Ward this quarter from a S136.

The table below shows the county that the young persons originated from and where they were assessed for the period April 20 - March 21

County Originated from and where assessed.

County	East	Central	West
Wrexham	3		1
Flintshire	6	3	
Denbighshire	1	2	2
Conwy		1	4
Gwynedd			3
Ynys Mon			5
Out of Area			

A

Advisory Report - Forensic

Section	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021
Section 35:	0	0	0	0	0	0	0	0	0	0	0	0
Section 37:	1	1	1	0	0	0	0	0	0	0	0	0
Section 37/41:	12	12	9	9	9	8	8	9	8	9	9	9
Section 38:	0	0	0	1	1	1	1	0	0	0	0	1
Section 47:	4	4	2	2	2	2	3	3	3	3	3	3
Section 47/49:	4	4	2	2	3	3	2	2	2	3	3	4
Section 48:	0	0	0	0	0	0	0	0	0	0	0	0
Section 48/49:	0	0	0	0	0	0	0	0	0	0	1	0
Section 3:	2	2	2	2	2	3	3	3	3	3	3	3
Section 45A	1	1	1	1	1	1	1	1	1	1	1	1
Total:	24	24	17	17	18	18	18	18	17	19	20	21

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.

Advisory Report - Transfers

Total Transfers for the Quarter

	Nov 2020	Dec 2020	Jan 2021
Internal Transfers	19	25	20
External Transfers (Total)	6	8	6
External Transfers (In)	3	6	2
External Transfers (Out)	3	2	4

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

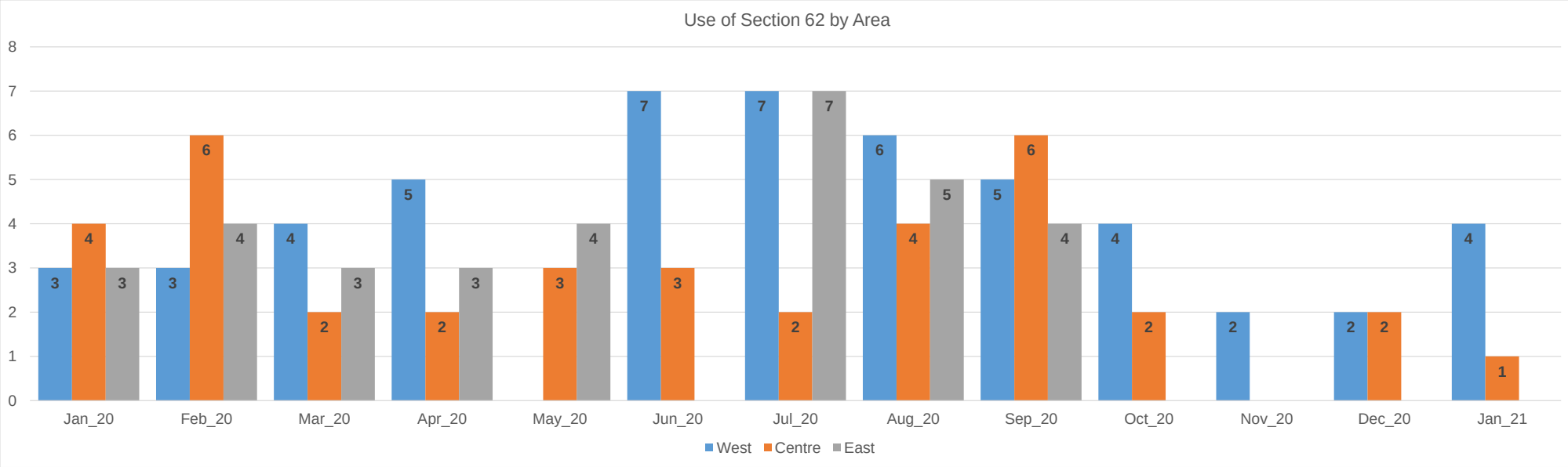
External Transfers
This data only includes detained patient transfers both in and out of BCU facilities. The majority will be facilities in England and will also include any complex cases requiring specialist service. Those repatriated are returning to their home area or transferring in for specialised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

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

Patients detained in Independent Hopsitals (in Wales and outside of Wales) There are a number of persons who will be detained in independent hospitals that are offering services required. Currently there are 79 detained patients within independent hospitals 40 of these are outside of Wales ie out of area placements, this is a reduction on the last figures reported.

Month	Transfers In
Nov_20	HMYOI Swinfen Hall (Flintshire)
Nov_20	Priory, Cheadle (Conwy)
Nov_20	Priory Cheadle (Denbighshire)
Dec_20	HMP Durham (Conwy)
Dec_20	Cygnet, Coventry (Gwynedd)
Dec_20	Arbury Court (Gwynedd)
Dec_20	Cygnet, Coventry (Conwy)
Dec_20	Delfryn House (Wrexham)
Dec_20	The Priory, Middleton St George, Darlington (Wrexham)
Jan_21	Chadwick Lodge (Wrexham)
Jan_21	The Priory Bristol (Ynys Mon)

Month	Transfers Out
Nov_20	Edgware Community Hospital (Conwy)
Nov_20	Delfryn House Mold (Conwy)
Nov_20	Cygnet, Harrogate (Repatriated)
Dec_20	To Cygnet CAMHS Coventry (Gwynedd)
Dec_20	Prior Hospital, Middleton St George, Darlingto, Co Durham (Chester Ward)
Jan_21	To Cygnet Manor Nottingham (Gwynedd)
Jan_21	Cygnet Hospital, Middlesex (Flintshire)
Jan_21	Cygnet Hospital, Sheffield (Wrexham)
Jan_21	The Priory, Bristol (Conwy)



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.

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Betsi Cadwaladr
University Health Board

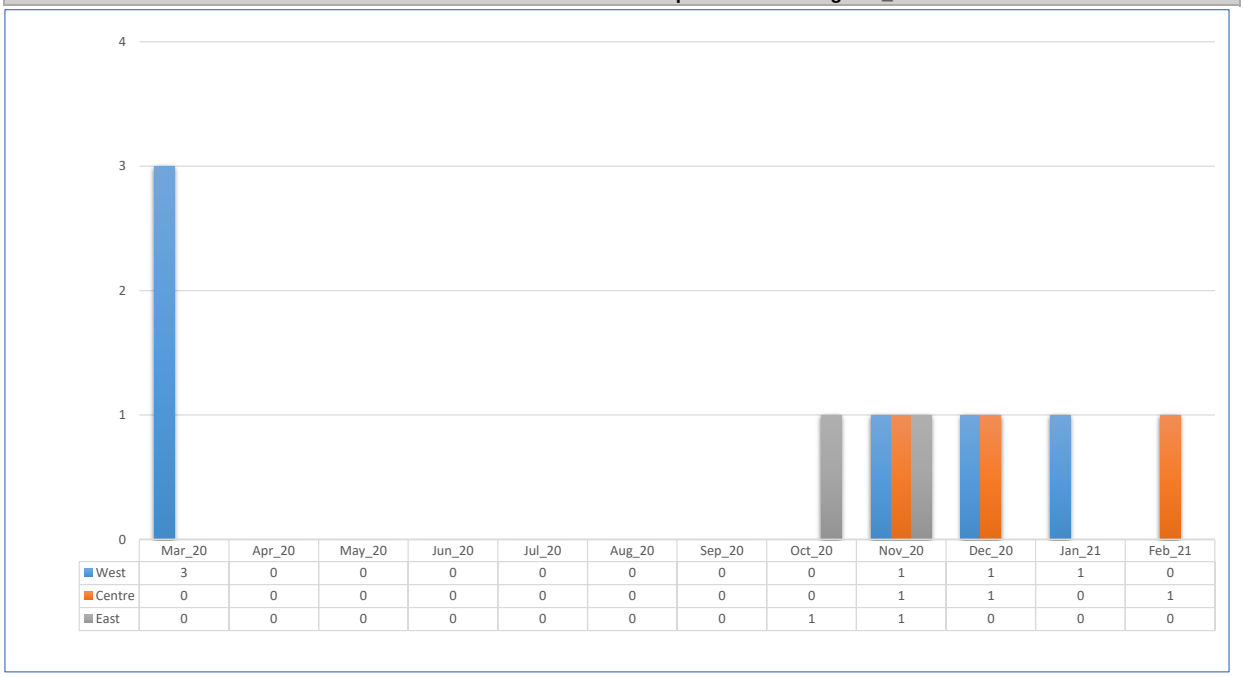
Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

S.136/135 use in BCUHB	
KPI Report for:	**February 2021**

Data Source:	BCUHB MHA Database
Report Created on:	04/03/2021
Report Created by:	Performance Directorate

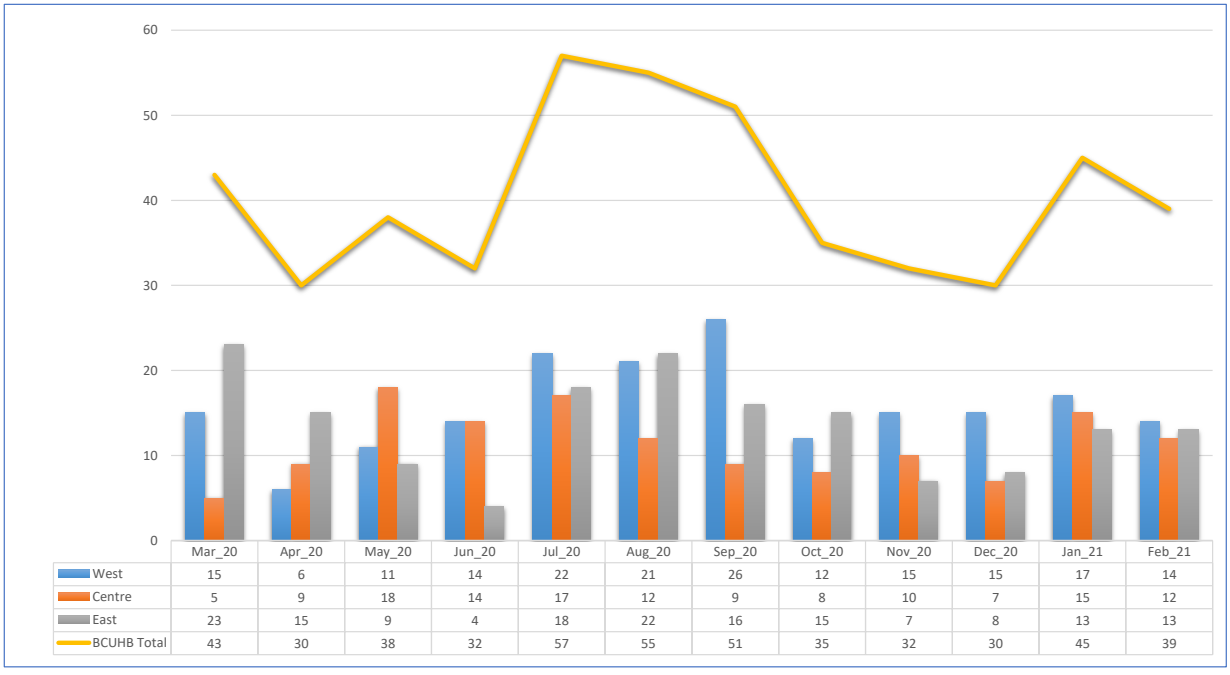
Section A: 12 Month Data and Trends

1.1: Section 135 twelve month trend up to and including Feb_21



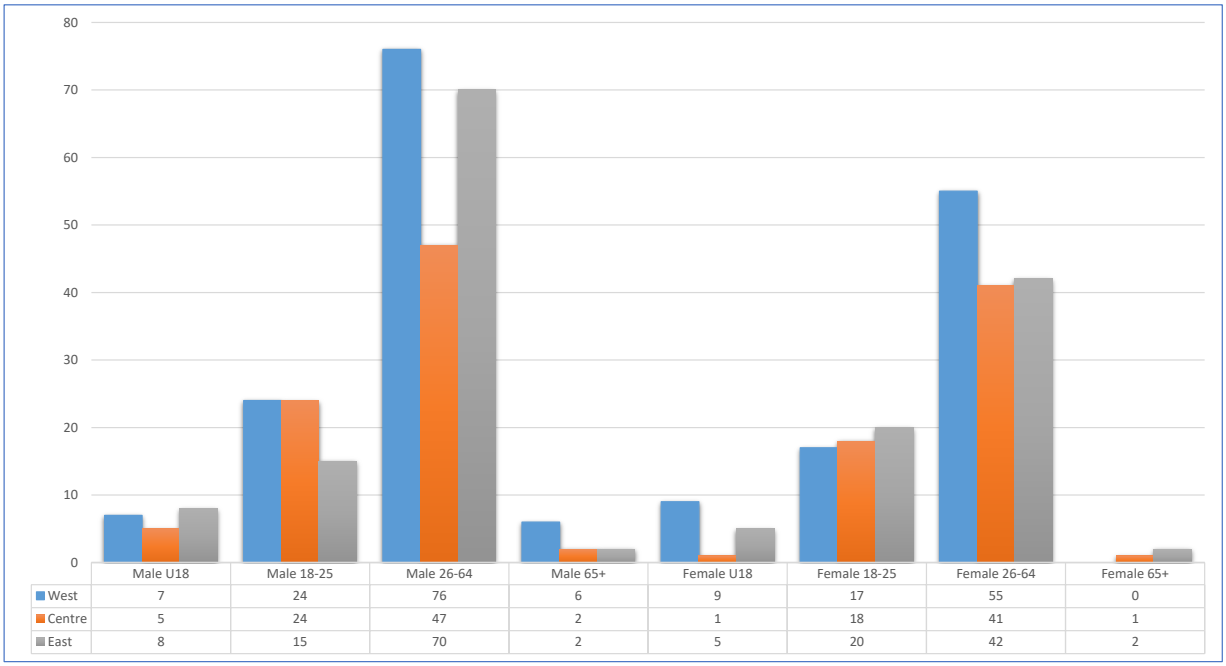
	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	3	0	0	0	0	0	0	0	1	1	1	0
Centre	0	0	0	0	0	0	0	0	1	1	0	1
East	0	0	0	0	0	0	0	1	1	0	0	0

2.1: Section 136 twelve month trend up to and including Feb_21



	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	15	6	11	14	22	21	26	12	15	15	17	14
Centre	5	9	18	14	17	12	9	8	10	7	15	12
East	23	15	9	4	18	22	16	15	7	8	13	13
BCUHB Total	43	30	38	32	57	55	51	35	32	30	45	39

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



	Male U18	Male 18-25	Male 26-64	Male 65+	Female U18	Female 18-25	Female 26-64	Female 65+
West	7	24	76	6	9	17	55	0
Centre	5	24	47	2	1	18	41	1
East	8	15	70	2	5	20	42	2

4: 1st Place of Safety 12 month trend up to and including Feb_21

Area Split - 1st Place of Safety by category

	Feb_21			12 Month Total		
1st Place of Safety	**West**	**Centre**	**East**	**West**	**Centre**	**East**
A&E	1	3	3	27	30	28
Ward	0	0	0	0	0	0
PICU	0	0	0	0	0	0
136 Suite	12	9	10	152	103	126
Hospital	0	0	0	3	2	4
Independent Hospital	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0
Police Station (Custody)	1	0	0	5	0	3
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0
Any other place	0	0	0	0	1	0

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

1st Place of Safety: A&E Split	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	2	0	3	2	2	4	2	2	2	3	4	1
Centre	2	3	4	5	5	1	2	2	0	0	3	3
East	8	0	1	0	3	1	1	3	1	2	5	3

1st Place of Safety: 136 Suite Split	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	13	6	7	12	18	16	23	10	11	11	13	12
Centre	3	6	14	9	12	11	5	5	10	7	12	9
East	13	14	8	4	15	20	12	12	5	6	7	10

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

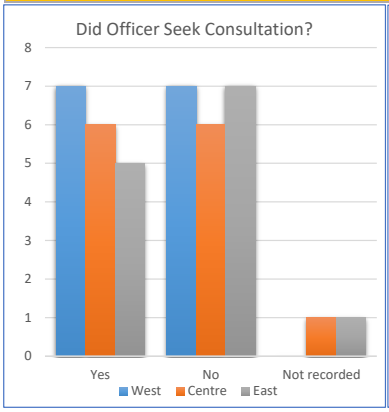
5.1: Area split 3 month table up to and including Feb_21 and latest 12 month total

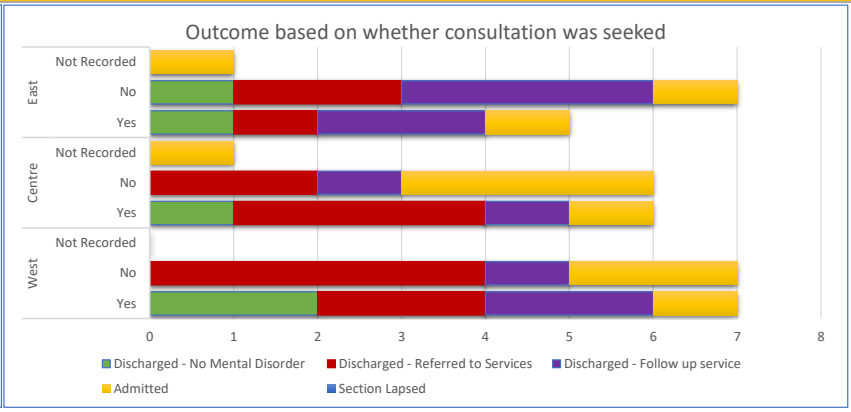
West	Dec_20	Jan_21	Feb_21	12 Month Total	Centre	Dec_20	Jan_21	Feb_21	12 Month Total	East	Dec_20	Jan_21	Feb_21	12 Month Total	Incident rate by county (12 mth total)	
Ynys Mon	2	1	4	**30**	Ynys Mon	0	1	0	**4**	Ynys Mon	0	0	0	**1**	Ynys Mon	**4.99**
Gwynedd	7	5	5	**72**	Gwynedd	1	3	0	**9**	Gwynedd	0	1	0	**1**	Gwynedd	**6.63**
Flintshire	0	2	0	**17**	Flintshire	0	1	2	**16**	Flintshire	1	5	4	**52**	Flintshire	**5.49**
Wrexham	0	2	2	**12**	Wrexham	1	1	1	**25**	Wrexham	7	5	7	**92**	Wrexham	**9.27**
Conwy	5	4	3	**34**	Conwy	2	2	5	**31**	Conwy	0	0	0	**5**	Conwy	**5.99**
Denbighshire	1	3	0	**14**	Denbighshire	3	7	4	**46**	Denbighshire	0	1	2	**10**	Denbighshire	**7.33**
Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	0	0	0	**0**	Powys	**#N/A**
OOA	0	0	0	**2**	OOA	0	0	0	**0**	OOA	0	1	0	**1**	OOA	**#N/A**
Incident Rate per 10,000 population	0.77	0.88	0.72	**9.34**	Incident Rate per 10,000 population	0.33	0.71	0.56	**6.17**	Incident Rate per 10,000 population	0.27	0.44	0.44	**5.51**	BCUHB	**6.77**

***Please note:** due to County Detained was only captured from November 2017, residents per detention by county detained will only be accurate from November 2018 onwards. Area data is accurate from April 2016

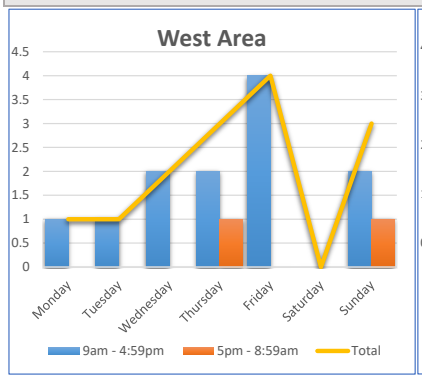
Section B: 12 Month Data for Feb_21

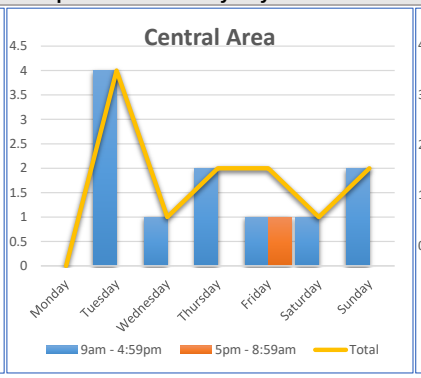
6.1: Consultations and Outcomes all areas during Feb_21

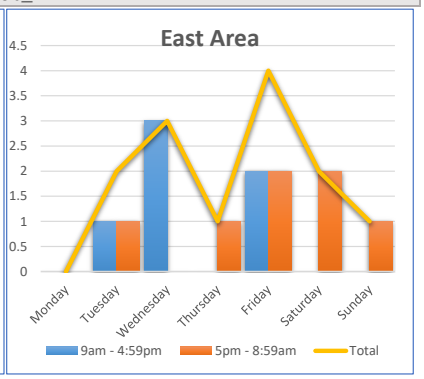




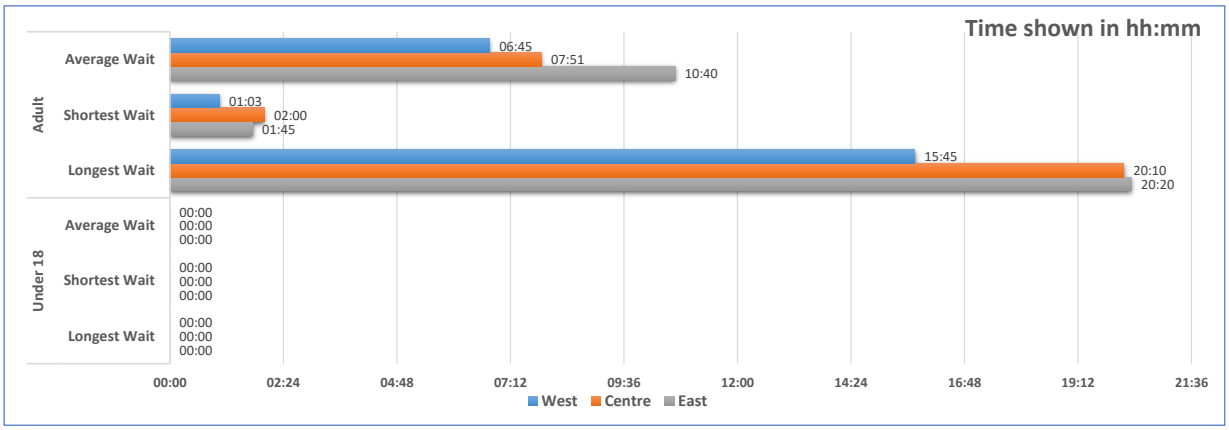
7.1: Area split of S.136 use by Day and Time for Feb_21



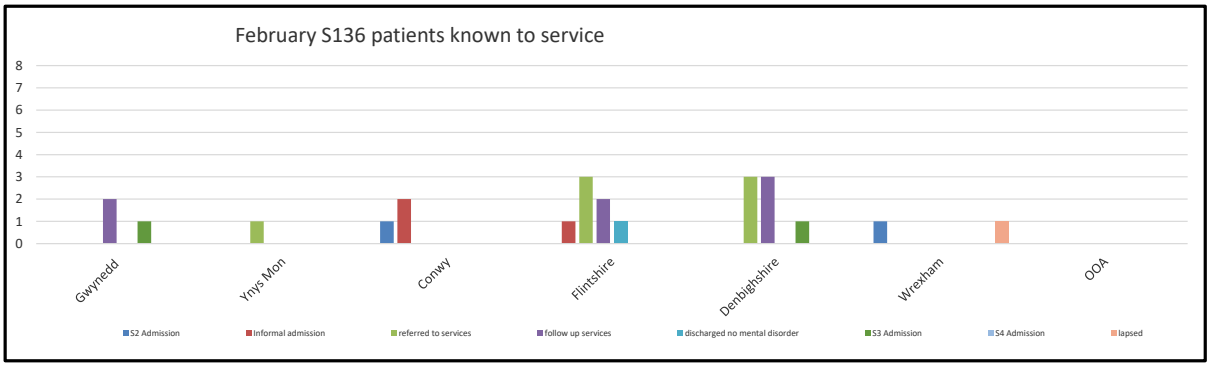




8.1: Duration in S.136 Suite for Feb_21



Within this month there were no S136 detentions for young persons under 18, no lapses and no extensions.



The table below shows the area that someone originates from, where they were detained and which S136 suite they were taken to. Out of the 39 S136 detentions 8 people were not seen within the closest S136 suite.

6 were due to no capacity, and 2 did not have the reason recorded.

Local Authority Originates from	Detained in	S136 Suite assessed at
Wrexham x 2	Wrexham x 2	Hergest
Conwy	Conwy (Abergele)	Hergest
Flintshire	Wrexham	Ablett
Flintshire x 2	Flintshire x 2	Ablett
Denbighshire x 2	Denbighshire x 2	Heddfan

The Criminal Justice Liaison Service is now actively involved in the police control rooms with qualified nursing staff on hand to assist the police with advice prior to the use of S136.
The department has now began monitoring the instances where the use of S136 does not occur due to the person being diverted to another form of help following consultation either with the Duty Nurse or the Criminal Justice Liaison Service.

Within the month of February the Mental Health Act Office has received notification that there have been six instances where the Criminal Justice Liaision Nurses have assisted in preventing a S136 and signposting to a different support network.
Consultations with the service that have lead to a S136 are monitored for the month of February there have been eight of these instances, one being recorded as against the advice of the CJLS service.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Cyfarwyddiaeth Perfformiad
Performance Directorate
Tim Rheolaeth Perfformiad
Performance Management Team

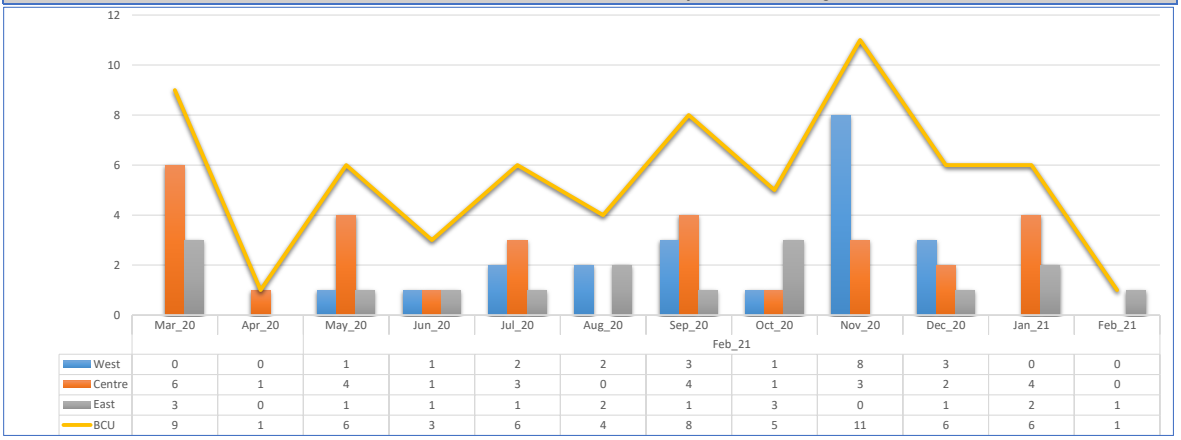
Under 18's detentions in North Wales

KPI Report for: February 2021

Data Source:	BCUHB MHA Database
Report Created on:	02/03/2021
Report Created by:	Performance Directorate

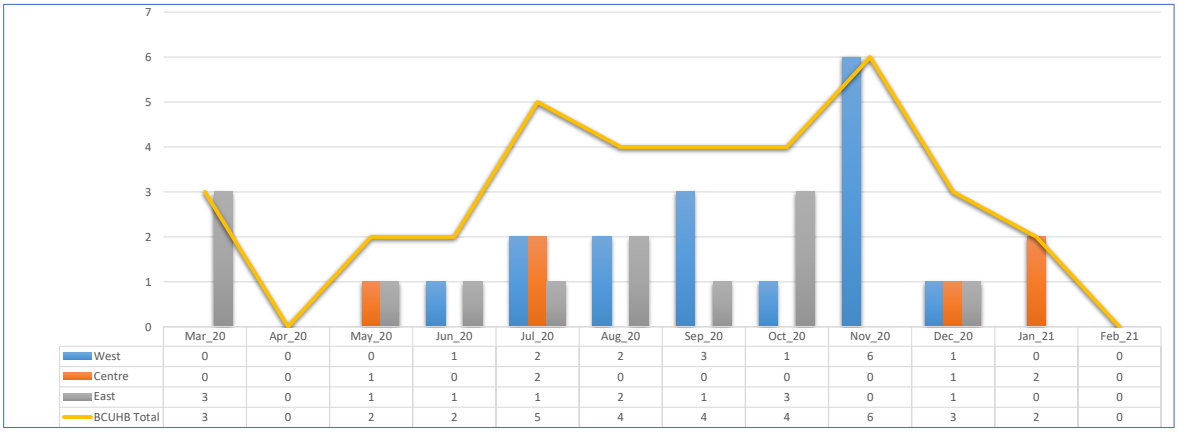
Section A: 12 Month Data and Trends

1.1: All Detentions for U18's twelve month trend up to and including Feb_21



	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	0	0	1	1	2	2	3	1	8	3	0	0
Centre	6	1	4	1	3	0	4	1	3	2	4	0
East	3	0	1	1	1	2	1	3	0	1	2	1
BCU	9	1	6	3	6	4	8	5	11	6	6	1

2.1: Section 136 twelve month trend up to and including Feb_21

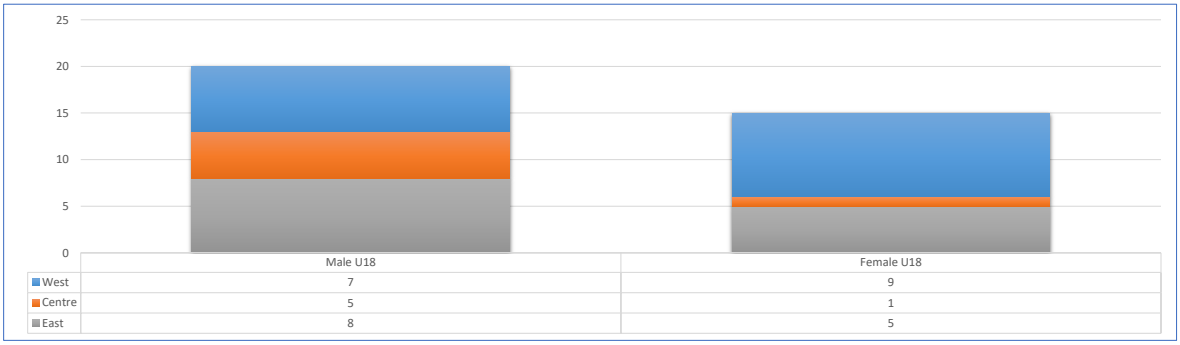


	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	0	0	0	1	2	2	3	1	6	1	0	0
Centre	0	0	1	0	2	0	0	0	0	1	2	0
East	3	0	1	1	1	2	1	3	0	1	0	0
BCUHB Total	3	0	2	2	5	4	4	4	6	3	2	0

2.2: Section 136 Outcomes twelve month trend up to and including Feb_21

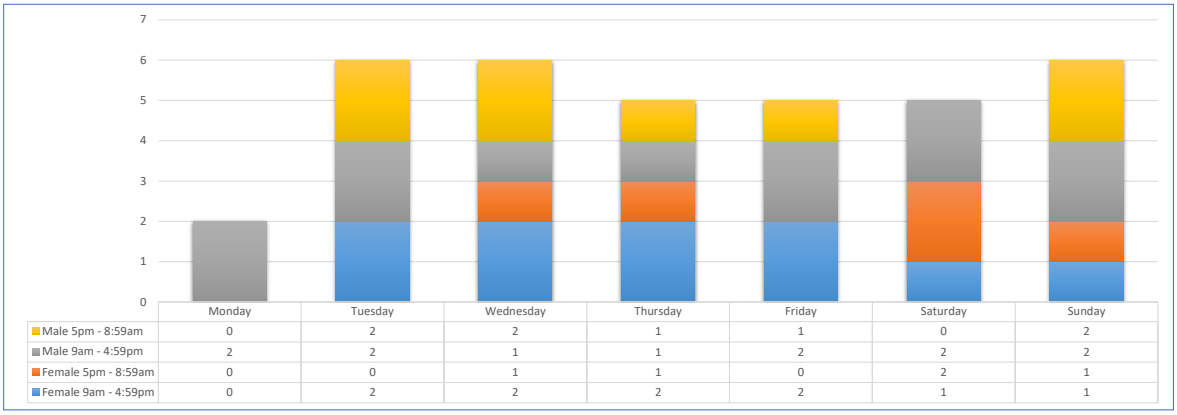
Outcome of 136 detention	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
Discharged - No Mental Disorder	1	0	0	0	0	0	1	0	1	0	0	0
Discharged - Referred to Services	0	0	0	0	3	1	0	0	1	1	0	0
Discharged - Follow up service	1	0	0	1	2	2	1	3	0	1	2	0
Admitted	1	0	2	1	0	1	2	1	4	0	0	0
Section Lapsed	0	0	0	0	0	0	0	0	0	1	0	0

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



	Male U18	Female U18
West	7	9
Centre	5	1
East	8	5

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



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

4: 1st Place of Safety 12 month trend up to and including Feb_21

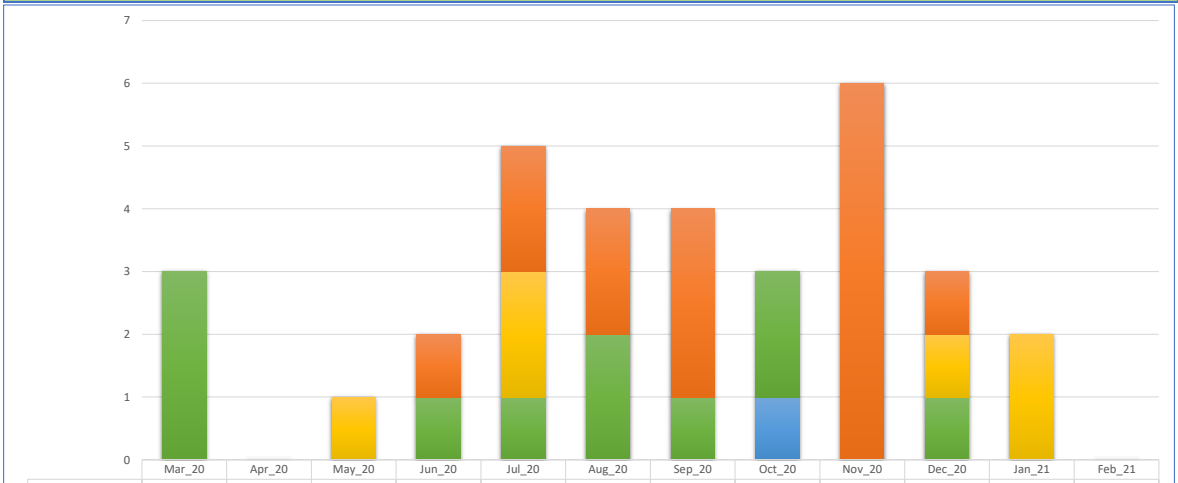
4.1: 1st Place of Safety by BCUHB and split by category

1st Place of Safety	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
A&E	0	0	1	0	0	2	0	1	1	1	0	0
Ward	0	0	0	0	0	0	0	0	0	0	0	0
PICU	0	0	0	0	0	0	0	0	0	0	0	0
136 Suite	3	0	1	2	5	2	4	3	3	2	2	0
Hospital	0	0	0	0	0	0	0	0	1	0	0	0
Independent Hospital	0	0	0	0	0	0	0	0	0	0	0	0
Care Home for mentally disordered persons	0	0	0	0	0	0	0	0	0	0	0	0
Police Station (Custod)	0	0	0	0	0	0	0	0	0	0	0	0
Residential accommodation provided by Social Services Authority	0	0	0	0	0	0	0	0	0	0	0	0
Any other place	0	0	0	0	0	0	0	0	0	0	0	0

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

1st Place of Safety: A&E Split	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West	0	0	0	0	0	2	0	1	1	1	0	0
Centre	0	0	1	0	0	0	0	0	0	0	0	0
East	0	0	0	0	0	0	0	0	0	0	0	0

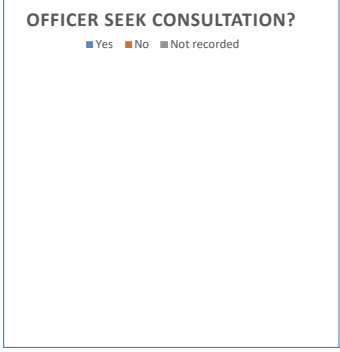
5.1: Police and Ambulance conveyancing by Area 12 month trend up to and including Feb_21

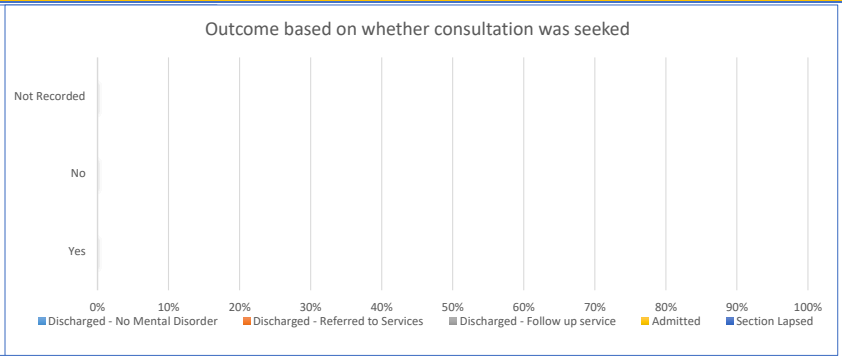


	Mar_20	Apr_20	May_20	Jun_20	Jul_20	Aug_20	Sep_20	Oct_20	Nov_20	Dec_20	Jan_21	Feb_21
West Police	0	0	0	1	2	2	3	0	6	1	0	0
Centre Police	0	0	1	0	2	0	0	0	0	1	2	0
East Police	3	0	0	1	1	2	1	2	0	1	0	0
West Ambulance	0	0	0	0	0	0	0	1	0	0	0	0
Centre Ambulance	0	0	0	0	0	0	0	0	0	0	0	0
East Ambulance	0	0	0	0	0	0	0	0	0	0	0	0

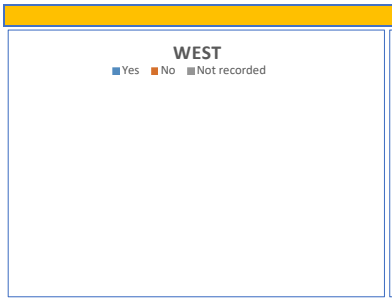
Section B: Data for Feb_21

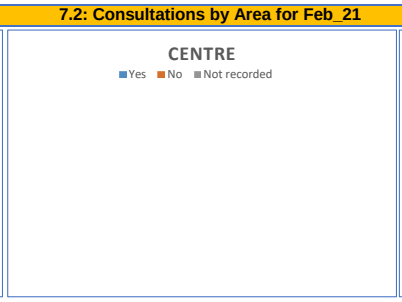
7.1: Consultations and Outcomes for Feb_21

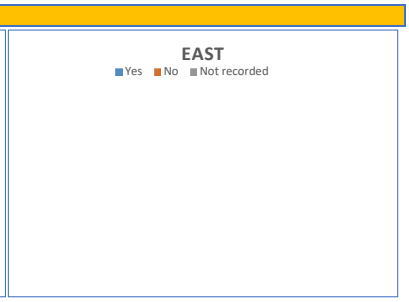




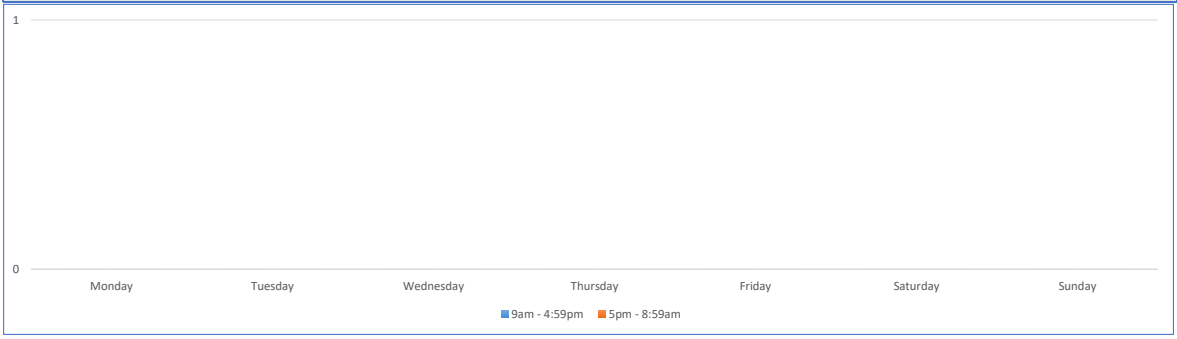
7.2: Consultations by Area for Feb_21



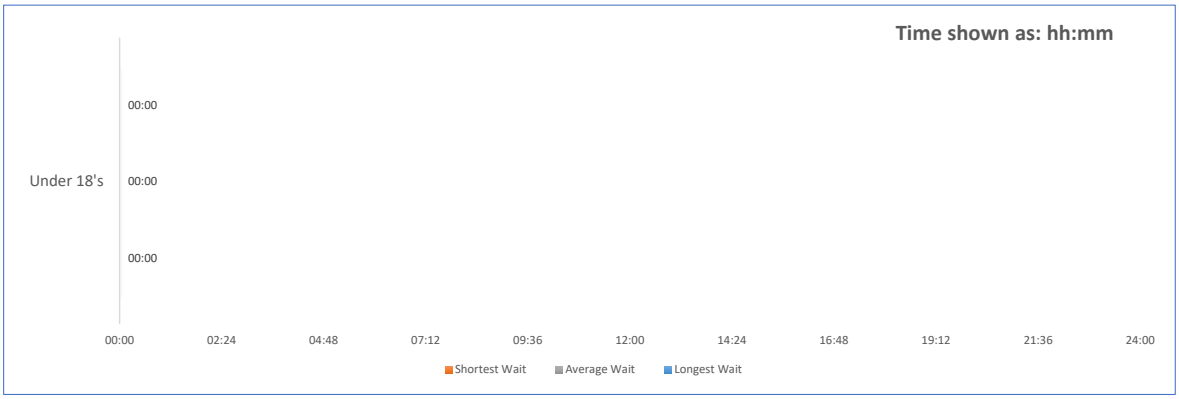




8.1: S.136 use by Day and Time for Feb_21

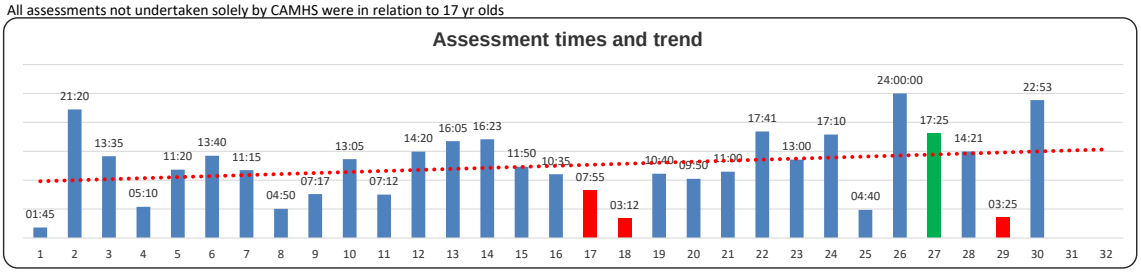


9.1: Time spent in S136 Suite / 1st place of safety until Outcome Feb_21



10.1: Narrative for Feb_21

There were no S136 detentions in February, one young person was placed on a section but this was not following a S136.
The chart below details the length of time that young people have been detained under a S136 and a trend line for the last 30 detentions. The columns have been defined by colour:
Blue are in reference to CAMHS assessments, Red for Adult and Green for joint.
All assessments not undertaken solely by CAMHS were in relation to 17 yr olds



Cyfarfod a dyddiad: **Meeting and date:**	**Mental Health Act Committee** **12.03.2021**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Healthcare Inspectorate Wales (HIW) Monitoring Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Iain Wilkie, Divisional Director of Mental Health and Learning Disabilities (Interim)
Awdur yr Adroddiad **Report Author:**	Hilary Owen, Head of Governance Wendy Lappin, Mental Health Act Manager
Craffu blaenorol: **Prior Scrutiny:**	Gold Command on behalf of MHLD Senior Leadership Team Quality Safety and Experience Group 20.02.2021
Atodiadau **Appendices:**	Appendix 1 – Inspections Update Appendix 2 – HIW report: Quality Check Summary Glan Clwyd Hospital – Ablett Unit

Argymhelliad / Recommendation:

The Committee is asked to note the report.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

This paper (Appendix 1) provides an update in relation to the inspections conducted by Healthcare Inspectorate Wales (HIW) covering a period of 12 months. New and updated inspections are included. Those which have been dealt with, and are still within the 12 month period are noted for information.

The HIW report is included in (Appendix 2).

Cefndir / Background:

HIW is the independent inspectorate and regulator of all health care in Wales.
HIW conduct announced and unannounced visits to services offered by Betsi Cadwaladr University Health Board.

The primary focus for visits are:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizen's experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed

- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all

As part of a new tiered approach to assurance, HIW have begun undertaking “quality checks” to examine how healthcare services are meeting the Health and Care Standards 2015 and other relevant regulations.

The focus for the quality checks are for four key areas:

- Covid-19 arrangements
- Environment
- Infection prevention and control
- Governance

This report provides assurance that following the inspections, actions/recommendations are followed up appropriately.

Asesiad / Assessment & Analysis

Strategy Implications

The Health Board’s Wellbeing objectives, sustainable development principles and the Strategy are all considered when inspections are conducted by HIW. The focus is around the quality of patient experience, the delivery of safe and effective care, and the quality of management and leadership.

Options Considered

Not applicable for this report.

Financial Implications

The issues highlighted by HIW may have financial implications. However the aspects covered in this document (namely the Mental Health Act and Mental Health Measure) require no financial consideration at present.

Risk Analysis

Outstanding HIW Actions are reviewed within the MHLD division Area Quality Safety and Experience (QSE) meetings on a monthly basis.
Policies –Policies regularly require updating and change as statute and documents change.
The MHLD Policy Implementation Group is working to ensure policies are kept up to date and reviewed by appropriate personnel. This is reported monthly to the MHLD Senior Leadership Team QSE meeting and reported to the Health Board QSE committee meetings.

Legal and Compliance

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.

Impact Assessment

This is a retrospective report and therefore no EQIA is required. All policies which link in with HIW actions will be Equality Impact Assessed.

Appendix 1.

Inspections within the last 12 months

New Inspections and updates are provided below.

1 Quality check Summary: Glan Clwyd Hospital – Ablett Unit NEW

Inspection Date: 20 November 2020

Publication of report due: 16 December 2020

HIW considered the Mental Health Act aspect in the Governance section of their report with specific questioning on: *In light of the impact of Covid 19 how are services continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights*.

The report details positive evidence relating to:

- Staffing
- The needs of patients being met by the involvement of families
- Continued improvement of communication with Community Mental Health Teams (CMHTs)
- The support of the MHA administration team in providing guidance to ensure patients are aware of their rights and the continued facilitation of tribunals and access to advocacy.

No required improvements were identified in relation to the Mental Health Act.

2 Quality Check Summary: Bryn Y Neuadd Hospital – Carreg Fawr Unit UPDATE

Inspection Date: 29th September 2020

Publication of report due: 5th November 2020

Under the Governance section, HIW enquired how in light of the impact of COVID-19, was the unit continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

HIW were provided with evidence that the frequency of Mental Health Act Review Tribunals had not been affected by the pandemic. Participation at meetings, solicitor and Independent Mental Health Advocate (IMHA) access was being maintained by telephone rather than face to face.

The MHLD Bed Escalation Policy was highlighted as a concern given the expired review date. The Health Board was asked to ensure that policies are consistently reviewed and updated as and when scheduled, and that

governance arrangements are clear. The response and actions are detailed below and have been submitted to HIW for assurance.

Improvement Needed	Service Action	Timescale
The health board should review the governance arrangements in place to ensure policies are consistently being reviewed and updated when required.	The MHLD Division policy group terms of reference were agreed on the 27.08.2020. It meets on a monthly basis. All documents which are nearing the review date are highlighted in advance to ensure allocation of a professional to review, and monthly updates are required as to process and any obstacles which may need escalation. Polices are also considered in relation to risk and the effect of removal from the intranet and circulation if they have not been reviewed and updated prior to the review date. During March to September 2020 the Policy group was stood down due to Covid 19; since resuming documents are now being tracked and reviewed with a monthly report produced for the MHLD Leadership Team, Quality Safety and Experience Meeting. The MHLD 0045 Bed Escalation Policy has been reviewed and this has been sent for consultation until the 12 November 2020 to then be presented at the MHLD Policy Group meeting on the 17 December 2020 for ratification.	Complete 17.12.2020 The above meeting was cancelled. The document is due for ratification at the February meeting. 25.02.2021

3 Heddfan Unit Wrexham Maelor FOR INFORMATION

Inspection Date: 7th - 9th July 2020

Publication of report due: 7th October 2020

The visit to Heddfan was not to focus on the specifics of the Mental Health Act. The informal feedback did not raise any issues in regards to the use of legislation, and the report does not detail any actions in terms of the Mental Health Act.

The purpose was to gain assurance on whether sufficient attention was being given by the Health Board to address issues that had been raised through concerns reported to HIW. The focus was specifically on: patient care, governance and leadership, safeguarding, staffing and infection prevention and control.

The report highlighted the availability of a wide range of relevant information leaflets for patients, families and other visitors including information on mental health issues and guidance around legislation.

In terms of Mental Health Measure, care plans viewed were noted to be of a good standard, and clear evidence detailed of multidisciplinary involvement. The Covid 19 care plans were noted to be individualised, detailed and well developed. Two items of note were highlighted under the record keeping element, and these are detailed in the table below. These relate to the Mental Health Measure documentation of unmet needs.

Improvement Needed	Service Action	Timescale
The health board must ensure that unmet needs are evidenced and documented within patient care plans.	Teams have been reminded by a memo to ensure unmet needs are documented within the Mental Health Measure documentation. There is a daily Acute Care Meeting (Mon-Fri) where any identified unmet needs have clear actions for resolution. A weekly audit will include a monitoring question on unmet needs captured in the Mental Health measure documentation and gaps immediately rectified.	Complete Memo dated 19 August 2020 and distributed The unmet needs are now part of the template for the meetings and are discussed. Complete

Appendix 2

Quality Check Summary Glan Clwyd Hospital – Ablett Unit

Quality Inspection Summary Ablett Uni

(Item attached separately).

Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Quality Check Summary

Ablett Unit (Glan Clwyd Hospital)

Activity date: 20 November 2020

Publication date: 16 December 2020

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

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

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Digital ISBN 978-1-80082-633-5

Findings Record

Our Approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Ablett Unit at Glan Clwyd Hospital as part of its programme of assurance work. The Ablett Unit provides NHS mental health services and is managed by Betsi Cadwaladr University Health Board.

HIW's quality checks form part of a new tiered approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015 (and other relevant regulations). Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality Checks are a snapshot of the standards of care within healthcare settings. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to inspections can be found here.

We spoke to the Interim Acute Care Clinical Site Manager on 20 November 2020 who provided us with information and evidence about their setting. We used the following key lines of enquiry:

- How are you ensuring that the environment is safe and suitable for the needs of patients at this time? What changes, if any, have been made to the physical environment, ward routines and patients' access to leave as a result of COVID-19?
- How is the risk of infection assessed and managed to keep patients, visitors and staff safe?
- Considering the impact of COVID-19, how are you discharging your duty of care against the Mental Health Act and how are patients' rights being safeguarded?
- How are you ensuring that there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed?

Environment

During the quality check, we considered how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. We reviewed recent risk assessments, incident reviews and use of restraint and seclusion. We also questioned the setting on the changes they have made to make sure patients continue to receive the care and treatment according to their needs.

The Ablett Unit has traditionally been an acute care admissions unit for adults and functional older persons. However, in April 2020, the Ablett Unit was temporarily recommissioned to be the Acute Care Admissions Unit for all adult patients across North Wales. These new regional arrangements were implemented by the health board in an attempt to safely manage acute patients during the pandemic. Non-acute patients at the unit were relocated to other sites to accommodate this change.

The following positive evidence was received:

We were told that patients are generally very unwell when being admitted into the unit and therefore the new care pathways for patients through the temporary regional model in North Wales are communicated to the families and advocates of patients wherever possible.

We were provided with documentation that outlined the significant changes undertaken to ensure the unit could safely provide care to acute adult patients. Wards were designated as 'red', 'amber' and 'green' to help separate and manage patients according to their COVID-19 status. This has meant that for short periods the 'amber' ward will become a mixed ward. We were told that this had been risk assessed, and that bedrooms and bathrooms are segregated as much as possible to maintain the privacy and dignity of patients, and that staff monitor any shared spaces at all times.

We were told that the long stay rehabilitation ward was closed to allow for anti-ligature risk assessments to be undertaken. We saw evidence of the existing and additional control measures and modifications put in place to ensure the ward environment was appropriate and safe for acute patients. The other wards are subject to anti-ligature risk assessments annually.

We were told that visiting arrangements during COVID-19 shifted to virtual communication due to the national restrictions on visitors in healthcare settings. Patients have been able to stay in contact with their families, friends and/or carers using their own mobile phones or using an iPad made available to patients by the hospital.

We were told that all patients have risk management plans that include an assessment on

whether patients are eligible for Section 17 leave[1]. The Interim Acute Care Clinical Site Manager described how changes to granting patients' leave had been managed during COVID-19. Patients were typically not granted leave from hospital during periods of lockdown and staff undertook shopping on behalf of patients. When patient leave was granted after lockdowns had been lifted, we were informed that appropriate PPE was worn by staff and patients and social distancing was adhered to.

We reviewed data on the amount of incidents involving challenging behaviour and restraint at the unit and discussed this information with the Interim Acute Care Clinical Site Manager. We were told that the majority of such incidents that have occurred over the last three months involved a small number of patients with demanding acute needs. We saw that reviews of incidents had taken place and that learning opportunities and training needs had been identified and actioned where necessary.

The following areas for improvement were identified:

The Interim Acute Care Clinical Site Manager told us about a serious incident that occurred at the unit a few months ago, whereby a patient was admitted to the unit's Section 136 suite[2] instead of being admitted to a more appropriate setting. HIW understands the difficulties involved with identifying an appropriate placement for this patient, but the health board must ensure that patients are not inappropriately admitted to the unit to help protect staff and ensure patients receive the right care and treatment when needed.

Infection prevention and control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19. We considered how well the service manages and controls the risk of infection to help keep patients, visitors and staff safe. We reviewed infection control policies, infection rates and risk assessments. We reviewed key systems including the use of personal protective equipment (PPE).

The following positive evidence was received:

We spoke to the Interim Acute Care Clinical Site Manager about the arrangements in place to help stop the transmission of COVID-19 throughout the unit. Patients are triaged in the community by the Home Treatment Team to check for symptoms of COVID-19. All patients are then tested for COVID-19 upon admission to the unit and initially placed on the 'amber' ward. Patients are then either moved to the 'green' or 'red' ward depending on the result of their COVID-19 status. We were informed that appropriate Personal Protective Equipment

[1] Section 17 of the Mental Health Act allows detained patients to be granted leave of absence from the hospital for a defined purpose and duration to help patients in their recovery for discharge back into the community.
[2] A Section 136 suite is a facility for people who are detained by the Police under Section 136 of the Mental Health Act.

(PPE) is available for staff to barrier nurse patients on the 'amber' and 'red' wards in line with national guidance. Encouragingly, the unit has only reported two positive cases of coronavirus for patients.

We were told that all staff have been made aware of how to safely don and doff PPE and on which PPE to wear during different situations, for example, when undertaking a planned necessary restraint. The Interim Acute Care Clinical Site Manager confirmed that regular PPE refresher training is available for staff and that daily audits are undertaken to check their competency and understanding of their responsibilities in relation to PPE. Daily stock checks of PPE are undertaken by staff to ensure there are no incidents of shortages at the unit.

We saw that a COVID-19 social distancing action plan had been completed for the unit to ensure it could adhere to social distancing guidelines. The Interim Acute Care Clinical Site Manager confirmed that patients were being encouraged to socially distance wherever possible. Mealtimes have been split into two separate sittings to help facilitate extra space amongst patients and staff.

We saw evidence of a recent Infection Prevention (IP) Review Visit undertaken by the Clinical Service Lead for Infection Prevention at the health board, to check the infection prevention and control (IPC) arrangements in place at the unit. We noted that the review was positive.

We were provided with mandatory training statistics for staff and saw that compliance with IPC training was high across all staff members within each ward at the unit.

The following areas for improvement were identified:

We were told that there were no specific health board policies available in relation to infection prevention and control or in response to the COVID-19 pandemic. However, HIW are aware from previous quality checks undertaken recently within Betsi Cadwaladr University Health Board, that such policies are available. We were previously informed that relevant policies were being reviewed and were pending approval at the Infection Prevention Sub Group scheduled for 13 October 2020. The health board must ensure that all staff are aware of such policies and that findings from quality checks undertaken by HIW are recognised and shared across all health board settings.

The Interim Acute Care Clinical Site Manager told us that cleaning rotas have been altered to reflect the enhanced programme of cleaning undertaken at the unit since the onset of COVID-19. However, recent COVID-19 daily audit checklists show that domestic enhanced cleans are not being performed (e.g. additional cleans of high touch points) across the unit. The service must ensure that surfaces are regularly wiped down to help stop the transmission of COVID-19 throughout the unit.

Governance

As part of this standard, HIW considered how the setting ensures there are sufficient numbers of appropriately trained staff to meet patients' needs, with access to wider mental health professionals where needed. We also questioned the setting about how, in light of the impact of COVID-19, they are continuing to discharge their duty of care against the Mental Health Act and safeguarding patients' rights.

During the undertaking of the quality check it was apparent that staff have worked tirelessly and selflessly to meet the new challenges faced at the unit since the onset of COVID-19. This has included staff working overtime or working bank shifts to help ensure the unit can deal with the high volume of admissions of acute adult patients. HIW understands that plans are being implemented across the health board to move away from the regional model and move back to settings providing their traditional mental health services. We would support this move to help protect the health and wellbeing of staff working within mental health services across the health board. HIW will continue to seek assurance around the impact of the regional model, including the pressures faced by mental health services across North Wales through its Relationship Manager[3] role.

The following positive evidence was received:

We discussed the arrangements in place to help ensure that there is the right skill mix and number of staff on the unit during each shift. Rotas are normally reviewed on a monthly basis and we saw evidence of Staffing Escalation Procedures developed by the health board to help staff understand the steps required to ensure there are adequate numbers of staff working on each shift to meet the needs of patients. However, staffing requirements are now subject to daily scrutiny since the unit became the Acute Care Admissions Unit for all adult patients across North Wales.

We were informed that staffing levels are monitored constantly and any risks are escalated through either the acute care meetings held daily or the local safety huddles held three times a day. Staff are typically allocated to specific wards for an extended period of time to allow an element of consistency to the care provided to patients throughout their short stay on the unit. However, we were told that staff are redeployed based on need to areas identified as having the highest levels of risk at any given time when required.

The Interim Acute Care Clinical Site Manager described the support provided to staff in their roles. This included regular clinical supervision opportunities and the completion of annual Performance Appraisal and Development Reviews (PADR), to discuss objectives and to help identify any learning requirements. We were told that 83% of staff had received their annual PADR and that plans were in place to ensure those outstanding would be completed within the

[3] HIW Relationship Managers work closely with each health board and trust across Wales to understand the risks and issues faced by each organisation to help provide HIW with assurance on their performance.

next month. We saw evidence that compliance with mandatory and statutory training was high amongst staff working at the unit. Initiatives such as relaxation sessions have also been offered to help support staff with their wellbeing.

We were told that the needs of patients have continued to be met by involving patients and their families in the development and review, of their care and treatment plans. This has had to take place virtually during COVID-19, but has still involved relevant clinicians and multidisciplinary team members. We were informed that there were issues initially working remotely with Community Mental Health Teams (CMHTs) across North Wales. This was because patients were often admitted to the unit a long way away from their local area and support teams. Encouragingly, we understand communication has since improved and the required documentation is being provided by CHMTs to allow the unit to plan for the timely and appropriate discharge of patients.

The Interim Acute Care Clinical Site Manager told us that support is available to help the unit discharge its duties to patients with regards to the Mental Health Act (MHA). The MHA administration team at the health board provide guidance to staff when necessary to help ensure patients are aware of their rights. Patients have continued to have their cases reviewed by the Mental Health Review Tribunal for Wales and access to wider health professionals such as advocacy has been made available to patients remotely.

No improvements were identified.

What next?

Where we have identified improvements during our check, which require the service to take action, these are detailed in the improvement plan below.

Where an improvement plan is required, it should:

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

As a result of the findings from this quality check, the service should:

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

Improvement plan

Setting: Ablett Unit, Glan Clwyd Hospital

Date of activity: 20 November 2020

The table below includes improvements identified during the Tier 1 Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board must ensure that patients are admitted to mental health units across North Wales where they can receive the appropriate care and treatment for their needs.	Health and Care Standards Wales Standard 3.1 Safe and Clinically Effective Care	The MHLD Division has plan in operation to transition patient admissions within the Local Authority areas as per process pre pandemic. Each locality has submitted plans in liaison with Infection Prevention Team for their units regarding segregation and isolation of patients in relation to Covid. They are now progressing with any works required to complete the transition.	Heads of Operations	31st January 2021
2	The health board must ensure that findings from quality checks undertaken by HIW are recognised	Health and Care Standards Wales Standard 6.3	There is a governance process for communication regarding feedback such as findings from HIW reviews.	Director of Nursing	31st December 2020

	and shared across other health board settings.	Listening and Learning from Feedback	Communication through local and Divisional Quality Safety Experience Meetings and subsequently shared with equivalent meetings across the rest of the Health Board. Whilst each individual service/area take responsibility for their Improvement Plans and report via the internal governance reporting structure to ensure learning and communication, the Health Board also have a Corporate HIW Action Tracker which is overseen by Corporate Nursing. Bi-monthly reporting on progress against all actions, including matters for escalation, go to the Patient Safety and Quality Group which is chaired by the Executive Director of Nursing and up to the Corporate Quality and Safety Committee, when required. Collectively, these raise staff awareness to HIW Inspections and aid learning across the Health Board. To strengthen learning further, we are working to ensure the triangulation of data from intelligence such as Datix. Datix is an information system, which captures Risk, Complaints, Incidents, and Patient Experience. A HIW 'Test' Module has been built into Datix. Moving forward, this should allow us to triangulate and strengthen our learning from HIW and across other intelligence		

			as listed above.		
3	The service must ensure that domestic enhanced cleans are being undertaken to help stop the transmission of COVID-19 throughout the unit.	Health and Care Standards Wales Standard 2.4 Infection Prevention and Control (IPC) and Decontamination	The Acute Care Manager already escalated this prior to the quality check with Facilities Manager which is aligned to ensuring domestic staff are cleaning the unit as per expectation. The Acute Care Manager is monitoring this on a daily basis during their walk around and escalates any ongoing issues with Facilities Manager. Additionally, the Infection Team also carry out walk rounds on the unit and provide feedback regarding any issues and assist with any escalation. Locality Infection Prevention Group (LIPG) meetings are scheduled on a monthly basis are also in situ with MHLD included. Exceptions regarding any issues with audits such as Credits 4 Cleaning are received at this forum for assurance and any assistance, reporting any matters of significance into the Environmental Group.	Ablett Acute Care Manager.	Complete.

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

Name: Tom Regan, Head of Nursing, Mental Health & Learning Disabilities

Date: 10 December 2020

Cyfarfod a dyddiad: Meeting and date:	**Mental Health Act Committee 12th March 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Draft Committee Annual Report 2020/21
Cyfarwyddwr Cyfrifol: Responsible Director:	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance
Craffu blaenorol: Prior Scrutiny:	The draft Committee Annual Report has been scrutinised by the Committee Lead Executive and Chair of the Committee.
Atodiadau Appendices:	The Draft Committee Annual Report 2020/21 which also incorporates the Draft Cycle of Business 2021/22 and current Terms of Reference.

Argymhelliad / Recommendation:

The Committee is asked to:

- Consider the draft Committee Annual Report for 2020/21 (in particular, confirming agreement for the proposed RAG scores).
- Agree that Chair's Action can be taken to approve the final Committee Annual Report for submission to the Audit Committee meeting on 25th May.

Please tick one as appropriate (

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

Sefyllfa / Situation:

All Committees of the Board are required to produce an Annual Report.

Cefndir / Background:

The Committee Annual Report for 2020/21 has been prepared on a BCU-wide template and will be submitted to the Audit Committee on 25th May 2021, along with those of all other Committees and Advisory Groups.

Due to the scheduled meeting dates it is necessary for the Committee to consider a draft report which may then need further amendment following the March 2021 meeting of the Committee. In line with governance arrangements, Chair's Action can then be taken to agree the final version for submission to the Audit Committee.

It should also be noted that the governance review may result in changes being made to the terms of reference and cycle of business of the committee over the coming year.

Asesiad / Assessment & Analysis
Strategy Implications N/A **Options considered** N/A **Financial Implications** N/A **Risk Analysis** N/A **Legal and Compliance** All Committees are required to produce an annual report which forms part of a composite report to the full Health Board. **Impact Assessment** N/A

Draft Mental Health Act Committee Annual Report 2020-21

*Including an overview of the work of the Power of Discharge Sub-Committee

1. Title of Committee:

Mental Health Act Committee

2. Name and role of person submitting this report:

Matthew Joyes, Acting Associate Director of Quality Assurance

3. Dates covered by this report:

01/04/2020-31/03/2021

4. Number of times the Committee and Sub-committee met during this period:

The **Mental Health Act Committee** was routinely scheduled to meet 4 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 3 occasions with 1 cancellation in June 2020 due to the COVID-19 pandemic and in-line with Welsh Government governance requirements. The September 2020 scheduled meeting had been postponed and held in October 2020.

Attendance at meetings of the Committee are detailed within the table below:

Members of the Mental Health Act Committee	12/06/20	19/10/20	08/12/20	27/03/20
Lucy Reid (Chair)	Meeting cancelled due to COVID-19 pandemic	P	P	
Cheryl Carlisle Independent Member		P	A	
Eifion Jones Independent Member		P	A	
Jackie Hughes Independent Member (co-opted)		-	P	
Vacant Independent Member		-	-	
Formally In Attendance	12/06/20	19/10/20	20/12/19	27/03/20

Andy Roach (Lead Director) Director of Mental Health & Learning Disabilities Lesley Singleton (Interim) Lead Director of Mental Health & Learning Disabilities Iain Wilkie Interim Director of Mental Health & Learning Disabilities	Meeting cancelled due to COVID-19 pandemic	P (IW)	P (IW)	
Alberto Salmoiraghi Medical Director for Mental Health		A	P	
Alison Cowell Assistant Area Director Centre - Childrens		A	P	
Ben Thomas Consultant Nephrologist		◆	A	
Caniad Service User Representative & Carer Representative		X	X	
Chris Pearson Safeguarding Specialist Practitioner/DoLS Manager, Safeguarding		P	A	
Chris Stockport Executive Director Primary & Community Care		◆	A	
Frank Brown Associate Hospital Manager		P	P	
Gill Harris Executive Director of Nursing and Midwifery / Debra Hickman Acting Executive Director of Nursing & Midwifery		A	A	
Heulwen Hughes All Wales Approval Manager For Approved Clinicians And Section 12(2) Doctors Lynda King All Wales Project Support Manager		P	P P	

Matthew Joyes Acting Associate Director of Quality Assurance		P	P	
Hilary Owen Head of Governance And Compliance		P	A	
Joan Doyle – Unillas IMCA Advocacy IMHA Advocacy		X	X	
Mark Jones Interim Senior Head of Service Adult Social Care, Wrexham County Borough Council		P	P	
Steve Forsyth Nursing Director for Mental Health Mike Smith Interim Director of Nursing, Mental Health & Learning Disabilities		P (MS)	P (MS)	
Rachel Turner Royal College of Nursing, Accredited Steward		X	P	
Steve Riley Consultant Nurse, Child & Adolescent Mental Health		P	◆	
Teresa Owen Executive Director of Public Health Executive Lead, Mental Health & Learning Disabilities		P	P	
Unison representation		X	P	
Vacant Associate Hospital Manager		◆	◆	
Wendy Lappin Mental Health Act Manager		P	P	

Key:

P - Present
P* **-** Present for part meeting
A - Apologies submitted
X - Not present
◆ Not a member of the Committee at this time.

The **Power of Discharge Sub-Committee** was scheduled to meet 4 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 3 occasions with 1 cancellation in June 2020 due to the COVID-19 pandemic and in-line with Welsh Government governance requirements. The September 2020 scheduled meeting was postponed and held in October 2020.

Attendance at meetings of the Committee are detailed within the table below:

Members of the Power of Discharge Sub-Committee	12/06/20	19/10/20	20/12/19	27/03/20
Lucy Reid (Chair)	Meeting cancelled due to COVID-19 pandemic	P	P	
Cheryl Carlisle Independent Member		P	A	
Eifion Jones Independent Member		P	P	
Vacant Independent Member		-	-	
Formally In attendance				
Ann Owens Associate Hospital Manager	Meeting cancelled due to COVID-19 pandemic	◆	◆	
Delia Fellows Associate Hospital Manager		◆	◆	
Diane Arbabi Associate Hospital Manager		P	P	
Frank Brown Associate Hospital Manager		P	P	
Helena A Thomas Associate Hospital Manager		P	P	
Hugh E Jones Associate Hospital Manager		P	A	
Jackie Parry Associate Hospital Manager		P	P	
John Williams Associate Hospital Manager		P	P	
Satya Schofield Associate Hospital Manager		P	P	
Shirley Davies Associate Hospital Manager		P	P	
Vacant Associate Hospital Manager		◆	◆	
Vacant Associate Hospital Manager		◆	◆	

Key:

P - Present	P* - Present for part meeting
A - Apologies submitted	X - Not present

◆ Not a member of the Committee at this time.

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee/Group/Forum. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Health Board's Mental Health Act Committee has a very narrow remit. The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and provide assurance to the Board. Governance, leadership, quality and safety matters relating to mental health fall within the remit of the Quality, Safety and Experience Committee.

The **Committee** is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;
- consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;
- receive and review DoLS reports regarding authorisations and associated reasons;
- receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved;
- receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure;
- receive the results of clinical audits and any other reviews relating to the use of

the Mental Health Act and oversee the implementation of recommendations;

- consider any other information, reports, etc. that the Committee deems appropriate.
- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:
  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
  - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of non-members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

*Note – HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE) however any specific recommendations relating to the Mental Health Act or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The terms of reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee is the responsibility of the Committee Business Management Group (CBMG). The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

Furthermore a fundamental review of the Governance Structures has been undertaken by the Interim Director of Governance. This work is being finalised at the point of producing this Annual Report.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were XX breaches of this nature in terms of either *individual papers / *whole agenda not being available 7 days before the meeting. (Kate Dunn will provide this data at year end)

6. Overall *RAG status against Committee's annual objectives / plan: AMBER

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*	**Committee assessment of the quality of the Assurance provided** *(please provide in narrative format)*
Ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities.		The Committee received reports during the year regarding training however there has been changes in personnel during the year and it was noted in some areas training levels were below the Health Board target (*including as identified in a HIW inspection*).	Amber – based on training compliance being below target in some areas. Reporting to the Committee on compliance with be strengthened.
Identify matters of risk relating to Mental Health and Capacity legislation and seek assurance that such risks are being mitigated;		The Committee receives reports detail areas of legislation that have been breached including lapses and illegal detentions. However, the Committee has not received a specific report regarding risk management or a risk	Amber – based on not receiving a consolidated report on risks. This will be addressed through changes to report content.

		register report, and is therefore unable to provide full assurance on mitigating measures.	
Monitor the use of the legislation and consider local trends and benchmarks;		Reports were received by the Committee. (They did not include benchmarking data from similar organisations in Wales due to no all-Wales benchmarking reports being issued during the reporting period, as a result of the pandemic).	Green – The framework for receiving the reports is in place.
Consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;		A report produced for the Power of Discharge Sub-Committee. This details activities undertaken by Associate Hospital Managers. This includes the hearings activity and the scrutiny of detentions that are undertaken as a separate part of the role. These reports are received by Divisional QSE, Power of Discharge Sub-Committee and	Green – The framework for receiving the reports is in place

		the Mental Health Act Committee. The Mental Health Act Manager has established an Associate Hospital Managers Forum, and any issues that require escalation are raised in the Power of Discharge Sub-Committee and escalated to Mental Health Act Committee as necessary.	
Ensure that **all** other relevant associated legislation is considered in relation to Mental Health Act and Capacity legislation;		The Committee has received reports in relation to MHA compliance and DoLS however limited assurance has been provided on compliance with the wider requirements of the Mental Capacity Act (MCA).	Amber – the Committee has requested Corporate Safeguarding to strengthen the reports. Further consideration is needed of MCA compliance across the organisation not just within MHLD. This will be addressed through the governance review and the updating the cycle of business.
Consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating		Any actions arising in relation to Mental Health Act legislation from external inspections e.g. HIW are monitored	Green – Inspection reports and action plans are received by the Committee.

to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports		locally via the QSE sub groups which in turn report to Divisional QSE, to corporate PSQ, and the Mental Health Act Committee.	
Consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation		There have been no relevant reports during the reporting period.	
Receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors		The Committee has received reports in relation to the approval for all Wales Approved Clinicians and Section 12(2) Doctors.	Green – The Committee receives assurance reports.
Consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate		The Committee received assurance that a list of policies was in place that met the requirements of legislation. However it was not assured that all policies were reviewed and in-date. A number of policies were identified as out of date. Assurance was provided that the MHLD Policy Group was addressing this aspect.	Amber - The Committee has received updates on policies throughout the year, but has not received a specific assurance report on overall policy status. This will be addressed in the changes to future report content.
Receive and review DoLS reports regarding		The Committee has received reports in	Green – The Committee has

authorisations and associated reasons		relation to DOLS compliance.	received reports and has requested Corporate Safeguarding to strengthen to provide greater assurance across the organisation not just MHL Division.
Receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved		The Committee received information on compliance with the Measure, however consideration is underway as to whether this should be monitored by QSE.	Amber – The governance review will provide clarity on reporting against the Measure (i.e. by which Committee), and this will enable appropriate reports to be developed and scrutinized at the relevant Committee.
Receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure		No internal audits were presented to the Committee in the reporting period.	The Committee notes that no internal audits were presented in the previous two reporting periods either, and decided that this is a risk. The Committee will consider how it directs internal audit to support assurance decisions.
Receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations		No clinical audits were presented to the Committee in the reporting period.	The Committee notes that no audits were registered in the previous two reporting periods, and decided that this is a risk. The Committee will need to consider how it

			directs clinical audit to support assurance decisions.
Consider any other information, reports, etc. that the Committee deems appropriate		The Committee has received ad-hoc reports as required.	Green – Reports have developed as requested by the Committee.
Investigate or have investigated any activity (clinical and non-clinical) within its terms of reference		The Committee has not needed to commission investigations during the reporting period but is aware of its right to do so.	
Obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;		The Committee has not needed to obtain outside independent or legal advice during the reporting period but is aware of its right to do so.	

Key:

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Committee during this reporting period:

The following section summarises the main evidence received by the Committee during the reporting period:

Standing Items:

- Patient story scheduled at each meeting.
- Deprivation of Liberty Safeguards: Quarterly Report

- Hospital Manager's Update Report
- MHA Performance Report
- Report on Approval for All Wales Approved Clinicians and Section 12(2) Doctors)
- Consideration of HIW inspection reports and audit reports as appropriate to the meeting remit.

Governance Items:

- Cycle of Business Review
- Committee Annual Report and review of Terms of Reference (including the Power of Discharge Sub-Committee Terms of Reference).

Full details of the issues considered and discussed by the Committee are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
19.10.2020	• The Committee were not assured that inadequacies identified through the "Deprivation of Liberties Safeguards applications" were being addressed by the service. A bid had been submitted to Welsh Government for funding to create a training package and a Standard Operating Procedure had been produced and a further review of this was required. • The Committee were concerned about the lack of progress in relation to the availability for section 12(2) doctors that had been raised in previous meetings. The mental health leads committed to providing a report and action plan to the meeting in January 2021.
08.12.2020	• The Committee noted with concern the outstanding discussions to address the recruitment and management of Section 12(2) doctors despite requests that this be addressed. The Committee agreed that the relevant Executive Leads need to convene to confirm how these issues will be managed and that this requires a multi-disciplinary approach.

9. Review of Effectiveness

The Committee has sought to discharge its responsibilities in line with the scrutiny applied by the new Committee Chair and recognising the significant impact of the COVID-19 pandemic. The ongoing governance review will provide further direction to the Committee's business and this review has identified some areas of improvement including strengthening the reporting of mental health law compliance beyond the

remit of Mental Health and Learning Disabilities and the better use of audit resources to support assurance discussions.

10. Focus for the year ahead

The primary focus of the Committee over the next twelve months will be the objectives set out in the Terms of Reference. This is attached as Appendix 1.

In line with the ongoing governance review the Committee will review its scope and effectiveness as outlined above.

A cycle of business is in place (Appendix 2) however in line with the governance review and findings of this assessment, the Associate Director of Quality Assurance will review the cycle of business and report requirements with the secretariat, lead executive and chair to strengthen these aspects going forward.

V1.1

Appendix 1

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

MENTAL HEALTH ACT COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as the **Mental Health Act Committee**. The detailed terms of reference and operating arrangements in respect of this Committee are set out below. Background information in relation to the Mental Health Act, the Mental Health Measure and the Mental Capacity Act is set out in Annex 1. The Committee will also consider, when appropriate, any other legislation that impacts on mental health and mental capacity. It will regularly report to the Board and advise it of any areas of concern.

2. PURPOSE

2.1 The purpose of the Committee is to consider and monitor the use of the Mental Health Act 1983 (MHA), Mental Capacity Act 2005 (which includes the Deprivation of Liberty Safeguards (DoLS) (MCA) and the Mental Health (Wales) Measure 2010 (the Measure) and give assurance to the Board that:

- Hospital Managers' duties under the Mental Health Act 1983;
- the functions and processes of discharge under section 23 of the Act;
- the provisions set out in the Mental Capacity Act 2005, and
- in the Mental Health Measure (Wales) 2010

are all exercised in accordance with statute and that there is compliance with:

- the Mental Health Act 1983 Code of Practice for Wales
- the Mental Capacity Act 2005 Code of Practice
- the Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
- the Human Rights Act 1998
- the United Nations Convention on the Rights of People with Disabilities
- the associated Regulations and local Policies

3. DELEGATED POWERS AND AUTHORITY

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

- ensure that those acting on behalf of the Board in relation to the provisions of Mental Health and Capacity legislation, including the Measure, have the requisite skills and competencies to discharge the Board's responsibilities;
- identify matters of risk relating to Mental Health and Capacity legislation and

seek assurance that such risks are being mitigated;
- monitor the use of the legislation and consider local trends and benchmarks;
- consider matters arising from the Hospital Managers' Power of Discharge Sub-Committee;
- ensure that **all** other relevant associated legislation is considered in relation to Mental Health and Capacity legislation;
- consider matters arising from visits undertaken by Healthcare Inspectorate Wales Review* Service for Mental Health in particular, issues relating to Mental Health Act 1983 and monitor action plans that inform responses to HIW reports;
- consider any reports made by the Public Services Ombudsman for Wales regarding complaints about Mental Health and Capacity legislation;
- receive and review reports on the approval for all Wales Approved Clinicians and Section 12(2) Doctors;
- consider and approve on behalf of the Board any LHB policy which relates to the implementation of mental health and capacity legislation as well as any other information, reports etc. that the Committee deems appropriate;
- receive and review DoLS reports regarding authorisations and associated reasons;
- receive and review reports on the implementation of the Mental Health Measure and be satisfied that positive outcomes for people are being achieved;
- receive and review the results of internal audit reports relating to care and treatment plans, as well as any other relevant reports relating to the Mental Health Measure;
- receive the results of clinical audits and any other reviews relating to the use of the Mental Health Act and oversee the implementation of recommendations;
- consider any other information, reports, etc. that the Committee deems appropriate.
- investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:
  - employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and
  - other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.
- obtain outside legal or other independent professional advice and to secure the attendance of non members with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

*Note – HIW report recommendations are the remit of Quality Safety and Experience Committee (QSE) however any specific recommendations relating to Mental Health or the Mental Capacity Act will be the remit of this Committee who will respond as appropriate ensuring the Board and QSE are appraised accordingly.

Sub Committees/Panels

3.2 The Committee may, subject to the approval of the Health Board, establish Sub-Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

3.3 Sub-Committee - In accordance with Regulation 12 of the Local Health

Boards (Constitution, Procedure and Membership) (Wales) Regulations 2003 (SI 2003/149 (W.19), the Board has appointed a Sub-Committee of this Committee, to be known as the Power of Discharge Sub-Committee, terms of reference for which are attached as Annex 2.

3.4 Panel -Three members drawn from the pool of designated Associate Hospital Managers will constitute a panel to consider the possible discharge or continued detention under the MHA of unrestricted patients and those subject to Supervised Community Treatment Order(SCT).

3.5 The Board retains final responsibility for the performance of the Hospital Managers' duties delegated to particular people on the staff of Betsi Cadwaladr University Local Health Board, as well as the Power of Discharge Sub-Committee.

4. MEMBERSHIP

4.1 Members

Four Independent Members of the Board to include one who is a Member of the Quality, Safety and Experience Committee and one who shall be the Chair of the Power of Discharge Sub-Committee.

4.2 In attendance

Director of Mental Health & Learning Disabilities
Executive Director of Nursing and Midwifery
Medical Director for Mental Health
Nursing Director for Mental Health
Mental Health Director
Mental Health Act Manager
Service User Representative
Carer Representative
Social Services Representative
North Wales Police Representative
Welsh Ambulance Services NHS Trust Representative
IMCA Advocacy provider Representative
IMHA Advocacy provider Representative
MCA representative
DoLS representative
Two Associate Hospital Managers (as nominated by the Power of Discharge Sub-Committee) appointed for a period of four years with re-appointment not to exceed a maximum of eight years in total.

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

4.4 Trade Union Partners are welcome to attend the public session of the

Committee

4.4 Member Appointments

4.4.1 The membership of the Committee shall be determined by the Board, based on the recommendation of the Health Board Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members. The Vice-Chair of the Health Board will be the Chair of this Committee and shall retain the role of Chair of this Committee throughout their tenure of appointment.

4.4.2 Other appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.5 Secretariat

4.5.1 Secretary: as determined by the Board Secretary.

4.6 Support to Committee Members

4.6.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. COMMITTEE MEETINGS

5.1 Quorum

5.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair.

5.2 Frequency of Meetings

5.2.1 Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

6. RELATIONSHIP AND ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

7.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities, via the Chair's assurance report as well as the presentation of an annual Committee report;

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

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

• Quorum

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

V4.0 Approved:

Audit Committee 30.5.19

Chair's Report to Board 25.7.19

Annex 1

BACKGROUND INFORMATION REGARDING THE ASSOCIATED LEGISLATION

Mental Health Act 1983 (as amended by the Mental Health Act 2007)

The Mental Health Act 1983 covers the legal framework to allow the care and treatment of mentally disordered persons to be detained if deemed to be a risk to themselves or others.
It also provides the legislation by which people suffering from a mental disorder can be detained in hospital to have their disorder assessed or treated against their wishes.

The MHA introduced the concept of "Hospital Managers" which for hospitals managed by a Local Health Board are the Board Members. The term "Hospital Managers" does not occur in any other legislation.

Hospital Managers have a central role in operating the provisions of the MHA; specifically, they have the authority to detain patients admitted and transferred under the MHA. For those patients who become subject to Supervised Community Treatment (SCT), the Hospital Managers are those of the hospital where the patient was detained immediately before going on to SCT - i.e. the responsible hospital or the hospital to which responsibility has subsequently been assigned.

Hospital Managers must ensure that patients are detained only as the MHA allows, that their treatment and care is fully compliant with the MHA and that patients are fully informed of and supported in exercising their statutory rights. Hospital Managers must also ensure that a patient's case is dealt with in line with associated legislation. With the exception of the Power of Discharge Sub-Committee, arrangements for authorising day to day decisions made on behalf of Hospital Managers have been set out in the Health Board's Scheme of Delegation.

Mental Health Measure

The Mental Health (Wales) Measure received Royal Assent in December 2010 and is concerned with:

- providing mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health;
- making provision for care and treatment plans for those in secondary mental health care and ensure those previously discharged from secondary mental health services have access to those services when they believe their mental health may be deteriorating;
- extending mental health advocacy provision.

Mental Capacity Act

The MCA came into force mainly in October 2007. It was amended by the Mental Health
Act 2007 to include the Deprivation of Liberty Safeguards (DoLS). DoLS came into force in
April 2009.

The MCA covers three main issues:

- The process to be followed where there is doubt about a person's decision-making abilities and decisions therefore where 'Best Interest' may need to be made on their behalf (e.g. about treatment and care)
- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for caring for adult, mentally disordered, incapacitated people in situations where they are deprived of their liberty in hospitals or care homes (DoLS) and/or where Court of Protection judgements are required.

Thus the scope of MCA extends beyond those patients who have a mental disorder.

Annex 2

POWER OF DISCHARGE SUB-COMMITTEE
TERMS OF REFERENCE AND OPERATING ARRANGEMENTS

1. INTRODUCTION

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

2. PURPOSE

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

3. DELEGATED POWERS AND AUTHORITY

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

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

- undertake the functions of Section 23 of the Mental Health Act 1983, in relation to hearing cases of detained powers ensuring that three or more members of the Sub-Committee form a Panel and only a minimum of three members in agreement may exercise the Power of Discharge Sub-Committee. The Panel will be drawn from the pool of members formally designated as Hospital Manager as reported to the Sub-Committee.

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

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

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

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

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

4. MEMBERSHIP

4.1 Members

Three Independent Members of the Board.
A maximum of ten (10) appointed MHA Managers (as nominated and agreed by the Sub-Committee) (Appointed for a period of four years with appointment not to exceed a maximum of eight years in total).

4.2 Attendees

Director of Mental Health
Senior Mental Health Clinicians
Mental Health Act Manager
Officer Representatives for Learning Disabilities and Children's Services

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

Trade Union Partners are welcome to attend the public session of the sub-committee

4.3 Member Appointments

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

4.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed from the Committee by the Board. Independent Members may be reappointed up to a maximum period of 8 years.

4.4 Secretariat

4.4.1 Secretary: as determined by the Board Secretary.

4.5 Support to Committee Members

4.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

5. SUB-COMMITTEE MEETINGS

5.1 Quorum

At least two Independent Members and four Associate Hospital Managers must be present to ensure the quorum of the Sub-Committee one of whom should be the Chair or Vice-Chair.

5.2 Frequency of Meetings

Meetings shall routinely be held on a quarterly basis.

5.3 Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

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

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

7.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Sub-Committee's performance and operation as part of the overall review of the Mental Health Act Committee.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- owing to the nature of the business of the Sub-Committee, meetings will not be held in public.

9. REVIEW

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

V4.0

Appendix 2

Draft - to be agreed for the year 2021 - 2022

Agenda Item	18.09.20	11.12.20	12.03.21
Opening Business			
Apologies	**x**	**x**	**x**
Declaration of Interests	**x**	**x**	**x**
Previous Minutes, Matters Arising and Summary Action Plan	**x**	**x**	**x**
Minutes of previous POD meeting and oral update from the earlier meeting	**x**	**x**	**x**
CANIAD – Patient Story	**x**	**x**	**x**
Deprivation of Liberty Safeguards: Quarterly Report	**x**	**x**	**x**
Hospital Manager's Update Report (Oral summary only based on feedback from earlier POD Sub-Committee meeting)	**x**	**x**	**x**
Performance Report	**x**	**x**	**x**
Approval for All Wales Approved Clinicians and Section 12(2) Doctors)	**x**	**x**	**x**
Consideration of any HIW/Inspection reports/Audit reports etc as appropriate to meetings remit.	**x**	**x**	**x**
Agree CoB for coming year			**x**
Committee Annual Report and review of TOR and Power of Discharge Sub-Committee			**x**
Issues of Significance	**x**	**x**	**x**
Any Other Business	**x**	**x**	**x**
Date of Next meeting(s)	**x**	**x**	**x**